MEDICARE-MEDICAID ADMINISTRATIVE AND REIMBURSEMENT REFORM

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

NINETY-FOURTH CONGRESS

SECOND SESSION

ON

S. 3205

A BILL TO PROVIDE FOR THE REFORM OF THE ADMINISTRATIVE AND REIMBURSEMENT PROCEDURES EMPLOYED UNDER THE MEDICARE AND MEDICAID PROGRAMS AND FOR OTHER PURPOSES

JULY 26, 27, 28, 29, AND 30, 1976

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MEDICARE-MEDICAID ADMINISTRATIVE AND REIMBURSEMENT REFORM

MONDAY, JULY 26, 1976

U.S. SENATE,
SUBCOMMITTEE ON HEALTH OF THE
SENATE FINANCE COMMITTEE,
Washington, D.C.

The subcommittee met, pursuant to notice, at 8 a.m. in room 2221, Dirksen Senate Office Building, Hon. Herman Talmadge (chairman of the subcommittee) presiding.

Present: Senators Talmadge, Dole, and Packwood.

Senator TALMADGE. The hearing will be in order.

Today we begin a full week of hearings on the provisions of my bill, S. 3205, to bring about basic reforms in the administration and reimbursement aspects of Medicare and Medicaid.

[The press release announcing these hearings and the bill S. 3205 follow. Hearing commences on page 27.]

OFFICE OF HERMAN TALAMADGE OF GEORGIA, U.S. SENATE

(Statement of U.S. Senator Herman E. Talmadge [D.Ga.], Chairman, Subcommittee on Health of the Senate Finance Committee, in Opening Hearings on S.3205, Legislation for Medicare/Medicaid Administrative and Reimbursement Reform, Monday, July 26, 1976)

FOR RELEASE IN THE P.M.'S OF MONDAY, JULY 22, 1976

We begin a full week of hearings on the provisions of my bill, S.3205, to bring about basic reforms in the administration and reimbursement aspects of Medicare and Medicaid.

The situation is indeed urgent. Medicare and Medicaid will cost federal and state taxpayers more than $38 billion in fiscal 1977—an increase of $7 billion over fiscal 1976.

The increasing costs of these programs continually outstrip the rate of rise in federal revenues. The choice is a simple one—either we make Medicare and Medicaid more efficient and economical, or we reduce benefits.

We have just too many worthwhile demands on the federal dollar to be able to allocate increasingly disproportionate amounts to Medicare and Medicaid.

There is, of course, another choice—we can increase taxes. But even if that hard decision were taken we would, without necessary changes, be pouring dollars down a bottomless pit.

As they now operate, Medicare and Medicaid clearly could absorb every single dollar the federal government can come up with. To do that, hard decisions have to be made—decisions which I believe this bill makes. If these decisions are not made now, we may well be confronted with the need to cut and slash payments to hospitals and doctors indiscriminately, and often inequitably. That path is exactly what S.3205 seeks to avoid.

States are now moving to place ceilings on payments to hospitals. Blue Cross plans are moving in that direction. The Administration proposes a flat 7 per cent limit on hospital cost increases. Momentum is rapidly increasing for arbitrary controls on payments to providers and practitioners. This bill, however, seeks to avoid cutoffs of this sort.

In Colorado, for example, the state has ordered a 5 per cent reduction in Blue Cross payments to hospitals and a 5 per cent cut in Blue Shield payments to doctors.

At the National Governors' Conference held in Hershey, Pennsylvania, just last month, the Governors of this country stated that the "rapidly escalating costs of the Medicaid program are bankrupting the states and their localities." The Governors' resolution noted that there is "a need for better control over both the rates paid for health services and the utilization of these services by the patient."

The Governors' Conference urged state governments to intensify efforts to manage their Medicaid programs better and also urged related cooperative action by the federal government to revise "existing regulations and legislation which pose obstacles to effective cost control procedures."

It is my strong belief that S. 3205 is certainly consistent with the resolution of the Governors' Conference. I look forward to the testimony this morning of the able and distinguished Governor of my state, Governor Busbee, who will speak on behalf of our nation's Governors. The National Association of Counties, from whom we will also hear today, has called for immediate wage and price controls on hospitals to avoid bankrupting costs.

But, there is an overriding need to get a handle on Medicare and Medicaid costs apart from the federal, state and local budget effects. There is no question that the way we pay for care under our programs serves to inflate health care costs for all Americans. That situation needs correction now.

There is an absolute need for the federal and state governments to effectively manage the existing health care programs. It is difficult, if not foolhardy, to extend health insurance coverage to other segments of the population until we are satisfied that we can manage what we've got now.

I believe we have a representative range of witnesses this week. It is my hope that these hearings will provide the basis for timely Congressional action on necessary changes in the way government conducts Medicare and Medicaid.

As I have stated repeatedly, none of the provisions in S.3205 are locked in concrete. Hopefully, constructive changes and improvements will be a product of these hearings.

But, while improvements can and should be made, no one should mistake a willingness to make changes as a sign of weakness. With many billions of public tax dollars at stake, there will of course be those who presently profit from waste, inefficiency, fraud and abuse, and outdated methods of payment who will not want any changes made. Often these are the same people who in forums and cocktail parties constantly decry "big wasteful government." Nonetheless, they will come here to try and preserve their own share of that "big government" and those wasteful expenditures." It's always the "other guy" they're talking about. Well, they can't have it both ways. And, they won't have it both ways if we do our job.

I want to assure those people that the limits of tolerance have been reached. What has been glossed over, ignored, or sidestepped in the past will now be faced head-on. We owe that much to the American people.

[94th Cong., 2d sess., S. 3205]

A BILL To provide for the reform of the administrative and reimbursement procedures currently employed under the medicare and medicaid programs, and for other purposes

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Medicare-Medicaid Administrative and Reimbursement Reform Act".

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ESTABLISHMENT OF HEALTH CARE FINANCING ADMINISTRATION

SEC. 2. (a) Section 702 of the Social Security Act is amended—

(1) by inserting "(a)" immediately after "SEC. 702.", and

(2) by adding at the end thereof the following new subsection:

"(b)(1) The Secretary shall establish, within the Department of Health, Education, and Welfare, a separate organizational unit to be known as the Health Care Financing Administration (which shall include the functions and personnel of administrative entities known, as of the date of enactment of this subsection, as the 'Bureau of Health Insurance', the 'Medical Services Administration', the 'Bureau of Quality Assurance', and the 'Office of Nursing Home Affairs' and related research and statistical units) which shall be under the direction of the Assistant Secretary for Health Care Financing, who shall report directly to the Secretary and who shall have policy and administrative responsibility for the programs established by titles XVIII and XIX, part B of title XI, and for the renal disease program established by section 226. Such Assistant Secretary may not have any other duties or functions assigned to him which would prevent such Assistant Secretary from carrying out the duties imposed by the preceding sentence on a full-time basis.

"(2)(A) There shall be established, within the Department of Health, Education, and Welfare, an Office of Central Fraud and Abuse Control. Such unit which shall be under the direction of the Inspector General for Health Administration established under section 1124 shall have overall responsibility for (i) monitoring activities which are designed to deal with fraud and abuse, at various program levels, in the programs establishd by titles V, XVIII, and XIX, part B of title XI, and the renal disease program established by section 226, and (ii) initiating and conducting direct investigation with respect to alleged, actual, or potential fraud or abuse in any of such programs. Such unit shall also provide investigative support and assistance to United States attorneys and State law enforcement authorities, upon their request, in the development of fraud cases arising out of any such programs.

"(B) The General Counsel of the Department of Health, Education, and Welfare is authorized to prosecute any civil fraud case, arising out of any such programs, when in his opinion the Department of Justice has not acted in timely fashion following referral of such case to the appropriate United States attorney and when in the opinion of the General Counsel such prosecution is appropriate.".

(b)(1) There shall be in the Department of Health, Education, and Welfare an Assistant Secretary for Health Care Financing, who shall be appointed by the President, by and with the advice and consent of the Senate.

(2) Section 5315 of title 5, United States Code, is amended in paragraph (17) by striking out "(5)" and inserting in lieu thereof "(6)".

INSPECTOR GENERAL FOR HEALTH ADMINISTRATION

SEC. 3. (a) Title XI of the Social Security Act is amended by adding immediatly after section 1123 the following new section:

"INSPECTOR GENERAL FOR HEALTH ADMINISTRATION

"SEC. 1124. (a)(1) In addition to other officers within the Department of Health, Education, and Welfare, there shall be, within such Department, an officer with the title of 'Inspector General for Health Administration' (hereinafter in this section referred to as the 'Inspector General'), who shall be appointed initially and reappointed on of after February 1, 1977, by the President, by and with the advice and consent of the Senate. In addition, there shall be a Deputy Inspector General for Health Administration (hereinafter referred to as the 'Deputy Inspector General'), and such additional personnel as may be required to carry out the functions vested in the Inspector General by this section.

"(2) The term of office of any individual appointed or reappointed to the position of Inspector General shall expire 6 years after the date he takes office pursuant to such appointment or reappointment.

"(b) The Inspector General shall report directly to the Secretary of Health, Education, and Welfare (hereinafter in this section referred to as the 'Secretary'); and, in carrying out the functions vested in him by this section, the Inspector General shall not be under the control of, or subject to supervision by, any officer of the Department of Health, Education, and Welfare, other than the Secretary.

"(c)(1) It shall be the duty and responsibility of the Inspector General to arrange for, direct, or conduct such reviews, inspections, and audits of the health insurance program established by title XVIII, the medical assistance programs established pursuant to title XIX, and any other programs of health care (including related programs) authorized under any other title of this Act as he considers necessary for ascertaining the efficiency and economy of their administration, their consonance with the provisions of law by or pursuant to which such programs were established, and the attainment of the objectives and purposes for which such provisions of law were enacted.

"(2) The Inspector General shall maintain continuous observation and review of programs with respect to which he has responsibilities under paragraph (1) of this subsection for the purpose of—

"(A) determining the extent to which such programs are in compliance with applicable laws and regulations;

"(B) making recommendations for the correction of deficiencies in, or for improving the organization, plans, procedures, or administration of, such programs; and

"(C) evaluating the effectiveness of such programs in attaining the objectives and purposes of the provisions of law by or pursuant to which such programs were established.

"(d)(1) For purposes of aiding in carrying out his duties under this section, the Inspector General shall have access to all records, reports, audits, reviews, documents, papers, recommendations, or other material available to the Department of Health, Education, and Welfare which relate to the programs with respect to which the Inspector General has responsibilities under this section.

"(2) The head of any Federal department, agency, office, or instrumentality shall, and the head of any State agency administering or supervising the administration of any State plan related to health care approved under the Social Security Act shall, at the request of the Inspector General, provide any information which the Inspector General determines will be helpful to him in carrying out his responsibilities under this section.

"(3) The Inspector General may refer directly to any other departments or agencies for appropriate consideration and action in such matters and cases as may be within their areas of concern and responsibility.

"(4) The Inspector General may, in his discretion, provide assistance within his competence, with the approval of the Secretary, to any department, agency, or subagency of the Federal Government upon request of the chief officer of any such department or agency.

"(e)(1) The Inspector General may, from time to time, submit such reports to the Committee on Finance of the Senate and the Committee on Ways and Means and the Committee on Interstate and Foreign Commerce of the House of Representatives relating to his activities as he deems to be appropriate.

"(2) Whenever any of the committees referred to in paragraph (1) makes a request to the Inspector General to furnish such committee with any information, or to conduct any study or investigation and report the findings resulting therefrom to such committee, the Inspector General shall comply with such request.

"(f) The Inspector General may make expenditures (not in excess of $100,000 in any fiscal year) of a confidential nature when he finds that such expenditures are in aid of inspections, audits, or reviews under this section; but such expenditures so made shall not be utilized to make payments, to any one individual, the aggregate of which exceeds $5,000. The Inspector General shall submit annually a confidential report on expenditures under this provision to the Committee on Finance of the Senate and the Committees on Ways and Means and Interstate and Foreign Commerce of the House of Representatives.

"(g)(1) Expenses of the Inspector General relating to the health insurance program established by title XVIII shall be payable from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund, with such portions being paid from each such Fund as the Secretary shall deem to be appropriate. Expenses of the Inspector General relating to medical assistance programs established pursuant to title XIX shall be payable from funds appropriated to carry out such title; and expenses of the Inspector General relating to any program of health care authorized under any title of this Act (other than titles XVIII and XIX) shall be payable from funds appropriated to carry out such program.

"(2) Notwithstanding any other provision in law, personnel requirements for the Central Fraud and Abuse Control Unit and the Office of the Inspector General shall not be subject to numerical or budgetary limitation. The personnel and budgetary requirements of such units shall be submitted as 'line items' by the President in the submission of his budget.

"(3) There are hereby authorized to be appropriated such sums as may be necessary to carry out the purposes of this section.

"(h) The Secretary shall provide the Inspector General and his staff with appropriate and adequate office space within the central and regional facilities of the Department of Health, Education, and Welfare, together with such equipment, office supplies, and communications facilities and services, as may be necessary for the operation of such office and shall provide necessary maintenance services for such office and the equipment and facilities located therein."

(b) Section 5315 of title 5, United States Code, is amended by inserting at the end thereof:

"(95) Inspector General for Health Administration."

STATE MEDICAID ADMINISTRATION

SEC. 4. (a) Section 1902(a) is amended by adding at the end thereof the following new subsections:

"(37) provide—

"(A) for the making of eligibility determinations under the plan, on the basis of applications for coverage, within thirty days of the date of such application for all individuals: (i) receiving aid or assistance (or who except for income and resources would be eligible for aid or assistance) under any plan of the State approved under title I, X, or XVI (for the aged and the blind) or part A of title IV, or (ii) with respect to whom supplemental security income benefits are being paid (or who would except for income and resources be eligible to have paid with respect to them supplemental security income benefits) under title XVI on the basis of age or blindness, and

"(B) for the making of eligibility determinations under the plan, on the basis of applications for coverage, within sixty days of such application for all individuals: (i) receiving aid or assistance (or who except for income and resources would be eligible for aid or assistance) on the basis of disability under any plan of the State approved under title XIV or XVI, or (ii) with respect to whom supplemental security income benefits are being paid (or who would except for income and

resources be eligible to have paid with respect to them supplemental security income benefits) under title XVI on the basis of disability;

"(C) for the making of redeterminations of eligibility for persons specified in subparagraphs (A) and (B): (i) when required on the basis of information the agency has previously obtained on anticipated changes in the individual's situation, (ii) within thrty days after receiving information on changes in an individual's circumstances which may affect his eligibility, and (iii) periodically but not less often than every six months;

"(38) provide for methods and procedures to assure accuracy in the determinations of eligibility for medical assistance and provide that the error rate for eligibility determinations made on or after October 1, 1977, may not exceed the rate specified in section 1911 (b); and

"(39) provide for claims payment procedures which assure that (A) 95 per centum of clean claims (claims for which no further written information or substantiation is required from the provider or any other person, in the absence of which payment may not be made) be paid within thirty days of receipt of the claim from the provider, and that 90 per centum of such claims be paid within ninety days, and (B) both prepayment and postpayment claims review procedures are performed, including—

"(i) review, on a reasonable sample or more extensive basis, to determine the accuracy of data entry;

"(ii) review to determine that the provider is a participating provider;

"(iii) review to determine whether the service is covered under the State's plan;

"(iv) review to determine that the recipient is eligible for medical assistance;

"(v) review of claims against recipient utilization patterns;

"(vi) review to determine that the charge is a reasonable charge, and that payments made are not in excess of those allowable under the program;

"(vii) review to determine and recover any third party liability;

"(viii) review to assure that there has been no duplicate billing;

"(ix) review on a reasonable sample or more extensive basis, for determination of possible fraud, including identification and investigation of situations in which fraud may exist, and referral of such situations to law enforcement officials.".

(b) Section 1902(a)(6) is amended by adding the following at the end thereof: "such reports are to be made in an accurate and timely fashion, no later than sixty days following the close of the reporting period for monthly and quarterly reports, and no later than one hundred and five days following the close of the reporting period for yearly reports, and shall include at a minimum—

"(A) quarterly reports to the Secretary on—

"(i) eligibility determinations, including the number of applications for medical assistance pending at the beginning of the quarter, the number approved, disapproved, or withdrawn during the quarter, and the number pending at the end of the quarter, including statistics on the number of such determinations made within the time periods specified in section 1902(a)(37) (A) and (B);

"(ii) the State's quality control programs, including statistics on those declared ineligible who are found upon reexamination to be eligible, those declared eligible who are found upon reexamination to be ineligible, and those for whom an incorrect determination of financial liability was made;

"(iii) claims payment, including statistics on the number of claims pending at the beginning of the quarter, submitted during the quarter, paid during the quarter, and pending at the end of the quarter, distributed by specified time periods during which the claim was held, including the number held for the time periods specified in subsection (a)(39)(A), and information on the results of the claims review procedures required under subsection (a)(39)(B);

"(B) statistics on the number of providers participating in the State program authorized under this title, (by bed size in the case of institutions) and major geographic locations;

"(C) information on utilization of services under the State program, including statistics on—

"(i) recipients and payments by basis of eligibility and maintenance assistance status of the recipient and the type of medical services received;

"(ii) selected units of service, including admissions and days of care for inpatient care, and the number of visits or items, such as physician visits and drug prescriptions, for outpatient care;

"(iii) approximate number of recipients in skilled nursing facilities, intermediate care facilities, and mental hospitals, whose care was reviewed with either independent professional review or medical review;

"(iv) utilization of services, by age cohorts, sex, and race of the recipient; and

"(v) information relating to the number of recipients receiving inpatient care and their primary diagnoses;

"(D) data on the eligible population, including the number of those eligible by basis of eligibility and maintenance assistance status, and information on the review procedures required under section 1902(a)(39)(B).".

(c) Amend section 1903 by adding at the end thereof the following new subsection:

"(n)(1) Effective with the calendar quarter beginning on October 1, 1977, and for each subsequent calendar quarter, the amount paid to each State under paragraphs (a)(2), (a)(3), and (a)(6) shall be subject to a reduction or termination unless the State makes a showing satisfactory to the Secretary that—

"(A) 95 per centum of medical assistance eligibility determinations are made within the time frames specified under section 1902(a)(37) (A) and (B);

"(B) the State's error rate for eligibility determinations is equal to or below the rate specified in section 1911(b) except that for purposes of determining whether a State has met the requirements of this paragraph there shall not be taken into account the error rates for those persons whose eligibility is determined under a State plan approved under titles I, X, XIV, XVI, or part A of title IV or by the Secretary pursuant to an agreement under section 1634;

"(C) the State is processing claims for payment within the time frame specified in section 1902(a)(39)(A) and applying prepayment and postpayment claims review procedures specified in section 1902(a)(39)(B); and

"(D) the State is making timely and complete reports to the Secretary on the operation of its medical assistance program within the time frame and including such information as is specified in section 1902(a)(6).

"(2) The Secretary shall conduct an onsite survey in each State at least annually of State performance in each category under paragraph (1). The methodology and procedures employed for such onsite survey for each State must be formally approved (which may involve onsite evaluation) by the Comptroller General of the United States;

"(3) Any State which fails to meet one or more of the requirements specified in subparagraphs (A), (B), (C), or (D) of paragraph (1) as determined in an onsite survey as provided under paragraph (2) shall be formally notified within thirty days of such survey of such deficiencies and a State so notified shall be given an appropriate and specified time (not to exceed six months) for the correction of specified deficiencies;

"(4) Any State which fails to correct the deficiencies within the time frame specified under paragraph (3) as determined by the Secretary (and certified by the Comptroller General) shall be so notified and subject to a reduction in Federal matching as specified in paragraph (5) beginning on the first day of the first calendar quarter following the date on which the Secretary specified the deficiencies must be corrected under paragraph (3);

"(5)(A) In the case of a State which the Secretary has determined has failed to meet the requirements of one of the subparagraphs (A), (B), (C), or (D) of paragraph (1) and which has not made the requisite corrections as determined under paragraph (4), such State shall be subject to a reduction in Federal matching of an amount equal to 50 per centum of what the State would otherwise receive under subsections (a)(2), (a)(3), and (a)(6).

"(B) In the case of a State which the Secretary has determined has failed to meet the requirements of two or more of the subparagraphs (A), (B), (C), or

(D) of paragraph (1) and has not made the requisite corrections as determined under paragraph (4), such State shall be subject to a termination of Federal matching under subsections (a)(2), (a)(3), and (a)(6).

"(6)(A) Any State for which a reduction or termination in Federal matching has been imposed under paragraph (5) shall continue to have the matching reduced or terminated as specified in such paragraph applicable to such State until the Secretary has determined (and the Comptroller General of the United States has certified) that the specified deficiency (or deficiencies) has (or have) been corrected.

"(B) A State which has been determined (as provided in subparagraph (A)) to have made the requisite corrections in all categories specified as deficient shall be entitled to the matching rate specified in subsections (a)(2), (a)(3), and (a)(6) beginning on the first day of the calendar quarter in which such determination was made.

"(C) In the case of a State for which matching has been terminated under subsections (a)(2), (a)(3), and (a)(6) as provided under subparagraph (5)(B) and the Secretary determines pursuant to subparagraph (A) that deficiencies continue to exist in only one of the four specified categories, such State shall, beginning on the first day of the calendar quarter in which such determination is made, be so notified and be entitled to the reduced matching rate specified in subparagraph (5)(A).

"(7) In the case of any State which is determined to substantially exceed the requirements of at least two of the subparagraphs (A), (B), (C), or (D) of paragraph (1) and meet the requirements of the remaining such subparagraphs as determined in an onsite evaluation as provided in paragraph (2), such State shall be so notified and entitled effective for the calendar quarter beginning on October 1, 1977, or for subsequent calendar quarters, whichever is appropriate, to a Federal matching rate under subsection (a)(6) of 75 per centum and such amount shall be applicable for each calendar quarter for which the Secretary determines the State continues to meet the requirements of this paragraph;

"(8) The Secretary shall in a timely fashion provide or arrange for the provision of technical assistance by experienced and qualified personnel to any State which requests assistance (and for whom the Secretary determines such request is reasonable) and in meeting the requirements of paragraph (1). Such assistance may include arranging for personnel from other States with useful experience in meeting the requirements of paragraph (1) to provide technical assistance to requesting States and such arrangements shall provide for compensation of such personnel in an amount determined reasonable by the Secretary;

"(9) The Secretary shall make available to the States in a timely fashion information on actions taken by specific States which have enab'ed them to effectively fulfill the requirements of paragraph (1) when such information would prove useful to other States in helping them meet such requirements;

"(10) In the case of any required notification by the Secretary to a State under this section respecting identification of deficiencies, or a reduction, termination, or increase in Federal matching, simultaneous notification shall also be made to the Governor of such State, the chief executive officer of each body of the State legislature, and (to the extent such information is known) the chairman of the legislative committees in such State with jurisdiction over the medical assistance program authorized under this title.".

(d) Title XIX of the Social Security Act is amended by adding at the end thereof the following new sections:

"QUALITY CONTROL

"SEC. 1911. The Secretary shall—

"(a)(1) publish by September 1, 1976, the error rates in making eligibility determinations recorded for each State for the period October 1, 1975, through March 31, 1976, as reported under the medicaid eligibility quality control program (as specified in regulations of the Secretary prior to March 1, 1976), and specify actions (together with the projected time frame) to be taken by him to assist the States in improving the accuracy of their eligibility determination processes;

"(b) set a normative standard error rate defined as that rate which equals the 50th percentile of the rates reported by the States under (a)(1); and

"(c) provide or arrange for the provisions of timely, technical, and professional assistance to the States to assist them in improving their eligibility determination process.

"REPORT BY THE SECRETARY

"SEC. 1912. (a) The Secretary shall prepare a biannual report (beginning with fiscal year 1976) on the characteristics of the State programs of medical assistance financed under this title, including as a minimum (1) a description of the amount, duration, and scope of benefits available in each State, (2) a description of eligibility criteria for all groups eligible for medical assistance in each State, (3) a specification of the reimbursement rates paid under the State program for the major types of services in each State, and (4) a listing of all fiscal agents contracted with for administration of the program. Such report shall be submitted to the Senate Committee on Finance and the House Committee on Interstate and Foreign Commerce and made generally available no later than six months following the close of the fiscal year.

"(b) The Secretary shall prepare a quarterly summary update of the report required in subsection (a) and submit it to the Senate Committee on Finance and the House Committee on Interstate and Foreign Commerce no later than four months following the close of the calendar quarter.".

PROCEDURES DESIGNED TO ASSURE ECONOMICAL PROCESSING OF CLAIMS BY CARRIERS

SEC. 5. (a) Section 1842(b) of the Social Security Act is amended by adding at the end thereof the following new paragraph:

"(6)(A) The Secretary shall by regulation establish procedures, consistent with prevailing Federal procurement requirements, which are appropriately designed to assure that claims processing functions to be performed by carriers pursuant to any contract entered into under this section will be performed on the basis of a prospective fixed price per claim. Such procedures shall provide for the establishment of such fixed price on the basis of the economical and efficient performance of such functions, and after taking into account estimates of the reasonable costs which will be incurred in the performance thereof by the various entities (including the carrier) which are available to perform such functions, under subcontract or otherwise.

"(B) Regulations under this paragraph shall provide that, in the performance of any such claims processing function under any such contract, there will be provided to the Secretary (or any duly authorized employee of the Department of Health, Education, and Welfare) such access to the claims processing operation and the costs thereof and such information and data relating thereto as he deems to be necessary or appropriate to enable him to ascertain whether such operation is being properly conducted.".

(b) The regulations referred to in section 1842(b)(6) of the Social Security Act (as added by subsection (a) of this section) shall be promulgated by the Secretary of Health, Education, and Welfare and made effective with respect to all contracts entered into, or renewed, after September 30, 1976, pursuant to section 1842 of such Act.

CLAIMS PROCESSING AND INFORMATION RETRIEVAL SYSTEMS FOR MEDICAID PROGRAMS

SEC. 6. (a) Section 1903(a)(3) of the Social Security Act is amended—

(1) in clause (A)(i), by inserting ", and capable of being integrated into," immediately after "compatible with"; and

(2) in clause (B), by inserting ", or to each individual in a sample group of individuals who are furnished such services," immediately after "covered by the plan".

(b) The amendment made by subsection (a) shall be applicable only with respect to expenditures under State plans approved under title XIX of the Social Security Act made on and after the first day of the first calendar month which begins more than sixty days after the date of enactment of this Act.

REGULATIONS OF THE SECRETARY; SAVINGS PROVISION

SEC. 7. (a)(1) Section 1102 of the Social Security Act is amended—

(A) by inserting "(a)" immediately after "SEC. 1102.", and

(B) by adding at the end thereof the following new subsection:

"(b) Whenever the Secretary, in compliance with applicable requirements imposed by law, causes to be published in the Federal Register a general notice of any proposed rule or regulation to be promulgated by him, such notice shall indicate whether the prompt promulgation thereof is urgent. In the case of any

such notice, which respect to a proposed rule or regulation, which does not indicate that the prompt promulgation thereof is urgent, such rule or regulation shall become effective not less than sixty days after publication of such notice; in any other case, such rule or regulations shall become effective without regard to the provisions of this subsection and in the manner prescribed in accordance with applicable provisions of law.".

(2) The amendments made by paragraph (1) shall be effective in the case of proposed rules published in the Federal Register on and after the first day of the first calendar month which begins more than thirty days after the date of enactment of this Act.

(b)(1) Except as otherwise specified in this Act or in a provision of law which is enacted or amended by this Act, any regulation of the Secretary of Health, Education, and Welfare (hereinafter in this section referred to as the "Secretary"), which is necessary or appropriate to implement any provision of this Act or any other provision of law which is enacted or modified by this Act, shall, subject to paragraph (2), be promulgated so as to become effective not later than the first day of the thirteenth month following the month in which this Act is enacted.

(2) Nothing contained in paragraph (1) shall be construed to require the Secretary to promulgate any rule or regulation, which shall become effective within the time period referred to in paragraph (1), respecting any matter, if the Comptroller General has certified that, due to circumstances or conditions beyond the control of the Secretary, it is not feasible for the Secretary to do so.

(c) The Secretary shall, in issuing any major policy guidelines (other than those issued through regulations) to carry out any provision of this Act or any provision of law enacted or modified by this Act, employ procedures with respect thereto under which interested parties will, prior to any such guideline becoming final, be afforded reasonable opportunity to make known to the Secretary their comments thereon and suggestions with respect thereto.

TERMINATION OF HEALTH INSURANCE BENEFITS ADVISORY COUNCIL

SEC. 8. (a) The Health Insurance Benefits Advisory Council (established pursuant to section 1867 of the Social Security Act) is abolished, effective on the first day of the first calendar month which begins more than thirty days after the date of enactment of this Act, and the terms of office of all members of such Council shall end on such first day.

(b) At the earliest practicable date after the date of enactment of this Act (and in no event later than the first day referred to in subsecion (a)), such Advisory Council shall turn over all of its records, files, equipment, and materials to the Secretary of Health, Education, and Welfare.

(c) Effective with the close of the first day of the first calendar month which begins more than thirty days after the date of enactment of this Act, section 1867 of the Social Security Act is repealed.

IMPROVED METHODS FOR DETERMINING REASONABLE COST OF SERVICES PROVIDED BY HOSPITALS

SEC. 10. (a)(1) Section 1861(v)(1)(A) of the Social Security Act is amended, in the first sentence thereof, by striking out "The" and inserting in lieu thereof "Subject to subsection (aa), the".

(2) Section 1861(v) of such Act is further amended by adding at the end thereof the following new paragraph:

"(8) For additional requirements applicable to determination of reasonable cost in the case of services provided by hospitals, see subsection (aa).".

(b) Section 1861 of such Act is further amended by adding after subsection (z) the following new subsection:

"ADDITIONAL CRITERIA FOR DETERMINING REASONABLE COST OF HOSPITAL SERVICES

"(aa)(1) In order more fairly and effectively to determine the reasonable cost incurred in the provision of hospital services for which payment may be made under this title, not later than July 1, 1978, the Secretary shall, in consultation with appropriate knowledgeable national organizations, establish—

"(A) a uniform system of accounts and cost reporting (including uniform procedures for allocation of costs) for determining operating and capital

costs of hospitals providing such services, thereby assuring that operating and capital costs will be determined in the same manner for each hospital furnishing such services, and

"(B) an ongoing system of hospital classification under which hospitals furnishing such services will initially be classified as follows:

"(i) as to size, with each of the following sizes of hospitals being classified in separate categories: (I) those having more than 5, but fewer than 25, beds, (II) those having more than 24, but fewer than 50, beds, (III) those having more than 49, but fewer than 100, beds, (IV) those having more than 99, but fewer than 200, beds, (V) those having more than 199, but fewer than 300, beds, (VI) those having more than 299, but fewer than 400, beds, (VII) those having more than 399, but fewer than 500, beds, and (VIII) those having more than 499 beds,

"(ii) as to type of hospital, with (I) short-term general hospitals being in a separate category, (II) hospitals which are the primary affiliates of accredited medical schools (with one such hospital to be nominated by each accredited medical school) being in one separate category (without regard to bed size), and (III) psychiatric, geriatric, maternity, pediatric, or other specialty hospitals being in the same or separate categories, as the Secretary may determine to be appropriate in light of the extent to which differences in specialty do or do not significantly affect the routine costs of such hospitals, and

"(iii) such other criteria as the Secretary may deem appropriate;

but such system of hospital classification shall not differentiate between hospitals on the basis of the ownership thereof.

"(2) As used in this subsection, the term 'routine operating costs' does not include any of the following:

"(A) capital costs (including interest expense on loans to purchase capital assets, and depreciation),

"(B) direct personnel and supply costs of hospital education and training programs,

"(C) costs of interns, residents, and medical (but not nursing) personnel,

"(D) energy costs associated with heating or cooling the hospital plant.

"(3)(A) During the calendar quarter commencing on January 1 of each calendar year (beginning with the calendar year 1977) the Secretary shall, in accordance with the succeeding provisions of this paragraph, determine, for the hospitals classified in each category of the hospital classification system established pursuant to paragraph (1)(B), an average per diem routine operating cost amount which shall (except as is otherwise provided in this subsection) be utilized in determining, for purposes of making payment under this title to such hospitals for services furnished by them during the fiscal year which commences on or after July 1 of such calendar year, the reasonable cost of that portion of the hospital's costs which consists of routine operating costs.

"(B) A determination under this paragraph made during any such calendar quarter shall be made on the basis of data, with respect to amount of routine operating costs of the hospitals involved, for the preceding fiscal year.

"(C) For purposes of making any such determination, routine operating costs of the hospitals involved in any category shall be divided into two components: a personnel component, and a nonpersonnel component.

"(D)(i) The routine operating costs attributable to the nonpersonnel component and the personnel cost component for each of the hospitals (other than hospitals excluded pursuant to clause (ii)) in any particular classification category shall be aggregated to arrive at the total amount of routine operating costs of all hospitals in such category. Such total shall then be divided by the total number of days of routine care provided by the hospitals in such category to determine the average per diem routine operating cost for such hospitals.

"(ii) In making the calculations prescribed in clause (i), the Secretary shall exclude therefrom any hospital (and data pertaining to any such hospital) which has significant understaffing problems or otherwise experiences significant cost differentials resulting from failure of the hospital fully to meet the standards and conditions of participation as a provider of services under this title, as determined by the Joint Commission on Accreditation of Hospitals, State agency certification procedures, or any other finding or information available to the Secretary.

"(E) On the basis of the average per diem routine operating cost amount determined, pursuant to the preceding subparagraphs of this paragraph, for

any category of hospitals, there shall be determined for each hospital in such category a per diem payment rate for routine operating costs. Such payment rate for any such hospital shall be equal to the average per diem routine operating cost amount for the hospitals of the category in which such hospital is classified, except that the personnel component thereof shall be adjusted through the use of a wage index based on general wage levels (including fringe benefit costs) in the areas in which the hospitals are located so as properly to adjust such component to the general wage levels (including fringe benefit costs) in the area in which such hospital is located. If the Secretary finds that, in the area where one or more hospitals in any such classification category are located, for the fiscal year ending June 30, 1970, the wage level (including fringe benefit costs) for hospitals is significantly higher than the general wage level (including fringe benefit costs) in such area (relative to the relationship between hospital wages and general wages in other areas), then the general wage level in such area shall, for purposes of this subsection, be deemed to be equal to the wage level for hospitals in such area, but only during the first year in which the provisions of this subsection are effective in determining payment rates to hospitals (the fiscal year beginning on or after June 30, 1970).

"(4)(A)(i) As used in this paragraph, the term 'adjusted per diem payment rate for routine operating costs', when used in reference to any hospital, means the 'per diem payment rate for routine operating costs' (as determined under paragraph (3)) applicable to such hospital plus the increase in prices per centum determined pursuant to the succeeding provisions of this subparagraph.

"(ii) The amount of the per diem payment rate for routine operating costs for any hospital for any fiscal year (as determined under the preceding provisions of this subsection) shall be increased, so as to reflect (I) the per centum of increase (if any) which has occurred in the cost of the mix of goods and services (including personnel and nonpersonnel costs) which comprises routine operating costs (as determined under the preceding provisions of this subsection), or (II) if less, the actual per centum of increase (if any) which has occurred in the costs incurred by such hospital for such goods and services during such period.

"(iii) In making payments for services furnished by such hospital prior to the date such a determination of the proper amount of increase applicable to such services is made, the Secretary may add a semiannual per centum of increase, in the cost of the mix of goods and services referred to in clause (ii), equal to whichever of the following is the smaller: (I) the per centum of such increase as estimated by such hospital, or (II) the per centum of such increase in the area applied to such hospital's costs as estimated by the Secretary.

"(iv) At the end of the fiscal year, a retrospective adjustment shall be made to the amounts paid pursuant to clause (iii) to reflect the lesser of (I) the actual cost increase incurred by the hospital or (II) the actual increase in prices which has occurred in the mix of goods and services referred to in clause (ii).

"(B) Except as otherwise provided in subparagraph (C), in determining, for purposes of payment under this title, the amount of the reasonable cost incurred by a hospital in furnishing services under this title, so much of the costs so incurred by such hospital as are attributable to routine operating costs shall be deemed to be equal—

"(i) in the case of a hospital the actual routine operating costs of which are equal to or greater than the amount arrived at through the application of such hospital's adjusted per diem payment rate for routine operating costs, an amount equal to the greater of the following:

"(I)(a) 120 per centum of the amount arrived at through the application of such hospital's adjusted per diem payment rate for routine operating costs, or, (b) if less, the amount of such hospital's actual routine operating costs, or

"(II)(a) the amount of such hospital's actual routine operating costs, or (b) if less, the amount which would have been determined for such hospital under clause (I)(a) if such hospital had been classified in the category nearest (in terms of the number of beds in such hospital and minimum number of beds specified for the various categories of hospitals) the category to which such hospital actually is classified, and

"(ii) in the case of a hospital the actual routine operating costs of which are less than the amount arrived at through the application of such hos-

pital's adjusted per diem payment rate for routine operating costs, an amount equal to (I) the amount of such hospital's actual routine operating costs, plus (II) whichever of the following is the smaller: (a) an amount equal to 5 per centum of such hospital's adjusted per diem payment rate for routine operating costs, or (b) an amount equal to 50 per centum of the amount by which such hospital's adjusted per diem payment rate for routine operating costs exceeds such hospital's actual routine operating costs.

"(C) Any hospital which is, pursuant to paragraph (3)(D)(ii), excluded by the Secretary from the calculation prescribed under paragraph (3)(D)(i), shall be reimbursed for routine operating costs according to the lesser of (i) actual costs or (ii) reimbursement determined under this section.

"(D) Not later than the April 1 following the determination by the Secretary during any calendar quarter as to the average per diem operating cost amount for each category of hospital and as to the adjusted per diem payment rate for routine operating costs applicable to each of the hospitals in such categories, such determinations shall be published by the Secretary; and the Secretary shall notify the hospital administrator and the administrative governing body of each hospital with respect to all aspects of such determination which affect such hospital.

"(E) In the case of a hospital determined by the Secretary to be—

"(i) located in an underserved area where hospital services are not otherwise available,

"(ii) certified as being necessary by an appropriate planning agency, and

"(iii) underutilized,

the adjusted per diem payment rate determined under this paragraph shall not apply to that portion of such hospital's routine operating costs as are attributable to the maintenance of so much of such hospital's underutilized capacity as is necessary to assure the availability of hospital services to individuals in the area served by such hospitals. Such portion of routine operating costs to which the adjusted per diem payment rate does not apply shall be reimbursed at cost.

"(F) In the case of any hospital which is determined by the Secretary to have an unusual case mix which—

"(i) requires a greater intensity of care than that obtaining generally among hospitals in the same classification as such hospital, and

"(ii) increases the level of such hospital's routine operating costs over the level obtaining generally among hospitals in the same classification as such hospital,

the adjusted per diem payment rate determined under this paragraph shall not apply to that portion of such hospital's routine operating costs as are attributable to the requirements (as described in clauses (i) and (ii)) of such hospital. Such portion of routine operating costs to which the adjusted per diem payment rates does not apply shall be reimbursed at cost.

"(G) In the case of any hospital located in Alaska or Hawaii, the Secretary may further adjust the adjusted per diem payment rate to reflect the higher prices prevailing in such areas.

"(H) In the case of any hospital which the Secretary finds has deliberately altered its patient mix, or patient flow, or lowered its quality of patient care, the routine operating costs of such hospital shall be deemed to be equal to which ever is the lesser: the amount determined without regard to this subsection, or the amount prescribed under subparagraph (B)."

(c) The Secretary shall, at the earliest practicable date, develop and on a basis consistent with this section comparable reimbursement methods with respect to payment for any or all other hospital cost centers, skilled nursing and intermediate care facilities as well as home health agencies. The Secretary shall, as such methods are developed, but not later than three years from enactment, submit appropriate recommendations to the Congress.

(d) The provisions of section 1861 (aa) (2), (3), and (4) of the Social Security Act—

shall be applicable for informational purposes only with respect to services furnished by any hospital prior to July 1, 1979, and

(2) shall be applied, with respect to services furnished by any hospital in the fiscal year beginning on or after June 30, 1979, as if any difference between the amount of the actual routine costs of such hospital and the amount arrived at through the application of such hospital's adjusted per diem payment rate for routine operating costs were reduced by one-half.

(3) shall be fully applied in the fiscal year beginning on or after June 30, 1980.

(e) Nothing in this section shall be construed as otherwise limiting the authority of the Secretary to continue otherwise authorized efforts toward development of improved systems of reimbursement, including development of multivariate statistical techniques (including evaluation of factors such as possible appropriate significant variation in case mix and intensity of care) as a means of making equitable comparison of the costs of institutional providers and agencies and their reimbursement.

(f)(1) Section 1902(a)(13)(D) of the Social Security Act is amended by inserting "(and after application of section 1861(aa))" immediately after "section 1861(v)".

(2) The amendment made by paragraph (1) shall take effect on the first day of the first calendar month which begins not less than sixty days after the date of enactment of this Act.

(g) To the extent that amendments made under the preceding provisions of this section are inconsistent with provisions of 1861(v) of the Social Security Act which relate to the establishment of limits on overall covered costs, such amendments shall supersede such provisions.

INCLUSION IN REASONABLE COST OF HOSPITAL SERVICES AN ALLOWANCE FOR RETIREMENT OR CONVERSION OF UNDERUTILIZED FACILITIES

SEC. 11. (a) Part A of title XI of the Social Security Act is amended by adding at the end thereof the following new section:

"INCLUSION IN REASONABLE COST OF HOSPITAL SERVICES AN ALLOWANCE FOR RETIREMENT OR CONVERSION OF UNDERUTILIZED FACILITIES

"SEC. 1132. (a)(1)(A) The Secretary shall, within the three-month period which begins on the first day of the first calendar month which commences after the date of enactment of this section, establish a Hospital Transitional Allowance Board (hereinafter in this section referred to as the 'Board') which shall consist of five members, appointed by the Secretary without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, from persons who are especially knowledgeable in hospital planning and hospital operations (including such persons who are otherwise in the employ of the Federal, State, or local governments). At least one member of the Board shall be a representative of the largest private non-profit third-party payer for hospital services in the Nation.

"(B) The term of office of members of the Board shall be three years, except that the Secretary shall appoint the initial members of the Board for shorter terms to the extent necessary to permit staggered terms of office.

"(C) Members of the Board shall be entitled to receive per diem compensation at rates fixed by the Secretary, but not exceeding the per diem equivalent (at the time the service involved is rendered by such members) for grade GS-18 in section 5332 of title 5, United States Code.

"(D) The Board shall be provided such technical assistance by the Secretary as may be required to carry out its functions, and the Secretary shall, in addition, make available to the Board such secretarial, clerical, and other assistance as the Board may require to carry out its functions.

"(2) It shall be the duty and function of the Board to receive, and act upon in accordance with this section, applications by hospitals certified for participation (other than as 'emergency hospitals') under titles XVIII and XIX for transitional allowances.

"(b) For purposes of this section—

"(1) The term 'transitional allowance' means an amount which—

"(A) shall, solely by reason of the provisions of this section, be included in determining the reasonable cost incurred by a hospital in furnishing services on account of which payment is authorized to be made under title XVIII, under a plan or program approved under or instituted pursuant to title V, or under a plan approved under title XIX, and

"(B) is established by the Secretary, in accordance with the provisions of this section, for a hospital in recognition of a reimbursement detriment (as defined in paragraph (3)) suffered by it because of a qualified facility conversion (as defined in paragraph (2)) made by it.

"(2) The term 'qualified facility conversion' means a retirement, modification, or change in usage, of underutilized hospital facilities—

"(A) which is carried out by a hospital which, for not less than one year prior to the commencement of such retirement, modification, or change in usage, of such facilities, furnished on a regular basis services with respect to which payment was (at the time the services were furnished) authorized to be made under title XVIII or a State plan approved under title XIX, and

"(B) the effect of which is to promote efficient and economical delivery of health care services covered under medicare and medicaid by (i) eliminating excess bed capacity, or (ii) discontinuing an underutilized service for which there are adequate alternative sources serving the same area (as determined by an appropriate health care facility planning agency) as that served by such hospital, or substituting for such underutilized service some other service which is needed in such area (as determined by such an agency).

"(3) A hospital, which has carried out a qualified conversion or closure and which continues in operation following such conversion or closure, shall be regarded as having suffered a 'reimbursement detriment' because of such conversion or closure (A) if and to the extent that, solely because of such conversion or closure, there is a reduction in the aggregate of the amounts attributable to capital-related reimbursement (but only to the extent such capital was accepted as reasonable for purposes of reimbursement eligibility) which are taken into account in determining, for purposes of making payments under title XVIII or title XIX to such hospital with respect to services furnished by it, the reasonable cost (as such term is used for purposes of such title) incurred by such hospital in the furnishing of such services; (B) if such conversion or closure results, on an interim basis, in increased operating costs (such as severance pay, et cetera) to the extent that such operating costs exceed amounts ordinarily reimbursable under titles XVIII and XIX, or (C) in the case of complete closure of a non-profit, nongovernmental (except local government) hospital other than for purposes of replacement of such hospital, actual debt obligations to the extent previously recognized as reasonable for purposes of reimbursement, to the extent that such debt remains outstanding and less any salvage value.

"(c)(1) Any hospital may file an application with the Board (in such form and containing such data and information as the Board, with the approval of the Secretary, may prescribe) for a transitional allowance with respect to any qualified conversion or closure which was commenced after December 31, 1976, and was completed within the six-month period preceding the filing of such application.

"(2) The Board shall consider any application filed by a hospital under paragraph (1), and if, with respect to any such application filed by a hospital, the Board finds that—

"(A) the facility conversion or closure with respect to which the application relates was commenced and completed within the time limits prescribed in paragraph (1),

"(B) such facility conversion or closure is a qualified facility conversion, and

"(C) such hospital is suffering a reimbursement detriment because of having carried out such qualified facility conversion or closure,

the Board shall transmit to the Secretary its recommendation that the Secretary establish, in such amounts reasonable in relation to prior or prospective usage of such facilities by titles XVIII and XIX and for a period (which shall not be in excess of twenty years) specified by the Board, a transitional allowance for such hospital with respect to such facility conversion or closure; and, if the Board finds that the criteria specified in clauses (A), (B), and (C) are not met, it shall transmit to the Secretary its recommendation that the Secretary not establish any transitional allowance for such hospital with respect to such facility conversion or closure, in the case of an approved closure or partial closure under subsection (b)(3)(C) the Board may recommend or the Secretary may, in his discretion, approve a lump-sum payment in lieu of periodic allowances, where such payment would constitute a more efficient and economic alternatives.

"(3)(A) At the time the Board transmits to the Secretary its recommendation, as prescribed in paragraph (2), with respect to a transitional allowance applied for by a hospital, it shall notify such hospital of its action and shall transmit a copy of such recommendation to such hospital.

"(B) Any hospital which is dissatisfied, wholly or in part, with such a recommendation made with respect to it may obtain an informal or formal hearing on the matter in the discretion of the Secretary, by filing (in such form and manner and within such time period as the Secretary shall by regulations prescribe) with the Secretary a request for such a hearing.

"(4)(A) The Secretary shall, within thirty days after the date he receives a recommendation from the Board respecting a transitional allowance for which a hospital has applied under this section or, if later, within thirty days after a hearing (obtained pursuant to paragraph (3)(B)) with such a recommendation, make a final determination as to whether, and if so in what amount and for what period of time, such a transitional allowance will be granted to such hospital pursuant to the application with respect to which such recommendation was received by him. Any such final determination of the Secretary shall not be subject to judicial review.

"(B) The Secretary, upon making a final determination under subparagraph (A) as to the granting of any transitional allowance to a hospital, shall notify such hospital and such other parties as may be appropriate (including State agencies administering or supervising State plans approved under title XIX) of such determination.

"(C) Any transitional allowance established under a final determination of the Secretary under this section for a hospital shall take effect on a date prescribed by the Secretary but not earlier than the date of completion of the qualified facility conversion on the basis of which such allowance was established. After such effective date, such transitional allowance shall be included as an allowable cost item in determining the reasonable cost incurred by such hospital in providing services for which payment is authorized under this title.

"(d) In addition to the requirements imposed by law as conditions of approval of a State plan for maternal and child health services under title V or a State plan for medical assistance under title XIX, there is hereby imposed the requirements (and the plan shall be deemed to require) that, in determining the amount of the reasonable cost incurred by a hospital in furnishing services with respect to which payment is authorized by such plan, any transitional allowance established for such hospital by the Secretary pursuant to this section shall be included as an allowable cost item.

"(e)(1) Notwithstanding the foregoing provisions of this section, the Secretary shall not, prior to the expiration of the twenty-four-month period which begins January 1, 1977, establish—

"(A) a transitional allowance for any hospital after a transitional allowance for such hospital has previously been established, or

"(B) a transitional allowance for more than a total of fifty hospitals.

"(2) On or before September 1, 1979, the Secretary shall submit a report to the Congress evaluating the operation and effectiveness of the program established under this section and containing such recommendations with respect to continuing or improving the implementation of the program established under this section.".

RETURN ON EQUITY TO BE INCLUDED IN DETERMINING "REASONABLE COST" OF SERVICES FURNISHED BY PROPRIETARY HOSPITALS

SEC. 12. (a) Section 1861(v)(1)(B) of the Social Security Act is amended—

(1) in the first sentence thereof, by inserting "hospital or" immediately after "Such regulations in the case of", and

(2) in the second sentence thereof, by striking out "one and one-half times" and inserting in lieu thereof "twice".

(b) The amendments made by subsection (a) shall be applicable only with respect to services furnished by a hospital or skilled nursing facility for fiscal years of a hospital or skilled nursing facility beginning on and after the first day of the first calendar month which begins after the date of enactment of this Act.

CRITERIA FOR DETERMINING REASONABLE CHARGE FOR PHYSICIANS' SERVICES

SEC. 20. (a)(1) So much of section 1842(b)(3) of the Social Security Act as follows the first sentence thereof is amended to read as follows:

"(3A)(A) In determining the reasonable charge for services for purposes of paragraph (3), there shall be taken into consideration the customary charges for similar services generally made by the physician or other person furnishing such services, as well as the prevailing charges in the locality for similar services.

"(B)(i) Except as otherwise provided in clause (iii), no charge may be determined to be reasonable in the case of bills submitted or requests for payment made under this part after December 31, 1970, if it exceeds the higher of (I) the prevailing charge recognized by the carrier and found acceptable by the Secretary for similar services in the same locality administering this part on December 31, 1970, or (II) the prevailing charge level that, on the basis of statistical data and methodology acceptable to the Secretary, would cover 75 per centum of the customary charges made for similar services in the same locality during the last preceding calendar year elapsing prior to the start of the fiscal year in which the bill is submitted or the request for payment is made.

"(ii) In the case of physican services the prevailing charge level determined for purposes of clause (i)(II) for any fiscal year beginning after June 30, 1973, may not (except as otherwise provided in clause (iii)) exceed (in the aggregate) the level determined under such clause for the fiscal year ending June 30, 1973, except to the extent that the Secretary finds, on the basis of appropriate economics index data, that such higher level is justified by economic changes. Any increase under this clause (ii), by reason of findings of the Secretary regarding economic changes, in such prevailing charge level for any particular service or procedure, when performed in any particular locality of a State for which there has been established (pursuant to subparagraph (E)) a statewide prevailing charge level for physicians' services, shall not be applied if, and to the extent that, the resulting prevailing charge level for such service or procedure, when performed in such locality, would exceed by more than one-half the statewide prevailing charge level therefor.

"(iii) Notwithstanding the provisions of clauses (i) and (ii) of this subparagraph, the prevailing charge level in the case of a physician service in a particular locality determined pursuant to such clauses for the fiscal year beginning July 1, 1975, shall, if lower than the prevailing charge level for the fiscal year ending June 30, 1975, in the case of a similar physician service in the same locality by reason of the application of economic index data, be raised to such prevailing charge level for the fiscal year ending June 30, 1975.

"(C) In the case of medical services, supplies, and equipment (including equipment servicing) that, in the judgment of the Secretary, do not generally vary significantly in quality from one supplier to another, the charges incurred after December 31, 1972, determined to be reasonable may not exceed the lowest charge levels at which such services, supplies, and equipment are widely and consistently available in a locality except to the extent and under circumstances specified by the Secretary.

"(D) The requirement in paragraph (3)(B) that a bill be submitted or request for payment be made by the close of the following calendar year shall not apply if (i) failure to submit the bill or request the payment by the close of such year is due to the error or misrepresentation or an officer, employee, fiscal intermediary, carrier, or agent of the Department of Health, Education, and Welfare performing functions under this title and acting within the scope of his or its authority, and (ii) the bill is submitted or the payment is requested promptly after such error or misrepresentation is eliminated or corrected.

"(E) The Secretary shall determine separate prevailing charge levels for each State with two or more localities in accordance with the criteria prescribed in the preceding provisions of this paragraph except that such prevailing charge level shall cover 50 per centum, instead of 75 per centum, of the charges made for similar services in such State.

"(F) Notwithstanding any other provision of this paragraph, any charge for any particular service or procedure performed by a doctor of medicine or osteopathy shall be regarded as a reasonable charge for such service, if—

"(i) such service of procedure is performed in a physician shortage area (which has been designated as such by the Secretary),

"(ii) such physician has a regular practice in such area and he first established such practice therein after such area had been designated by the Secretary as a physician shortage area, and

"(iii) such charge does not exceed the prevailing charge level for such service or procedure, as determined under the preceding subparagraphs of this paragraph.".

(2) The amendment made by paragraph (1) shall take effect on the date of enactment of this Act, except that the provisions of the second sentence of paragraph (3A)(B)(ii) of section 1842(b) of the Social Security Act and paragraph

(3A)(E) of such section (as amended by paragraph (1) of this subsection) shall be effective only to determinations made under section 1842(b)(3A)(B)(i)(II) and (ii) of such Act for fiscal years beginning after September 30, 1976.

AGREEMENTS OF PHYSICIANS TO ACCEPT ASSIGNMENT OF CLAIMS

SEC. 21. (a)(1) Part C of title XVIII of the Social Security Act is amended by adding immediately after section 1867 the following new section:

"AGREEMENTS OF PHYSICIANS TO ACCEPT ASSIGNMENT OF CLAIMS

"SEC. 1868. (a) For purpose of this section—

"(1) the term 'participating physician' means a doctor of medicine or osteopathy who has in effect an agreement entered into pursuant to this section (except that, with respect to any claim for payment under this part for services performed outside the United States, no physician shall be considered to be a participating physician), and

"(2) the term 'nonparticipating physician' means a doctor of medicine or osteopathy who does not have in effect such an agreement.

"(b)(1) Any physician who desires to do so may enter into an agreement with the Secretary under this section under which the physician agrees to accept, with respect to any service performed by him for an individual who is enrolled under part B, an assignment of claim (which shall be in such form as may be prescribed under regulations of the Secretary) the terms of which provide that—

"(A) all claims which such individual would, except for such assignment, have under part B for payment for such service are conferred upon such physician and such physician accepts such assignment in lieu of any such payment, and

"(B) the reasonable charge for such service (as determined under this title) will be the full charge therefor.

"(2) An agreement under this section may be terminated by either party upon thirty days' notice to the other party (filed in such form and manner as may be prescribed in regulations of the Secretary).

"(b) Notwithstanding any other provision of this title, no payment under part B shall be made, on the basis of an assignment of claim, to any physician for or on account of physicians' services performed by him, if such physician is a nonparticipating physician.

"(c) In order to assure the expeditious processing of claims by participating physicians for services performed by them, the Secretary shall establish procedures and develop appropriate forms under which—

"(1) each such physician will submit his claims on a simplified and multiple-listing basis rather than on an individual patient basis,

"(2) there will, within five working days after any particular batch of such claims is received from such a physician, be paid to him an amount with respect thereto which is based on an estimate of the precise amount due (with the payment made with respect to any such batch of claims being increased or reduced, as is appropriate, on account of any prior payment, based on a previous estimate, being greater or lesser than the precise amount due); and

"(3) any such estimate, with respect to any batch of such claims submitted by such a physician, shall be designed to assure that the amount thereof is not less than 50 per centum of the amount which is estimated to be payable hereunder with respect thereto, and such estimate shall be made on the assumption that all patients with respect to whom such claims relate have met the deductible imposed by section 1833(b).

"(d)(1) In addition to other payments authorized to be made to carry out the insurance program established by part B of this title, there are hereby authorized to be made such payments as may be necessary to provide for the payment of 'administrative cost-savings allowances' as specified in the succeeding provisions of this subsection.

"(2)(A) With respect to each batch of claims submitted on a multiple-listing basis by a participating physician in accordance with the procedures established pursuant to subsection (c), there shall (subject to subparagraph (B)) be paid to such physician, an administrative cost-savings allowance equal to $1 multiplied by the number of patients for whom payment for services was claimed in such

batch of claims and any such amounts shall be treated as an administrative expense for the administration of the insurance program established by part B of this title.

"(B) Not more than $1 shall be payable under subparagraph (A) to a physician with respect to any particular patient on account of services provided to such patient by such physician in more than one instance in any week. If a physician provides to a patient in two or more visits services which ordinarily would be provided in a single visit, then not more than $1 shall be payable under subparagraph (A) with respect to such patient on account of such services.

"(e)(1) Notwithstanding the preceding provisions of this section, no administrative cost-savings allowance shall be payable on account of any physicians' services performed in a hospital for an individual (whether on an inpatient or outpatient basis) unless—

"(A) such services are in the form of surgical services or anesthesiological services, or

"(B) such services are physicians' services (other than those referred to in subparagraph (A)) performed by a physician (as an attending or consulting physician) whose office or regular place of practice is at a locale other than in such hospital,

and the physician concerned ordinarily bills directly (and not through such hospital) for his services, and no administrative cost-savings allowance shall be payable on account of services which consist solely of laboratory and X-ray services (or either of such services) performed outside the office of the physician claiming payment therefor.".

(2) The amendments made by paragraph (1) shall take effect on July 1, 1977.

(b) On and after the effective date of the amendments made by subsection (a), the authority contained in section 1842(b)(3)(B)(ii) of the Social Security Act shall not be applicable to participating or nonparticipating physicians as defined in section 1868 of such Act.

HOSPITAL-ASSOCIATED PHYSICIANS

SEC. 22. (a)(1) Section 1861(q) of the Social Security Act is amended by adding "(1)" immediately after "(q)" and by adding, immediately before the period at the end thereof, the following: "; except that such term does not include any service that a physician may perform as an educator, an executive, or a researcher; or any patient care service unless such service (A) is personally performed by or personally directed by a physician for the benefit of such patient and (B) is of such a nature that its performance by a physician is customary and appropriate".

(2) Section 1861(q) is further amended by adding the following new paragraphs at the end thereof:

"(2) In the case of anesthesiology services, a procedure would be considered to be 'personally performed' in its entirety by a physician only where the physician performs the following activities:

"(A) preanesthetic evaluation of the patient;

"(B) prescription of the anesthesia plan;

"(C) personal participation in the most demanding procedures in this plan, including those of induction and emergence;

"(D) following the course of anesthesia administration at frequent intervals;

"(E) remaining physically available for the immediate diagnosis and treatment of emergencies; and

"(F) providing indicated postanesthesia care:

Provided, however, That during the performance of the activities described in subparagraphs (C), (D), and (E), such physician is not responsible for the care of more than one other patient. Where a physician performs the activities described in subparagraphs (A), (B), (D), and (E) and another individual performs the activities described in subparagraph (C), such physician will be deemed to have personally directed the services if he was responsible for no more than four patients while performing the activities described in subparagraphs (D) and (E) and the reasonable charge for such personal direction shall not exceed one-half the amount that would have been payable if he had personally performed the procedure in its entirety.

"(3) Pathology services shall be considered 'physicians' services' only where the pathologist personally performs acts or makes decisions with respect to a patient's diagnosis or treatment which require the exercise of medical judgment. These include operating room and clinical consultations, the required interpretation of the significance of any material or data derived from a human being, the aspiration or removal of marrow or other materials, and the administration of test materials or isotopes. Such services shall not include such services as: the performance of autopsies; and services performed in carrying out responsibilities for supervision, quality control, and for various other aspects of a clinical laboratory's operations that are customarily performed by nonphysician personnel.

(3) Section 1861(b) of such Act is amended—

(A) by striking out "or" at the end of paragraph (6),

(B) by striking out the period at the end of paragraph (7) and inserting in lieu of such "; or", and

(C) by adding at the end thereof the following new paragraph:

"(8) a physician, if the services provided by such physician are not physicians' services within the meaning of subsection (q).".

(b)(1) Section 1861(s) of the Social Security Act is amended by adding the following sentence at the end thereof: "The term 'medical and other health services' shall not include the services described in paragraphs (2)(A) and (3) if furnished to the inpatients of a hospital unless the Secretary finds that, because of the size of the hospital or for some other reason acceptable to him, it would be less efficient to have such services furnished by such hospital (or by others under arrangement with them made by the hospital) than to have them furnished by another party.".

(2) Section 1842(b)(3A) of such Act, as added by section 20 of this Act, is amended by adding the following new subparagraphs at the end thereof:

"(G) The charges of a physician or other person which are related to the income or receipts of a hospital or any subdivision thereof shall not be taken into consideration in determing his customary charge pursuant to subparagraph (A) to the extent that such charges exceed an amount equal to the salary which would reasonably have been paid for such services (together with any additional costs that would have been incurred by the hospital) to the physician performing them if they had been performed in an employment relationship with such hospital plus the cost of such other expenses (including a reasonable allowance for traveltime and other reasonable types of expense related to any differences in acceptable methods of organization for the provision of such services) incurred by such physician, as the Secretary may in regulations determine to be appropriate.".

(c) Section 1861(v) of the Social Security Act is amended by adding at the end thereof the following new paragraph:

"(8)(A) Where physicians' services are furnished under an arrangement (including an arrangement under which the physician performing such services is compensated therefor on a basis which is related to the amount of the income or receipts of the hospital or any department or other subdivision thereof) with a hospital or medical school, the amount included in any payment to such hospital under this title as the reasonable cost of such services (as furnished under such arrangement) shall not exceed an amount equal to the salary which would reasonably have been paid for such services (together with any additional costs that would have been incurred by the hospital) to the physician performing them if they had been performed in an employment relationship with such hospital (rather than under such arrangement) plus the cost of such other expenses (including a reasonable allowance for traveltime and other reasonable types of expense related to any differences in acceptable methods of organization for the provision of such services) incurred by such physician, as the Secretary may in regulations determine to be appropriate.".

(d)(1) Section 1833(a)(1)(B) of the Social Security Act is amended by inserting "(except as otherwise provided in subsection (h))" immediately after "amounts paid shall".

(2) Section 1833(b)(2) of such Act is amended by inserting "(except as otherwise provided in subsection (h))" immediately after "amount paid shall".

(3) Section 1833 of such Act is further amended by adding at the end thereof the following new subsection:

"(h) The provisions of subsection (a)(1)(B) and clause (2) of the first sentence of subsection (b) shall not be applicable for expenses incurred for services

referred to therein unless the physician performing such services has entered into an agreement with the Secretary under which such physician agrees to be compensated therefor on the basis of an assignment the terms of which are described in section 1842(b)(3)(B)(ii).".

(e) The amendments made by this section shall, except for the amendment made by subsection (d), apply with respect to services furnished after the first day of the first accounting period of the hospital with respect to which such services were furnished which begins after the month following the month of enactment of this Act. The amendment made by subsection (d) shall be effective on July 1, 1977.

PAYMENT FOR PHYSICIANS' SERVICES UNDER MEDICAID

SEC. 23. Section 1902(a)(13) of the Social Security Act is amended—

(1) by striking out "and" at the end of clause (E) thereof, and

(2) by adding after such clause (E) the following new clause:

"(F) effective July 1, 1977, that the amount which shall be paid under the plan for any physician service provided outside of a hospital setting thereunder shall not be less than 80 per centum of the reasonable charge for such service (as determined under title XVIII);".

PAYMENT FOR CERTAIN ANTIGENS UNDER PART B OF MEDICARE

SEC. 24. (a) Section 1861(s)(2) of the Social Security Act is amended—

(1) by striking out "and" at the end of clause (C),

(2) by inserting "and" at the end of clause (D), and

(3) by adding after clause (D) the following new clause:

"(E) antigens (subject to quantity limitations prescribed in regulations of the Secretary) prepared by an allergist for a particular patient, including antigens so prepared which are forwarded to another qualified person for administration to such patient, from time to time, by or under the supervision of another physician;".

(b) The amendment made by subsection (a) shall be applicable with respect to items furnished on and after the first day of the first calendar month which begins more than thirty days after the date of enactment of this Act.

PAYMENT UNDER MEDICARE OF CERTAIN PHYSICIANS' FEES ON ACCOUNT OF SERVICES FURNISHED TO A DECEASED INDIVIDUAL

SEC. 25. (a) Section 1870(f) of the Social Security Act is amended, in the matter following clause (2) thereof, by—

(1) inserting "(A)" immediately after ", and only if", and

(2) by inserting immediately before the period the following: ", or (B) the spouse or other legally designated representative of such individual requests (in such form and manner as the Secretary shall by regulations prescribe) that payment for such services without regard to clause (A)".

(b) The amendment made by subsection (a) shall be effective with respect to payments made on and after the first day of the first calendar month which begins more than thirty days after the date of enactment of this Act.

PROHIBITION AGAINST ASSIGNMENT OF FEES BY PHYSICIANS AND OTHERS

SEC. 26. (a) Section 1842(b)(5) of the Social Security Act is amended by adding at the end thereof the following new sentence: "Any payment for a service, which under the provisions of the preceding sentence may be made directly to the physician or other person furnishing such service, may not be made to a person claiming such payment under an assignment, including a power of attorney (other than an assignment established by or pursuant to the order of a court of competent jurisdiction from such physician or other person furnishing such service); but nothing in this paragraph shall be construed to preclude any agent, of the physician or other person furnishing the service, from receiving any such payment, if (but only if) such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for his services for or in connecton with the billing and/or collection of any such payment is unrelated (directly or indirectly) to the amount of the billing and/or payment (or the aggregate of similar billings and/or payments), and is not dependent upon the actual collection of any such payment (or the aggregate of such payments).

(b) Section 1902(a)(32) of such Act is amended—

(1) by inserting "(A)" immediately after "provide that",

(2) by redesignating clauses (A) and (B) as clauses (i) and (ii), respectively, and

(3) by adding immediately before the semicolon at the end thereof the following: ", and (B) any payment for a service, which under the provisions of subparagraph (A) may be made directly to the physician or other person furnishing such service, may not be made to a person claiming such payment under an assignment, including a power of attorney (other than an assignment established by or pursuant to the order of a court of competent jurisdiction from such physcian or other person furnishing such service); but nothing in this paragraph shall be construed to preclude any agent, of the physician or other person furnishing the service, from receiving any such payment, if (but only if) such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for his services for or in connection with the billing and/or collection of any such payment is unrelated (directly or indirectly) to the amount of the payment (or the aggregate of similar billings and/or payments) and is not dependent upon the actual collection of any such payment (or the aggregate of such payments).".

(c) The amendments made by this section shall take effect on the first day of the first calendar month which begins not less than sixty days after the date of enactment.

REIMBURSEMENT RATES UNDER MEDICAID FOR SKILLED NURSING AND INTERMEDIATE CARE FACILITIES

SEC. 30. Section 1902(a)(13)(E) of the Social Security Act is amended by inserting "(and which may, at the option of the State, include a reasonable profit for the facility)" immediately after "cost related basis".

MEDICAID CERTIFICATION AND APPROVAL OF SKILLED NURSING FACILITIES

SEC. 31. (a) Section 1910 of the Social Security Act is amended to read as follows:

"CERTIFICTION AND APPROVAL OF SKILLED NURSING FACILITIES

"SEC. 1910. (a) The Secretary shall make an agreement with any State which is able and willing to do so under which the services of the State health agency or other appropriate State or local agencies (which ever are utilized by the Secretary pursuant to section 1864(a)) will be utilized by him for the purpose of determining whether an institution in such State qualifies as a skilled nursing facility for purposes of section 1902(a)(28). To the extent that the Secretary finds it appropriate, any institution which such a State or local agency certifies to him to be a skilled nursing facility may be treated as such by the Secretary.

"(b) The Secretary shall advise the State agency administering the medical assistance plan of his approval or disapproval of any institution certified to him as a qualified skilled nursing facility for purposes of section 1902(a)(28) and specify for each such institution the period (not to exceed twelve months) for which approval is granted, except that the Secretary may extend such term for a period not exceeding two months, where the health and safety of patients will not be jeopardized thereby, if he finds that such extension is necessary to prevent irreparable harm to such facility or hardship to the individuals being furnished items or services by such facility or if he finds it impracticable within such twelve-month period to determine whether such facility is complying with the provisions of this title and regulations thereunder. The State agency may enter into an agreement for the provision of services and the making of payments under the plan with any skilled nursing facility approved by the Secretary for a period not to exceed the period of approval specified.

"(c) The Secretary may cancel the approval of any skilled nursing facility at any time if he finds that the skilled nursing facility fails to meet the requirements contained in section 1902(a)(28), or if he finds grounds for termination of his agreement with such institution pursuant to section 1866(b). In such event the Secretary shall notify the State agency and the skilled nursing facility that the approval of eligibility of such institution to participate in the programs established by this title and title XVIII shall be terminated at such time as may be specified by the Secretary. The approval of eligibility of any such institu-

tion to participate in such programs may not be reinstated unless the Secretary finds that the reason for termination has been removed and there is reasonable assurance that it will not recur.

"(d) Effective July 1, 1977, no payment may be made to any State under this title with respect to skilled nursing facility services furnished by any institution—

"(1) which does not have in effect an agreement with the State agency executed pursuant to subsection (b), or

"(2) whose approval of eligibility to participate in the programs established by this title or title XVIII has been terminated by the Secretary and has not been reinstated, except that payment may be made for up to thirty days with respect to skilled nursing facility services furnished to any eligible individual who was admitted to such institution prior to the effective date of such termination.".

CRITERIA UNDER MEDICAID PROGRAM FOR DETERMINING REASONABLE VALUE OF CERTAIN TRANSFERRED FACILITIES

SEC. 32. (a) Section 1902(a)(13) of the Social Security Act is amended—

(1) in clause (D) thereof, by inserting "and subsection (g)" immediately after "section 1122", and

(2) in clause (E) thereof, by inserting ", consistent with subsection (g)", immediately after "methods and standards".

(b) Section 1902 of such Act is further amended by adding at the end thereof the following new subsection:

"(g) The reasonable value of any facility or organization (which is a hospital, skilled nursing facility, intermediate care facility, or other health care organization) shall, for purposes of determining allowable depreciation, interest or lease expense, and any related capital items of cost, be determined in accordance with the criteria employed under title XVIII for determining the reasonable value of such a facility or organization for such purpose for the period following a change of ownership (whether by sale, lease, or other transfer) of the facility or organization of the business which operates the facility or organization, if, during any period prior to such change of ownership, such facility or organization provided (or arranged for) services for which payment was made under a State plan approved under this title.".

(b) The amendment made by subsection (a) shall be applicable to facilities or organizations the ownership of which is changed after June 30, 1976.

VISIT AWAY FROM INSTITUTION BY PATIENTS OF SKILLED NURSING OR INTERMEDIATE CARE FACILITIES

SEC. 33. Section 1903 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"(i) In the administration of this title, the fact that an individual, who is an inpatient of a skilled nursing facility or an intermediate care facility, absents himself therefrom to make visits outside the institution shall not be regarded as conclusively indicating that such individual is not in need of the services which such facility is designed to provide; but such visits, and the frequency and length thereof, shall be taken into account, together with other evidence, in determining whether such individual is in need of such services.".

PROCEDURES FOR DETERMINING REASONABLE COST AND REASONABLE CHARGE; DISCLOSURE OF OWNERSHIP AND FINANCIAL INFORMATION

SEC. 40. (a) Part A of title XI of the Social Security Act is amended by adding after section 1132 thereof (as added by section 11 of this Act) the following new section:

"PROCEDURES FOR DETERMINING REASONABLE COST AND REASONABLE CHARGE; DISCLOSURE OF OWNERSHIP AND FINANCIAL INFORMATION

"SEC. 1133. (a)(1) In determining, for purposes of ascertaining the amount of any payment for a health service, or services furnished under title XVIII, under a program established pursuant to title V, or under a State plan approved under title XIX, when such payment is based on the reasonable cost or reasonable

charge for such service (or services), no element comprising any part of such cost or charge shall be considered to be reasonable if, and to the extent that, such element is—

"(A) a commission, finder's fee, or for a similar arrangement, or

"(B) an amount payable for any facility (or part or activity thereof) under any rental or lease arrangement

which is, directly or indirectly, determined, wholly or in part as a per centum, fraction, or portion of the charge or cost attributed to any health service (or health services) (other than such element) or any health service (or health services) including, but not limited to, such element.

"(2) The Secretary shall by regulations provide that, in determining the reasonable charge or reasonable cost of any health service (for purposes of title XVIII, any program established pursuant to title V, or any State plan approved under title XIX), appropriate account will be taken of the relationship between direct and indirect overhead costs and the direct costs involved with the provision of such service, and, in connection with the making of any such determination with respect to any such service, there shall be included as a part thereof an indication of the ratio of such overhead costs with respect to such service and the total costs involved in the furnishing of such service.

"(b)(1) The Secretary shall by regulation establish procedures whereby, in the administration of title XVIII, programs established pursuant to title V, and State plans approved under title XIX, there will be review and advance approval of any contract which—

"(A) constitutes an element of cost of any health service for which payment is authorized under title XVIII, a program established pursuant to title V, or a State plan approved under title XIX;

"(B) is a consulting, management, or service contract; and

"(C) involves payments with respect to any consecutive period of twelve months which aggregate $10,000 or more.

"(2) Such procedure shall provide that advance approval of such a contract will be given only if—

"(A) the services to be furnished thereunder are found to be services which may appropriately be furnished on a contract basis;

"(B) the contracting party is qualified to furnish the services called for under such contract;

"(C) the contract price for the services called for thereunder is reasonable; and

"(D) any part of the payment called for under the contract is to be paid in advance, the amount of the payment will be based on the needs of the contracting party for the advance payment.

"(c)(1) The Secretary shall by regulations (or by contract provision) provide that any entity (other than a public agency) which is—

"(A) a provider of services which furnishes services with respect to which payment is claimed under title XVIII, under any program established pursuant to title V, or under a State plan approved under title XIX; or

"(B) a party to an agreement with the Secretary entered into pursuant to section 1816 or 1842(a);

shall promptly comply with any request, made by the Secretary or the Comptroller General of the United States for any or all of the following:

"(C) full and complete information as to the identity (i) of each person having (directly or indirectly) an ownership interest of 1 per centum or more in such entity or who is the owner (in whole or in part) of any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by such entity or any of the property or assets thereof, (ii) in case such entity is organized as a corporation, of each officer and director of the corporation, and (iii) in case such entity is organized as a partnership, of each partner;

"(D) full and complete information as to any business dealings between such entity and persons referred to in clause (C), and

"(E) a consolidated certified costs report with respect to its costs and charges, including costs and charges of related organizations (as that term is employed for purposes of title XVIII).

"(2)(A) If at the close of the sixty-day period which begins on the date a request (as described in paragraph (1)) is made of an entity described in paragraph (1) (A) or (B), such request has not been fully complied with, then—

"(i) in case such entity is an entity described in paragraph (1)(A), the Secretary shall notify such entity that no payment will be made to such entity under title XVIII, and no Federal funds shall be available with respect to any expenditures made under or pursuant to title V or XIX (or a program or plan approved thereunder), for or on account of any services furnished by such entity on or after the first calendar month which begins not less than thirty days after the date such notice is sent, and

"(ii) in case such entity is an entity described in paragraph (1)(B), the Secretary shall notify such entity that any agreement between such entity and the Secretary entered into pursuant to section 1816 or section 1842 is terminated effective on the first day of the first calendar month which begins not less than thirty days after the date such notice is sent.

In case the Comptroller General makes a request (as described in paragraph (1)) which is not complied with prior to the sixty-day period described in paragraph (2), then he shall, at the earliest practicable date after the close of such period, advise the Secretary of that fact that such request was made by him and was not complied with within such period, so as to enable the Secretary to notify the entity involved as provided in subparagraph (A) (i) or (ii).

"(B) Notwithstanding any other provision of law—

"(i) payments otherwise authorized to be made under title XVIII, and Federal funds otherwise available with respect to expenditures under or pursuant to title V or XIX (or a program or plan approved thereunder) shall be subject to the limitations referred to in a notice sent by the Secretary pursuant to subparagraph (A)(i), and

"(ii) agreements referred to in subparagraph (A) (ii) shall be terminated as indicated by the Secretary in a notice sent by him pursuant to subparagraph (A)(ii),

except that the Secretary, for good cause shown, may terminate the application of such limitation after it has been in effect for not less than three months. Whenever an agreement between the Secretary and any entity is terminated pursuant to clause (ii) of the preceding sentence, the Secretary shall not enter into another agreement with such entity under section 1816 or section 1842 sooner than three months after such agreement was so terminated.

"(d) Notwithstanding any other provision of law—

"(1) no payment shall be made under title XVIII, and

"(2) no Federal funds shall be available under title V or XIX with respect to expenditures made under a State program or plan approved thereunder,

for goods and services furnished, on or after the first day of the first calendar month which begins not less than ninety days after the date of enactment of this subsection, to a patient (directly or indirectly) by any entity which is an independent pharmacy or laboratory unless there is in effect an agreement between such entity and the Secretary or in the case of title XIX the State agency under which such entity agrees to provide to the Secretary (or any authorized officer or employee of the Department of Health, Education, and Welfare) reasonable access to the books and records thereof which pertain to the provision of billing and payment for goods and services supplied or rendered by such entity.".

(b) The amendments shall, except as otherwise specified therein, take effect, in the case of a provider for fiscal years beginning or or after July 1, 1976 and, in the case of any other person on July 1, 1976.

STANDARDS FOR PAYMENTS UNDER MEDICAID TO HEALTH MAINTENANCE ORGANIZATIONS

SEC. 41. Section 1903 of such Act is amended by inserting at the end thereof the following new subsection:

"(m) Payment under the preceding provisions of this section shall be made with respect to any amount expended during calendar quarters commencing after December 31, 1976, by a State as payment on a per capita or similar basis for the provision of medical assistance only if—

"(1) the entity to which such payment is made meets the definition of a health maintenance organization contained in section 1876 as amended,

"(2) of the enrolled members of such entity not less than (A) 50 per centum of such members (in case such entity is not an entity described in clause (B)) are individuals who are neither entitled to benefits under title XVIII nor eligible for medical assistance under the State plan approved

under this title, or (B) in case such entity serves a geographic area in which individuals (referred to in clause (A)) constitute less than 50 per centum of the total population, a per centum equal to whichever of the following is the larger: (i) a per centum of such members equal to the per centum of such total population which consists of such individuals, or (ii) 25 per centum of such members; and

"(3) such payment is made under a contract or other arrangement which has been approved in advance by the Secretary and which meets requirements imposed by regulations which the Secretary shall prescribe for the purpose of assuring that payments by a State on a per capita or similar basis for the provision of medical assistance are subject to substantially the same requirements as those imposed by subsections (a) and (i) of section 1876 with respect to title XVIII.".

AMBULANCE SERVICE

SEC. 42. (a) Section 1861(s)(7) of the Social Security Act is amended by inserting:

"(including ambulance service to the nearest hospital which is: (a) adequately equipped and (b) has medical personnel qualified, in the opinion of the hospital, to deal with, and available for the treatment of, the individual's illness, injury, or condition)" immediately after "ambulance service".

(b) The amendment made by subsection (a) shall be applicable with respect to services furnished on and after the first day of the first calendar month which begins after the date of enactment of this Act.

GRANTS TO REGIONAL PEDIATRIC PULMONARY CENTERS

SEC. 43. (a) Section 511 of the Social Security Act is amended—

(1) by inserting "(a)" immediately after "SEC. 511.", and

(2) by adding at the end of such section the following new subsection:

"(b)(1) From the sums available under paragraph (2), the Secretary is authorized to make grants to public or nonprofit private regional pediatric respiratory centers, which are a part of (or are affiliated with) an institution of higher learning, to assist them in carrying out a program for the training and instruction (through demonstrations and otherwise) of health care personnel in the prevention, diagnosis and treatment of respiratory diseases in children and young adults, and in providing (through such program) needed health care services to children and young adults suffering from such diseases.

"(2) For the purpose of making grants under this subsection, there is authorized to be appropriated, for the fiscal year ending September 30, 1977, and each of the next four succeeding fiscal years, such sums (not in excess of $5,000,000 for any fiscal year) as may be necessary. Sums authorized to be appropriated for any fiscal year under this subsection for making grants for the purposes referred to in paragraph (1) shall be in addition to any sums authorized to be appropriated for such fiscal year for similar purposes under other provisions of this title.".

(b) Section 502(2) of such Act is amended by inserting "(a)" immediately after "511".

RESOURCES OF MEDICAID APPLICANT TO INCLUDE CERTAIN PROPERTY PREVIOUSLY DISPOSED OF TO APPLICANT'S RELATIVE FOR LESS THAN MARKET VALUE

SEC. 44. (a) Section 1902(a)(17) of the Social Security Act is amended by striking out "and (D)" and inserting in lieu thereof the following: "(D) provide that, in determining the amount of the resources of any individual who is an applicant or recipient of medical assistance under the State plan, there shall (in addition to all resources actually owned by the individual) be included an amount equal to the current market value of any property of such individual if and to the extent that, within the one-year period immediately preceding the date the determination is made, such property was disposed of to a relative of such individual for less than fair market value, and (E)".

PENALTY FOR DEFRAUDING MEDICARE AND MEDICAID PROGRAMS

SEC. 45. (a) Section 1877(b) of the Social Security Act is amended—

(1) by striking out "misdemeanor" and inserting in lieu thereof "felony", and

(2) by striking out "one year" end inserting in lieu thereof "two years".

(b) Section 1909(b) of such Act is amended—

(1) by striking out "misdemeanor" and inserting in lieu thereof "felony", and

(2) by striking out "one year" and inserting in lieu thereof "two years".

Senator TALMADGE. I am glad that Senators Long, Ribicoff, Eastland, Hollings, Moss, Inouye, Domenici, Percy, Stone, Pell, Randolph, Gravel, Nunn, and Hartke as well as both the majority and minority leaders, Senators Mansfield and Scott, have joined me in this vital and urgent effort.

The situation is indeed urgent. Medicare and medicaid will cost Federal and State taxpayers more than $38 billion in fiscal year 1977—an increase of $7 billion over fiscal year 1976.

The increasing costs of these programs continually outstrip the rate of rise in Federal revenues. The choice is a simple one—either we make medicare and medicaid more efficient and economical, or we reduce benefits.

We have just too many worthwhile demands on the Federal dollar to be able to allocate increasingly disproportionate amounts to medicare and medicaid.

There is, of course, another choice—we can increase taxes. But even if that hard decision were taken we would, without necessary changes, be pouring dollars down a bottomless pit.

As they now operate, medicare and medicaid clearly could absorb every single dollar the Federal Government can come up with. It is time, in fact past time, to put our house in order. To do that, hard decisions have to be made—decisions which I believe this bill makes. If these decisions are not made now, we may well be confronted with the need to cut and slash payments to hospitals and doctors indiscriminately and often inequitably. That path is exactly what S. 3205 seeks to avoid.

States are now moving to place ceilings on payments to hospitals. Blue Cross plans are moving in that direction. The administration proposes a flat 7 percent limit on hospital cost increases. Momentum is rapidly increasing for arbitrary controls on payments to providers and practitioners. This bill, however, seeks to avoid cutoffs of this sort.

In Colorado, for example, the State has ordered a 5 percent reduction in Blue Cross payments to hospitals and a 5 percent cut in Blue Shield payments to doctors.

At the National Governors' Conference held in Hershey, Pa., just last month the Governors of this country stated that the "rapidly escalating costs of the medicaid program are bankrupting the States and their localities." The Governors' resolution noted that there is "a need for better control over both the rates paid for health services and the utilization of these services by the patient."

The Governors' Conference urged State governments to intensify efforts to manage their medicaid programs better and also urged related cooperative action by the Federal Government to revise "existing regulations and legislation which pose obstacles to effective cost control procedures."

It is my strong belief that S. 3205 is certainly consistent with the resolution of the Governors' Conference. I look forward to the testimony this morning of the able and distinguished Governor of my own State, Governor Busbee, who will speak on behalf of our Nation's Governors. The National Association of Counties, from whom we will also hear today, has called for immediate wage and price controls on hospitals to avoid bankrupting costs.

But there is an overriding need to get a handle on medicare and medicaid costs apart from the Federal, State, and local budget effects. There is no question that the way we pay for care under our programs serves to inflate health care costs for all Americans. That situation needs correction now.

There is an absolute need for the Federal and State governments to effectively manage the existing health care programs. It is difficult, if not foolhardy, to extend health insurance coverage to other segments of the population until we are satisfied that we can manage what we've got now.

I believe we have a representative list of witnesses this week. It is my hope that these hearings will provide the basis for timely congressional action on necessary changes in the way Government conducts medicare and medicaid.

As I have stated repeatedly, none of the provisions in S. 3205 are locked in concrete. Hopefully, constructive changes and improvements will be a product of these hearings.

But, while improvements can and should be made, no one should mistake a willingness to make changes as a sign of weakness. With many billions of public tax dollars at stake, there will of course be those who presently profit from waste, inefficiency, fraud and abuse, and outdated methods of payment who will not want any changes made. Often these are the same people who in forums and cocktail parties constantly decry "big wasteful government." Nevertheless, they will come here to try to preserve their own share of that big government and those wasteful expenditures. It's always the other guy they're talking about. Well, they can't have it both ways and they won't have it both ways if we do our job.

I want to assure those people that the limits of tolerance have been reached. What has been glossed over, ignored, or sidestepped in the past will now be faced headon. We owe that much to the American people.

Now it is with a great deal of pleasure that we welcome the distinguished Secretary of Health, Education, and Welfare, the Honorable David Mathews.

Mr. Secretary, you may proceed as you see fit, sir.

STATEMENT OF HON. DAVID MATHEWS, SECRETARY, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE; ACCOMPANIED BY THEODORE COOPER, ASSISTANT SECRETARY FOR HEALTH; STUART ALTMAN, DEPUTY ASSISTANT SECRETARY FOR PLANNING AND EVALUATION/HEALTH; J. BRUCE CARDWELL, COMMISSIONER OF SOCIAL SECURITY; THOMAS TIERNEY, DIRECTOR, BUREAU OF HEALTH INSURANCE, SOCIAL SECURITY ADMINISTRATION; AND M. KEITH WEIKEL, COMMISSIONER, MEDICAL SERVICES ADMINISTRATION, SOCIAL AND REHABILITATION SERVICE

Secretary MATHEWS. Thank you very much, Mr. Chairman.

I might say before I commence my formal remarks that we prepared this testimony in recognition that is indeed a major national problem, one in which we join you in concern.

The underlying structural characteristics of the health care industry, the prevalence of public and private insurance coverage and the reimbursement practices of these third parties have resulted in chronic inflation in health care costs and tremendous increases in public and private outlays. For example, hospitals which are, for the most part, non-profit institutions are generally reimbursed for all reasonable costs associated with patient care. This reimbursement method is inherently inflationary since there is little formal incentive to keep the hospital's costs down. Similarly, it is generally the physician, who is reimbursed on the basis of his billed charge, who decides on the amount and type of services to be provided. Thus, the higher the billings and the more services provided, the higher the physician's income.

The inflationary effects of these reimbursement methods are clearly exaggerated by the virtual guarantee of payment by a public or private insurer and the dependence of the consumer on the medical care provider. In fiscal year 1975, 92 percent of all hospital expenses and 65 percent of all physician expenses were paid for by a public or private insurance program. In fiscal year 1975, $103 billion was spent in the United States for personal health care services. Almost 70 percent of these expenditures were paid for by public and private insurance programs.

The two major Federal financing programs, medicare and medicaid, spent $22 billion of Federal funds in fiscal year 1975. The States for their share of medicaid spent an additional $5.6 billion. Many of the current problems in these programs that this bill is designed to address stem from their original design. When these two programs were established by Congress in 1965, they were designed not to interfere with and to rely to the maximum extent possible on the existing private health care delivery system and reimbursement arrangements. Thus, cost-based reimbursement for hospitals and fee-for-service reimbursement of physicians were adopted; the medicare program relied on private insurance companies to administer program reimbursements; and State medicaid programs were given great flexibility with respect to reimbursement practices, scope of benefits, and program administration.

The cumulative effect of these organizational, administrative, and reimbursement arrangements, coupled with the growth of private health insurance coverage has been chaotic. Over the past 10 years, hospital costs and physician fees have increased over 50 percent faster than the overall cost of living. Health care expenditures have increased from 5.9 percent of gross national product in 1966 to 8.3 percent in 1975. Over the last 2 years, Federal medicare and medicaid outlays have increased 40 percent and now exceed 80 percent of the entire HEW health budget. Many State medicaid programs are in severe financial difficulties. Private health insurance premiums increased this year on the order of 30 to 60 percent. Medicare beneficiaries are facing increased out-of-pocket costs and medicaid beneficiaries in many States face great difficulties in getting access to care.

To help alleviate these problems the Federal Government has proposed several major legislative and program initiatives. We believe that a comprehensive approach to financing health care involving Federal and State governments and the private sector is potentially the most effective from both a health delivery and cost containment perspective. This administration is working to effect improvements in the existing Federal health care programs and to strengthen the capacity of State governments and the private sector to meet these problems. The medicare improvements of 1976 was designed to provide protection against the catastrophic costs of illness for medicare beneficiaries and to control rising health care costs.

The Department is vigorously attempting to control costs in the Federal programs through its hospital cost and physician fee limitation authorities obtained through the 1972 Social Security Amendments. The President also proposed a $10 billion consolidation program, the Financial Assistance for Health Care Act, which would combine 15 categorical health service programs and the medicaid program and provide States with increased flexibility and funds to meet their health needs.

The PSRO program is becoming fully operational and should result in better quality and more appropriate levels of care for medicare and medicaid beneficiaries. The Health Planning and Resources and Development Act of 1974 establishes a network of health planning and resource development agencies at the regional level to improve the development and allocation of resources, as do the more limited end stage renal disease and emergency medical services programs.

We are supporting demonstrations of how to accomplish redirection of the delivery system toward ambulatory and preventive care through our support of health maintenance organizations and manpower development programs. Our preventive and health education efforts also include immunizations, fluoridation, rehabilitation, regulation of foods, drugs, cosmetics, protection of workers from occupational hazards, as well as the early and periodic screening, detection and treatment program for all eligible children up to age 21.

S. 3205 must be viewed in light of these initiatives and the current institutional structure of the health care industry. Some of its provisions would make major structural changes in these programs and cause major organizational changes within HEW. Others would

effectuate minor changes in the benefit packages, reimbursement or administration of medicare and medicaid.

While I believe that some of the proposed solutions have considerable merit, I am not totally confident that the bill, as a whole, would be as effective as intended. My concern is with any measure that is aimed only at governmental health financing programs. Nevertheless, I see this bill as addressing the widest range of medicare and medicaid program issues since the 1972 Social Security Amendments.

We are currently in the process of analyzing the 27 different provisions of this bill as well as other proposals affecting our health financing programs and will submit our legislative recommendations as part of the next budget/legislative cycle. Nevertheless, I would at this time like to share with you my preliminary views on the bill.

It seems to me that as we engage together in an analysis of ways to remedy current problems, we should agree on the criteria against which to test the proposed remedies. Among the chief criteria I would apply are the effects on the overall health care delivery system as well as on the medicare and medicaid programs.

In particular, each provision must be evaluated for its effects on program beneficiaries, program costs, overall health care costs, accessibility of resources, medical care providers' behavior and private health insurance coverage.

In assessing the individual provisions of this bill, two fundamental and interrelated issues must be addressed. First, does the particular provision address a real programmatic problem? Second, is the proposed legislative solution likely to be effective or are there alternative solution that would more effectively solve the specific problem? Furthermore, in attempting to deal with the problems in the medicare and medicaid programs, we must guard against creating additional problems on the private side of the health care delivery system.

The major reimbursement reforms in S. 3205 address very real problems. The Department agrees with the general direction suggested in section 10 to change medicare and medicaid hospital reimbursement from a retrospective cost basis to a prospective budget related approach. However, while we fully recognize the problems of cost reimbursement for hospitals, we have some concerns about the particular solution offered.

First, by excluding all teaching, energy, and capital costs from the routine cost limits, only about 35 percent of the hospital's costs would be subject to the prospective limits. This would likely result in hospitals shifting costs internally or raising their charges to nonmedicare-medicaid patients—the result being no change in overall hospital costs. In fact, because of the noninclusive definition of routine costs, this proposed system could be less effective than the current prospective routine cost limits established under section 223 of the 1972 social security amendments, which apply to about 50 percent of a hospital's costs.

We are also concerned about the proposed hospital classification system. As you know, developing an appropriate system to group hospitals for reimbursement purposes is very difficult. While we appreciate the simplicity of the system developed in section 10, we are quite concerned about the lack of an appropriate local wage index to adjust personnel costs among hospitals.

The Department, in cooperation with several States, is experimenting, demonstrating and evaluating a variety of prospective reimbursement systems using authorities obtained in section 222 of the 1972 Social Security Amendments and section 1526 of the planning title in the PHS Act. We are also continually refining the section 223 classification system and cost limits. These efforts should provide the information necessary to develop an effective and equitable hospital prospective reimbursement system.

We are also supportive of the intent of the physician reimbursement provisions, sections 20 through 23. Current reimbursement differentials between urban and rural areas reflect differences in physicians' customary charges. This reimbursement system was not intended to address the shortages of physicians in rural areas but some narrowing in these differentials might be useful in addressing this problem. Nevertheless, I would express some reservations about the possible effectiveness of the mechanism proposed in section 20. The problem of physician location is much more complicated than a medicare-medicaid reimbursement issue. We see a need for a broader approach. The Department is actively developing both manpower and reimbursement policies designed to encourage physicians to locate in rural areas.

The Department is also analyzing alternative policies and incentive mechanisms to encourage physicians to accept assignment. We support the intent of the participating and non-participating physician concepts developed in section 21. We do, however, question both the potential effectiveness of the proposed incentives to encourage acceptance of assignment and the impact of "always" or "never" alternatives. In addition, we are quite concerned about the administrative costs to both the physician and the medicare program of adopting these incentives. The Department supports efforts to develop a more appropriate reimbursement method for hospital-based physicians. We support the effects in section 22 to tie reimbursement to the actual services performed.

We share the concern of S. 3205 that medicaid physician reimbursement levels in some States do not provide the accessibility to care for medicaid beneficiaries that is available to more affluent persons. Nevertheless, there are several major issues which must be considered, including whether these rates should be raised. First, many States medicaid programs are experiencing cutbacks in eligibility, benefits and/or provider reimbursement as a result of State budgetary difficulties. Second, since there is nothing sacrosanct about medicare reimbursement rates, there is no way to know at what "appropriate" level to set the medicaid reimbursement rates.

Sections 2 and 3 of the bill would result in a major administrative reorganization of health programs within HEW. This is an area of particular interest to me. However, the issues involved in establishing an Assistant Secretary for Health Care Financing and an Inspector General for Health as well as merging the Bureau of Health Insurance, the Medical Services Administration, the Bureau of Quality Assurance and the Office of Nursing Home Affairs are extremely complicated. Organizational changes do not necessarily solve problems.

On the one hand, combining these programs organizationally is a way to increase standardization and coordination. It could lead to

more efficient management and a more consistent system. But we are not sure that it would lead to better quality care nor are we yet convinced that organizational consolidation is the best way to achieve efficiency. The two financing programs have important fundamental differences with respect to their client populations, eligibility standards and benefits covered.

For example, even under the proposed reorganization, the medicare program would still have to rely on the Social Security Administration for eligibility determinations, but medicaid would continue to rely on State welfare systems. The medicare skilled nursing facility (SNF) benefit (average length of stay about 30 days) is quite different from the medicaid SNF benefit (average length of stay 2 years). In effect, the proposed reorganization runs the risk of mixing apples and oranges.

Furthermore, we are quite concerned about the coordination between medical care quality standards and reimbursement procedures to insure that the essential requirements of both are preserved. The Department is currently analyzing issues of this kind and is looking at alternative organizational patterns to bring about the efficiencies we all seek without destroying the benefits of the existing organizational relationships.

Since coming to the Department, I have become convinced that there is a real need for an Inspector General type of activity. The need for this organization, however, is not only in the health care programs but is departmentwide. Therefore, I have begun to make the necessary organizational changes to accomplish this end.

Last December I issued a reorganization order establishing an independent Office of Investigations reporting directly to the Under Secretary. This activity complements our audit responsibilities. In addition, a major Federal-State campaign was launched in March to curb fraud and abuse in the medicaid program.

These activities have been accomplished without new legislative authorities. In my view, a legislatively mandated system and particularly one that only partially addresses the problem, would retard the progress we are now making and would not work to carry out the objectives that we all seek.

In concluding, I would like to say that this bill has evoked a healthy debate about the problems in our health care financing programs. Because of the size and technical complexity of this bill, we believe that there is insufficient time during this session of Congress to fully debate and work out the best options to accomplish its objectives.

Over the next few months the Department will work closely with this committee and other components of Congress fo develop the most appropriate and effective solutions to our health care financing and delivery problems. Mr. Chairman, this concludes my remarks. My associates and I will be pleased to answer any questions you have.

Senator TALMADGE. Thank you, Mr. Secretary.

If there is no objection, we will limit the questioning on the first round to 5 minutes for each Senator, and each Senator who wants a second round and maybe a third will have such opportunity.

Mr. Secretary, you commented on some aspects of the bill but not others. Will you submit to us a detailed recommendation on each

provision in the bill and alternative recommendations where you do not think we have developed the best solution?

Secretary MATHEWS. I will be pleased to, Senator.

[The following was subsequently supplied by the Department of HEW.]

As I stated in my prepared remarks, we are currently analyzing the 27 provisions of this bill. Given, the size, technical complexity, interdependence among various provisions, and the many possible alternative recommendations for addressing the problems raised by the bill, the Department's in-depth analyses of the individual provisions are still underway. I have shared with you my preliminary views on several provisions; we will be happy to make available to you our final recommendations as soon as our technical analyses are completed.

Senator TALMADGE. Mr. Secretary, the bill requires uniform accounts and cost reporting. We do not have that in medicare and medicaid today. I understand that hospitals can shift costs around under the present system and thereby avoid much of the impact of the present limits on excessive costs on the medicare. For example, I understand that one way of doing this is to shift excess inpatient cost to the outpatient cost. Is my information correct?

Secretary MATHEWS. I think substantially correct, Senator. There are those here who join me at the table who can comment on this but I believe you are substantially correct in your view on that matter.

Senator TALMADGE. Mr. Secretary, while it is true that the hospital reimbursement provision would initially set limits that apply to only about 35 percent of the hospital cost, there is the authority to go further as the Department develops the ability to correctly evaluate the value of the additional components of hospital costs. You state that at present section 223, which applies to about 50 percent of the hospital costs, might be more effective than the proposal we have offered. Exactly how effective has the present system been in reducing hospital costs?

Secretary MATHEWS. My statement was predicated really on the simple fact that 50 was more than 35. With respect to our current hospital cost limits, I certainly could not in light of the statistics that I cited in my report about rising hospital cost argue that these limits have been totally effective.

Senator TALMADGE. Mr. Secretary, I notice your concern that cost determination is excessive under medicare and medicaid and might be passed on by a hospital in nonmedicare and medicaid patients. It is our intention to handle this possibility by including in the provider contracts of the hospitals and skilled nursing, a provision precluding the transfer of costs found to be excessive under medicare and medicaid. How does the Department propose to deal with the same problem where you call for a 7-percent limit on the cost increase?

Secretary MATHEWS. In both of these cases we would run into the problem that we are in effect controlling only part of the total health care financing in these hospitals and the contingent that the hospitals made when we made our proposal—and I feel they would make in this case—that they have costs that they cannot control and that these costs build up. If we put in our official barrier or an artificial barrier or a legislative barrier holding down part of the costs and yet do nothing to affect the source of those costs, there are costs really between two forces with no place to go. That is really a major difficulty

in our health financing system and nobody yet has come up with a good solution for that problem.

Senator TALMADGE. Is there an artificial barrier where hospitals are measured against other hospitals?

Secretary MATHEWS. I think that is reasonable but I think we would still have to deal with their argument that even as compared to other hospitals their costs are driven by forces over which they have no control. I said arbitrary. Perhaps a better term would be fixed limits.

Senator TALMADGE. Senator Packwood.

Senator PACKWOOD. Mr. Secretary, on page 1 of your statement you say:

> For example, hospitals which are, for the most part, nonprofit institutions are generally reimbursed for all reasonable costs associated with patient care. This reimbursement method is inherently inflationary, since there is little formal incentive to keep the hospital's costs down. Similarly, it is generally the physician, who is reimbursed on the basis of his billed charge, who decides on the amount and type of services to be provided. Thus, the higher the billings and the more services provided, the higher the physician's income.

Then you note that the bulk of the money received comes from private or public insurers.

Are you saying as a general rule that hospitals, physicians, and nursing homes are charging unduly high prices or providing unnecessary services because they know these will be paid for?

Secretary MATHEWS. No; I am not impugning them that way. I was simply drawing the distinction between the way that the health-financing system operates and the way any other economic system operates. There is an inherent difference and the hospital medical system is simply much more vulnerable to inflationary pressures because of its billing practices, not because one would make the case that they are bent and bound and determined to do that. All the hospital administrators I talked to have yielded to no one in their concern about controlling these costs.

Senator PACKWOOD. I think I agree with your conclusion, although there are a few bad apples here, most try to be honest and cost conscious.

Now if that is true, in your estimation what percent of the cost of medicare and medicaid could be saved if you had perfect administration of this program?

Secretary MATHEWS. I will turn to Dr. Altman who is a known national authority on this subject.

Senator PACKWOOD. I am premising it, Doctor, not on changing the benefit levels that you are entitled to but on the perfect management of the present system.

Dr. ALTMAN. When you speak about management, it is really not the management of the program. Let me just back up a minute on the question you asked before. If you forgive me, Mr. Secretary, I would answer it slightly different. I think you have to answer it slightly different in order to answer the second question. When you get to the medical community you are dealing with professionals who are trained to do a particular service and to whom you have provided all the resources they need to do it. It is not that they do things that are really unnecessary or that they do it in a way just to line their own pockets, but any professional faced with the need to do good and all the money

they need to do it, is bound to err on the margin of doing more rather than in the middle or less. I think what you have to consider if you want to cut down on the spending of this program is that this profession would have somewhat fewer resources to do what it needs to do.

Senator PACKWOOD. You are going to have a reimbursement schedule of some kind. You are in a position for certain kinds of services. We are going to pay you *x* dollars or you say we are not going to reimburse you for certain services, we are going to cut back your resources.

Dr. ALTMAN. If you take the proposals in S. 3205, the idea there is that a comparable hospital can do things at a different cost than others and that there are different ways of putting together the costs to do the same service. We don't question the need for that. We have some concern how maybe it is put together. By and large there is a feeling that the resources that are better being used in this industry are excessive and that the services of high quality medical care can be provided for less percentages in the order of 10 percent or 15 percent—what we can't say—but there is little question among people who have analyzed this industry is that because of the reimbursement systems and because of the way patients view this type of service more resources are being used than needed.

Senator PACKWOOD. I will come back to this.

Senator TALMADGE. Senator Dole.

Senator DOLE. Thank you, Mr. Chairman.

I only want to echo much of what has just been said regarding the pressures on our medicare and medicaid budgets, and commend Senator Talmadge for his dedicated efforts at bringing about the kind of reforms it will take to achieve some measure of control in this area.

I think the seriousness of the task before us is illustrated by the very occurrence of these hearings. We as a subcommittee do not meet very often, so when we do convene formally, it has to considered a significant occasion.

The fact that we would choose the hour of 8 in the morning is further indication, perhaps, of the importance of the subject matter involved. It may be, too, that since the committee has been accused of writing its tax legislation in the dark of night, we want to demonstrate our versatility by deliberating health legislation at the crack of dawn.

In any event, I believe we are all in agreement that something has to be done about the soaring cost of Federal health programs generally—and the intolerable abuses revealed over the past years specifically. S. 3205 is one comprehensive attempt at addressing the problems inherent in both.

Speaking for the minority members of the Health Subcommittee I might just say the fact none of us has yet become a cosponsor of this proposal does not mean we are not interested in the objectives it seeks. Certainly, as a member of this committee as well as the Committee on Budget—which this spring tried to mandate a $1.2 billion cutback in medicare and medicaid expenditures—I feel a special obligation in this area.

We do, however, want to demonstrate that there is room for difference of opinion as to how those goals should be reached. Moreover, we want to remain open to alternative approaches that might be worthy of our advocacy.

Senator Talmadge has said several times since introducing his bill that he is not trying to engage in legislative overkill and that none of its provisions is locked in concrete. Certainly, the whole reason for holding these hearings is that of capitalizing on such flexibility by receiving and reviewing new ideas and opinions which can hopefully lead to development of a consensus response.

To that end we are all committed—and look forward to the challenge of the week ahead. Seldom do we have the opportunity to discuss something that touches every aspect of the health industry as deeply as do changes in our medicare and medicaid administration and reimbursement systems—and we appreciate highly the participation of those joining us for that purpose.

May I just add a special welcome to those testifying today from the National Association of Counties; the National Conference of State Legislatures; Governor Busbee of the National Governors Conference; and Secretary Mathews. I believe this is the Secretary's first appearance before any part of the committee since his confirmation hearing over a year ago—and that in itself should underscore the importance of this undertaking.

Mr. Chairman, I thank you for the courtesy of these few comments and pledge my cooperation and support in trying to get a handle on the problems which confront us.

Now, to proceed with the questioning I had wanted to direct to Secretary Mathews, I would just note that there have been many investigative journalism articles and horror stories about medicaid scandals, but one of the first to catch my attention appeared in the Time magazine dated May 26, 1975. It stated therein that according to a recent GAO check, 28 percent of those receiving medicaid benefits in New York City were generally ineligible for them.

So I would just ask, what has been done in that area to make certain that we provide benefits to those who should be eligible and deny benefits to those who should not?

Secretary MATHEWS. Two things, Senator, and I address these in the last section of my remarks. There are some people who are receiving benefits. I think the article you have reference to concerns medicaid applicants who are simply not eligible or the moneys are spent in cases where people are fraudulently abusing the system. The best way to deal with that problem is to deal with it directly—we have to improve our capacity to deal with fraud and abuse in the system.

We have had up until about 8 months ago only 10 criminal investigators working on this program. Now mind you it is a program administered at the State level. We have in the creation of this new Office of Investigations, significantly with the assistance of Congress, increased the size of that staff, integrated it with our audit effort and are working with States using their own resources to try to cut down on the expenditure. However, despite whatever we might do in trying to control fraud and abuse we cannot by those efforts make up for poor program design.

One difficulty the States have is that they simply cannot keep up with this program. Their management information system for this program is inadequate to its size and complexity and we have developed what is in effect a model management information system and we

are quite anxious to work with States to provide the necessary technical assistance so that they can develop a surveillance system somewhat like the one we use in IRS that keeps up with the pattern of expenditures so that we are monitored. Those efforts together I think are a good portion of the answer to the problem described in this article.

Senator DOLE. We had the same problem in administering the food stamp program. There have been charges of abuse with families having incomes up to $16,000 or more qualifying for food stamps. I assume you have similar stories.

This article in Time also mentioned so-called "medicaid mills"—clinics set up to sort of "ping-pong" patients through several doctors or utilize what we call "family ganging" techniques, where they look at everyone in the family. Is there actual evidence of those types of operations and are they extensive or is that just one isolated story?

Secretary MATHEWS. I am thinking particularly of the State we have just gone into where, with the cooperation of the Governor, we have been looking at a series of cases, but I don't recall one that is exactly of the form that you described here. There is fraud and abuse in medicare and it is very simple. There are any number of devices for carrying it out.

Even with nonprofit institutions, the nursing homes and others, we see the establishment of pharmaceutical companies that are owned by the same people who own the drug companies. There is an indication of improper kickbacks for laboratories that do work. There are a whole host of unsavory practices. There are service problems. The cost to the Federal Government is somewhere in the order of $750 million a year.

Senator DOLE. You say $750 million?

Secretary MATHEWS. That is the figure we used in our last testimony.

Secretary TALMADGE. Mr. Secretary, one of the problems which has concerned us currently is the lack of followthrough by the U.S. attorney's office on cases of fraud developed by the medicare and medicaid programs. What actions have you taken to assure that cases will be brought to trial by U.S. attorneys, and do you feel that this is a problem area?

Secretary MATHEWS. We have directed our attack and plotted our strategy in cooperation with the States. By joining with the States in this effort we have been able to get at the problems a lot sooner, bring a case to the point, and fashion the case so that it can be turned over to the prosecutor. I have heard no comment in our Department about difficulties with the Justice Department. I would ask Dr. Weikel to comment. We are bringing these cases in Federal court, in State court, or in both?

Dr. WEIKEL. In the case of medicaid it is to go through the State board for prosecution. If for any reason at all that does not take place, then we are prepared and we have as part of the process involved meeting with the U.S. attorneys in the particular States in which we are working with the fraud and abuse initiative.

Now in the past I think it is fair to say that there has been less than enthusiastic acceptance of medicaid cases by some of the U.S. attorneys. On the other hand, we have some cases. We have one case in New York State involving at least $2 million of Federal funds,

50 to 100 providers, where the U.S. attorney is prosecuting that case and we are working with him in developing the case.

Senator TALMADGE. Do you think there is adequate followup on the medicare-medicaid cases referred to the U.S. attorneys?

Dr. WEIKEL. It is too early for us to give you a concrete answer on that in terms of the new initiative. In the past there was very little activity at the Federal level in medicaid fraud and abuse and therefore we don't have much history. I think medicare probably has much more history than medicaid.

Secretary MATHEWS. In medicare we do have a record of very vigorous activity in bringing cases before and getting action in the Federal court.

Mr. Tierney, do you have those figures at hand that are in the annual report of investigations and prosecutions?

Mr. TIERNEY. I am not sure I have the precise figure, Mr. Secretary. I could give you some general figures that I think would give you the picture, Senator Talmadge. As of June 30, 1976, there have been, since the inception of the medicare program, 43,822 allegations of abuse or fraud; 23,281 of those were fraud allegations. Now these include statements from people who simply say that there is an item in a bill for a service I never received; often their allegation turns out to be a mistake. That gets down, when we finally complete our investigation of such allegations, to somewhere around 2,300 fraud cases which we have gone all the way through a——

Senator TALMADGE. What has happened to the 23,000 cases?

Mr. TIERNEY. Then we started to screen those cases.

Senator TALMADGE. You reduced them to 2,300?

Mr. TIERNEY. Yes.

Senator TALMADGE. What happened to the 2,300?

Mr. TIERNEY. In those cases, Mr. Chairman, about 578 of them we referred to the Justice Department.

Senator TALMADGE. How many convictions did you get?

Mr. TIERNEY. I would like to submit that information.

Senator TALMADGE. We would like to have it for the record.

Mr. TIERNEY. Yes; but let me give you the picture. We have secured 267 indictments and about 200 convictions. Now that does not sound like much but to give it a little perspective, Mr. Chairman, that is more indictments and convictions—I am not saying this is our prime goal in medicare—but that is more indictments and convictions for that kind of fraud than have been secured by all the rest of the health insurance industry combined prior to the medicare program. So I think we have an active program, Mr. Chairman, and I think we have a tremendously effective deterrent program.

[The material referred to above follows:]

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL SECURITY ADMINISTRATION,
Baltimore, Md., July 26, 1976.

Hon. HERMAN E. TALMADGE,
Chairman, Subcommittee on Health, U.S. Senate, Washington, D.C.

DEAR SENATOR TALMADGE: During the course of this morning's hearings you and other members of your subcommittee asked questions about the number of fraud allegations, investigations, and convictions which had occurred in the Medicare program. At the time, I did not have the precise numbers and asked your permission to submit them for the record.

To date, we have received and investigated approximately 20,000 allegations of possible fraud. Generally, these allegations arise from beneficiaries who simply question the receipt of items of service or supplies for which they have been billed. In the vast majority of cases, these allegations turn out to be the result of a mistake or a misunderstanding. Nevertheless, our program integrity units, centrally and regionally, investigate every such assertion.

We have referred 550 cases to the Justice Department for prosecution, 182 cases are awaiting prosecution, and 163 have resulted in convictions. The balance were either declined, or the charges were dismissed, or the defendant acquitted.

In addition to these fraud cases, we have investigated some 10,000 incidents of possible abuse of the program. As a result of these investigations we have secured the repayment of approximately $30,000,000. As Senator Packwood pointed out, these end results seem very small in view of the amount of effort expended, but we believe that the deterrent effect of aggressive investigation is valuable to the program.

Sincerely yours,

THOMAS M. TIERNEY,
Director, Bureau of Health Insurance.

Senator TALMADGE. My time has expired.

Senator Packwood.

Senator PACKWOOD. Let me go back to the original question I was pursuing. I think if you are successful in all of your criminal indictments regarding fraud—if you are lucky, you may save enough money, maybe, to be the difference in one year's increase in its cost and after that you are off and running again. I think that is what the doctor was about to say, that it is not going to be enough to tighten it up and manage the present program but something else has got to be tightened up. I am curious what are some of the things you are talking about. Where do we start to cut back? What types of services do we minimize or cut off? What kind of service do we cut down?

Dr. ALTMAN. First of all I think the best thing is not to try to second guess the front line people, the providers. You look for incentives either in the form of financial or in the form of regulatory. You essentially ask the provider community to cut back. The surgery program is a good example of that. When you talk about cutbacks of 40 percent in the rate of surgery, that is billions of dollars nationally but that is the first line.

Senator PACKWOOD. I will put it in layman's language. You say to a hospital: Your reimbursements last year were a million dollars; this year we will give you only $950,000. You live with that.

Dr. ALTMAN. That would be the second line. The first line was essentially we create a reimbursement on the HMO's where you have a fixed amount of money and you say to the medical community: You are going to provide any amount of care that you believe is necessary but you are not going to get any more money.

Senator PACKWOOD. Let me ask a question about the HMO's because I recall the doctor's testimony 3 or 4 years ago on the subject of medicare where the HMO said that their real secret on cost study was really in preventive medicine but when it came down to the actual cost of running a hospital for those that had to be hospitalized they could not run them any cheaper than the normal nonprofit or they would not have a hospital.

Dr. ALTMAN. Dr. Cooper is much more familiar with that than I am but that is true. The real savings is not having someone in the hospital in the first place and therefore building a smaller facility so that they use fewer hospital beds per year.

Senator PACKWOOD. In this medicare program how do you go about encouraging less hospital care?

Dr. ALTMAN. We favored a more positive approach towards HMO development than is currently in medicare and medicaid.

Senator PACKWOOD. Let me separate those two. You don't have to have HMO's to reach this goal you are talking about.

Dr. ALTMAN. No.

Senator PACKWOOD. Fewer hospitals.

Dr. ALTMAN. And the alternative way that is in the statute of the 1972 amendments is in the PSO program where you ask medical providers in the community to be concerned about the need for surgery. Again Dr. Cooper is in a much better position to discuss that.

Let me just say on the reimbursement side you want to couple it. The medical side is one side but you do need in my view some kind of financial constraints. There needs to be a budget that a provider goes up against, whether it is a hospital or a physician.

Senator PACKWOOD. Let's go back to what kind of a budget would you need. What do you say to a private practicing physician in order to live within his budget?

Dr. ALTMAN. I am less concerned about the individual physician in the office. When he gets in the institution, the amount of tests he orders, the amount of procedures he has available to him—if the hospital faces a limited budget, it cannot just simply have all the tests that anyone could want, all the drugs, and so there would have to be some give and take within the medical community and the hospital administrative staff on how can we cut back. I would hate to see us try to dictate from on high you could do this and not that. I have listened to medical people enough to know that that is not a wise move.

Senator TALMADGE. Senator Dole.

Senator DOLE. I don't want to take all the time on what actions have been taken so far by U.S. attorneys, but it is my understanding that most violations now are misdemeanors. Is that correct?

Dr. WEIKEL. That is correct.

Senator DOLE. Under the Talmadge bill it will be changed to felonies.

Dr. WEIKEL. In the case of medicaid we are very supportive of that.

Senator DOLE. I think the same has been true in other areas where we have had very little, if any, prosecution. It is hard to interest the U.S. attorney in a misdemeanor charge when he is going to spend more time in the investigation than he might be able to justify otherwise. So you support the change from misdemeanors to felonies?

Dr. WEIKEL. Very definitely.

Senator DOLE. With reference to the 19,000 complaints pared down to 2,000, did you get some fix on the number of final convictions?

Mr. TIERNEY. Yes. As I said to the chairman, Senator, the number of actual convictions is about 200. That is very small.

Senator DOLE. Do you have any idea of the fraud that is involved in terms of total dollars?

Mr. TIERNEY. No, sir, I don't.

Senator DOLE. What is the biggest abuse or "ripoff" you have experienced in medicare and medicaid?

Mr. TIERNEY. Well, Senator, it all depends whether you are talking about individual physicians or whether you are talking about institutions. The ripoff part is not the big thing. When you actually get a case of fraud it is because the doctor is charging for services that he didn't provide or he is agreeing to take an assignment and then goes ahead and bills the patient also. That does not necessarily mean that there is a lot of money involved.

I think, in reply to Senator Packwood's series of questions, it does not make a great difference—the actual recovery of money or the actual fraud involved—but the potential is nevertheless very great.

Now the abuse of services, Senator, probably involves a lot more money than the fraud. In other words, a doctor who keeps on providing more and more and more unnecessary services, commits no fraud. He is abusing the program and his abuse involves substantial amounts of money. The amount of money involved in medicare fraud is not a significant financial item.

Senator DOLE. Mr. Secretary, you have stated in your testimony that much of the internal consolidation and reorganization contemplated by the Talmadge bill can be done administratively—that is, without legislation—and that that is the way you would prefer to handle it. Have you analyzed the bill to see if there are other areas which you might address the same way, and, if so, could that be made available for the record?

Secretary MATHEWS. We would be pleased to make this information available when the Department has completed its analysis of the bill.

I commented on the other because of my concern that these matters be approached on a departmentwide basis. I have the same conviction the Senator does about the need for expanding our capacity but we have other areas of the Department where we have problems with fraud and abuse. It would make much better sense for us to have a single comprehensive fraud and abuse and Inspector General program combined and allied with our audit effort than it does to have a series for each of the particular problems that we have had. [But whether we do have other activities underway that would have some impact on this legislation, we would be pleased to comment on those in the context of the comment of the Senator.]

Senator TALMADGE. Mr. Tierney, you have had many years of experience dealing with hospitals and doctors, first as the president of the Blue Shield-Blue Cross plan and then as Director of Medicare. Based upon that extensive experience is it your view that arrangements whereby hospital associated physicians such as radiologists and pathologists are paid through a lease or percentage arrangement leads to excessive payments?

Mr. TIERNEY. Senator, I was never a part of Blue Shield, just Blue Cross. That is just for the record.

Senator, this has been a problem since at least the early fifties and I think it has long since been time, as the Secretary said in his testimony, to take a whole new look at that arrangement. This concept of physician payment on a percentage of the gross charges of a radiology department or pathology department is simply, in my opinion, not realistic and does result in inflated costs, inflated bills.

Senator TALMADGE. As you know, we have had a great deal of difficulty in developing a noninflationary and equitable approach to paying doctors under medicare. Some medical associations advocate usage of the statewide fee schedules in place of the present complex method of paying doctors under medicare. Do you see advantages in changing over to the use of the statewide fee schedules and, if so, what are they and what are any disadvantages?

Secretary MATHEWS. I might comment in general and then ask Tom to comment particularly what they are.

Senator TALMADGE. Fine.

Secretary MATHEWS. I think it would be very useful for the statement that any medical associates take a look at the fee schedule or the rationale behind it because, as Tom just testified, those practices do not always meet the final test of logic and they do in fact have an inflationary impact. This is something that we would hope that the State and other professional associations would undertake. It would immeasurably help us with our responsibilities under the 1972 Social Security Amendments.

Tom may have some more particulars or comment.

Mr. TIERNEY. Well, Senator, first of all from a program point of view, I think our present system which, of course, was dictated in the original law has, over a period of years, really become too complicated. We try very hard through vast computer exercises to determine the customary charges of individual physicians and the prevailing charges for similar services by all physicians in a given area. We have over 200 such areas in the country now.

One result is that we really cannot tell the medicare beneficiary at a given time what the program will pay. We really can't even tell a doctor what the program will pay. It has to come out of this massive computerized operation, and I think that is bad.

Second, it seems to me that a well-established, well-negotiated, well-reasoned fee schedule can form a better basis for future changes than going through, as I say again, this simply massive computation of the charges that have been made. There is one problem, Senator, and that is that when you talk about a statewide schedule there are tremendous variances not only within a State but even within a locality. If you think in terms, for example, of an extreme case like New York City, it would be unreal to apply, the same fee schedule to physicians in the Harlem area as you do physicians on Park Avenue or physicians in Beverly Hills against physicians in Watts. The facts are that in such disparate areas doctors simply do not charge the same fees. It would result in inequity. Doctors would be getting much more than they charge in one area and much less in the other.

So there are problems when you talk about statewide, regional, or other appropriate areawide fee schedules. If they are well reasoned and carefully developed, however, they could result in tremendous simplification for the program.

Senator TALMADGE. Senator Packwood.

Senator PACKWOOD. No other questions.

Senator TALMADGE. Does the staff have any questions?

Thank you.

Secretary MATHEWS. Thank you.

Senator TALMADGE. Next we will hear from the Honorable George D. Busbee, the Governor of Georgia.

Governor, we are delighted to have you appear before this committee. You have had many problems trying to administer this program in your state and you can speak with knowledge and from experience.

STATEMENT OF HON. GEORGE D. BUSBEE, GOVERNOR OF GEORGIA

Governor BUSBEE. Thank you, Mr. Chairman.

I have with me Gail Moran from the National Governors' Conference and Bob Castellani who is general counsel to the National Governors' Conference task force on Medicaid who is from Georgia and Mr. Jack M. Burris with the Georgia Office of Planning and Budget.

I appreciate the opportunity to share my views with you on one of the most critical issues facing Governors today, medicaid reform.

Let me say at the outset that there is absolutely no doubt in my mind that the basic goal and thrust of the medicaid program—to guarantee adequate health care for those in need—is unquestionably one of the most humane and honorable endeavors ever undertaken by the Congress and our Federal system of governments. I actively supported the program in Georgia in 1967 and, as majority leader in the Georgia House of Representatives at that time, helped secure my State's entry into the program. I favor continuation of the concept and would certainly not want anything I may say here today to be interpreted as opposition to the basic idea behind this worthy program.

On the other hand, it is equally clear to me, after 18 months as Governor of Georgia, that the present medicaid program is the most complex, confusing, duplicative and administratively wasteful system ever conceived by man—one that will surely bankrupt the States and the Federal Treasury unless substantial reforms are undertaken, both at the State and Federal levels.

In terms of program growth alone, the first year of medicaid operation—fiscal year 1968—in Georgia saw expenditures of some $28 million for approximately 347,000 needy recipients. By fiscal year 1975, program expenditures had climbed to more than $267 million to serve more than 675,000 eligible persons. This year we spent $364,688,844 for medicaid assistance. Just during the last year, Georgia's medicaid budget expanded by 37 percent—and that increase required two regular sessions and one special session of our general assembly.

Even with this tremendous increase, program cuts were necessary. This is in part due to the fact that the State's share of the cost has increased while the share of the Federal Government has decreased. In 1968, the Federal Government shared in 75 percent of the program's costs. Today Federal participation has dropped to 66 percent.

In terms of sheer complexity and volatility, the medicaid program certainly ranks as the most difficult program to administer. The Georgia program, as with most other States, represents the largest single processing and payment system in the State. During this last fiscal year, for example, more than 40 million pieces of paper were processed, representing some 7.5 million claims.

We in Georgia, like the majority of the States, have not wrung our hands in despair or shirked our responsibility. I have made every

effort known to me to try to efficiently and effectively manage the program as presently authorized.

I've been sued, cussed and blamed because of my honest efforts to meet congressional intent, keep our budget balanced, honor conflicting Federal guidelines and comply with court rulings—while at the same time steadfastly trying to maintain a quality standard and array of medical services for those least able to defend or fend for themselves.

Since taking office my administration, with the help of the Georgia Legislature, has:

1. Initiated a physician payment profile system to provide a mechanism for an annual review and update of physician payments which will significantly aid the State in the detection of overpayments and fraud.

2. Implemented a medicaid management information system (MMIS). Georgia was one of the first States to receive approval of its advance planning document and because of the critical issues we felt this system would help solve implemented the MMIS in only 12 months. As with anything new, the program encountered some problems. However, I have recently reorganized the department of human resources' medicaid section to bring about more efficient processing of medicaid claims under this new system.

I just heard the statement, something to the effect of a model design for a management information system. I say to you it cannot be done except through experience because I had pitfalls.

3. We became one of the first States to have recognized by HEW an operational surveillance and utilization review subsystem (S/UR). This provides one possible long range solution to detecting and eliminating provider and recipient abuse and overutilization of the present medicaid system.

4. Adopted statewide policies and procedures for the medicaid program which implemented several cost saving measures and provided additional deterrents to overutilization. I hope I am questioned on this and I am prepared to talk about fraud. Among other things, these policies excluded from reimbursement services which were unnecessary, provided a prior authorization mechanism for services which had been overutilized and required formal provider agreements and individual enrollment by physicians in the program.

5. Applied for several waivers from Secretary Mathews in order to experiment with what we feel would be better, more humane and efficient methods of providing medical care to the poor and afflicted. One of these demonstration projects, entitled "Cost Effective Alternatives to Nursing Home Institutionalization," was approved the first of this month and seeks to develop a system of community-based foster and day care programs as an alternative to the more costly and often debilitating nursing home.

6. Implemented a system of copayments for drugs and other optional medicaid services which saved some $2 million.

I am not alone in the search for methods to better manage the medicaid program. Governors in every State are constantly trying to bring this runaway program under control. Unfortunately, our efforts are not enough. Federal reforms are needed—comprehensive national reforms developed by all interested groups involved in administering and delivering medicaid services.

As you mentioned, Senator Talmadge, at our last national meeting in Hershey, Pa., 3 weeks ago, the Governors unanimously adopted a resolution calling for medicaid reform. In simple language we urge Congress to provide legislation and authority which will:

1. Control the spiraling costs of medicaid without holding the poor hostage to forces beyond their control;

2. Grant greater flexibility to States in determining appropriate reimbursement costs;

3. Stress incentives for cost control rather than penalties;

4. Assure adequate mechanisms to control the utilization of service; and

5. Reduce the duplication and conflict between medicaid programs and administrative requirements with other health and human resource programs.

As partners in our Federal system—and we are partners in administering the program—Governors in turn pledge an intensified effort—where possible—to manage the program better and, most importantly, we pledge a thorough review of the medicaid programs in each State.

These are simple goals, many of which are incorporated in the legislation you are considering today.

First, there is no doubt that all Governors favor a consolidation of the confusing bureaucratic nightmare—the plethora of agencies in HEW which attempts to run, rule and regulate this program. Recently I requested and was granted by Secretary Mathews a waiver to test a copayment plan as a tool for controlling overutilization in the medicaid program. One would think that there is adequate precedent for such an experiment.

Unfortunately, this is not the case. Since receiving the Secretary's approval, I have been sued in Federal court and along with him gotten conflicting opinions from within HEW and finally had the waiver disapproved by an Institutional Review Board which was created and operates under guidelines promulgated by HEW. It is this sort of confusion and resistance to change that stymies any hope of ever improving the existing HEW medicaid management. I believe the consolidation into one financing unit of the various bureaus, offices and administrations now competing with each other over who has the right to say what to whom, when and why to the States is a positive step that will lead to more uniform and consistent medicaid policy development.

There is also no doubt that all Governors endorse the principle embodied in S. 3205 that seeks to crack down on fraud and abuse in medicaid and medicare. I personally favor the creation of a Central Fraud and Abuse Unit under the direction of an inspector general.

One of the first acts I took after being elected Governor and prior to taking the oath of office was to request from then Governor Carter's emergency fund the resources necessary for an analysis of medicaid provider payments in order to detect any potential program abuses. This initial analysis prompted subsequent audits by the Department of Human Resources in Georgia and revealed over $183,000 in payments for invalid services.

In addition the Department's audit identified an even larger amount in inadequate services and expensive treatments in cases which

could have been handled at significantly less cost to the State and to the Federal Government.

We discovered nursing homes billing the State for a water ski boat, trips to Hawaii, and purchases at a large Atlanta department store for which there was no accounting.

We had dentists who, in recent years, had billed the State more than $200,000 for work which, upon examination, was simply not found in the mouths of patients. I don't think anyone, unless they are involved, has any idea what a dental audit involves when you have the number of patients we have in the dental program.

We found patients who were treated for, say, three crowns and two root canals who had not even had a filling and we were charged for it. We found patients who went doctor shopping when one physician failed to prescribe the drug they happened to want. We were double billed when patients ran to the hospital emergency room for the slightest ache because they didn't desire to be inconvenienced by a brief wait in a doctor's office.

I fully appreciate, Senator, what you have in your bill for doctors to be available for treatment to keep patients from going to emergency rooms but we found overutilization. We found a mother with three children there to get cold shots rather than go to a doctor's office who was available and sit there with everyone else.

This waste, extravagance, and outright fraud is coming to a screeching halt. I have appointed a special prosecutor to work with auditors and dentists in a continuation and expansion of the dental audit. One of those being audited recently called the State Auditor and asked, "How much do I owe?" That does not settle the matter as far as I am concerned. We'll be sending out bills to recover overpayments in the near future, and those might not be the only bills the prosecutor has in mind.

I am confident that with increased support from Washington, as provided in S. 3205, and with increased muscle backing up the efforts already underway in the States, we can significantly reduce fraud and provider abuse in the medicaid program.

Along these lines, the provisions of S. 3205 regarding the availability of increased technical assistance to the States for improving the management, administration, and operation of the medicaid program are welcomed by the Governors. For too long HEW has been eager to tell us what we cannot do but slow to show us how we can make programs more effective and efficient. Such cooperation between HEW and the States could avoid the situation we face with the current regulations governing medicaid funding of intermediate care facilities for the mentally retarded, a horrendous problem for all the States.

Over the last several years the State of Wisconsin built new facilities for their mentally retarded citizens which provided 90 square feet of floor space for each patient. This exceeded the minimum standard of 80 square feet set by the Joint Commission on the Accreditation of Hospitals. The standards were developed by mental health professionals representing such nationally recognized groups such as the Association for Mental Deficiency and the Council for Exceptional Children. Recently, HEW regulations mandated 100

square feet per patient—they had built 90 on the standard of 80. These regulations would have required Wisconsin to drastically remodel the facilities at a great cost or withdraw from the program.

At Gracewood State Hospital in Georgia these regulations would require the separation of mentally retarded children which require constant medical surveillance. Physicians have informed me that compliance with these regulations would result in the death of some of these children. I will illustrate that, Mr. Chairman, if I might. I doubt that many people who wrote these regulations have ever gone into one of the institutions that we are talking about but I did and I would just like to relate one thing.

Senator TALMADGE. Would you yield at that point?

Governor BUSBEE. Yes.

Senator TALMADGE. I am thoroughly familiar with what you are talking about. The director of the staff is now working on the matter. I think you are entirely correct, the people who wrote the regulations have not been in those institutions.

Governor BUSBEE. I don't think there is any magic in the number four which limits you to four patients per room and requires you to build a wall. It took us 18 months before we found out we could build a partial wall where we continue to have air conditioning and so forth.

Where you have 275 children that are patients, of this 275 there are 252 that have seizures on the average of 30 to 60 times per month, and where half of them have tubes such as in a tracheotomy to sustain life—and I am not going to describe any further the condition of these people other than to say that each time they vomit they must be resuscitated and if they are not they die.

To say that you are going to build a wall around each four beds down there, even if it can come down from the ceiling 3 feet, is something that we will not do regardless of the regulation if it is going to kill these patients.

Needless to say, I will not jeopardize their lives. Now with the cooperation of Secretary Mathews, negotiations are underway to modify these arbitrary requirements. If HEW had consulted more effectively with States and assisted in the development of plans of compliance, a great deal of cost, confusion and suffering could have been avoided.

The Governors applaud the provisions of S. 3205 which require that regulations pertaining to this act must be issued by the HEW Secretary within 13 months of passage. We waited for almost 4 years for regulations from HEW that would guide us in complying with the Federal law requiring States to reimburse nursing homes on a reasonable cost-related basis. Now after waiting 4 years we received the guidelines on July 1, 1976, the same day that the law regarding reasonable cost reimbursement was to have taken effect. It will now be another 18 months before congressional intent is fully implemented —more than 5 years after the law was passed.

On these provisions we are in general agreement. Like the principles of our resolution on medicaid reform, the answers to these problems are relatively simple and straightforward in other areas, while we are in agreement on principle as to what should be addressed, solutions are not so simple or straightforward.

Recognizing this, the Governors took an additional action at our last conference in support of our medicaid resolution. In order to assist in the development of specific solutions in reforming the medicaid program, Governor Cecil Andrus of Idaho, chairman of the National Governors' Conference, named an 11-member special task force. As chairman of this task force I pledge to you our full cooperation and willingness to work with you in providing ideas, gubernatorially certified accurate data, and the benefit of our experience in the day to day management of this complex program.

I believe reforms should be developed just as the medicaid program is administered—in a partnership way, by the Federal, State and local governments. Regardless of whatever legislation you have I cannot overemphasize from the regulation standpoint that the people that administer the program and have had experience under the program should be involved.

During the next several months, the Governors' task force will be addressing in considerable detail the various specific aspects of medicaid reform, many of which are addressed in S. 3205. As you know, the Governors have not taken a specific position on the bill before your committee and it would be inappropriate for me to address on behalf of all Governors the specific provisions of the bill. Nor do I wish to prejudice in any way the work that lies before our task force.

However, as Govenor of Georgia there are certain elements of the bill I would like to discuss and points I would like to bring to your attention.

I favor the inclusion of incentives to the States and providers for superior performance in the administration of title XIX. I would suggest, however, that States will likely require more lead time than the proposed October 1977 effective date offers for complying with the many new administrative requirements included in the bill.

Second, I question the necessity or wisdom of determining medicaid eligibility semiannually for the aged, blind or disabled. I recognize you are combining this but these people who are blind or aged are not going to change as frequently as other groups and you have fewer changes in the status compared with the medically needy. Consequently, the cost of administering redetermination every 6 months is likely to be greater than the benefits.

Although I concur that we must ensure efficient administration of the program, I believe that setting error rate goals at the 50 percentile of rates reported by the States will severely penalize many States. This approach also seems to assume that States do not want to reduce errors and are not making every effort to do so. As a Governor who is faced daily with the tough budgetary and political decisions provoked by medicaid, I can unequivocally assure you that this is not true.

As an alternative, I would propose that States develop plans of compliance, in cooperation with HEW, which are aimed at reducing the error rates progressively within each State. This is not true today because a person who qualifies as an ADC family, the grandmother might move in tomorrow and today they are qualified, tomorrow they are not. They say that is an error even though they have to make this determination every 6 months.

These plans should clearly define errors and set out specific goals for reducing error rates within each State on a yearly basis. States would then be judged on their efforts in complying with these plans. If States refuse to cooperate or fail to show good faith in carrying out their plans, then I believe fiscal sanctions are necessary and appropriate. When solutions are identified, the States and HEW should make every effort to communicate these answers to other States as quickly as possible. This approach recognizes that solutions to the problems of controlling errors are not clear, while ensuring that a concerted national effort will be made to work toward the most efficient management of the program.

Concerning the provider reimbursement provisions, the only point I would like to urge the committee to consider at this time is that States be given appropriate flexibility to demonstrate and experiment with reimbursement systems they believe may prove to be superior in efficiency and cost control to the system outlined in the bill.

Many States, like New Jersey, are well along with implementation of reimbursement systems that are proving to be effective. States have always been crucibles of change and innovation and I would hate to see this pioneering spirit stifled in any way.

There are other areas of the bill that give me concern but I have no specific positive alternatives to offer at this time. Areas which I hope to have our task force address and advise your committee on in detail—and with a unified position—include:

1. The provision providing for allowable hospital cost increases tied to the increases in costs to the medical industry as a whole. Since medical industry costs are increasing at a rate much greater than the economy as a whole, perhaps some other national or regional indicator may be more appropriate as a measure of the extent that cost increase should be allowed.

I have charts that demonstrate this attached to my testimony.

2. A consensus definition of an "error rate." I believe there should be a distinction made between errors that are truly made by the State at the point of eligibility determination and errors that are subsequently discovered over which the State has no control. Surely States should not be sanctioned for mistakes for which we are not responsible, as is the case under present regulations.

That is the grandmother argument. If subsequently the family becomes ineligible, we are charged with an error.

3. Safeguards which might prevent hospital administrators from passing on increased costs in this medicaid program to other third parties in order to avoid Federal penalties which have been previously discussed.

4. The specificity of some of the provisions of the bill.

5. Possible increased State costs that may be associated with certain provisions in the bill.

In conclusion, the Nation's Governors are most encouraged by the work of this committee toward reforming the medicaid program. We, the Finance Committee and the Governors, are in concert in principle and are united in our determination to provide quality health care to our Nation's poor and afflicted at an affordable cost and through efficient businesslike administration.

As Senator Talmadge indicated in his introductory remarks on the bill, the time has come to put "our" house in order. Hard decisions will have to be made. On behalf of the Governors' Conference, I offer you our resources, data, and full cooperation in making these decisions and in putting our collective houses in order.

The bill is the first step in a long walk—one I hope we will take together.

Thank you.

I admire what you said, Senator, in your printed remarks that you read in the record about not being cast in concrete and expressing some clear fluidity in your thinking at this point in the program.

[The charts referred to previously, follow:]

MEDICAID

While the purpose of medicaid is sound—medical assistance for the poor—the design and administration of the program has produced a system which is bankrupting the States and their localities.

Medicaid has become the most rapidly escalating cost of State budgets and the largest item in many local government budgets. In some States, the amount of money spent by medicaid on a person's health care is greater than that person's welfare benefits. Many governments approach a time when they will be financially unable to provide adequate assistance for the poor and medically indigent. That is unconscionable, and cannot be allowed to happen.

The spiraling costs of this program must be controlled, but we must do so without holding the poor hostage to forces beyond their control. The fundamental issues are the need for better control over both the rates paid for health services and the utilization of these services by the patient.

State government, which is responsible for the management of the medicaid program, must intensify its effort to manage the program better.

To accomplish this, the Federal Government, in cooperation with the states, must revise existing regulations and legislation which pose obstacles to effective cost control procedures States must have greater flexibility in determining appropriate costs for reimbursement, must be given incentives for cost control rather than penalties, and must be assured of adequate mechanisms to control the utilization of services.

Also, the Federal Government must reduce the duplication and conflict between medicaid programs and administrative requirements with other health and human resource programs.

Unless reasonable, strong and immediate action is taken by the Federal Government, the States cannot promise continually to supply these needed services at the requisite levels, for they will be unable to afford them.

The governors pledge to review the medicaid programs in their respective States and urge Federal action, on a priority basis, to address the problems created for State and local governments by the continuing rapid increase in medicaid costs.

It is the intent of the national governors' conference that medicaid be an item of highest priority during the next year and that the conference provide leadership in working with congress and HEW to develop needed reforms in the medicaid program.

SELECTED DATA ON THE MEDICAID PROGRAM

Source Document for Table I through VI is committee print No. 18 Data on the Medicaid Program: Eligibility, Services, Expenditures Fiscal Years 1966–76, January 1976.

Table I (Source Document Pg. 17) displays increased dollar totals of Total Federal and State Medicaid Program Payments.

Table II (Source Document Pg. 18) shows the percentage increase in Medicaid Payments.

Table III (Source Document Pg. 21) details the growth in the number of recipients by category of eligibility from F.Y. 1970 through F.Y. 1976.

Table IV (Source Document Pg. 20) shows the percentage increase in the number of recipients from F.Y. 1970 through F.Y. 1976.

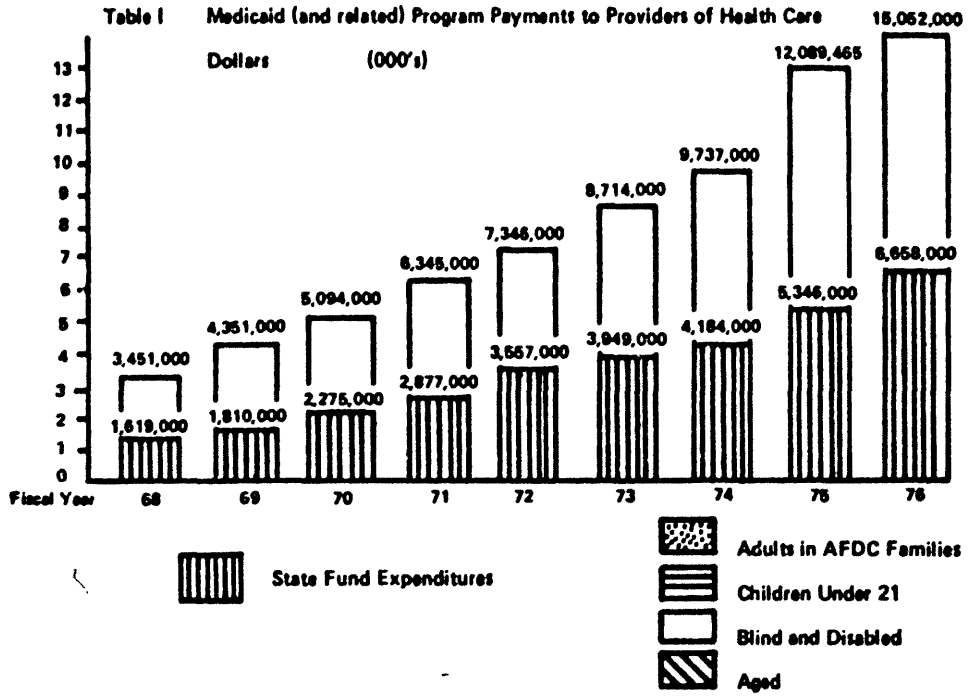
Table V (Source Document Pg. 26) displays the Federal Medical Assistance Percentages in effect since enactment for selected States. The Federal share of State medical vendor payments is determined according to a statutory formula designed to provide increased Federal matching (up to 83%) to states with low per capita income, and less matching to States with higher per capita income (the minimum Federal share is 50%).

Table VI (Source Document Pg. 22) details total program expenditures for each of the major types of service from F.Y. 1967 through F.Y. 1974.

Table VII displays selected years of National Health Expenditures and the percent share bore by the public and private sectors; (Source: SSA, Social Security Bulletin, February 1975, Pg. 5).

Table VIII details selected medical care components of the Consumer Price Index; (Source: U.S. Department of Labor, Bureau of Labor Statistics).

Table IX shows the average annual index for consumer prices and medical care components, selected calendar years, 1950–74 (1967=100); (Source Consumer Price Index, Bureau of Labor Statistics).



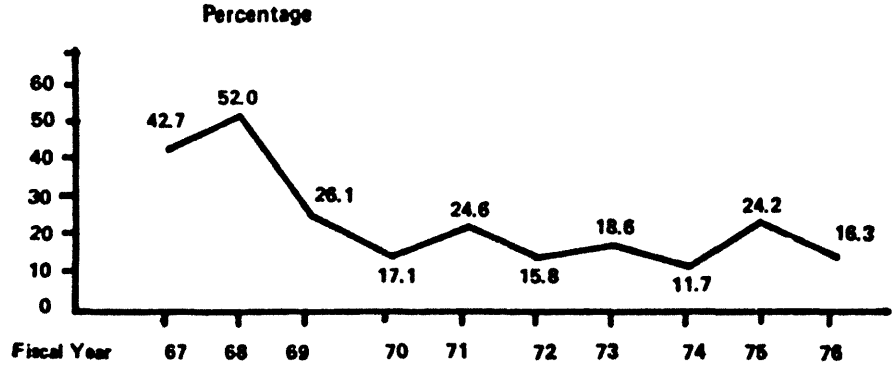


Table III Number of Medicaid Recipients (000's)

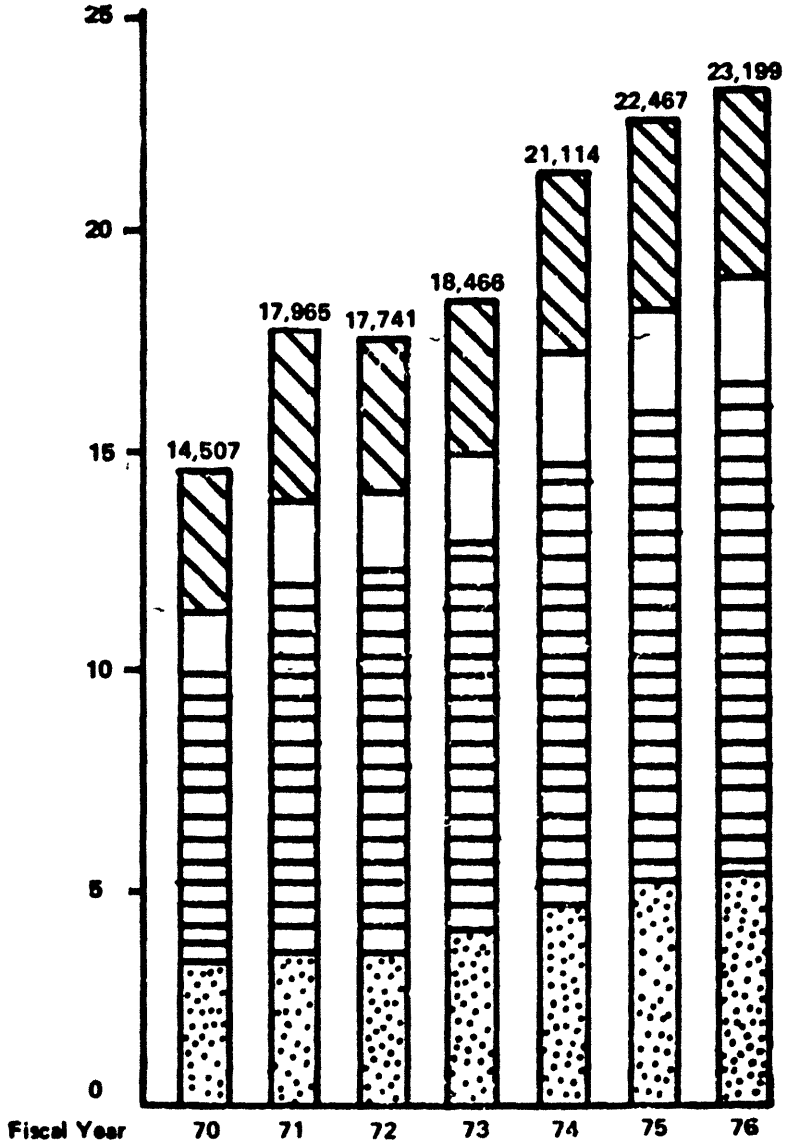


Table IV Annual Percent Increase in Recipients from Previous Fiscal Year

V.—FEDERAL MEDICAL ASSISTANCE PERCENTAGES

	January 1976 to June 1977	July 1967 to June 1969	July 1969 to June 1971	July 1971 to June 1973	July 1973 to June 1975	July 1975 to June 1977
Louisiana	76.41	74.58	73.57	73.49	72.80	72.41
Georgia	74.91	72.85	71.48	69.67	66.96	66 10
Indiana	55.77	53.39	52.85	55.05	57.01	57.47
Connecticut	50.00	50.00	50.00	50.00	50.00	50.00
Minnesota	60.46	58.40	56.95	56.82	57.37	56.84
Alaska	50.00	50.00	50.00	50.00	50.00	50.00
Maine	69.57	69.92	68.33	69.43	70.03	70.60
Colorado	53.08	55.31	56.24	57.61	57.22	54.69
Nebraska	60.39	60.48	57.25	58.48	57.86	55.59
Arizona	NA	NA	NA	NA	NA	NA
Wyoming	55.47	59.20	60.38	62.73	60.99	60.94
Kansas	61.45	57.90	57.78	59.06	55.37	54.02
Oregon	54.12	54.37	56.35	57 39	59.40	59.04
Delaware	50.00	50.00	50.00	50.00	50.00	50.00
Tennessee	76.86	76.14	74.62	74.35	72.28	70.43

VI.—TOTAL MEDICAID BENEFIT EXPENDITURES, BY TYPE OF SERVICE

Type of service	1967	1968	1969	1970	1971	1972	1973	1974
Totals (millions)	$2,271	$3,451	$4,368	$5,112	$6,476	$7,713	$8,810	$10,149
Inpatient hospital	913	1,361	1,586	1,827	2,288	2,944	3,113	3,399
Nursing home care	766	1,064	1,291	1,321	1,674	1,778	1,849	2,027
Intermediate care			95	304	537	743	1,162	1,601
Physicians	225	380	516	578	717	804	955	1,086
Dental care	72	190	209	169	181	186	211	265
Prescribed drugs	179	235	301	395	473	549	612	707
Other services	115	271	369	457	605	710	907	1,063

VII.—NATIONAL HEALTH EXPENDITURES BY SOURCE OF FUNDS

Fiscal year	Total expenditures	Percent	
		Private	Public
1929	$3,589,000,000	86.7	13.3
1955	17,330,000,000	74.5	25.5
1960	25,856,000,000	75.3	24.7
1968	53,765,000,000	62.7	37.3
1974	[1] 104,239,000,000	60.4	39.6

[1] Estimate.

TABLE VIII.—SELECTED MEDICAL CARE COMPONENTS OF THE CONSUMER PRICE INDEX, SELECTED CALENDAR YEARS 1940-73 (1967=100)

Calendar years	Total CPI	Total medical care	Hospital semiprivate room	Physicians' services	Dentists' fees
1940	42.0	36.8	13.7	39.6	42.0
1950	72.1	53.7	30.3	55.2	63.9
1955	80.2	64.8	42.3	65.4	73.0
1960	88.7	79.1	57.3	77.0	82.1
Average annual percentage change, 1940-60	3.8	3.9	7.4	3.4	3.4
1965	94.5	89.5	75.9	88.3	92.2
1966	97.2	93.5	83.5	93.4	95.2
1967	100.0	100.0	100.0	100.0	100.0
1968	104.2	106.1	113.6	105.6	105.5
1969	109.8	113.4	128.8	112.9	112.9
1970	116.3	120.6	145.4	121.4	119.4
Average annual percentage change, 1965-70	4.3	6.1	13.9	6.6	5.3
1971	121.3	128.4	163.1	129.8	127.0
1972	125.3	132.5	173.9	133.8	132.3
1973	133.1	137.7	182.1	138.2	136.4
1974	147.7	150.5	201.5	150.8	146.8
Average annual percentage change, 1971-74	6.8	5.4	7.3	5.1	4.9
1975:					
January	156.1	161.0	222.8	160.9	156.0
February	157.2	163.0	226.1	162.9	157.2
March	157.8	164.6	227.8	165.0	158.7
April	158.6	165.8	228.8	166.2	159.7
May	159.3	166.8	230.1	167.2	161.2
Annualized rate of change, January to May 1975	6.1	11.2	10.2	12.2	10.2

Source: U.S. Department of Labor, Bureau of Labor Statistics.

TABLE IX.- AVERAGE ANNUAL INDEX FOR CONSUMER PRICES AND MEDICAL CARE COMPONENTS, SELECTED CALENDAR YEARS, 1950-74 (1967=100)

Item	1950	1955	1960	1965	1970	1971	1972	1973	1974	1975 January	1975 February	1975 March	1975 April	1975 May	1975 June	1975 July
CPI, all items	72.1	80.2	88.7	94.5	116.3	121.3	125.3	133.1	147.7	156.1	157.2	157.8	158.6	159.3	160.6	162.3
Less medical care			89.4	94.9	116.1	120.9	124.9	132.9	147.7	156.0	156.9	157.5	158.2	158.9	160.3	162.0
CPI, all services	58.7	70.9	83.5	92.2	121.6	128.4	133.3	139.1	152.1	161.3	162.6	163.2	164.1	164.5	165.7	166.6
Less medical care			85.2	93.2	121.3	127.7	132.6	138.3	151.0	159.9	160.9	161.4	162.2	162.6	163.7	164.4
Medical care, total	53.7	64.8	79.1	89.5	120.6	128.4	132.5	137.7	150.5	161.0	163.0	164.4	165.8	166.8	168.1	169.8
Medical care services	49.2	60.4	74.9	87.3	124.2	133.3	138.2	144.3	159.1	170.7	172.9	174.7	175.9	177.0	178.4	180.4
Hospital service charges [1]							102.0	106.6	115.1	125.3	127.3	128.4	129.3	130.1	131.1	133.2
Semiprivate room	30.3	42.3	57.3	75.9	145.4	163.1	173.9	182.1	201.5	222.8	225.1	227.8	228.8	230.1	232.8	239.0
Operating room charges				82.9	142.4	156.2	168.6	179.1	201.3	225.6	230.6	232.7	234.6	236.3	237.2	240.6
X-ray diagnostic series, upper G.I.				90.9	110.3	124.9	129.1	131.8	140.6	150.1	151.0	151.4	153.0	154.2	155.8	156.8
Professional services:																
Physicians' fees	55.2	65.4	77.0	88.3	121.4	129.9	133.8	138.2	150.9	160.9	162.9	165.0	166.2	167.2	168.8	169.7
General physician, office visits	54.9	65.4	75.9	87.3	122.6	131.4	134.8	139.5	154.3	165.3	167.4	169.7	170.6	171.2	173.0	173.8
General physician, house visits	52.9	61.2	75.0	87.6	122.4	131.0	136.7	141.7	151.3	161.7	163.4	166.4	167.2	168.5	169.4	170.5
Hemorrhaphy (adult)				91.3	115.0	123.4	128.2	131.3	138.6	146.2	147.5	148.4	150.2	150.6	151.8	151.8
Tonsillectomy and adenoidectomy	60.7	69.0	80.3	91.0	117.1	125.2	129.9	132.3	144.2	152.4	155.8	159.5	160.2	162.2	164.1	165.5
Obstetrical cases	51.2	68.6	79.4	89.0	121.8	129.0	133.8	128.1	149.0	157.7	158.7	160.2	163.6	164.6	166.8	167.5
Pediatric care, office visits				85.8	122.7	132.0	136.2	140.5	153.4	164.4	166.1	167.4	169.1	170.3	172.1	173.2
Psychiatrist, office visits				92.1	119.4	124.8	129.2	133.6	141.0	147.9	147.8	148.8	149.6	151.8	153.0	153.4
Dentists' fees	63.9	73.0	82.1	92.2	119.4	127.0	132.3	136.4	140.8	156.0	157.2	158.7	159.7	161.2	161.8	163.0
Other professional services:																
Examination, prescription and dispensing of eyeglasses	73.5	77.0	85.1	92.8	113.5	120.3	124.9	129.5	138.6	144.6	145.8	146.9	148.1	148.7	149.2	150.3
Routine laboratory tests				94.8	111.4	116.1	120.4	122.8	135.4	145.0	145.3	148.1	150.5	152.5	153.1	154.0
Drugs and prescriptions	88.5	94.7	104.5	100.2	103.6	105.4	105.6	105.9	109.6	114.7	116.0	116.8	117.5	118.1	118.7	119.4
Prescriptions	92.6	101.6	115.3	102.0	101.2	101.3	100.9	100.5	102.9	106.7	107.4	107.7	108.1	108.5	109.0	109.6
Over-the-counter items				98.0	106.2	110.2	111.3	112.4	117.6	124.3	126.3	127.6	128.8	129.5	130.3	131.2

[1] January 1972=100 (the date the index was introduced).

Source: Consumer Price Index, Bureau of Labor Statistics.

Senator TALMADGE. Thank you very much, Governor, for your intelligent, and forceful, and logical statement. The committee and the staff intend to continue to work with the Governors' Conference as we have in the past in developing this bill. We would appreciate further contributions on your part as well as the National Governors' Conference because I think you are one of the Governors in the country that is taking the lead in trying to get a handle on these problems.

You commented in your testimony about over-utilization. Would you comment further on that?

Governor BUSBEE. Yes; I would like to.

I mentioned about an experiment that we conducted in copayment. On your optional program you can have some experimentation you cannot have under your nonoptional programs. For instance, Virginia was the first of the States to implement a 50-cent charge on drugs. This 50 cents reduced the amount of overutilization on drugs by decreasing by one-third the total drug bills. I have 500,000 drug bills each month to pay at the State level. We implemented the $1 charge authorized by statute and approved by HEW Secretary Mathews' and a $1 charge for a doctor's visit and a $2 charge for the emergency room. This would further deter those people who go to the emergency room.

We have to pay, say, $10 for Bufferin down there, et cetera, and the costs that we have in the emergency room. We find that people can afford this. Now when you compare these people and say you should not charge anything on the medicaid for a patient that is bound or limited to a number of visits they can have or restrain the amount of drugs they have or have any cost to them, you have overutilization. You allow this under medicare to say that for the blind and for the aged that they have to pay 20 percent after the basic payment and not be able to do anything. Overutilizaton is the biggest problem that we have.

Senator TALMADGE. What do you think the extent of overutilization is, Governor?

Governor BUSBEE. I think the extent of overutilization exceeds by threefold the amount of fraud in the program. I want to get into the fraud because I think we have done more in the fraud area than any other State. I think overutilization by the patient of the user is as great as anything else in the program.

Senator TALMADGE. How much do you think could be saved in the Georgia program if the overutilization is stopped?

Governor BUSBEE. I have savings on the things that we have done to try and cut down overutilization. Say if there was some magic formula where we could do away with all overutilization, this would be an astronomical sum in the neighborhood of $60 million per year. I would say you are talking about $60 million per year.

Senator TALMADGE. In other words, 20 percent approximately. How much do you think fraud costs the program?

Governor BUSBEE. I will give you some good examples on this and what you are talking about because there is a lot of interest. I think the best thing that I culd say about the interest that you have in fraud, which was the first interest that I took because we had some bad apples in the barrel, is that now we have made extensive audits. Take the

dental audit we had. It is a very difficult thing to do. I think this can demonstrate what we have involved.

We had a computer random sample involved to select those who participated with the charges which we would chart. During the period from July 1973 to March of 1975 we had 86,796 patients treated at the cost of $17.4 million in this operational program. Of these 86,796 we said we want to bring in a sample of 2,632 physically to examine their mouths and compare their mouths. Of the 86,796 we selected the 2,632 and were able to have our caseworkers bring in 2,134 to be reviewed by dentists in other areas. Of the 2,134 we found discrepancies in 396 which would be 18.5 percent.

If I were to indicate to you that that is all fraud, I would be in error because after I had gone into detail through the audit and through each dentist that was audited we found that the real fraud is maybe less than 5 percent and you do have some bad apples in the barrel. It should be corrected. I have a full-time prosecutor on this now. We cannot stop now with the 2,134. This might be just 12 patients that one dentist treated in the entire year. If he has abused patients on those, he has on others and we have to bring them all in and we have to proceed civilly and criminally and we have a fraud unit to do this.

Senator TALMADGE. How many indictments have you had to date?

Governor BUSBEE. We have not yet prosecuted the first one. I have a copy of the dental audit with me. We are bringing in other patients in addition to the ones whose mouths have been examined on certain of the doctors that we know have violated the law and charged for things that were not done, so we are in the middle of it right now.

We have had some success in the fraud area. I want to say to the chairman that everytime we have the fraud corrected on welfare we are at the same time correcting fraud in medicaid because these people are also not eligible in medicaid and we are having a good deal of success in that area.

If you want to know, I will give you this. I don't have firsthand information on it. Like in welfare benefits, we had one judge in Georgia that had two recipients sentenced to 2 years in prison. This must have been more than a misdemeanor because it involved thousands of dollars. We had 52 people in the county come in voluntarily. We had a young lady go into all these local offices. I went into the office in Macon, Ga., which you have been in. One lady in the first 28 days she was there discovered $18,000 in fraud payments. She had gotten over a dozen individuals in just 28 days. So every time they qualify they are then eligible for medicaid and you are going to have to look at it from the ineligibility angle also.

Senator TALMADGE. Senator Dole.

Senator DOLE. In the National Journal of this May, there was an article which discussed not only the long history of problems in the State of Georgia but also some of the measures that you implemented to bring order out of what apparently had been chaos. It mentioned that a $25 in-patient cost-sharing charge had been imposed. How successful was that?

Governor BUSBEE. There was a $25 charge together with the dollar charge for the doctor's visit and $2 for the emergency. Now this is what was thrown out by the Review Board and the reason is you

passed the bill in the Congress as a result of the syphilis experiment over in Alabama where they let people go untreated and it was a horrible thing. They said any time you experiment on humans that you have to have a review board approve it.

The determination was made to charge $1 to $2 and then $25 in the hospital which is greatly less than you charge the blind, the aged, and the disabled under medicare. It is much less. They said that there is human risk involved as far as medicaid is concerned, you cannot charge a dime for anything no matter what the Secretary said even though you can do it for drugs because they are optional. This is done in the Southern States at this time.

Senator DOLE. Do you think the changes you have implemented have had any impact on the quality of care? I ask that because there has been a charge made by the Brookings Institute—not the most conservative group in America, but nevertheless one we hear from frequently—that what you have done is deprive blacks of adequate care and cause a lot of doctors to drop out of the program, resulting in poorer care in the State of Georgia.

Governor BUSBEE. No, sir, this is not true. It didn't last that long. I don't agree with that at all.

Now as to what I have done in medicaid, this started in February 1975 and it has paid up and this is just one paragraph that you speak of, but I am going to say to you that if you are going to prosecute doctors and dentists and institutions for fraud without saying that you are going to address overutilization and abuse by the recipients, you are not going to get to the root of the problem.

I don't think when you compare what your grandmother would pay if she were to get medicare as compared to what someone else on medicaid would pay, nothing, I don't think that you can say that it is unreasonable to charge the dollar to the medicaid patient in an effort to avoid overutilization.

When I went in there we had patients that would go to 8 and 10 doctors a week—doctor shopping. We found this with the card when the doctor did not even know they had been some other place. They would shop for drugs in the same way. We have a system in HEW—one run by doctors and one is on the recipient. We found these people that abuse the program, and we tried to put some restraints on them.

I will say this: When you get something for nothing you tend to get more of it than when you have to pay something for it, and this is demonstrated under the medicaid program.

Senator DOLE. I have heard the same statement about food stamps.

Governor BUSBEE. You must address overutilization some way. We are attempting to do this by experimenting. It worked in the drug programs, and I think it can work in others. Senator Dole, I think you are going to have to face some hard political things, too. You look at how much we have paid for drugs in 1968 in this Nation and you look at what we are paying today for drugs. We have 8,000 some odd drugs and we are trying to reduce it to 4,000 some odd drugs. We can do a lot of things if we are willing to stand up to political pressures just like I have been to the dentists, just like I have dealt with the nursing homes. You also have to stand up to the recipients themselves in this program and investigate the whole gamut and not just the providers.

Senator DOLE. Has there been a big dropoff as far as the number of participants is concerned?

Governor BUSBEE. Yes; and I will tell you what it is. We have to balance our budget down there and operate on a balanced budget. We had a system where we were on a cash basis and every bill submitted within that fiscal year we paid it. After this accounting period it was changed and we paid it on an accrual basis which meant that if I get an order in September for available services rendered prior to June 30 that had to be paid on the previous fiscal year. We now have provider agreements with each of the doctors which they didn't want to sign to begin with but we didn't want to obligate ourselves beyond that.

We factor mandatory programs in order to balance the budget, and when we factor them we are not paying the doctors the full fee and we are requiring that they sign these provider agreements which we had to do under the regulations. Many of them elected not to come under the program. Now I will say this though, that more and more are coming under the program at this time.

Senator TALMADGE. Governor, you stated on page 6 of your testimoney in chief: "First, there is no doubt that all Governors favor a consolidation of the confusing bureaucratic nightmare—the plethora of agencies in HEW which attempts to run, rule and regulate this program." Secretary Mathews stated that he would prefer to do that administratively. I take it that you and the Governors favor the portion of our bill that tries to put it all under one roof in one direction.

Governor BUSBEE. Senator, I will say this. We have taken no position on that bill. We have just met in Hershey. I would say there would be such overwhelming support for that that I could almost speak for them without talking to them.

I do have one concern, Senator, and I will be very candid with you about administration under this bill S. 3205 and that is that at the present time we are trying to operate this program with a broad statute which you wisely used, I think, because you cannot write every detail for every institution for every program.

You give to HEW now, and HEW writes regulations, and we administer programs under these regulations. Now even though you combine the activities within HEW—and this has just been an ungodly nightmare for me to have inconsistent things going on in the Department and me be sued and have conflicting testimony from existing divisions and lose all credibility—I admire what you have done.

What you have done is you are going to start off with your legislation on medicaid and medicare and you are going to combine them under this administrative function. Now what you have done though is rather than having to be sanctioned and deal and sue and be sued, get approval and get waivers from HEW, when we create a system such as MMIS we not only have to get under this bill but we also have to get GAO's approval. The General Accounting Office of course being under Congress I realize that you want some controls. I think HEW being under the executive branch of the Government we are going to be dealing under both of them as it is written. While I fully appreciate the fact that you are not satisfied with the controls that have been implemented in HEW and this will be an additional burden, we would like to make recommendations I am sure in this area.

Senator TALMADGE. We would like to have any recommendations you care to offer.

I notice your concern in medicare performance, having no distinction among the States. Supposing instead of grouping all the States together we classify the States by types of medicaid programs in terms of eligibility differences and comprehensiveness of benefit.

Governor BUSBEE. Personally Senator, I think this would be much better in view of what you said about concrete. I am glad to see you thinking in that direction now. I think this would be much better really.

Senator TALMADGE. Given the serious financial difficulties which medicare has created for States, should the Federal Government consider giving the States more discretion in determining hospital and nursing home payments under medicaid?

Governor BUSBEE. We are going to have to have it. I think we have to have some discussion on balancing the budget and dealing with the mandatory and nonmandatory and optional programs. We can only factor in the mandatory area; drugs are optional. Care facilities are optional. We can drop those entire programs but we need more flexibility where I am not put to the test that I was put to of dropping dental care for adults. We just dropped it. This is bad. We have got the factoring factors. The doctors won't sign their agreements.

I will say this in answer to your question, Mr. Chairman. If we had some more flexibility and I had $360 million which we are now spending without all of the restraints that we now have and I could put in all the controls we want, we would give a lot more health service to the people that need it.

Senator TALMADGE. At less money?

Governor BUSBEE. With that amount of money, yes.

Senator TALMADGE. Senator Dole.

Senator DOLE. Would that indicate support for the President's bloc grant approach?

Governor BUSBEE. I think, Senator Dole, to be frank with you, I would say yes, I kind of lean in that direction. I would have some concern. I could not say that every State would adequately address the problem but to come out with the specificity that they do in regulations like in instituitions. I just mentioned in one State where it has $7.5 million for an ICF/MR facility and put all the detail in there without giving them a chance to justify the total institutions and the standards of that total institution. That is wrong. We need some latitude to deal with this and not be confined and restrained to the extent we are. If we have some latitude, we can more effectively manage the program.

Senator DOLE. Did the Governors at Hershey also indicate that the Federal Government might take over the whole welfare program? I want to see if everything is consistent here.

Governor BUSBEE. I am not in favor of that being done, no.

Senator DOLE. I'm not either. There are some Governors, however, who think that is the best way to escape.

Governor BUSBEE. I was one of two people who came up to the White House when we started revenue sharing under President Nixon. I was one of two that opposed it at the time because I knew it would be that way.

Senator DOLE. Are you familiar with the results of the North Carolina medicaid plan and some others, perhaps, where they apparently tried to turn it over to a private, prepaid medical service system?

Governor BUSBEE. I am familiar but I didn't want to comment on it. I will now that you brought it up. I was urged when they implemented this program in North Carolina by some provider groups that this is the way to do it. This is the perfect way—like you were talking about a moment ago perfect management—but it just didn't work out that way and I didn't think it would.

Senator TALMADGE. If you would yield at that point.

Senator DOLE. Yes.

Senator TALMADGE. At my request GAO made a study of the North Carolina situation and the savings I think were more illusory than real.

Governor BUSBEE. What is more illusory?

Senator TALMADGE. More illusory than real.

I am not opposed to any experimentation in that field but apparently that one didn't work out too well.

Governor BUSBEE. Senator, this is the one thing I really can't argue too much on, your dealings with GAO, because I know you had them making an analysis in North Carolina. Well, the State had to bail it out after 11 months down there when this program started. I don't want to say anything about another State but let me just say this about the failures. Anybody can tear a house down; it takes a man to build one.

The easiest thing to attack in this country is welfare, medicare and things of this nature but every now and then you have a State that is doing a remarkable job and some mayors. I think that you don't just pick out North Carolina's failure on this thing because we have had some States that have been successful in regulations. The positive should be accentuated along with the negative.

Senator DOLE. Finally, do you feel there are more problems with overutilization than with outright fraud?

Governor BUSBEE. I believe I have been into it as deeply as anyone. I have been at the actual local office. I reviewed all the local audits that we had, individual and institution. I think the amount of overutilization alone is at least three times the amount of fraud.

Senator TALMADGE. Thank you very much.

Governor BUSBEE. Let me give you a good example. We had a review board. We have plans of treatment that have to be approved and things like this. I had a friend who was a doctor and he wanted to place a woman in the hospital and provide care. He wanted the review board to say that she had to be there 3 days and not penalize the hospital. He placed her in the hospital to allow the family to go on a vacation in Florida. She was old so they put her in the hospital. We have all kinds of overutilization; it does not cost anything.

Senator DOLE. That is the same fear many of us have with respect to national health insurance.

Governor BUSBEE. I know that you combine medicare and medicaid in one administrative unit right here in the event you ever did have the national health insurance. But notwithstanding national health

insurance I am completely in support of combining the way this bill does these administrative units that are consolidated.

Senator TALMADGE. Thank you very much, Governor. We greatly appreciate your appearance and contribution to the committee's deliberations.

Next is the Honorable Richard S. Hodes, chairman of the human resources task force, National Conference of State Legislatures.

Mr. Hodes, you may insert your full statement in the record and summarize it, if you will.

STATEMENT OF HON. RICHARD S. HODES, CHAIRMAN, HUMAN RESOURCES TASK FORCE, NATIONAL CONFERENCE OF STATE LEGISLATURES

Mr. HODES. Thank you, sir.

Mr. Chairman, I am Representative Richard Hodes of the State of Florida and I have been chairman of the Committee on Social Services in the State of Florida for the last 8 years and also chairman of the Health and Rehabilitative Services Committee.

With me as a panel presentation is Mr. Frank Francois, a councilman in Prince Georges County, Md., and vice president of the National Association of Counties, and he will present testimony after I do.

Also I would like to add for the information of the committee that I am not legislating. I am a practicing anesthesiologist. I want to say that in reading the bill I was very impressed with the inside of the investigation of the staff that the chairman demonstrated in dealing with that particular question. I am impressed with the knowledgeability that the chairman demonstrates.

Senator TALMADGE. If the witness will yield at that point, we had excellent cooperation with the American Society of Anesthesiologists.

Mr. HODES. I noticed on your witness list that the day after tomorrow Dr. John Ditzler, president of the American Society of Anesthesiologists, will be here.

Senator TALMADGE. He has been most helpful.

Mr. HODES. Thank you, sir. I am glad to hear that our organization is working well.

Nevertheless, speaking as a legislator with the other hat on, I certainly am, as the chairman of the committee knows, perfectly aware of the unacceptable growth in medicaid expenditures over the last few years and that really is one of the most troublesome problems that we face at all levels of government because of the open ended growing costs.

Now needless to say, such cost escalations have had a tremendous impact on State budgets. Medicaid expenditures are already assuming a disproportionate share of the limited State funds available to finance social programs for low income individuals. As you so correctly noted in your introduction of S. 3205, Mr. Chairman: "The choice is a simple one—either we make medicare and medicaid more efficient and economical or we reduce benefits."

Now some of what I say may be duplicative of what Governor Busbee said but we are particularly concerned with the fact that waste

and mismanagement is likely to continue unless the conduct of the administration is appropriately checked. This is the duty and the function of the State legislature. In addition to its policy and program development role, the responsibility of the legislature extends to the control of policy and program after the stage of formulation. The legislature must review the performance of its administrators—conducting oversight, curbing dishonesty and waste, insuring compliance with legislative intent and challenging bureaucrats. It must also assess the effectiveness of State policies and programs.

In addressing the problem of rising medicaid costs State legislatures have basically three options: continue to appropriate money to the program at increasing rates; cut benefits and reimbursements; or effect savings within the program itself. The latter option implies getting a better handle on managing and administering the program. Yet, at this point, State legislators generally lack the information needed to insure the reductions in expenditures for the medicaid program shall come out of the waste and inefficiency in the program and that as little harm as possible will be done to the comprehensiveness and the quality of the health care extended to the Nation's poor.

As you are aware, some of the most effective and innovative measures in controlling health costs have been introduced through State medicaid programs. Most of the attention so far, however, has been on curbing fraud and abuse in the program. For example, during 1970, New Jersey developed a computer system to detect patterns of fraudulent practice and abuse. Fraud and abuse is certainly an area that has to be considered.

The need is great, therefore, for an effort at the Federal level which can effectively encourage the application of proven cost containment measures and sound management procedures by all levels of government and the medical care industry. We believe that the Talmadge bill is a good step in the direction of achieving those goals.

To begin with, a copy of S. 3205 was forwarded to every State legislative committee responsible for the medicaid program. Comments have flowed back to us which have helped shape our thinking on the bill. Moreover, last month at NCSL's initiative, a group of 30 State and local officials met in Washington, D.C., for the exclusive purpose of examining S. 3205 and formulating a set of recommendations with respect to the proposal.

I also would like to mention there that we had excellent cooperation from this subcommittee staff in meeting with us and helping to discuss the particular provisions in the bill and had a very fruitful exchange with your staff director.

In general, Mr. Chairman, I would state that State legislators are enthusiastic about the legislation. Now those items that we found most attractive are the following:

Consolidation, we think, is particularly valuable because of the multiple problems that are faced with having to deal with conflicting areas.

We are concerned with the idea that all contracts over $10,000 be reviewed, which is going to inundate the review process so heavily that, in fact, no contract will be reviewed. I would suggest that perhaps the $50,000 threshold for review of the contracts would provide for review.

If we stay with the $10,000 contract, we are going to end up with a significant number of contracts to the extent that probably none of them will be reviewed satisfactorily. We would suggest the $50,000 threshold contract.

In addition, the provision of technical assistance to the States for improving the management, administration and operation of the program. We feel that technical assistance in establishing an MIS program is very valuable and we think that is an important aspect of the bill.

We are also very delighted with the requirement that regulations pertaining to this act must be issued by the Secretary within 13 months. That is a particularly fruitful thing. You have heard about the 4 year story just now but we are concerned about one thing and that is that the need for expedition of the promulgation of the rules does not infringe upon the mandate. There will be greater clarity in the rule-making process because in the exercise of speed there may be an exercise in confusion as well.

We would suggest the requirement that information regarding deficiencies in the administration of a State's medicaid program be made available not only to the Governor of the State but also be shared with the legislative leader in each house in the State legislature as well as the chairman of the legislative committees with jurisdiction over the medicaid program. This is the one with which we are both pleased and flattered that we as legislators are receiving the legislation proposed by the subcommittee. We are greatly involved in this particular process and delighted that you have given us your consideration and applaud that with much enthusiasm. This provision will unquestionably strengthen the legislatures' ability to oversee the administration of their medicaid program. Moreover, it should spur greater interest on the part of the appropriate committees to continually evaluate the performance of their own State agencies.

The area that I would like to tee in on particularly is one that deals with the standards relating to quality control which do give us considerable difficulty. To begin with, a maximum error rate for eligibility determination set at the 50th percentile of rates reported by the States (between October 1975 and March 1976) will always be an arbitrary standard. For example, if a wide variation among State error rates existed, the median (50 percent) might not reflect even the majority of States. More equitable measures which recognize State capacities could be developed rather than legislating such a rigid statistical requirement.

Even more troublesome is the tying of a fiscal penalty to certain tolerance levels. Given the fact that "quality control" is still an art and not a precise science—that is to say, no one has the answer as to what combination of factors will guarantee a reduction in errors—we find the attachment of fiscal penalties to tolerance levels unacceptable. Instead, we would prefer to see a nationwide quality control system developed as a management tool which would allow elected officials, program managers, and the public to reliably and validly know the accuracy of the eligibility system at regularly recurring intervals.

The basic principles of this nationwide quality control system should be applied not only to medical assistance but to AFDC, SSI,

and food stamps as well. Additional administrative standards should not be mandated by the Federal Government without prior consultation with States and localities and until there is clear evidence of their cost effectiveness.

We further believe that no national performance tolerance levels should be established at this time. Instead, all States should be required to develop periodic corrective action plans acceptable to the Department of Health, Education, and Welfare geared to the individual conditions of each State and including the State's specific targets for error reduction.

Sanctions, if necessary, should be applied only through the existing compliance procedure and only in those instances where a State refused to propose an acceptable corrective action plan or fails to appropriately implement the actions in the agreed-upon plan.

We also recommend that the publicity of quality control findings should be continued with the following modifications:

More emphasis should be placed on publicizing in each jurisdiction the record of that single jurisdiction.

Public recognition should be given to those jurisdictions with low error rates or which are making significant improvements.

More emphasis should be placed on clarifying the causes of errors and the content of corrective action plans.

That generally is the area of quality control that we are particularly concerned with.

Now we recognize as legislators that this bill, particularly the cost control provisions of it which is the majority of it, could easily be the same types of operation that might occur on the national health insurance program without prior consideration of cost control which would be in error. So I would suggest, Mr. Chairman, that we deal with this bill in that manner. We have put together a coalition on health insurance and a coalition of many in-state agencies.

Thank you.

Senator TALMADGE. Thank you very much. I want to particularly commend you for the diligent work you have done not only in trying to develop this legislation but also in contacting the legislatures of all of the 50 States and getting their recommendations and staying in touch with our staff in order to improve the legislation during the legislative process. I hope that you will continue doing that because you and other legislators similarly situated have made a tremendous contribution in developing this bill.

I want you to know that we were directly involved with your people in discussing the provisions of S. 3205 relating to the adequacy of the State determination of eligibility under medicaid. We intend to exclude from the judgment of State performance all elgibility which was basically determined by the Federal Government such as under the SSI program. Unfortunately, due to a technical error, that exclusion was not included in the text of the bill. The change will be made.

Mr. HODES. That is encouraging, Mr. Chairman. Thank you very much.

Senator TALMADGE. Senator Dole.

Senator DOLE. Thank you. I have no questions.
[The prepared statement of Mr. Hodes follows:]

STATEMENT OF REPRESENTATIVE RICHARD S. HODES, FLORIDA, ON BEHALF OF THE NATIONAL CONFERENCE OF STATE LEGISLATURES

My name is Richard S. Hodes and I am a State representative from Florida. I have served in the Florida House of Representatives for the past 10 years—eight of those years as chairman of the Health and Rehabilitative Services Committee. For the past 3 years I have had the privilege of chairing the human resources task force of the National Conference of State Legislatures (NCSL) and it is in that capacity that I appear before you today. I should add that my nonlegislative days are consumed by my practice as an anesthesiologist.

I am delighted, Mr. Chairman, to appear before you and the members of this committee, as the initial spokesman of a panel representing State and local governmental interests. This panel is a manifestation of the fact that the issues of concern to State and local governments in the fields of health and welfare are not that divergent and that where our interests coincide we should strive to cooperate with one another to the best of our ability. Because of the cooperation extended by these organizations, you will discover that considerable degree of accord exists with respect to the various positions we have taken on S. 3205.

STATE LEGISLATIVE INTERESTS

I need not tell you that the unacceptable growth in medicaid expenditures over the past few years is undoubtedly one of the most troublesome problems facing all levels of Government today. You will recall that in its first year of operation a decade ago, State and local governments, along with the Federal Government, spent $1.6 billion on the medicaid program. Projections for fiscal year 1977 estimate the cost of the program at nearly $17 billion—a 700 percent increase that has all levels of government searching for ways to bring the expenditures back within acceptable bounds.

Needless to say, such cost escalations have had a tremendous impact on State budgets. Medicaid expenditures are already assuming a disproportionate share of the limited State funds available to finance social programs for low income individuals. As you so correctly noted in your introduction of S. 3205, Mr. Chairman: "The choice is a simple one—either we make medicare and medicaid more efficient and economical or we reduce benefits."

While the factors contributing to the rapid expansion in the costs of providing medicaid services are easily discernible—inflation in medicaid prices and fees, expansion in the number of eligibles served, growth in the utilization per eligible person—effective and equitable methods for controlling the acceleration of costs are more elusive.

In the face of growing budgetary restraints, the most common response by the States has been to focus on reducing either the scope of services offered or the number of individuals served under the program. Other short term steps taken to reduce costs would include such actions as increasing patient cost-sharing requirements for basic and optional services and lowering the reimbursement fee levels for ambulatory services. Random examples of the above include: The elimination of adult dental services from coverage by Maryland, Florida, Georgia, New Hampshire, and Louisiana; the institution of a $2 copayment for eyeglasses in Virginia; and the restriction of one physician visit per month in Alabama and Georgia.

Increasing recognition is being given to the contribution poor management and administration of the medicaid program makes to the problems of costs. Estimates indicate, for example, that between $750 million and $1.5 billion in medicaid expenditures are wasted each year through fraud and abuse. Additionally, millions of dollars could be saved by insuring that patients are not inappropriately hospitalized or that their institutionalization is no longer than what is absolutely necessary.

Waste and mismanagement is likely to continue unless the conduct of the administration is appropriately checked. This is the duty and the function of the State legislature. In addition to its policy and program development role, the responsibility of the legislature extends to the control of policy and program after the stage of formulation. The legislature must review the performance of

its administrators—conducting oversight, curbing dishonesty and waste, insuring compliance with legislative intent, and challenging bureaucrats. It must also assess the effectiveness of State policies and programs.

In addressing the problem of rising medicaid costs State legislatures have basically three options: Continue to appropriate money to the program at increasing rates; cut benefits and reimbursements; or effect savings within the program itself. The latter option implies getting a better handle on managing and administering the program. Yet, at this point, State legislators generally lack the information needed to insure that reductions in expenditures for the medicaid program shall come out of the waste and inefficiency in the program and that as little harm as possible will be done to the comprehensiveness and the quality of the health care extended to the Nation's poor.

As you are aware, some of of the most effective and innovative measures in controlling health costs have been introduced through State medicaid programs. Most of the attention so far, however, has been on curbing fraud and abuse in the program. For example, during 1970, New Jersey developed a computer system to detect patterns of fraudulent practice and abuse. The ingredients of that system were adopted by HEW in developing the Federal medicaid management information system (MMIS). New Jersey's system resulted in a $27 million saving just by prescreening claims. Additional savings were incurred through an aggressive investigation and prosecution of several nursing home operators, pharmacists, and doctors.

The Michigan legislature has supported surveillance and utilization review as effective cost containment efforts. The Michigan system has on computer a gross provider module to help pinpoint where the overutilization is coming from. Additionally, Michigan is experimenting with a maximum fee screen structure which sets a specific fee for a given procedure (the fee varying to some extent regionally).

The State of California has instituted several methods to reduce overutilization. Each recipient's medical card indicates the services the recipient is entitled to. Additional services sought by the recipient beyond those mentioned on the card must be approved by a medical field office before payment can be made. Moreover, a new program implemented at the end of 1975 requires every hospital serving medicaid patients to include a team composed of a physician, a nurse, and a social worker. The team, in cooperation with the attending physician, must make a determination regarding the recipient's length of hospital stay. Preliminary results indicate that the average length of hospital stay has been reduced.

The State legislature in Wisconsin established a 30-member strike force against medicaid fraud. Investigation and audits carried out by the Illinois bureau of special investigation and the Governor's task force on medicaid fraud resulted in the suspension of 60 medicaid providers. Illinois has also reduced costs by changing the formula for reimbursing pharmacists for medicaid prescriptions. In New York State, audits of the nursing home industry are expected to help return almost $70 million in overcharges to the State's treasury.

Experiments with new approaches to administering the medicaid program are at hand. In North Carolina, for example, a private health care contractor has administered the State's medicaid program on a prepaid basis. The results of that experiment are undecisive, particularly in light of recent revelations that significantly more eligible recipients participated than originally planned. Nevertheless, the North Carolina experience should offer some invaluable lessons for the possibility of private sector involvement in the administration of medicaid.

States retain the authority to determine rates and methods of reimbursement. Although somewhat constrained by Federal regulations, States have developed a variety of policies in this area. Through the budget process, State legislatures have dictated reimbursement policy to a certain extent. A few States have developed sophisticated reimbursement policies, each tailored to a specific provider program. Some States have experimented with regulating the medical care industry, on the assumption that controlling costs only in one part of the health care sector will only result in a "ballooning out" effect in other areas of the sector. As an example, in 1973 Connecticut created a commission on hospitals and health care, with decisionmaking authority over capital expenditures and annual operating budgets, as well as reviewing rates and analyzing costs. As a result, in its first year of operation the CHCC reported that the percentage of increase in cost per adjusted patient day was 8.4 percent compared to 10.9 percent nationally. Presently, eight State governments are operating rate review systems.

Since 1970, several States have supported experiments with the delivery of services to medicaid recipients through prepayment plans. The experiences of such programs in Washington, Kansas, Kentucky, Michigan, New Jersey, and the District of Columbia are worth studying.

In spite of the significant advancements illustrated by the preceding examples, progress remains limited to only a handful of States. The need is great, therefore, for an effort at the Federal level which can effectively encourage the application of proven cost containment measures and sound management procedures by all levels of government and the medical care industry. We believe that the Talmadge bill is a good step in the direction of achieving those goals.

THE TALMADGE BILL

Mr. Chairman, we at the State and local level realize the enormous time and energy that was devoted to the creation of this legislation. Moreover, we sincerely appreciate the willingness—and even the initiative—taken by your staff to meet with representatives of State and local government on the merits of this bill. Over the past 3 months, your very able staff director, Mr. Jay Constantine has conferred with members of our organization, as well as members of the associations represented on this panel, on at least three separate occasions, and at each meeting, it was made clear that while the Talmadge bill is the result of considerable thought and expertise, its ingredients are by no means "locked in concrete", and that the contributions of State and local governments are most highly valued by the committee. We have taken this invitation most seriously, Mr. Chairman. In preparation for this testimony we have gone through a series of steps to insure a broad range of inputs from elected officials and program administrators at the State and local level.

To begin with, a copy of S. 3205 was forwarded to every State legislative committee responsible for the medicaid program. Comments have flowed back to us which have helped shape our thinking on the bill. Moreover, last month at NCSL's initiative, a group of 30 State and local officials met in Washington, D.C. for the exclusive purpose of examining S. 3205 and formulating a set of recommendations with respect to the proposal. The composition of that advisory group included State legislators, State and county medicaid directors, and representatives of Governors' offices. Additionally staff representatives from the National Association of Counties, the National League of Cities/U.S. Conference of Mayors, The National Governors's Conference, The American Public Welfare Association and The National Conference of State Legislatures also participated in the discussion.

The recommendations developed at that meeting were then shared with the Human Resources Task Force of the Intergovernmental Relations Committee of the NCSL. The task force, comprised of members of health and welfare committees from pratically every State legislature, spent a good deal of time reviewing the recommendations with the purpose of formulating a policy position with respect to S. 3205. That policy position was then considered by our full Intergovernmental Relations Committee and was adopted unanimously. For your information, the Intergovernmental Relations Committee of the NCSL includes over 500 State legislators, representing every State and both political parties, and has the exclusive authority to speak on behalf of the organization with respect to issues affecting State-Federal relations.

As chairman of NCSL's Human Resources Committee I have been asked to represent the thinking of our organization on this very important legislative proposal.

In general, Mr. Chairman, State legislators are enthusiastic about this bill. Reasonable attempts to fulfill the many objectives stated in S. 3205 deserve the attention and support of all levels of Government. Those objectives specifically relate to addressing several problem areas in the medicaid and medicare programs. Those problem areas include: the lack of uniform and efficient program management and administration; excessive and steadily rising costs in medicare and medicaid; ineffective enforcement of regulations by HEW; lack of provider fraud and abuse detection in programs; inefficient cost-generating reimbursement policies of hospitals, nursing homes, and, to some extent, physicians; and lack of coordination among HEW agencies which influence Government health financing mechanisms.

Several provisions within S. 3205, if implemented, offer an excellent chance of resolving many of the aforementioned problems. NCSL specifically supports the following key measures:

I. CONSOLIDATION OF MEDICAID AND MEDICARE INTO A NEW ADMINISTRATION FOR HEALTH CARE FINANCING

Since the enactment of titles XVIII and XIX, policy has not been developed in a uniform and consistent fashion, thereby contributing to substantial frustration to all concerned parties. The more recent involvement of the office of nursing home affairs (ONHA) in the development of conditions of medicare and medicaid participation and the bureau of quality assurance (BQA), whose PSRO's will perform utilization review for medicaid and medicare, has enhanced these difficulties. There have been occasions when all four agencies promulgated different regulations on the same subject matter. Consequently, the consolidation under consideration would insure more uniform and consistent policy development for all the affected programs.

II. CREATION OF A CENTRAL UNIT TO CONTROL FRAUD AND ABUSE IN MEDICAID AND MEDICARE

With respect to the provision in the bill requiring all contracts for services in excess of $10,000 be subject to review and advance approval, we feel that a $50,000 level would be more appropriate. Undoubtedly, service contracts are a source of abuse; however, the $10,000 threshold is unreasonably low and will likely lead to an inundation by proposed contracts.

III. PROVISION OF TECHNICAL ASSISTANCE TO THE STATES FOR IMPROVING THE MANAGEMENT, ADMINISTRATION AND OPERATION OF THE PROGRAM

On numerous occasions States have sought technical guidance from the federal and regional offices, only to be ignored or refused because the necessary technical expertise was unavailable. Given the increased number and complexity of Federal statutes and regulations, as well as performance standards expected under the proposal, improved technical assistance is indispensable to the ultimate effectiveness of this legislation. We are nevertheless concerned that while the bill calls for increased technical assistance, no recommendation appears calling for additional Federal dollars to be allocated for that purpose. Moreover, we would like to be assured that if the resources are available, they not be consumed by monitoring and enforcement functions to the detriment of needed technical assistance services.

IV. REQUIREMENT THAT REGULATIONS PERTAINING TO THIS ACT MUST BE ISSUED BY THE SECRETARY OF HEW WITHIN 13 MONTHS OF PASSAGE

The record of the department over the past few years in issuing timely regulations has been extremely poor. On several occasions States have been plagued with complying with requirements which become effective before final regulations are published and under which their compliance will ultimately be evaluated. One concern, however, is that the need for expedition not infringe on the need for greater clarity in the regulations.

V. REQUIREMENT THAT INFORMATION REGARDING DEFICIENCIES IN THE ADMINISTRATION OF A STATE'S MEDICAID PROGRAM BE MADE AVAILABLE NOT ONLY TO THE GOVERNOR OF THE STATE, BUT ALSO BE SHARED WITH THE LEGISLATIVE LEADER OF EACH HOUSE IN THE STATE LEGISLATURE, AS WELL AS THE CHAIRMAN OF THE LEGISLATIVE COMMITTEES WITH JURISDICTION OVER THE MEDICAID PROGRAM

Mr. Chairman, as a legislator who for several years sat as chairman of the Health and Rehabilitative Services Committee in the Florida House, with major responsibilities for the States' medicaid program, our committee was frequently one of the last to know when things were going wrong with the program.

The deference S. 3205 pays to the importance of the State legislative branch of government—in recognizing its accountability for the expenditure of State funds and assuring program effectiveness—is unprecedented in Federal legislation and welcomed with great enthusiasm.

This provision will unquestionably strengthen the legislatures' ability to oversee the administration of their medicaid program. Moreover, it should spur greater interest on the part of the appropriate committees to continually evaluate the performance of their own State agencies.

S. 3205 calls for specific reforms in the administration of medicaid by establishing specific performance standards in four areas: (1) eligibility determination; (2) quality control; (3) claims processing; and (4) program reports and statistics.

While the introduction of performance standards represents an appropriate step toward improving program administration and management, we feel the following specific concerns must be accommodated:

(1) Since compliance with the performance standards in the four broad areas is largely dependent on the assistance of fully operating management information systems, State and local governments will need more lead time than the proposed October 1977 effective date offers. Additionally, we recommend that the Federal Government assume the full cost of the development and operation of these management information systems.

(2) With respect to the specific requirement that medicaid eligibility be redetermined every 6 months, we strongly feel that this provision should not extend to the aged, blind, or disabled who qualify for assistance. The frequency of change in circumstances in these groups is so slight as to make a redetermination every 6 months administratively unnecessary and burdensome. The focus of eligibility redetermination should be on the medically needy under AFDC. Moreover, the time period for processing medically needy disabled applications should be changed from 60 days to 90 days, since verification in this program is often lengthy and detailed.

(3) The medicaid requirements are extremely detailed and specific. The advisability of locking such regulatory language into a statute is seriously questioned.

(4) While several States already meet or exceed the performance standards in the bill, many other States will be unable to comply without a substantial increment in State expenditures.

(5) The standards related to the area of quality control give us considerable difficulty. To begin with, a maximum error rate for eligibility determination set at the 50th percentile of rates reported by the States (between October 1975 to March 1976) will always be an arbitrary standard. For example, if a wide variation among State error rates existed, the median (50%) might not reflect even the majority of States. More equitable measures which recognize State capacities could be developed, rather than legislating such a rigid statistical requirement.

Even more troublesome is the tying of a fiscal penalty to certain tolerance levels. Given the fact that "quality control" is still an art and not a precise science—that is to say no one has the answer as to what combination of factors will guarantee a reduction in errors—we find the attachment of fiscal penalties to tolerance levels unacceptable. Instead, we would prefer to see a nationwide quality control system developed as a management tool which will allow elected officials, program managers, and the public to reliably and validly know the accuracy of the eligibility system at regularly recurring intervals.

The basic principles of this nationwide quality control system should be applied not only to medical assistance but to AFDC, SSI and food stamps as well. Additional administrative standards should not be mandated by the Federal Government without prior consultation with States and localities and until there is clear evidence of their cost effectiveness.

We further believe that no national performance tolerance levels should be established at this time. Instead, all States should be required to develop periodic corrective action plans, acceptable to the Department of Health, Education and Welfare, geared to the individual conditions of each State and including the State's specific targets for error reduction.

Sanctions, if necessary, should be applied only through the existing compliance procedure and only in those instances where a State refused to propose an acceptable corrective action plan or fails to appropriately implement the actions in the agreed upon plan.

We also recommend that the publicity of quality control findings should be continued with the following modifications:

More emphasis should be placed on publicizing in each jurisdiction the record of that single jurisdiction (national publicity makes it difficult for the public to evaluate the program which operates in their own localities).

Public recognition should be given to those jurisdictions with low error rates or which are making significant improvements.

More emphasis should be placed on clarifying the causes of errors and the content of corrective actions plans.

Concerning the bill's provisions related to hospital reimbursement, we recommend the following changes:

(1) States that have a successfully demonstrated hospital reimbursement program in operation should be allowed to utilize their system in lieu of the system recommended in the bill.

(2) Allowable cost increases should be reasonably related to the Consumer Price Index.

(3) More than one primary affiliate for a medical school should be allowed since States are experimenting with such efforts as community based schools and area health education centers.

In conclusion, Mr. Chairman, we suggest that while S. 3205 contains numerous worthwhile features that deserve widespread support, the bill should not be represented as the exclusive answer to controlling health care costs. Medicaid and Medicare account for only one-third of the total health care dollars spent nationally; therefore, the regulation of medicaid and medicare cannot control costs throughout the entire health care sector. Even if the bill's provisions succeed in holding medicaid and medicare hospital costs in line, there are virtually no safeguards to prohibit the reallocation of those costs to other third parties.

We believe that the development of a national health policy offers the most effective means of containing costs throughout the health care sector in the long run. Such a policy at a minimum would link decisions on provider reimbursement to effective health planning authorities. It would correct the present imbalance in the health care system between the emphasis on treatment of illness and the deemphasis on promotion of health. A national health policy can begin to grapple with some of the difficult public policy issues being forced on society by the proliferation of expensive, sophisticated technologies, such as, what kinds of health services shall be provided and where shall our limited resources be concentrated?

Many are looking to the Talmadge bill as the first step toward a national health insurance system. In your introductory remarks on S. 3205 you indicated Mr. Chairman, that the kinds of administrative and payment changes advocated in the bill, "Are absolutely necessary prior to any expansion of the Federal role in providing more health insurance to more people." You go on to suggest that absent these changes, "Any expansion would be an open invitation to fiscal disaster."

While, of course, our presence here today is not to debate the merits or demerits of the various national health insurance proposals pending before Congress, we do anticipate that that debate may be forthcoming fairly soon and when the time comes, State and local governments will be anxious to make a contribution to a consensus as to the kind of health care system America ought to have.

In preparation for that possibility, State and local organizations have been working together over the past year to learn how their constituents feel about certain key issues in the national health insurance discussion, as well as to delineate what roles and authorities State and local governments ought to exercise under any new health care system. For the record, I would like to submit some attachments which describe in detail our concerns in this area, as well as some of the tentative recommendations we have developed.

We hope that once the national health insurance debate really begins, your committee and staff will be as solicitous of our input as it has been with respect to S. 3205.

Thank you once again for this opportunity to meet with you.

Attachment to Testimony

Report of the Human Resources Task Force

PREAMBLE

In recognition of the ongoing consideration of a national health policy by the Federal Government, and without taking a position either in favor or against a comprehensive national health insurance program, the National Conference of State Legislatures in cooperation with organizations representing

State and local elected officials and health program administrators has developed positions to be taken by the coalition of State and local governments within the national debates on specific issues raised.

ADMINISTRATION AND FINANCE

A. State and local governments should be directly involved in the administration of a national health insurance system consistent with minimum Federal functions and considering State and local governments' historic responsibilities. State administration should be maintained and strengthened.

B. Administration and regulation responsibilities which should be retained include:

1. Certification and regulation of providers—under a national health program the Federal Government should set minimum standards which the State and local governments could exceed. States should submit a plan and if it does not meet the minimum Federal requirements, the Federal Government should assume the administration of the program;

2. In determining whether the State and local governments are to retain the administration of capital expenditures controls, their experience under the Health Planning Act should be taken into consideration;

3. States should establish, subject to Federal approval, the rate establishment and reimbursement process.

4. The regulation of health insurance should remain with the State which should be the instrumentality for implementing Federal standards.

C. To the extent that a NHI program is financed through tax revenues, those revenues should be derived by the Federal Government.

D. While a National Health Insurance program should include a full range of benefits and universal coverage, its full implementation should be provided for in one act with a planned schedule for the phase-in of benefits, coverage, and financing to assure effective administration.

E. To the extent that there is a lack of coverage under NHI there may be a necessity for continuation of categorical grants which should be administered by State and local governments.

F. It is recognized, apart from personal health and medical services under NHI, that there will be a necessity for continuation of public health grants which should be administered by State and local governments.

G. The national health insurance program should not entail the waiver by State or local governments of rights guaranteed under the 11th amedment of the Constitution.

COVERAGE AND BENEFITS

A national health insurance plan should include universal coverage with incentive for maximum participation.

The ultimate goal of such a plan should be comprehensive coverage including preventive, diagnostic, rehabilitation, long-term care, dental and eye care, drugs, corrective devices, and mental health. Such coverage should be achieved through a phasing-in of benefits beginning with personal preventive health services.

Legislation should identify services that are suitable for inclusion for appropriate age cohorts. All health care for children 0–6 years of age should be considered preventive care.

Emphasis throughout should be on preventing overutilization of care through provision of coverage at less intensive levels of care (preventive and ambulatory) as well as institutional services.

A program of catastrophic care as a second phase-in component of NHI needs consideration as to limits of coverage, relationship of coverage to income and character of population to be served.

State and local governments should be encouraged to investigate costs of components of comprehensive health care. Congress should initiate experimental programs of assistance to State and local governments precedent to implementation of comprehensive coverage.

COST CONTROL

Background

Medical costs have been increasing at a rapid rate in recent years. Although there is some thought that this rate of increase is flattening out, increases continue to outpace the Consumer Price Index.

A number of factors have been implicated in this increase. Inflation of the general economy plus a catch up process following economic stabilization controls are the major factors which are unlikely to be controllable except by general economic conditions.

Specific characteristics in the economics of health care accelerate the rise in medical costs. Advancing technology and expanding public expectations from that technology increases the demand for expensive and sophisticated services. Borrowing for capital improvement is often at interest rates higher than capitalization costs in other industries. Underreimbursement by third party payers stimulates providers to recover losses from direct paying consumers. Overstaffing of hospitals, increased liability costs and overspecialization of labor can be added as major factors.

Overutilization of the health care system is more correctly termed inappropriate utilization. While one might say patient demand causes inappropriate utilization, it is ultimately the provider who controls utilization. The provider decides how the system will be utilized as he responds to patient demand and the demands of standards established by the courts in liability actions.

Statement

States should have the authority and responsibility for implementing programs to control costs and assure quality, utilizing those mechanisms they determine to be most appropriate for their individual needs and circumstances.

Controls should be applied through a combination of incentive devices to encourage adoption of low risk lifestyles, use of low-cost health personnel, reduction in hospital stays and administrative expenditures, balanced physician distribution—and mandatory government regulation—utilization review, relicensure and continuing medical education, rate review, prospective hospital reimbursement, peer review and certificate of need. The incentives and regulatory programs should be in operation prior to the implementation of NHI.

As a means of controlling consumer utilization, copayments are not really effective. Much consumer copayment is hidden in charges. The provider still makes the utilization decision and the consumer has little real control. Exceptions might exist in the drug and repeat office visit sectors. Nevertheless, copayments are valid as a revenue generating mechanism.

The use of means tests to exempt certain eligibles from copayment requirements would probably be counter productive as far as reducing excessive utilization is concerned. Income level exemption tends to confuse NHI with income maintenance. If deductibles or copayment requirements are high enough they could affect accessibility to health care, but in the face of real need will not deter patients from seeking service. There are many other social variables that affect access.

Advertising of services and prices is not likely to reduce the cost of services. Price publications might lower costs in the case of drugs and supplies.

Cost control programs in States would probably be more effective than those at the Federal level but the cost to State government of these programs must include Federal assistance. Some States are not likely to act without Federal encouragement.

State operated NHI programs would present problems because of population mobility unless they were set up as an indemnification plan for residents without the cost, quality and service controls envisioned for NHI.

Federal quality standards probably would not work because of vast geographic variables. Very minimum standards could be applied at best. Cost variables are also so wide as to defy controls except in reference to previous costs with very elastic parameters.

MANPOWER AND QUALITY CONTROL

To insure an adequate supply of providers to meet the increased demand for various health and medical services, a national health manpower policy must be a prerequisite to a phased-in national health insurance plan.

The Manpower Task Force unanimously agreed to support, in principle, the tenets enumerated in the Senate health manpower bill. "The Health Professions' Education Assistance Act" (S. 3239). The task force is in agreement with the bills' efforts to remedy three fundamental problems:

(1) The poor distribution of health professionals in rural and inner city areas;

(2) The overabundance of surgeons and the shortage of primary care physicians; and

(3) The increased reliance on foreign medical graduates (FMG's) to resolve both the geographic and specialty maldistribution problems.

Although we support the Senate bill, it should not preclude state initiatives. States must identify their own health manpower problems and actively pursue solutions. States should take the lead in developing innovative programs to ease manpower shortages in medically underserved areas. It is suggested that states explore the possibility of requiring that certain standards be met by medical schools and other health professions schools receiving state monies, such as the development of remote site training centers.

Before the enactment of a National Health Insurance plan, there must be efforts to improve the capability of assessing the quality of medical care.

There should be appropriate State procedures for renewal of licenses and for continuing education programs for health professionals and institutions.

Efforts to expand the use of allied health personnel should be undertaken, and studies should be conducted to explore the appropriatness of licensure, certification, or the establishment of performance standards for such personnel.

Medicaid reimbursement should be made on the basis of the service rendered and not on the basis of the provider.

To insure chronology of care, the task force recommends the development of a uniform patient record system which could be incrementally developed beginning with immunization histories.

Senator TALMADGE. Our next witness is Mr. Frank Francois, vice president of the National Association of Counties.

STATEMENT OF FRANK FRANCOIS, VICE PRESIDENT, NATIONAL ASSOCIATION OF COUNTIES, COUNCILMAN, PRINCE GEORGES COUNTY, MD.

Mr. FRANCOIS. Thank you, Mr. Chairman.

I am Frank Francois, councilman, Prince Georges County, Md. I am also fourth vice president of the National Association of Counties on whose behalf I am appearing today.

I am accompanied by Mr. Mike Gemmell to my left who is a NACo legislative representative.

As you well know, Mr. Chairman, county government provides medical care to those who cannot obtain it elsewhere. When no one else can or will, local government provides that care. Similarly, counties are responsible for assuring services in several areas not generally addressed by existing public (medicare and medicaid) or private insurance programs—problems such as alcoholism, drug abuse, mental health, emergency care, and preventive and health promotive services.

The purpose of my statement is twofold. First, I wish to put NACo on record as supporting in general the goals and objectives of S. 3205 and second, I wish to make Congress and the members of this subcommittee aware of the problems and opportunities facing counties as a result of the medicaid program.

We wish to commend the chairman and members of the subcommittee for proceeding with hearings on medicaid and medicare reform. We are submitting for the record a survey of health expenditures in 15 States that we believe provides representative examples of the role counties play in providing medical care through medicaid. The results of this survey clearly show the magniture of the financial commitment counties have made to health care.

We are also submitting for the record a resolution passed by the NACo membership during our recent annual convention.

Mr. Chairman, in that respect I would note in your statement released today on this bill you refer to the National Association of Counties as calling for immediate wage controls of hospitals. That position has been changed as of June. We are now in a posture, as you will note from the resolution, of encouraging incentives to hold down costs.

Senator TALMADGE. I am delighted to hear that because I think a freeze is too rigid.

Mr. FRANCOIS. Our membership after a rather intensive debate on the floor reached the same answer, sir.

As an example of the impact S. 3205 will have on counties, we urge you to take into consideration the amendments suggested by Los Angeles County.

NACo stands ready to support S. 3205 with the suggested amendments. We are specifically concerned about the potential negative fiscal impact of sections 4, 10, and 11 of the bill. Of course, those are the same ones that the Los Angeles County addressed themselves to.

These sections propose desirable administrative objectives. Enacting them into law, however, will result in increased administrative costs to counties. We understand that the subcommittee staff is aware of the problems inherent in these sections.

We believe S. 3205 will help eliminate overlap, duplication and redtape now in existence in the medicaid program. We believe it will also reduce high error rates.

Why are we supporting S. 3205? The attached survey clearly shows that the commitment of county governments to the medicaid program is substantial. As health care costs increase counties are being forced to rely on an already burdened property tax to support the health care of a small segment of their population. While dedicated to the provision and availability of health care for all citizens, counties face the dilemma of sacrificing other necessary and mandated services responsibilities to the burgeoning fiscal requirements of the medicaid program. Cutbacks in services and/or eligible population provide no relief for counties, which are traditionally the providers of last resort.

Persons whose major health problems fall into special categorical problem areas, and others whose life styles disqualify them for protection under Federal health programs (including disabled but working persons, intact families, childless couples, single persons between 21 and 65 years old, the working poor, nonresident aliens, prisoners and migrants) must turn to local government for help. However, our Nation's approach to the medically indigent through medicaid is uneven and highly inequitable. Inadequate benefits in some States create classes of medically needy which do not even exist in other States. These medically indigent persons also become the burden of local government.

Since counties cannot, by themselves, be expected to control costs and since we are always left to pick up the tab for all those who are not covered by a State or Federal program or private insurance, NACo has the following recommendations:

First, completely overhaul the eligibility process. This process is far too complex. In most States at least four categories of eligibility

are in use. The costs of administration are far too high. Eligibility errors are numerous—little effort has been expended to analyze the demographic characteristics of the eligible population, patterns of their residence or patterns in the use of covered services.

Millions of dollars are being expended to process eligibles—yet there is considerable indication that the high costs of eligibility succeeds merely in determining which level of government—Federal, State or local—must pay for the care of the medically indigent.

There is a need to standardize and simplify the eligibility process. The costs of weeding out a small percentage of people who are marginally ineligible probably far exceeds the cost of provisions of care to them. The diversion of financial resources from fruitless, expensive, repetitive processing could augment money needed to provide essential services.

Second, the revision of cost-sharing approach to funding of medicaid. The existing system of Federal, State, local sharing under medicaid is both unreasonable and inequitable, we believe. People in need of medical services who cannot afford to pay for them must either do without or have their care subsidized in whole or in part by local government. Failure to cover preventive and early diagnostic care and treatment in the long run boosts the cost of medical care which becomes the cost of neglect. Nationally millions of administrative dollars are being spent under medicaid simply to determine what portion of costs will be borne by Federal, State and county governments.

We argue for federalization of the medicaid program. We urge that consideration be given to eliminating the regressive, rigid property tax as a source of revenue for financing medicaid. If we seek equity of access to adequate care, we cannot depend on the property tax to provide that equity.

We are willing to work with the subcommittee staff, Mr. Chairman, which has been most cooperative in responding to our concerns, at your direction. We thank you for allowing us this opportunity to testify today.

I would like to put one more item into the record if I could. I always like to go to the people who operate these programs and get their viewpoints.

Senator TALMADGE. Without objection, it will be inserted in the record, sir.

Mr. FRANCOIS. I did that in my own county. I have a health officer's two-page memorandum outlining our view on the bill in Prince Georges County.

Senator TALMADGE. Delighted to have it as part of the record.

[The material follows:]

PRINCE GEORGE'S COUNTY HEALTH DEPARTMENT

JUNE 3, 1976.

Re U.S. Senate Bill 3205: Medicare Medicaid Reform Act—Senator Talmadge.
Memorandum to: Donald K. Wallace, M.D., Health Officer.
From: P. A. Lusk, Director, Institutional Care.

This is one of the finest Bills I've seen proposed in relation to Medicare and Medicaid since its advent in 1965. The advocating Senate Subcommittee seems to be a unique exception in that it is taking a very broad overview of the problems

of the Program rather than attempting to patch pieces without regard to the impact on the other parts of the Program. Generally, I would totally support the Bill and would hope that it gains passage.

(1) The cover letter highlights one of the primary problems at the local level—that is, Federal offices under different HEW administrations making decisions that conflict with others which creates total chaos to the local provider. The combining of Medicare, Medicaid. Quality Assurance and PSRO into a single administering agency of health care financing would eliminate the disputes, conflicts, duplication, gaps and basic distrust that has occurred between local providers and government (both State and Federal). Hopefully there would then be more resources and energy to go into provision of care.

(2) The proposed Central Fraud and Abuse Control Unit was needed a long time ago. Most of the fraud in the Medicare/Medicaid Programs is at the provider level, not the beneficiary level. Because program monies at the local level end up being mingled in the care of a single individual (that is to say, Medicare might pay for 70% of care and Medicaid might pick up the other 30 percent). It has been difficult to pursue provider abuse because of the differing regulations between Medicare and Medicaid. There have been instances when attempts at the State level to pursue abuse have been frustrated by the fact that the records of one Program (title XVIII) could not be reviewed by the other Program (title XIX). Without the ability to exchange information it becomes difficult to prevent double billing. Who is to say that Medicaid and Medicare have not both paid, resulting in a public fund reimbursement in excess of 100%.

(3) The intention of having an annual onsight evaluations of each State's medicaid administrative structure and operation would be welcome. The absence of a State-wide policy in the Medicaid Program has brought about unequal and off-times lax administration of performance standards in the varied counties. At this point in time, the Federal Government audits three to four years after payment has not been made. This means, that if the State fails to set performance standards and to audit compliance in a timely manner the Federal may pick up the omission years afterwards which leaves the family penalized. If the claim is disallowed YEARS after the service was rendered the family is then billed. This is particularly true in the long-term care parts of the Medicare/Medicaid Programs, therefore the impact of this proopsal to the local citizenry would be positive even though requirements on the State Health Department and possibility on the local Health Department would be greater.

(4) I also applaud the proposal that the Federal Government would withhold funds to States who do not straighten out their Program rather than just prohibiting payment to providers as they now do which penalizes the patient not the non-complying Agency.

(5) The proposed changes in the reimbursement formula for hospitals and skilled Nursing Homes seem valid. Certainly there has been abuse in the long-term field related to buying and selling among family or corporation members (so as to abuse the depreciation factors).

(6) The adding of a calculation factor which would encourage the conversion on usused hospital beds into Nursing Homes is a positive factor and might well encourage the District of Columbia (with these additional revenues) to begin using some of their surplus hospital beds for Nursing Homes which would thereby release the beds in Prince George's and Montgomery County Nursing Homes currently used by District of Columbia residents.

(7) The proposed change in reimbursement formula which encourages acceptance of assignment by physician might well encourge more of our physicians to accept Medicare and thereby make physician care more available to our residents.

(8) The proposal to alter the reimbursement factor to include a profit factor in the Not-for-Profit facilities is good. This will increase providers willing to accept Medicare/Medicaid beneficiaries. It should be recognized that the receipt of "cost only" will not allow for the maintenance effort of the facility and its administration nor does it allow for expansion and enrichment of the program or facility. I question however, the limitation of the profit factor to the "for-profit" facilities only. I think the profit factor should be available to all facilities. Non-profit facilities also have to address themselves to the maintenance of effort, maintenance of facility and to expansion and enrichment of program and facility. The difference between profit and non-profit is more semantic than real. The non-

profits frequently set salaries at a comfortable level and they fare far better than for-profit which have been known to have less profit to take home than if they had operated on salaries under the for-profit scheme.

(9) Under HR -1, there is a requirement that the State Medicaid Programs have a data system that will provide an explanation of benefits paid to each recipient. Senator Talmadge proposes the explanation of the benefits which is sent to GAO be only on a sample basis rather than each recipient. I hope that the States will still be required to have a data bank that would amass data on each recipient but only be required to forward to GAO a sample of that data bank. Certainly GAO would not be interested in the reams of paper required to report on the approximately 500,000 Medicaid recipients in Maryland. However, the full data should be available for sample selection. I don't see that this provision would make any particular impact on the local level.

(10) The requirement that the cost of hospital care of Medicare/Medicaid not be passed on to the private patient or private insurers would be beneficial and would seem to have the effect of requiring Medicare/Medicaid to their fair share which should hopefully result in a reduction of rates by local providers who have been forced to carry over their Medicare/Medicaid losses to the private Sector.

(11) The proposed revision of the reimbursement formula for hospitals by classification of natural groups of comparable size facilities appears to be an improvement over the current reimbursement system. However, I think there is not sufficient recognition of the regional difference of the inflationary floor and that there is an inflationary cost above and beyond that of wages. I am suggesting that perhaps an additional factor go into the calculation of reasonable reimbursement mechnism for providers which would increase availability of local services.

Mr. TALMADGE. Mr. Francois, I certainly appreciate your thoughtfulness and support.

My attention has been called to a probem in counties in some states with respect to payment of medicare and medicaid to illegal aliens. That is, the burden of the cost of this care has fallen solely on the counties. Would you care to comment on the situation?

Mr. FRANCOIS. It is a problem, Mr. Chairman, as is always true when the county government is involved and we always are because we are always there and when no one else pays the bill it comes to us. It is a problem. It is one that we are wrestling with particularly in the Southwest. Los Angles, Calif., spends in excess of $8 million on this problem. San Diego, Calif., spends nearly $1 million. While throughout that area of the Nation it is a more visible problem, it remains a national one that we would very much like to get some help on. We think it is an unfair burden.

Senator TALMADGE. We have a food stamp program. When the Senate passed a bill trying to reform it we prohibited illegal aliens from receiving food stamps, and I think we ought to do the same thing in all facets of medicare and medicaid.

Mr. FRANCOIS. The problem is how do we know what people are actually illegal and how are we going to pay the bills? They are still going to be knocking at the courthouse door and we will end up paying it one way or another. They will show up at our hospitals as indigents and those bills will ultimately end up in our hands. We think it is a national problem and that we have to get help from that source.

Senator TALMADGE. Thank you. I agree.

If there is nothing further, the committee will stand in recess until 8 a.m. tomorrow.

Mr. FRANCOIS. Thank you.

[The prepared statement of Mr. Francois follows:]

STATEMENT OF HON. FRANCIS FRANCOIS, COUNCILMAN, PRINCE GEORGES COUNTY, MD.

Mr. Chairman, members of the subcommittee, I am Francis Francois, councilman, Prince Georges County, Md. I am also fourth vice president of the National Association of Counties, (NACo)[1] on whose behalf I am appearing today.

As you well know, county government provides medical care to those who cannot obtain it elsewhere. When no one else can or will, local government provides that care. Similarly, counties are responsible for assuring services in several areas not generally addressed by existing public (medicare and medicaid) or private insurance programs—problems such as alcoholism, drug abuse, mental health, emergency care, and preventive and health promotive services.

The purpose of my statement is twofold: first, I wish to put NACo on record as supporting in general the goals and objectives of S. 3205; and, second, I wish to make Congress and the members of this subcommittee aware of the problems and opportunities facing counties as a result of the medicaid program.

We wish to commend the chairman and members of the subcommittee for proceeding with hearings on medicaid and medicare reform. We are submitting for the record a survey of health expenditures in 15 States that we believe provides representative examples of the role counties play in providing medical care through medicaid. The results of this survey clearly show the magnitude of the financial commitment counties have made to health care.

We are also submitting for the record a resolution passed by the NACo membership during our recent annual convention. The resolution urges Congress to federalize medicaid for reasons outlined in my testimony here today. As an example of the impact S. 3205 will have on counties, we urge you to take into consideration the amendments suggested by Los Angeles County, Calif. (attached).

NACo stands ready to support S. 3205 with the suggested amendments. We are specifically concerned about the potential negative fiscal impact of sections 4, 10, and 11 of the bill. Both sections propose desirable administrative objectives. Enacting them into law, however, will result in increased administrative costs to counties. We understand that the subcommittee staff is aware of the problems inherent in these sections.

We believe S. 3205 will help eliminate overlap, duplication and red tape now in existence in the medicaid program. It will also reduce high error rates.

Why are we supporting S. 3205? The attached survey clearly shows that the commitment of county governments to the medicaid program is substantial. As health care costs increase counties are being forced to rely on an already burdened property tax to support the health care of a small segment of their population. While dedicated to the provision and availability of health care for all citizens, counties face the dilemma of sacrificing other necessary and mandated services responsibilities to the burgeoning fiscal requirements of the medicaid program. Cutbacks in services and/or eligible population provide no relief for counties, which are traditionally the providers of last resort.

Persons whose major health problems fall into special categorical problem areas, and others whose lifestyles disqualify them for protection under Federal health programs (including disabled but working persons, intact families, childless couples, single persons between 21 and 65 years old, the working poor, nonresident aliens, prisoners and migrants) must turn to local government for help. However, our Nation's approach to the medically indigent through medicaid is uneven and highly inequitable. Inadequate benefits in some States create classes of medically needy which do not even exist in other States. These medically indigent persons also become the burden of local government.

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[1] The National Association of Counties is the only national organization representing county government in the United States. Its membership spans the spectrum of urban, suburban, and rural counties which have joined together for the common purpose of strengthening county government to meet the needs of all Americans. By virtue of a county's membership, all its elected and appointed officials become participants in an organization dedicated to the following goals: improving county government; serving as the national spokesman for county government; acting as a liaison between the nation's counties and other levels of government; and achieving public understanding of the role of counties in the federal system.

Since counties cannot, by themselves, be expected to control costs and since we are always left to pick up the tab for all those who are not covered by a State or Federal program or private insurance, NAC has the following recommendations:

First, completely overhaul the eligibility process. This process is far too complex. In most States, at least four categories of eligibility are in use. The costs of administration are far too high. Eligibility errors are numerous—little effort has been expended to analyze the demographic characteristics of the eligible population, patterns of their residence, or patterns in the use of covered services.

Millions of dollars are being expended to process eligibles—yet there is considerable indication that the high costs of eligibility succeeds merely in determining which level of government—Federal, State, or local—must pay for the care of the medically indigent.

There is a need to standardize and simplify the eligibility process. The costs of weeding out a small percentage of people who are marginally ineligible probably far exceeds the cost of provision of care to them. The diversion of financial resources from fruitless, expensive, repetitive processing could augment money needed to provide essential services.

Second, the revision of cost-sharing approach to funding of medicaid. The existing system of Federal, State, local sharing under medicaid is both unreasonable and inequitable. People in need of medical services who cannot afford to pay for them must either do without or have their care subsidized in whole or in part by local government. Failure to cover preventive and early diagnostic care and treatment, in the long run, boosts the cost of medical care—which becomes the cost of neglect. Nationally, millions of administrative dollars are being spent under medicaid simply to determine what portion of costs will be borne by Federal, State, and county governments.

We argue for federalization of the medicaid program. We urge that consideration be given to eliminating the regressive, rigid property tax as a source of revenue for financing medicaid. If we seek equity of access to adequate care we cannot depend on the property tax to provide that equity.

We are willing to work with the subcommittee staff, which has been most cooperative in responding to our concerns, Mr. Chairman, at your direction. We thank you for allowing us this opportunity to testify today.

SECTION 4—STATE MEDICAID ADMINISTRATION [1]

30–60 Day Case Processing

Summary: The bill would require that state Medicaid plans provide for determinations of eligibility for all applicants within at least 60 days, and for some applicants within 30 days. Redeterminations of eligibility would have to be made within 30 days of receiving information on changed circumstances, and in any event at least every six months.

Effect: Under present circumstances it is occasionally impossible to determine medicaid eligibility within 60 days because of the complexity of medicaid requirements as well as the inability of the Social Security Administration to provide information which must be obtained as part of the determination process. Although the percentage of cases which require clearance by SSA is not great, this is an area which should be resolved before the states are penalized for failure to comply.

50th Percentile Error Rate

Summary: States would have to provide methods to assure accuracy in determining eligibility so that the state's error rate for eligibility determinations after October 1, 1977, does not exceed the 50th percentile of the error rates for all states.

Effect: The requirement that states eligibility determination error rate not exceed the 50th percentile of error rates for all states would be impossible for all states to meet, if the 50th percentile is to be periodically adjusted. Since by definition nearly 50% of states would have an error rate above that level. It is necessary to specify that the error rate percentile be determined only once without future adjustment.

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[1] Suggested Amendments to S. 3205 by Los Angeles County, Calif.

Reporting Requirements

Summary: States also would be required to provide that 95 percent of those claims that require no additional information be paid within 30 days, and 99 percent be paid within 90 days. Extensive review of claims relating to accuracy, participation of the provider, eligibility of the recipient and other areas would be required. In addition, extensive reporting requirements would be established for states relating to eligibility determinations, quality control programs, claims payment, participating providers, utilization of services, and others.

Effect: Within California similar reporting requirements already exist. Without more specific detail it is impossible to evaluate the amount of additional reporting which would be required. However, it is possible that reports will be mandated for which we will not be able to obtain administrative reimbursement.

Quality Control

Summary: Effective October 1, 1977, federal contributions to a state for the state's Medicaid program would be subject to a reduction or termination unless the state makes a satisfactory showing to the HEW Secretary that it is meeting the above requirements for payment, determination of eligibility, etc. The Secretary would conduct annual on-site visits to each state to determine compliance with these requirements. Notice of failure to comply would be provided to a state. The states would have up to six months to correct the deficiencies.

The bill would add additional criteria for determining reasonable costs of hospital services under Medicare. The Secretary would establish, in consultation with appropriate knowledgeable national organizations:

1. A uniform system of accounts and cost reporting, including uniform procedures for allocation of costs, for determining operating and capital costs of hospitals providing Medicare services.

2. An ongoing system of hospital classification under which hospitals will be classified initially as to:

a. Bed size.

b. Type of hospital with separate categories for short-term general hospitals, hospitals that are the primary affiliates of accredited medical schools, and with psychiatric, geriatric, maternity, pediatric, or other specialty hospitals being in the same or separate categories as the Secretary determines.

c. Such other criteria as the Secretary deems appropriate but the classification would not differentiate between hospitals on the basis of ownership.

Amend: The bill should be amended to clearly state 50th percentile as acceptable error rate will be established initially and maintained at levels determined.

States that exceed substantially two or more requirements and meet the requirements would be entitled to a federal matching of 75 percent. The current maximum federal matching is 50 percent.

The bill would add new quality control provisions under Medicaid. These provisions relate to publishing state error rates in making eligibility determinations, setting the 50th percentile of state error rates, and providing technical assistance to the states to aid in their eligibility determinations.

A bi-annual report by the HEW Secretary describing benefits, eligibility, reimbursement rates, and listing all fiscal agents contracted with for administration of the Medicaid program would be required. Quarterly updates of these reports also would be required.

Effect: The county hospital's cases are presently controlled for quality by the Department of Public Social Services certifier. All quality reports are channeled through DPSS, therefore, this could not affect the county hospital cases.

As defined in the bill, routine operating costs would not include: capital costs; direct personnel and supply costs of hospital education and training programs, costs of interns, residents, and medical personnel; or energy costs associated with heating or cooling the hospital. Reimbursement for items not included as routine operating costs would continue as at present.

The Secretary, annually, would determine for each category of hospitals an average per diem routine operating costs amount that would be utilized in determining the reasonable cost of the portion of the hospital's costs that consist of routine operating costs. This determination would be made on the basis of routine operating costs data from the preceding year.

There would be nonpersonnel and personnel components to routine operating costs. These two components for all hospitals in each class would be aggregated to determine the total routine operating costs for all hospitals in the category.

This amount would be divided by the total number of days of routine care provided by such hospitals to arrive at the average per diem routine operating costs for each category of hospital. Hospitals that are significantly understaffed or that are not accredited would be excluded from these computations.

Payment to a hospital would be based on the average per diem routine operating cost amount determined for its category. Adjustments could occur in the personnel component because of wage variations in different geographic areas. Increases also would be allowed to reflect increases in the cost of goods and services that comprise routine operating costs.

In cases where hospital routine operating costs are equal to or exceed the average per diem routine operating cost for its category, reimbursement would be equal to the hospital's actual per diem routine operating costs up to 120 percent of the average routine operating costs for hospitals in its category. Hospitals with costs exceeding the 120 percent limit would not be reimbursed for these additional costs. Hospitals with costs below the average for their category would be reimbursed for their actual costs plus one-half the difference between their costs and the average for their category.

This additional bonus would be limited to 5 percent of the hospital's routine operating costs. Special provisions relate to hospitals located in underserved areas that are certified as necessary and that are underutilized. Special provisions also would apply to hospitals with special case mixes that require a greater intensity of care than that provided in the average hospital that increases the level of the hospital's routine operating costs.

The HEW Secretary would be directed to develop comparable reimbursement methods for other hospital cost centers, skilled nursing and intermediate care facilities, as well as home health agencies.

These new reimbursement provisions would be applicable for information purposes only prior to July 1, 1979. Differences in actual costs and average costs for a category of hospitals would be reduced by one-half for fiscal year 1980, and the provisions would be fully operative beginning in fiscal year 1981. These reimbursement provisions would apply under both the Medicaid and Medicare programs.

Uniform Accounting

Effect: The California Health Facilities Commission currently requires uniform accounting procedures and cost allocation methods. It has been difficult and costly for the Department of Health Services to comply with this requirement since our government accounting system differs from that of private hospitals. This has, in some instances, necessitated the keeping of dual records: one set to comply with County requirements and another for the California Health Facilities Commission. Conceivably the accounting system mandated under this legislation could require a third set of books.

Amendment: The bill should be amended to require that any uniform accounting procedures developed be compatible with existing state accounting requirements or to mandate that existing state systems be modified to conform with the Federal system.

Reimbursement of Routine Costs

Effect: Under existing federal law, ceilings have been established for the reimbursement of routine costs under medicaid and medicare. These ceilings now vary according to a hospital's bed size and the community in which it is located. This proposed legislation would vary the ceiling according to bed size, treatment categories and other criteria as the Secretary of HEW desires.

Under the present system three of our hospitals exceed the routine cost ceiling for Medicare and all of our hospitals are over the more stringent state imposed Medi-Cal ceiling. We assume that the ceilings under the new legislation would be comparable to the existing federal ceilings and that Medi-Cal/Medicare reimbursement would not be effected materially.

Amendments: The existing bill would place all hospitals with over 500 beds in the same size category. We feel that there should be further breakdowns at 650, 800, and 1,000 beds. Since costs vary considerably between areas, this legislation should establish categories for geographic areas by cost of living as is now being done by regulation for the establishment of reimbursement ceilings.

Teaching Hospitals

Effect: Hospitals which are the primary affiliates of accredited medical schools would be included in one category (without regard to bed size) for the purpose of establishing reimbursement ceilings.

Under this condition, only the LAC-USC Medical Center and Martin Luther King Jr. General Hospitals would qualify as teaching hospitals. UCLA affiliates, Harbor General Hospital and Olive View Medical Center, would not be qualified. Neither would Rancho Los Amigo or John Wesley Hospital, both of which are affiliated with the University of Southern California. Therefore, the cost of teaching programs in four of the hospitals operated by Los Angeles County will not be fully reimbursed. Additionally, the disregard of teaching hospital size will penalize the LAC-USC Medical Center since its costs would be substantially greater than those of a small teaching hospital.

Amendments: Section 10 (b) should be amended to delete from the proposed Social Security Act Section 1861 (aa) (1) (B) (ii) the word "primary" which precedes "affiliates" the parenthetical phrase following the word "schools" (which one such hospital to be nominated by each accredited Medical school)", and the parenthetical phrase following the word "category" (without regard to bed size)'.

SECTION 11: INCLUSION IN REASONABLE COST OF HOSPITAL SERVICES AN ALLOWANCE FOR RETIREMENT OR CONVERSION OF UNDERUTILIZED FACILITIES

Summary: The Secretary would create a five-member Hospital Transitional Allowance Board. The board would act on applications by hospitals certified for participation in the Medicare and Medicaid programs for transitional allowances. A transitional allowance would mean an amount that would be included in a hospital's reasonable cost and would be established by the Secretary for a hospital in recognition of a reimbursement detriment suffered by it because of a qualified facility conversion. No more than 50 such allowances could be made during the first two years following enactment of the bill.

A qualified facility conversion would mean a retirement, modification, or change in usage of underutilized hospital facilities that is carried out by a hospital that, for at least a year prior to the conversion, regularly furnished Medicare or Medicaid services, and the effect of which is to promote efficient and economical delivery of health care services by eliminating excess bed capacity or discontinuing an underutilized service for which there are adequate alternative sources in the area. Conditions are set out in the bill for determining whether a conversion results in a reimbursement detriment.

Effect: This section is potentially beneficial to the Department of Health Services in that we could realize additional revenue for hospitals which are to be converted or retired because of underutilization.

Amendments: This section is potentially beneficial to the Department of Health Services in that we could realize additional revenue for hospitals which are to be converted or retired because of underutilization.

The bill should be amended to eliminate the provision which limits this allowance to 50 hospitals during the first two years. Costs associated with the retirements or conversion of underutilized facilities are legitimate administrative costs and should be recognized as such in all applicable circumstances. There is no logical justification for arbitratily limiting this allowance.

With regard to the effective date of this section, it would be preferable for the section to take effect as of the beginning of the Federal fiscal year in which the bill is passed.

THE ROLE OF COUNTY GOVERNMENT IN MEDICAID—A SURVEY OF SELECTED STATES; BY JAMES KOPPEL, SURVEY DIRECTOR, AND JOHN F. CLARK, SURVEY ANALYST

INTRODUCTION

This study by the National Association of Counties (NACo) demonstrates the financial and administrative commitment of county resources to the Medicaid program. Although the Medicaid program is generally considered to be a federal-state partnership, local county governments are required to provide substantial financial and administrative support. In five of the fifteen states surveyed for this study, county governments paid over 20 percent of the total Medicaid program or administrative costs for the fiscal year July 1, 1975 to June 30, 1976.

NACo maintains that the funding of the Medicaid program should be completely assumed by the federal government. This position is based upon three

observations: 1) Medicaid plans vary from state to state; thus, the medically indigent residing in one state are commonly denied services available to those in other states; 2) counties must fill the gaps in services to the poor; thus, Medicaid programs which provide fewer services place a greater workload on county health agencies and hospitals; and 3) those states which require county support in Medicaid funding increase the burden on the major source of county revenue, the local property tax.

The purpose of this report is to demonstrate the burden the Medicaid program places on county government, to outline the major gaps in services to people, and to emphasize the need to address this problem in discussions concerning the reform of the Medicaid program. The escalating costs of the Medicaid program ($2 billion per year since 1974) have strained county budgets to the point where other mandated services areas are being jeopardized. Assumption of funding for the Medicaid program by the federal government would relieve counties of this burden, and enable them to maintain their efforts in other areas of responsibility, including public health and medical care.

ACKNOWLEDGEMENTS

The data presented in this report were obtained from officials working in the agencies responsible for the individual state medical assistance plans. In many cases, more than one official was consulted; however, the name of only the principal contact is provided for each state. The NACo staff wishes to express its appreciation to those state officials who provided the data necessary to complete this study.

METHODOLOGY

The survey was designed and directed by James Koppel of the NACo staff. John Clark authored the survey analysis.

Data for this report was obtained through personal interviews with officials of the departments responsible for administering the individual state medical assistance programs. Interviews were conducted between March and June, 1976. Where necessary, figures were projected to cover the fiscal year July 1, 1975 to June 30, 1976. The accuracy of the data, where available, was considered to be good. In some cases information could not be readily obtained from existing records, e.g., the number of state-operated skilled nursing and intermediate care facilities was in several cases unknown.

A total of fifteen states were interviewed, representing 47 percent of the country's Medicaid recipients (1973 figure). Geographical dispersion was obtained by selecting states located in the Northeast, South, Midwest, and West. Patterns in the provision of services, and participation in funding by the counties were identified.

Two types of costs were looked at for this report. Program costs were defined as costs for services provided. Administrative costs were defined as the costs associated with operating the Medicaid program, e.g., the costs of determining the eligibility of a recipient.

FINDINGS

Table 1 displays the states surveyed, the type of program operated (medically needy or SSI type), the optional services provided, and whether counties fund either the program or administrative costs of Medicaid.

Nine of the fifteen states operated a "medically needy" program, i.e., medical assistance was provided to poor persons other than those receiving AFDC or SSI. In seven of these nine states, counties participated in funding the program costs of Medicaid. In three of these states counties also contributed to the administrative costs of the program.

Six of the fifteen states operate a "categorically needy" program, i.e., eligibility for medical assistance is based upon qualification for either AFDC or SSI assistance. In three of these states counties pay part of the administrative costs of the program. One state, Nevada, has property taxes earmarked for the Title XIX fund. In eleven of the fifteen states surveyed (or 73.3 percent), counties are required to financially support the Medicaid program. The other thirty-nine states are not required to financially participate in the Medicaid program. However, most counties in these states finance the bulk of medical services to medically needy persons that are not covered under Medicaid.

Opposite this requirement of financial support by the counties, the degree of county control over the program, i.e., as far as the setting of standards for eligibility and the setting of benefit levels was reviewed. (Data are presented on individual state survey sheets.) In all fifteen states, standards for eligibility were set by the state. In fourteen of fifteen cases, the level of benefits was likewise determined solely by the state, Nebraska being the exception. The costly process of determining the eligibility of potential recipients was assigned to the counties in all but three states.

Table 2 presents the program and administrative costs of Medicaid to county governments from July 1, 1975 to June 30, 1976. Table 3 displays the percentage of total (federal and state) Medicaid costs funded by county governments for the same period. For those states having the medically needy program, the counties generally (7 or 9 cases) were required to assist in funding Medicaid costs, ranging from 2.4 percent to 27.5 percent of total programs costs. Support of administrative costs ranged from 2.88 percent to 35.4 percent of total administrative costs.

Table 4 displays the per capita contribution by county governments to Medicaid program and administrative costs. These figures were obtained by dividing the contribution of each state's counties to program (and administrative) costs by the average monthly served population, multiplied by twelve. The highest per capita contribution to program costs occurred in those states having the medically needy program. The highest per capita contribution to administrative costs was paid by Indiana counties ($13.17), and was nearly ten times the size of the next largest (New York at $1.34).

CUTBACKS

Between January 1, 1975 and January 15, 1976, five of the surveyed states (Ala., Md., N.H., N.J., Va.) reduced or eliminated mandatory or optional services to Medicaid recipients. Three more states (Ind., Neb., N.C.) plan to reduce or eliminate services in fiscal '77. The goal of reductions or eliminations in services provided under the states' Medicaid plans is cost control; the effects will surely be an increased burden on local governments, which are mandated to provide health services to their indigent populations.

States which have the medically needy program were slightly more likely to cutback on services than states with the more restricted SSI program (4 to 3).

County participation in Medicaid funding did not seen to prevent cutbacks in services. States in which counties funded Medicaid were as likely to cut back services as those states in which counties did not. Since county funding of Medicaid will continue, the ultimate losers in any cutback of services are the counties. The escalating costs of health care will require continued support by the counties at levels equal to or exceeding those of the past fiscal year. Meanwhile, those services to the poor that are no longer covered under Medicaid must be provided solely at county expense. A cutback in services or eligible population, while possibly serving the states' need for economy, only worsens the situation of the counties.

SUMMARY

This report has pointed out that the commitment of county governments to the Medicaid program is substantial. As health care costs increase, counties are being forced to rely on an already burdened property tax to support the health care of a small segment of their population. While dedicated to the provision and availability of health care for all citizens, counties face the dilemma of sacrificing other necessary and mandated service responsibilities to the burgeoning fiscal requirements of the Medicaid program. Cutbacks in services and/or eligible population provide no relief to counties, which are traditionally the providers of last resort. The effective response requires the federalization of Medicaid.

TABLE I

Services (optional) program type [1]	States providing service														
	Alabama	California	Colorado	Indiana	Maryland	Minnesota	Nebraska	Nevada	New Hampshire	New Jersey	New York	North Carolina	Ohio	Virginia	Wisconsin
	S	M	S	S	M	M	M	S	M	S	M	M	S	M	M
Clinic service		X		X	X	X	X	X	X	X	X	X	X	X	X
Prescribed drugs	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Dental services		X		X	X	X	X	X	X	X	X	X	X		X
Prosthetic devices	X	X	X	X	X	X	X	X	X	X	X		X	X	X
Eyeglasses	X	X		X	X	X	X	X	X	X	X	X	X	X	X
Private duty nursing				X		X	X	X	X		X		X		X
Physical therapy		X	X	X	X	X	X	X	X	X	X		X	X	X
Preventive rehabilitation		X		X		X	X	X	X	X	X	X	X	X	X
Emergency hospital	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
SNFS patients under 21	X	X	X	X		X	X	X	X	X	X	X	X	X	X
Optometry	X	X		X	X	X	X	X	X	X	X	X	X	X	X
Podiatry		X	X	X	X	X	X	X	X	X	X	X	X	X	X
Chiropractors		X		X		X	X	X	X	X	X	X	X		X
LTC within ICF	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Mental illness in geriatric care (65)	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Participation in funding [2]		B	A	A	P	B	P	(3)	P		B	B	A		

[1] M—Medically needy program. S—SSI eligibility program.
[2] P—Counties contribute to program costs. A—Counties contribute to administrative costs. B—Counties contribute to program and administrative costs.
[3] County property taxes exceeding $3,600,000 are put into the State Title XIX fund.

TABLE 2.—PROGRAM AND ADMINISTRATIVE COSTS TO COUNTIES, JULY 1, 1975, TO JUNE 30, 1976

Aggregated county costs (State)	Program	Administrative
Alabama		
California	[1] $313,573,044	
Colorado		$151,660
Indiana		[2] 16,370,000
Maryland	4,457,511	
Minnesota	13,405,573	1,393,750
Nebraska	13,228,000	
Nevada		
New Hampshire	3,917,550	
New Jersey		
New York	754,000,000	18,694,000
North Carolina	[1] 19,035,000	
Ohio		1,100,000
Virginia		
Wisconsin		

[1] Covers both program and administrative costs.
[2] $5,004,000 was reimbursed from Federal funds.

TABLE 3.—PERCENTAGE OF TOTAL MEDICAID COSTS FUNDED BY COUNTRIES, JULY 1, 1975 TO JUNE 30, 1976

State	Program costs	Administrative costs
Alabama		
California	[1] 15.0	[1] 15.0
Colorado		2.88
Indiana		35.4
Maryland	2.4	
Minnesota	4.4	25.0
Nebraska	20.3	
Nevada		
New Hampshire	11.8	
New Jersey		
New York	27.5	24.0
North Carolina	[2] 4.7	[2] 4.7
Oklahoma		
Virginia		
Wisconsin		

[1] 15 percent of the total program and administrative costs.
[2] 4.7 percent of the total program and administrative costs.

TABLE 4.—PER CAPITA CONTRIBUTION BY COUNTIES TO MEDICAID PROGRAM AND ADMINISTRATIVE COSTS JULY 1, 1975 TO JUNE 30, 1976

[Per capita dollar amounts]

State	Program	Administrative
Alabama	0	0
California	[1] 21.78	
Connecticut		.18
Indiana		13.17
Maryland	.89	
Minnesota	10.06	1.05
Nebraska	32.89	
Nevada		
New Hampshire	14.67	
New Jersey		
New York	54.23	1.34
North Carolina	[1] 9.70	
Ohio		.25
Virginia		
Wisconsin		

[1] California and North Carolina reported program and administrative costs as 1 figure.

RESOLUTION URGING CONGRESS TO ADOPT PROPOSALS TO HOLD DOWN RISING MEDICAL COSTS

Whereas the nation is facing a crisis is health care due to skyrocketing costs, inequitable availability of health services, lack of professional manpower in rural and underserved areas, fraud and abuse problems, and inadequate controls in the quality of health care given; and,

Whereas county government provides medical care to those who cannot obtain it elsewhere. When no one else can or will, counties provide it. Similarly, counties are responsible for assuring service in several areas not generally addressed by existing public (Medicare and Medicaid) or private insurance programs—problems such as alcoholism, drug abuse, mental health, emergency care, preventive and health promotive services, and health care to the medically indigent; and,

Whereas our nation's approach to the medically indigent through Medicaid is uneven and highly inequitable. Inadequate benefits in some states create classes of medically needy which do not even exist in other states. These medically indigent persons also become the burden of local government; and,

Whereas the rapid escalation of health care (or rather illness care) costs in the past few years means that counties, the providers of last resort, must allocate an increasingly large proportion of their scarce property tax dollars to health care; and,

Whereas the rate of Medicaid expenditures has consistently exceeded estimates, creating fiscal crises in states and counties with comprehensive programs; and,

Whereas counties cannot, by themselves, be expected to control costs and since counties are always left to pick up the tab for all those who are not covered by state, federal or private insurance: Now, therefore, be it

Resolved, That it is the intention of the National Association of Counties to support legislation to federalize the Medicaid program. Further, NACo will support measures to hold down skyrocketing medical costs.

NACo urges that: Congress completely overhaul the Medicaid eligibility process through standardization and simplification; Congress revise the present federal-state cost-sharing approach to Medicaid; Congress pass legislation curbing Medicaid fraud and abuse; and Congress take steps to assure maximum productivity of medical services and providers.

[Whereupon, at 10:12 a.m., the subcommittee recessed, to reconvene at 8 a.m., Tuesday, July 27, 1976.]

MEDICARE-MEDICAID ADMINISTRATIVE AND REIMBURSEMENT REFORM

TUESDAY, JULY 27, 1976

U.S. SENATE,
SUBCOMMITTEE ON HEALTH OF THE
SENATE FINANCE COMMITTEE,
Washington, D.C.

The subcommittee met at 8 a.m., pursuant to recess, in room 2221, Dirksen Senate Office Building, Hon. Herman E. Talmadge (chairman of the subcommittee) presiding.

Present: Senators Talmadge, Curtis, Dole, and Packwood.

Senator TALMADGE. The subcommittee will come to order.

I have two brief announcements. First, following this morning's testimony by the General Accounting Office we will apply the 10-minute rule with respect to oral testimony. While each witness will be limited to 10 minutes presentation, the committee will of course carefully study the presentations. The Senators' interrogation will be limited to 5 minutes for each Senator on each round.

Second, at tomorrow's hearing the meeting immediately following the testimony of Senator Bentsen, we will then hear from Senator Frank Moss of Utah.

Any objection?

Without objection, it is so ordered.

The first witness this morning is Mr. Gregory J. Ahart, Director of the Human Resources Division, General Accounting Office, accompanied by Mr. Robert E. Iffert, Jr., assistant director, and Robert Hughes, assistant director.

We are delighted to have you with us, Mr. Ahart. We are aware, of course, of the great amount of work the General Accounting Office has done in this area at my request and perhaps the request of other committees so we feel that you will be able to contribute a great deal to our deliberations. I want to recognize and thank you for your thorough and objective work also in the North Carolina medicaid contract, it is a highly useful report.

Without objection, your entire statement will be inserted in full in the record and you may proceed in any way you see fit, sir.

STATEMENT OF GREGORY J. AHART, DIRECTOR, HUMAN RESOURCES DIVISION, GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY ROBERT E. IFFERT, JR., ASSISTANT DIRECTOR, AND ROBERT HUGHES, ASSISTANT DIRECTOR

Mr. AHART. Thank you, Mr. Chairman.

75-502—76——7

We are pleased to be here today to discuss our views on S. 3205 which is a bill to provide for the reform of the administrative and reimbursement procedures currently employed under the medicare and medicaid programs.

We find that the thrust of many of the bill's provisions are consistent with various reports we issued over the past several years which were aimed at identifying problems and improving the administration of the medicare and medicaid programs. For example, we have issued reports or have work in progress dealing with the following problems addressed by S. 3205:

First, the need for better coordination of the medicare and medicaid programs. We have pointed out instances of the lack of effective coordination particularly in the areas of (1) provider reimbursement and auditing and (2) investigating allegations of fraud and abuse. For example, our April 14, 1975, report to this subcommittee entitled "Improvements Needed in Medicaid Program Management Including Investigations of Suspected Fraud and Abuse" recommended that HEW establish a single organizational unit for the systematic investigation of suspected medicare and medicaid fraud and abuse.

Section 2 of S. 3205 would establish a Health Care Financing Administration which would be responsible at the Federal level for administering medicare and medicaid. This provision is designed to facilitate coordination of the two programs. Included in section 2 is a provision which would establish within HEW an Office of Central Fraud and Abuse Control which would have overall responsibility to deal with fraud and abuse under the various health programs authorized under the Social Security Act.

Second, we have commented on the desirability of disclosing contractual and financial arrangements between hospitals and members of their governing boards and key employees. In an April 1975 report to the Congress we recommended legislation providing for public disclosure of such arrangements. While not going as far as we have proposed, section 40 of S. 3205 would require disclosure to the Secretary of HEW and the Comptroller General, on request, of (1) the officers, directors, owners and/or partners of any entity including hospitals which do business with the programs established under titles V, XVIII, or XIX and (2) full and complete information on any business dealings between the entity and these persons.

Third, circumvention of the intent of the Congress in its efforts to eliminate "factoring" from medicare and medicaid. In October 1973 and February 1976 we reported to HEW and the Congress, respectively, that the intent of section 236 of the Social Security Amendments of 1972—which essentially prohibited the reassignment of physician claims under medicare and medicaid—was being circumvented through the use of powers of attorney by so-called factors.

Section 26 of S. 3205 is designed to eliminate this loophole.

Fourth, the slowness of HEW's process for issuing final regulations. A number of our reports have dealt with HEW's problems in issuing regulations implementing health care related laws in a timely manner. For example, in January 1975, we reported that HEW had not published final regulations for medicaid's early and periodic screening, diagnosis and treatment program until 4 years after the enactment of

the provision and 2½ years after the program was supposed to be fully implemented.

Section 7 of S. 3205 would require HEW to publish final regulations to implement all provisions of the bill within a year to 13 months of enactment unless a provision of the bill specifies another time frame.

Fifth, the need for closer monitoring by HEW of States' medicaid administration. In response to this oft reported problem of a lack of HEW monitoring of State medicaid administration, section 4 of the bill would require HEW to make annual on-site reviews of each State's administrative operations to see whether States were meeting performance criteria specified by the bill.

Sixth, the effect of low medicaid reimbursement rates on the availability of medicaid services. In January 1975 we reported that low physician reimbursement rates under medicaid contributed to a lack of participation by physicians in the early and periodic screening diagnosis and treatment program. Section 23 of the bill would establish a lower limit or floor on the levels of payments for physician services.

Seventh, decreasing rates of assignment of medicare claims for physicians services. On two occasions in response to requests from the Congress we reported that fewer medicare claims for physicians' services were being accepted for assignment—the physician accepts medicare's reasonable charge as the full charge. Because medicare makes many reasonable charge reductions when paying claims, fewer assignments had the effect of increasing the out-of-pocket medical costs of medicare beneficiaries.

Section 21 of S. 3205 is designed to encourage physicians to accept assignments with medicare's reasonable charge as the full charge by simplifying and expediting the billing and payment processes for physicians who voluntarily agree to participate in such an arrangement.

Eighth, the need for access to the books and records of independent laboratories. In a report to be released shortly we discuss the difficulties we had in obtaining or disclosing information on physicians who obtained services from independent laboratories at one price and added large markups to their medicare bills for the services.

Section 40 of S. 3205 would require independent pharmacies and laboratories providing services under titles V, XVIII, and XIX to enter into agreements with HEW or the State agency to provide HEW with reasonable access to their books and records.

Mr. Chairman, we will provide detailed comments on specific provisions of S. 3205. These comments will deal with:

First, the role contemplated for the General Accounting Office which would substantially increase our workload and could impede the timely and effective administration of the proposed provisions. We are recommending that some of the requirements be deleted. We are also suggesting that the Comptroller General, as well as HEW, be given access to several kinds of records.

Second, matters pertaining to other recent, or pending, legislation where we are suggesting modification or deferral of action on specific provisions of S. 3205 to achieve coordination or consistency.

Third, questions of whether the language in some cases will bring about the results sought by the sponsors.

Fourth, changes which would clarify the bill or simplify the administration of the proposed amendments.

Mr. Chairman, my statement contains some brief details of the highlights. In the interest of time I think I will skip over those and make ourselves available for any questions that the subcommittee may have.

Senator TALMADGE. Thank you very much, Mr. Ahart, for your contribution. I do have a few questions.

You mentioned the problems HEW has experienced in issuing regulations to implement health related laws. Would you elaborate on this?

Mr. AHART. Yes, Mr. Chairman. We have in several of our reports over the years commented on the delays in getting out regulations which of course complicates the administration by HEW, the States and the providers of services. At the present time at the request of one of the committees of Congress we are looking into this process. We find that although HEW has internal requirements which would require regulations to be issued in final form within six months of enabling legislation, none of the 14 recall related regulations we received met the standard. In some cases it was a matter of years before they were issued in final form.

We will be making recommendations to HEW to try to shorten up this process so that they will be in a better position to get regulations out in a timely manner. Internally the Secretary of HEW has set up an Office of Regulatory Review which is charged with the responsibility of looking at this process, trying to speed it up as well as to look at existing regulations to see what changes ought to be made.

Senator TALMADGE. Your testimony indicates that one of the problems discussed in the prior GAO reports is need for better coordination between medicaid and medicare. In the areas of providing reimbursement do you have any examples in your current work which would indicate that such problems continue to exist?

Mr. AHART. Yes, Mr. Chairman, we have. One that comes to mind is a review we are doing which deals with reimbursement under medicaid and medicare to long-term care facilities and we have found cases of rather substantial duplicate payments where the facility was charging both part B of the medicare program and the medicaid program for the same services rendered by staff physicians. In the two cases, the two institutions that we looked at, this added up to about $1.6 million over a period of I think in one case about 5 years and in the other 3 years——

Senator TALMADGE. That is the same hospital?

Mr. AHART. It is the same facility being paid by both programs for the same service.

Senator TALMADGE. That is charging two bills for the same patient, one on medicaid and the other on medicare?

Mr. AHART. That is essentially correct, Mr. Chairman.

Senator TALMADGE. In your statement you said that you had problems obtaining laboratory records. What difficulties did you have in getting these records?

Mr. AHART. Well, the problem resolves itself down to the fact that under the law neither HEW nor the General Accounting Office has legal authority to go and look at independent laboratory records. Our difficulty stemmed from the fact that the laboratories to stay in business need to have the goodwill of the doctors which they serve and where the doctors may be doing what we found they were doing, adding rather large markups to the bills. The laboratories gave us access and said if any of this information was discussed that they might lose the doctors' business.

In a few cases, we did get agreement from the laboratory based on our pledge of confidentiality that we would not disclose either their names or the doctors' names. We got access to their records and were able to match the services paid for against the billings to medicare so we were able to find out what the doctor paid the laboratory and compare that with what the doctor charged the medicare program; but it was not as large a sample as we would have liked because we had to get the agreement from the laboratories and give them a pledge of confidentiality so they would not hurt their business.

Senator TALMADGE. Senator Packwood.

Senator PACKWOOD. I don't have any questions.

Senator TALMADGE. Senator Dole.

Senator DOLE. No questions.

Senator TALMADGE. I have two more. Could you give us some examples of what you found in your investigation of payments for laboratory services?

Mr. AHART. Yes. Let me ask Mr. Hughes who is responsible for that to deal with the specifics, Mr. Chairman.

Mr. HUGHES. Mr. Chairman, for example, in one case in Florida a physician paid an independent laboratory $4 for a battery of tests. The physician charged $20 for the tests, a 400-percent markup. Medicare allowed the entire amount.

Senator TALMADGE. Did you find any examples of such similar markups?

Mr. HUGHES. Four hundred percent was a rather large markup on an individual charge, Mr. Chairman. In our entire test in Florida, markups ranged from 117 percent to about 200 percent overall by physicians and averaged 158 percent.

Senator TALMADGE. What percentage of the investigation that you made did you find similar markups?

Mr. HUGHES. In most of the bills where we were able to match up records, we found similar markups.

Senator TALMADGE. What percentage of the investigations that you made did you find a markup above the cost of the laboratory fee?

Mr. HUGHES. In nearly all of them, Mr. Chairman.

Senator TALMADGE. Nearly all of them. Doesn't the Medical Board of Ethics prohibit that?

Mr. HUGHES. Yes, Mr. Chairman. The American Medical Association considers charging more than the physician paid for the test unethical and also calls for the physician to disclose where he obtained laboratory services when he did not perform them himself.

Senator TALMADGE. What are the flaws in our present system of reimbursing hospitals, nursing homes and physicians? Do you have some suggested improvements?

Mr. AHART. Yes, Mr. Chairman. Mr. Iffert here has been associated with these programs for a long period of time and I would like to ask him to respond to the question in terms of what flaws he sees in the reimbursement process.

Mr. Iffert.

Mr. IFFERT. Well, historically, the medicare and medicaid retrospective reasonable cost system for paying hospitals is essentially open-ended and except for the implementation of section 223 of the Public Law 92-603, there is virtually no limit to what hospitals have been paid. Of course, we have seen the effects of inflation—the costs going from the equivalent of about $40 a day when medicare first started to well over $100 a day now. In our detailed audits of hospital reimbursements under medicare, we have noticed a tendency for hospitals to charge whatever costs they can to certain cost centers to maximize reimbursement and as a result over the years we really had a lot of problems in comparing hospital costs, one hospital to another, because of the lack of assurance that we would be comparing the same things.

With respect to nursing homes, we have been concerned with the ranges of payment rates between the States and within some States with no apparent rational basis therefor, and historically, we have expressed concern about the virtual lack of medicaid audit activity in nursing homes in some States.

With respect to reimbursement for physicians' services under medicare, we have seen the system progress from virtually no reasonable charge screens or reductions in charges in 1968, when they were paying pretty much on a relative value scale as which really established an unfortunate precedent for the program, to where about 60 percent of all claims include some reduced charges in 1974. We think the customary and prevailing charge system has had a fair test going from one extreme to another and that other systems such as negotiated fee schedules should be tested to establish uniform criteria for what is reasonable.

In addition, under both medicare and medicaid the system for physicians' payments generates a very large number of relatively small charges which makes it virtually impossible or unfeasible to examine into the validity of these charges except on a very limited test basis or on an after the fact basis. I guess that summarizes it.

Senator TALMADGE. I understand under the present law whatever they submit as a reasonable cost, the sky is the ceiling, is that correct?

Mr. IFFERT. Not for physician services, no, sir.

Senator TALMADGE. Hospital services.

Mr. IFFERT. Whatever comes out to be actual reasonable cost, that is it.

Senator TALMADGE. Do you think that the system devised in this bill if compared to cost of hospital is reasonable?

Mr. IFFERT. I think it is a start. Under the long haul the increasing cost has to stop.

Senator TALMADGE. Any further questions?

Senator Dole.

Senator DOLE. What do you find was the greatest cause for the increased cost of medicare and medicaid—overutilization, fraud and abuse, administrative problems?

Mr. IFFERT. No, sir. We think the greatest cause has been the increases in hospital costs.

Senator PACKWOOD. What?

Mr. IFFERT. Increase in hospital costs.

Senator DOLE. Are those justified increases in cost?

Mr. IFFERT. Probably a lot of it was. When the programs started out, the wage levels were extremely low in hospitals and there were two or three years where they were catching up and then the trend started for more employees and then to the more sophisticated services and it has almost tripled.

Senator TALMADGE. There being no further questions——

Senator PACKWOOD. I have one question.

Senator TALMADGE. Senator Packwood.

Senator PACKWOOD. Your statement is most of the hospital costs can be justified. I am inclined to share that view. Would you concur with what the bulk of the witnesses said yesterday, that you are not going to make any significant saving in medicare and medicaid costs unless you are prepared to make a substantial cut in services?

Mr. AHART. If I may respond to that, Senator Packwood. As Mr. Iffert pointed out, I think we have to start somewhere. I think the question is not so much at this point in time of reducing substantially the reimbursement of hospital costs but trying to do something to help contain them. Several provisions of this bill would help do that, it would provide incentives for hospitals to keep costs down. It would also help hospitals in a situation where they are overbedded, they have too many beds. It would help them to divert those empty beds to some other use. So I would guess that it would be right in speculating we would not reduce it substantially from what it is today but we would help contain those increases which would naturally follow if they keep on the pattern that we are now on.

Senator PACKWOOD. You get reasonable control of fraud and abuse, you get reasonably efficient use of hospital and other health care providers. You save some pennies, but isn't this like getting any other government program when it comes down to the real nuts and bolts? If you save two bits——

Mr. AHART. Even if you save pennies in this program, considering the number of transactions, I think you are talking about substantial amounts of money. The program itself I think has been pretty much accepted. The medicare program for example, we would not have any thoughts about whether you take a look at the program as such as to whether you needed it. We don't have any views on that, but certainly the points at which we can enter the system and try to control costs to help contain the cost increases in the future, we think these efforts are certainly worthwhile.

Senator PACKWOOD. I don't want to quarrel about that but this tax reform battle, I see any number of people that are trying to convince other people that if you close loopholes for the rich we lower the tax group for the poor. That is not true. There is not enough money in the pot. Those who advocate social security, it is not going to provide enough money to greatly increase the benefits for everybody else.

I am just curious with this medicare and medicaid program—is it going out to middle income and lower income people? I don't know

if there is enough money in the cost of savings and efficiency to keep those costs very closely in line. Those are going to go up year after year unless you are prepared for an artificial lid on them as we do for social service programs. It makes all the benefits fit into that and cut back on hospital payments. That is the way we keep the cost in line.

Mr. AHART. That is a public policy issue. Obviously in the long run we have to keep the benefits we pay out somewhere comparable to the amount of revenues that are available, certainly.

Senator PACKWOOD. I have no further questions.

Senator TALMADGE. In the computer runs that were made in preparation of this bill we found very great variations between hospital costs similarly situated, some much more efficient than others and their costs were much less than others but we hope to use the yardstick in comparison between the cost of hospitals similarly situated and we think we can get a handle on it that way.

Now with reference to overutilization we had some witnesses yesterday that thought overutilization was probably three times as expensive to the Government as fraud. In fact, we had one witness yesterday that recited a specific case. A couple wanted to go to Florida on vacation and they didn't want to take their mother so they put her in the hospital during that period of time. Do you find much overutilization in that way?

Mr. AHART. Well, we have taken several looks into the different aspects of the utilization review requirements legislation, and certainly there is a need for improvement to see that people that are in hospitals and that are in nursing homes in fact need to be there. Part of the problem is a kind of problem we have talked about where there is not anybody available at least at a given time to give care to people that need care and they have to go into some kind of an institution to get it. A part of the problem is where there is not anybody to give care at any point in time, the lack of suitable facilities to try to provide the level of care which is needed where people might be better off in a nursing home but because of the lack of nursing home space, the doctor keeps them in the hospital because there is no place else for them to go.

I think, to some degree, there is a tendency, in some cases where a hospital has a lot of empty beds, to tend to keep people in the hospital longer than they need to be in there. Through the utilization review requirements, through the PSRO system which is starting to be implemented, some of these things should be brought under control I think also the health planning system which was enacted and is being implemented to provide better planning of what kind of service ought to be in place in relation to the needs of the area which is being served. If that is effectively done, that should help in this regard as well. But certainly there is a lot of money which goes into the utilization of facilities which is not necessary for the health of the individuals concerned.

Senator TALMADGE. Thank you very much, gentlemen.

Senator Dole.

Senator DOLE. In your investigation did you determine why it takes so long for HEW to implement regulations and for the 13-month provision of the bill to be adequate? That is one of your comments I note in your statement.

Mr. AHART. Yes.

Senator DOLE. Why does it take so long?

Mr. AHART. One basic problem was that we found that HEW at the front end when they know they are going to have to get regulations out, they are not really surfacing the major policy issues and getting them up to the Secretary for resolution. It has to really wait until the draft gets up there and it goes up and down the system from the bureau or agency within a bureau or branch that is responsible for the basic development of the regulation back up through the review process and General Counsel's office, the Secretary's office, the Assistant Secretary's office and then back down for changes and back up.

It is a very time-consuming up and down process. We are taking a look at that, as I mentioned. I think we are going to have some suggestions for improving the process. The Secretary has set up, as I mentioned, an Office of Regulatory Review which is also focusing on the problem of how to get regulations out in a more timely fashion.

Senator TALMADGE. Do you think the consolidation of the offices of medicare and medicaid would provide for better uniformity.

Mr. AHART. I think certainly bringing together the administration of these two programs at the Federal level should help in the coordination. Both programs are dealing with basically the same providers—the same hospitals, the same nursing homes, the same doctors. The reimbursement requirements are quite similar for the two programs. Reimbursement criteria are quite similar and it would seem to us that bringing them together for administration at the Federal level would make quite a lot of sense.

There are some problems because the medicare program is related, as you know, very closely to the same population that is served by the basic social security system which is administered by the Social Security Administration. The medicaid program as we know it, basically serves the same population that is dealt with by the Social Rehabilitation Service. It would seem to us though that on balance that because of the provider community out there, despite the fact that you have got different eligibility determinations, because you are dealing with this provider community and with the cost containment problems, the cost reimbursement problems that it makes a lot of sense to bring that administration together.

Senator TALMADGE. Thank you very much, Mr. Ahart, and your associates for the contributions for the committee's deliberations.

[The prepared statement of Mr. Ahart follows:]

PREPARED STATEMENT OF GREGORY J. AHART, DIRECTOR, HUMAN RESOURCES DIVISION

Mr. Chairman and members of the Subcommittee, we are pleased to be here today to discuss our views on S. 3205, a bill to provide for the reform of the administrative and reimbursement procedures currently employed under the Medicare and Medicaid programs.

We have reviewed S. 3205 and find that the thrust of many of the bill's provisions are consistent with various reports we issued over the past several years which were aimed at identifying problems and improving the administration of the Medicare and Medicaid programs. For example, we have issued reports or have work in progress dealing with the following problems addressed by S. 3205:

1. The need for better coordination of the Medicare and Medicaid programs.—We have pointed out instances of the lack of effective coordination particularly in the areas of (1) provider reimbursement and auditing and (2) investigating

allegations of fraud and abuse. For example, our April 14, 1975, report to this Subcommittee entitled, "Improvements Needed in Medicaid Program Management Including Investigations of Suspected Fraud and Abuse," recommended that HEW establish a single organizational unit for the systematic investigation of suspected Medicare and Medicaid fraud and abuse.

Section 2 of S. 3205 would establish a Health Care Financing Administration which could be responsible at the Federal level for administering Medicare and Medicaid. This provision is designed to facilitate coordination of the two programs. Included in section 2 is a provision which would establish within HEW an Office of Central Fraud and Abuse Control which would have overall responsibility to deal with fraud and abuse under the various health programs authorized under the Social Security Act.

2. The desirability of disclosing contractual and financial arrangements between hospitals and members of their governing boards and key employees.—In an April 1975 report to the Congress, we recommended legislation providing for public disclosure of such arrangements. While not going as far as we have proposed, section 40 of S. 3205 would require disclosure to the Secretary of HEW and the Comptroller General, on request, of (1) the officers, directors, owners, and/or partners of any entity including hospitals which do business with the programs established under titles V, XVIII, or XIX and (2) full and complete information on any business dealings between the entity and these persons.

3. Circumvention of the intent of the Congress in its efforts to eliminate "factoring" from Medicare and Medicaid.—In October 1973 and February 1976 we reported to HEW and the Congress, respectively, that the intent of section 236 of the Social Security Amendments of 1972—which essentially prohibited the reassignment of physician claims under Medicare and Medicaid—was being circumvented through the use of powers of attorney by so-called "factors."

Section 26 of S. 3205 is designed to eliminate this loophole.

4. The slowness of HEW's process for issuing final regulations.—A number of our reports have dealt with HEW's problems in issuing regulations implementing health-care related laws in a timely manner. For example, in January 1975, we reported that HEW had not published final regulations for Medicaid's early and periodic screening, diagnosis, and treatment program until 4 years after the enactment of the provision and 2½ years after the program was supposed to be fully implemented.

Section 7 of S. 3205 would require HEW to publish final regulations to implement all provisions of the bill within a year to 18 months of enactment unless a provision of the bill specifies another timeframe.

5. The need for closer monitoring by HEW of States' Medicaid administration.—In response to this oft reported problem of a lack of HEW monitoring of State Medicaid administration, section 4 of the bill would require HEW to make annual on-site reviews of each State's administrative operations to see whether States were meeting performance criteria specified by the bill.

6. The effect of low Medicaid reimbursement rates on the availability of Medicaid services.—In January 1975 we reported that low physician reimbursement rates under Medicaid contributed to a lack of participation by physicians in the early and periodic screening diagnosis and treatment program. Section 23 of the bill would establish a lower limit or floor on the levels of payments for physician services.

7. Decreasing rates of assignment of Medicare claims for physicians services.—In December 1973 and February 1976, in response to requests from the Congress we reported that fewer Medicare claims for physicians' services were being accepted for assignment (the physician accepts Medicare's reasonable charge as the full charge). Because Medicare makes many reasonable charge reductions when paying claims, fewer assignments had the effect of increasing the out-of-pocket medical costs of Medicare beneficiaries.

Section 21 of S. 3205 is designed to encourage physicians to accept assignments with Medicare's reasonable charge as the full charge by simplifying and expediting the billing and payment processes for physicians who voluntary agree to participate in such an arrangement.

8. The need for access to the books and records of independent laboratories.—In a report to be released shortly, we discuss the difficulties we had in obtaining or disclosing information on physicians who obtained services from independent laboratories at one price and added large markups to their Medicare bills for the services.

Section 40 of S. 3205 would require independent pharmacies and laboratories providing services under titles V, XVIII and XIX to enter into agreements with HEW or the State agency to provide HEW with reasonable access to their books and records.

We will provide detailed comments on specific provisions of S. 3205 for the record. These comments will deal with:

1. The role contemplated for the General Accounting Office which would substantially increase our workload and could impede the timely and effective administration of the proposed provisions. We are recommending that some of the requirements be deleted. We are also suggesting that the Comptroller General as well as HEW be given access to several kinds of records.
2. Matters pertaining to other recent, or pending, legislation where we are suggesting modification or deferral of action on specific provisions of S. 3205 to achieve coordination or consistency.
3. Questions of whether the language of the bill in certain cases will bring about the results sought by the sponsors.
4. Changes which would clarify the bill or simplify the administration of the proposed amendments.

Highlights of these comments in each of the four areas follows:

RESPONSIBILITIES ASSIGNED TO THE COMPTROLLER GENERAL

Section 4 of S. 3205 would require the Secretary of HEW to conduct at less annually an onsite survey in each State to determine whether the State's administration of Medicaid met certain specified performance criteria. If a State failed to meet one or more of the criteria, it would have to correct the deficiencies in not more than 6 months or have Federal sharing in its administration costs reduced or terminated.

Section 4 would require the Comptroller General to (1) approve the methodology and procedures to be used by HEW for the onsite surveys, (2) certify that a State had failed to correct deficiencies identified during the onsite survey within the required time, and (3) after Federal sharing in administration costs had been reduced or terminated, certify that the State had corrected the deficiency (or deficiencies) identified before full Federal sharing could be restored.

Not only would these requirements substantially increase our workload, they would also impede the timely administration of the proposed provisions and involve our Office in the direct management of the Medicaid program which would make it more difficult for us to impartially fulfill our review responsibilities.

We believe that the intent behind having the Comptroller General make these certifications could be achieved by authorizing GAO to approve HEW's methods and procedures for following up on deficiencies HEW identifies, in addition to reviewing HEW's methodologies for making the initial onsite survey.

We will suggest revised language in our detailed comments.

Section 7 of S. 3205 requires the Secretary to issue certain regulations to implement the bill within a year to 18 months after enactment unless he could not do so because of circumstances beyond his control. The Comptroller General would have to certify whether the circumstances were indeed beyond the Secretary's control. We see no purpose in this certification because whether or not it is made, the implementing regulations still would not have been issued. Therefore, we recommend that this certification requirement be deleted.

Section 5 and 40 provide the Secretary with access to the books and records of Medicare carriers and independent pharmacies and laboratories poviding services under the programs established by titles V, XVIII, and XIX. We believe our Office should also have access to these books and records so that we can better fulfill our audit responsibilities.

EFFECT OF RECENT OR PENDING LEGISLATION ON S. 3205

We noted several provisions in S. 3205 which are or would be impacted by recent or pending legislation. For example, section 10 of the bill would require the Secretary to establish for hospitals a uniform system of accounts and cost reporting as well as a classification system for hospitals. These systems would be used in a new procedure for determining payments to hospitals, established by section 10. The National Health Planning and Resources Development Act of 1974 (P.L. 93-641) approved January 4, 1975, required the Secretary to

establish a uniform system for cost accounting and cost reporting and a hospital classification system. We believe that S. 3205 should be modified to require coordination between the efforts undertaken in response to its provisions regarding a uniform system of accounts and cost reporting and a hospital classification system and those undertaken in response to Public Law 93-641. Such coordination should help prevent unnecessary duplication of effort.

Sections of the bill which could be effected by pending legislation are section 8—establishing an Inspector General for Health Administration—and section 41—payments for Health Maintenance Organizations with Medicaid contracts.

DOES THE LANGUAGE OF S. 3205 MEET THE SPONSORS' INTENT?

In some instances the language of S. 3205 does not appear to meet the intent behind the provisions. For example, section 7 of the bill as drafted provides that nonurgent regulations would become effective not less than 60 days after the publication of a notice of proposed rule making whereas urgent regulations would follow the established rules for promulgation of regulations. We understand that the intent of this provision was to ensure that urgent regulations would be effective no more than 60 days after publishing a notice of proposed rule making and that the public would have at least 60 days to comment on nonurgent regulations. In the material we will submit for the record, we will include revised language to meet this intent.

SUGGESTED CHANGES FOR CLARITY AND TO SIMPLIFY ADMINISTRATION

We are making a number of suggestions in the material to be submitted for the record which are designed to clarify the language in the bill or to simplify the administration of the programs. For example, under present law, there are four different Federal sharing rates (ranging from 50 percent to 100 percent) for State Medicaid administration costs. These four rates apply depending on which of seven different categories of administrative activities or functions are being performed. In order to correctly claim Federal shairng for administration costs, States must maintain complicated accounting and cost allocation systems to charge costs to these activities. The numerous sharing rates also complicate HEW's task of ascertaining whether the States have indeed correctly claimed Federal sharing. Section 4 of S. 3205 would provide an incentive payment system for Federal sharing in State Medicaid administration costs which features incentives for meeting certain performance criteria. We believe the process could be simplified and more emphasis placed on how well the States do rather than what they do by establishing a single composite sharing rate for administrative costs and applying the proposed performance incentive payment system to that rate. Therefore, we are suggesting that section 4 be modified to substitute performance based incentives for the existing activity or function based incentives.

Senator TALMADGE. The next witness is Mr. Charles B. Womer, president, Yale-New Haven Hospital, on behalf of the Association of American Medical Colleges accompanied by Richard M. Knapp, Ph. D., director, department of teaching hospitals, and John A. D. Cooper, M.D., president.

We are delighted to have you with us, gentlemen. You may insert your full statement in the record and summarize it, Mr. Womer.

STATEMENT OF CHARLES B. WOMER, PRESIDENT, YALE-NEW HAVEN HOSPITAL, ON BEHALF OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES; ACCOMPANIED BY RICHARD M. KNAPP, PH. D., DIRECTOR, DEPARTMENT OF TEACHING HOSPITALS; AND JOHN A. D. COOPER, M.D., PRESIDENT

Mr. WOMER. Thank you, Mr. Chairman.

The Association of American Medical Colleges represents 400 of the Nation's major teaching hospitals, all of the Nation's medical schools and 60 academic societies.

I will limit my remarks this morning to a brief discussion of three topics: cost containment and the routine operating cost ceiling, the legislative restrictiveness of several proposed amendments and the implementation requirements necessary for achieving effective medicare/medicaid reform.

I have submitted a more detailed written statement of the association's position on the proposed amendments for the subcommittee's consideration and for inclusion in the record of the hearing.

Senator TALMADGE. It will be inserted in full in the record.

Mr. WOMER. At the outset the association thanks the subcommittee chairman, members, and staff for their willingness to discuss underlying concepts and prospective provisions of S. 3250 during its development. We believe that both the Congress and the medical education community have benefited from efforts to understand each other's prospectives, problems and proposals. It is within the spirit of that continuing and open discussion that the association offers recommendations for improving the provisions of this bill.

While the association is ever mindful of the growing consensus that continued increases in the unit costs of health services are unacceptable and cannot continue, we are also appreciative of the administrative difficulties of achieving cost containment through increasingly complex reimbursement practices. As Dr. Alice Rivlin has stated in her May 17, 1976, testimony before the Subcommittee on Health of the Senate Committee on Labor and Public Welfare:

> It is clear that the development of financial incentives and disincentives which can restrain inflation and wasteful expenditures without at the same time curtailing desirable improvements in quality of health services and imposing undesirable rigidities on the delivery system will be a sensitive and difficult task.

The association commends the members and staff of this subcommittee for rejecting the administratively simple approach of containing costs through an arbitrary percentage cap on expenditure increases. Such a procedure does not recognize the impact on hospital costs of general economic inflation, increased benefits and services, advances in medical science and technology, expanded beneficiary population, and increased per capita utilization of services. Moreover, if the arbitrary percentage cap is inadequate, it can threaten the access of beneficiaries to needed services as well as the financial viability of the providers.

Reimbursement limitations derived from cross classification schemes which are carefully drawn and conscientiously implemented are one legitimate means of cost containment. Their usefulness in eliminating waste and efficiency is enhanced by insuring that comparable costs are being examined and controlled. Having proposed a cross classification and cost limitation approach in S. 3205, the association commends the subcommittee for removing from the comparison capital costs; direct personal and supply costs of hospital education and training programs; costs of intern, residents, and medical personnel; and energy costs associated with heating or cooling the hospital plant.

Each of these costs is subject to large and legitimate differences among hospitals. We also commend the subcommittee for including an adjustment for wage rate charges in calculating the ceiling. The

association would recommend, however, that malpractice insurance premiums and energy costs for lighting and facility operations be similarly excluded and that the wage rate adjustment reflect regional costs for technical and professional personnel.

As members of the subcommittee are undoubtedly aware, the association has brought suit against the Secretary of HEW for the manner in which the routine service cost limitations of section 223 of Public Law 92-603 were implemented. We firmly and honestly believe that those responsible for implementing that legislation have not complied with congressional intent in failing to recognize the impact of case mix on hospital costs and in not providing a viable exceptions process.

Because of this experience we share some of the subcommittee's concern about providing the executive branch with flexible legislation which permits congressional intent to be ignored. The association is equally concerned, however, with legislative provisions that attempt to insure congressional intent by including restrictive and overly specific legislation. Especially in hospital classification and cost control where the state of the art is quite elementary, some flexibility is needed to insure the public programs have the ability to adjust to new knowledge and developments without waiting for new legislation.

The association believes three provisions of S. 3205 are excessively rigid. First, the designation of specific hospital groups as specified in section 10. Given the lack of available data to analyze the proposed classifications, the association is concerned that the bill prescribes specific bed size and hospital type categories. If new data indicate this classification scheme is less than optimal, new legislation will be required to change it. To provide the desired flexibility, the association recommends that S. 3205 state that hospitals be classified by type and size, that explicit guidelines of intent be provided in the committee report and that a "National Technical Advisory Board" be appointed to recommend and evaluate alternative classification systems and groupings.

Second, the bill provides a separate category for the "primary affiliates of accredited medical schools." Because the current medicare reporting system does not provide appropriate data, it is difficult to evaluate the implications of establishing such a group. More importantly, by limiting the primary affiliates of accredited medical schools to one hospital per school, the legislation fails to recognize the complex reality of medical education in this nation. Given these conditions, the association strongly recommends more flexible language that directs the Secretary of HEW to examine the implications for reimbursement of alternative definitions of the term "teaching/tertiary care hospitals."

Senator TALMADGE. Would you yield at that point, Mr. Womer?

Mr. WOMER. Yes, sir.

Senator TALMADGE. We have asked your association, I believe, to give us a better definition than you have outlined there and we would certainly appreciate your cooperation in giving us a better definition if we have to give it consideration.

Mr. WOMER. We are experiencing the same difficulty, sir, in doing so that I am sure the committee staff and you had in writing the bill. It is a very difficult problem. I think the problem that we have is that

some medical schools have several primary teaching hospitals, and to limit it to one, or to come up with such a rigid definition, we believe would be unfair to many of those institutions.

Last, the proposed bill mandates a routine operating cost ceiling equal to 120 percent of the hospital's adjusted per diem rate for routine operating costs. As previously stated, the present medicare reporting system is unable to provide adequate data to evaluate the impact of this ceiling. The actual distribution of hospitals by adjusted per diem operating costs is unknown. Significant numbers of hospitals could exceed the 120 percent or only a few could exceed it. In this circumstance fixing the ceiling by legislation seems overly restrictive and the association recommends providing the Secretary of HEW with authority to establish the ceiling in accordance with congressional guidelines clearly stated in the committee report.

Senator TALMADGE. Thank you for an excellent statement, Mr. Womer. I want to thank you and your associates for the contributions that you have made in developing the bill. You have been extremely helpful and have made some excellent suggestions to the committee.

Now with reference to the arbitrary 7 percent cap which the administration has recommended, we think you are entirely correct. The Association of Counties testified yesterday, and they were one of the first to recommend an arbitrary cap on cost but on more pure reflection they reversed their recommendation yesterday in testimony to this committee that changed their mind on it and certainly that won't solve the situation. We have got to go beyond that to bring these costs under control.

I have only one question. What do you think of a State rate making for hospitals?

Mr. WOMER. Mr. Chairman, I would have to honestly say that my experience in one State, where I was until June 30 an industry representative on a hospital control commission, has left me significantly less than a disciple of State regulation. I think it is inefficient. I think that the opportunities for inconsistencies from State to State and for arbitrariness and capriciousness, in my view, are considerably greater than they are with Federal regulation.

Now I know that many people in the hospital field do not share my viewpoint in that regard—and by the way, this is my personal viewpoint, not the association's posture.

Senator TALMADGE. Senator Packwood.

Senator PACKWOOD. No questions.

Senator TALMADGE. Senator Dole.

Senator DOLE. You indicated that sometimes money has to be borrowed because of delay in payments. Do you have any specific examples of how this impacts on the cash flow, and to what extent this is a problem?

Mr. WOMER. Yes, sir. I think that hospitals having a large proportion of medicaid patients generally suffer because of slow payments in some States. In some States, there are a number of games played in regard to reimbursement. For instance, States that operate on a cash basis, at least one I know well, generally stops paying or slows payments down to a trickle near the end of the fiscal year. They have expended their budget and they wait until the next fiscal year to resume reimbursements.

In Connecticut, at least in the past, when this has happened it has caused severe problems to hospitals such as Yale-New Haven and others. Hospitals in the State have had to arrange for short-term borrowing of operating funds until the new State fiscal year started. I understand that in other States there is significant inefficiency in the processing of legitimate claims, and hospitals have to borrow more operating funds because of the slowness of reimbursement.

Senator TALMADGE. Would you yield at that point?

I understand there is no problem on the payment of medicare, the problem is with the payment of medicaid, is that correct?

Mr. WOMER. Again I am not speaking from an understanding of the national situation. By and large I understand the major problem to be medicaid although I think many hospitals were hurt when the current financing provisions in medicare were phased out a couple of years ago.

Senator TALMADGE. The bill you know provides in medicaid 95 percent of the payments must be made within 30 days. That would alleviate many of the problems of borrowing, wouldn't it?

Mr. WOMER. It certainly would.

Senator DOLE. Do you have any examples of just how much money has been borrowed by a particular hospital—to give us an idea of what the real impact has been? It is one thing to say the money was borrowed, but it would be more helpful to really talk about the actual amounts involved.

Mr. WOMER. I could not at this time, sir, give you actual dollar figures, national figures, as to the amount that has been borrowed.

Senator DOLE. Maybe this is something the GAO people might provide for the record if they have come up with some figures.

You also recommended that malpractice insurance premiums be excluded from routine operating costs. What do you feel is the most appropriate way to handle this expense, given the fact that the premiums are going up and up and up?

Mr. WOMYER. I have no definitive answer, sir, to the malpractive insurance problem any more than I think anybody else does. There have been a number of proposals, as you know, that have been brought forth and a number of them are being tried in many States. As far as I am concerned, and I have just read about this, I don't think anybody has found an answer or a set of answers to that problem. We were only proposing that they be excluded in the calculation of the ceilings for routine operating costs on the basis that malpractice insurance premiums vary so widely among States and various regions of the country.

Senator TALMADGE. Malpractice insurance premiums will be excluded and that is merely a technical error in the draft.

Any further questions?

Senator PACKWOOD. No.

Senator DOLE. No.

Senator TALMADGE. Thank you very much, Mr. Womer. We appreciate your contribution.

Mr. WOMER. Thank you, Mr. Chairman.

[The prepared statement of Mr. Womer follows:]

TESTIMONY SUBMITTED BY THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES

The Association of American Medical Colleges is pleased to have this opportunity to testify on the "Medicare-Medicaid Administrative and Reimbursement Reform Act (S. 3205) of 1976. The Association represents 400 of the nation's major teaching hospitals, all of the nation's medical schools, and 60 academic societies. Thus, the Medicare and Medicaid amendments proposed in S. 3205—concerning administrative, provider reimbursement and practitioner reimbursement reforms—are of a direct interest and concern to the Association's members.

For several months, the Health Subcommittee staff of the Senate Finance Committee has been most generous in discussing general concepts and tentative provisions of S. 3205 with Association representatives. These meetings were informative and we believe, of mutual benefit. For this dialogue and for the staff's concern in developing amendments to strengthen the Medicare and Medicaid programs, the Association expresses its appreciation to the Subcommittee and its staff.

The Association is well aware of the fact that spending for health care—as a result of general economic inflation, increased service availability, improvements in service quality, growth and changes in population, and increased per capita utilization—has increased more rapidly in the past two decades than have most other segments of the economy. This fact has focused consumer, industrial, governmental, and provider attention on the nation's health care expenditures. In recent legislation—such as Public Law 92-603 and Public Law 93-641—the Congress has attempted to establish programs and policies which will help stimulate a more efficient and effective health industry. The Association hopes that present legislative effort will attempt to further that objective of stimulating a more efficient and effective health industry.

Of equal concern to this Association is the objective of continually ensuring that quality patient care is not sacrificed as a result of program economy measures. Members of the Senate Finance Committee have demonstrated their interest in guaranteeing quality patient care to Medicare beneficiaries by establishing the Professional Standards Review Organization and Utilization Review procedures. In past Congressional testimony, the AAMC has spoken out against proposals which would be detrimental to the Medicare recipient. We will continue to do so and urge that the Subcommittee not lose sight of this important objective.

We assume the purpose of S 3205 is to stimulate efficient and effective programs while ensuring high quality patient care. Critical comments made in this testimony support those purposes and are submitted with the intention of strengthening the legislation. We also realize that some of the problems inherent in the proposal are not due to a lack of will by the Subcommittee and its staff but reflect the infant "state-of-the-art" in several areas.

The Association wishes to address one fundamental consideration concerning this legislation's principal philosophical and systematic approach. Underlying the proposed provider reimbursement reforms is an approach that recognizes the need for management flexibility. Retaining the freedom to organize and finance individual services within expenditure or cost limits is required for the hospital to continue to meet the needs of the population it supports. Reimbursement methods in S. 3205 for determining the hospital's routine operating cost essentially retain management's operational authority and flexibility. Other sections of the proposed bill—overhead cost controls and contract approvals, for example—reduce the manager's flexibility. As elaborated upon later in this testimony, the AAMC would encourage the Subcommittee to avoid implementation of an expenditure control system so restrictive that its administrative burden possibly outweighs its value.

ADMINISTRATIVE REFORMS

Establishment of Health Care Financing Administration

This section proposes a centralization of the Federal health care financing function and a unification of administrative entities presently known as the Bureau of Health Insurance, Medical Services Administration, Bureau of Quality

Assurance, Office of Nursing Home Affairs, and related research and statistical units. The Association supports efforts toward centralization and unification of Federal health care financing. Costs of hospitals which result from diffuse and conflicting administrative and reporting requirements and which add overhead to the provision of direct patient services should be somewhat moderated by the policy of unification and administrative standardization which should accompany this reorganization.

The present bill provides for an Assistant Secretary of Health Care Financing to direct the Health Care Financing Administration. The Assistant Secretary would report directly to the Secretary of Health, Education, and Welfare. Establishing the position of Assistant Secretary for Health Care Financing seems to contradict the present bill's emphasis on centralization and consolidation. At a minimum, the presence of two Assistant Secretaries reporting directly to the Secretary will require lengthened bureaucratic procedures for mutual coordination. And, in all likelihood, the presence of two Assistant Secretaries with major health care responsibilities reporting directly to the Secretary will result in problems of coordination and conflict which could reduce the benefits of centralization. To further the goal of a unified and coordinated Federal health care policy, the Association recommends the establishment of an Under Secretary for Health to whom both the Assistant Secretary of Health for Health Care Financing and the Assistant Secretary for Health would report. The Under Secretary for Health would then be the Department's central individual for all health matters.

Consolidation of Federal health care financing responsibilities will contribute to reducing administrative confusion presently faced by health care providers. If an Under Secretary for Health is established, gains of economy and efficiency will be preserved. While these would be valuable reforms, the Association believes the benefits of these reforms are limited by continuing the subordination of the health function within the Department of Health, Education and Welfare. A cabinet-level Department of Health is needed to serve as the single point of responsibility for the nation's critically important health policies and programs. The Association hopes that the proposed consolidation is the first step in the movement toward the creation of such a Cabinet-level Department of Health.

State medicaid administration

The reform of state Medicaid administration to provide more rapid payment of health care providers is strongly endorsed by the Association. Because of delays in Medicaid payments to hospitals, health care providers in many states have had to borrow funds at substantial interest rates to provide adequate cash flow. These additional interest costs add to the nation's health care expenses without contributing to the direct provision of personal health services. Decreasing the time required for Medicaid payments should contribute, in at least a small way, to moderating the nation's health expenditures as well as to reducing the tension between hospitals and state governments.

Regulations of the secretary

The Association understands and shares the general Congressional concern with present procedures for proposing, evaluating, and publishing Federal regulations. The provisions of Section 7, which would establish a 60 day comment period for regulation, are a much needed reform in this area. Sixty days will allow time for a more thorough evaluation and review. Moreover, it will enable individuals and groups to collect appropriate data to illustrate and substantiate their comments and to offer constructive suggestions. To help ensure that the Subcommittee's intentions are achieved, the Association recommends that some clarification or definition be provided in the Committee Report for the term "urgent" as it applies to the regulations. The Association would also like to emphasize that this reform should not be limited to Medicare and Medicaid programs alone. This Committee and others in both the House and the Senate are urged to consider the need for this reform and others in the area of administrative procedures for the publication of rules and regulations.

PROVIDER REIMBURSEMENT REFORMS

Uniform accounts, cost reporting, and allocation procedures

The most important prerequisite for proper evaluation and measurement of "routine operating costs" is the development of a system of uniform cost reporting.

A mechanism for assuring the comparability of financial data must be developed prior to full implementation of the program. Experiences in such states as California and Maryland, where uniform financial reporting systems are being developed and implemented, demonstrate that, with the present "state-of-the-art" in this area, enormous efforts are required to attain the goal. Similarly, Federal efforts to develop uniform accounting and reporting programs, which are being developed as specified in Section 1533(d) of Public Law 93-641, provide evidence of the difficulties in this area. Therefore, the Association urges the Subcommittee to provide an adequate and phased-in period of implementation for uniform cost reporting subsequent to final passage of the legislation.

Classification of hospitals

A fundamental concern of the Association is that the designation of specific hospital groups, and other matters, is fixed in the legislation. This eliminates much needed flexibility. Alterations based on experience will be most difficult to make on a timely basis. Recognizing that there is a lack of data available for analyzing the impact of this system, a more prudent approach would be to permit the agencies some flexibility with which to construct the system. At the same time, there are equally pertinent concerns with the extent to which Congressional intent is reflected in Executive Branch implementation. It is, thus, important that the Committee provide the Department with some specific guidelines and direction by which to proceed. Therefore, the Association recommends that S. 3205 states that hospitals "be classified by type and size" with some guidance in the Committee Report, rather than stipulate the specific bed categories and types of hospitals. It is further recommended that a "National Technical Advisory Board" be appointed to recommend and evaluate alternative classification systems of size and type, review progress, monitor implementation, examine problems encountered and make recommendations regarding appropriate solutions. The advisory board to be established should include representations from the Legislative and Executive Branches of Government, as well as knowledgeable individuals from the private sector.

The legislation provides for the creation of a separate group of hospitals which are the "primary affiliates of accredited medical schools." It is difficult to evaluate the implications of creating such a group because of the absence of data. Efforts to gain data and experience with a separate group are hampered by the inability of the current Medicare reporting process to identify and extract the elements to be excluded from the proposed scheme. Thus, there is uncertainty as to the relative merits of a separate group for teaching hospitals.

More importantly, the present legislation would restrict the "primary affiliates of accredited medical schools" to a single hospital per medical school. This is a gross injustice to many teaching hospitals. Limiting each medical school to one and only one "primary affiliate" is arbritrary and does not recognize the complexity or the reality of medical education in this nation. Therefore, the Association opposes the establishment of a specific classification for "primary affiliates of accredited medical schools" as proposed in S. 3205.

In the absence of adequate data and operational experience to evaluate the proposed classification scheme and to avoid arbitrarily limiting the "primary affiliates of accredited medical schools" to one hospital per school, the Association is of the opinion that the combination of a flexible classification system and an adequate phase-in period are essential elements of the program's chances for success. Thus, the Association strongly recommends that the Secretary of the Department of Health, Education and Welfare be directed to examine the implication for reimbursement of alternative definitions of the term "teaching/tertiary care hospitals." Instead of prescribing a pre-defined grouping for teaching hospitals, it is proposed that the Secretary be required to determine, in consultation with the appropriate knowledgeable health organizations, a definition which most accurately reflects the teaching hospital's role as a referral center for tertiary patient care services and as an educational institution. In performing these consultations, the Secretary should be required to distribute and share the data upon which alternative definitions are to be evaluated. This is a good example of an issue which would be brought before the above proposed Technical Advisory Board.

Determining routine operating costs

In the past, the Association has not specifically advocated a classification approach to cost limitations. Rather, if a cross-classification approach is to be

used, the Association has recommended the exclusion of specific components of routine operating costs which will help ensure that variations in the remaining costs are not due to the nature of the product produced or to characteristics of the production process. Therefore, the Association believes that the exclusion of capital costs; direct personnel and supply costs of hospital education and training programs; costs of interns, residents, and medical personnel; and energy costs associated with heating or cooling the hospital plant is a step in the proper direction.

Following a rather complicated calculation, S. 3205 establishes the ceiling for routine service costs at 120 percent of each classification group's average. As we have stated earlier, the present Medicare reporting system does not permit identification of costs to be excluded in computing routine service costs. Therefore, no one knows what the actual distribution of hospital costs by group will look like. The Association believes that a 120 percent ceiling should not be established by statute without knowledge of these distributions. It is recommended that the bill provide the agencies with some flexibility in determining the ceiling and that the Committee Report clearly state Congressional intent as guidance for Executive Branch action.

The Association recommends that two additional components of routine operating costs be excluded. S. 3205 does propose removing "energy costs associated with heating or cooling the hospital plant." This is appropriate and desirable; however, it ignores the energy costs associated with lighting and operating the hospital facility. Prices for these energy costs, like those for heating and cooling, are beyond the hospital's control. Therefore, the Association requests that energy costs for lighting and facility operations also be excluded from routine operating costs which are contained in the proposal. It has been our understanding that there was every intention of excluding malpractice premiums, although the proposed statute has omitted it. The exclusion of the additional energy costs and malpractice insurance premiums will help to ensure the remaining costs are comparable between facilities.

In determining routine operating cost, the proposed legislation includes a provision allowing for initial consideration of hospital wage levels, if available, for the local or state area where they are higher than the general wage levels in the area. Following this initial first year adjustment, future hospital increases would be controlled by increases for all wages in the area in which the hospital is located. While we do recognize some technical problems with these index computations, the Association believes that the general principal is one which should be supported.

A further consideration in the wage level methodology, however, relates to the particular nature of the tertiary care/teaching hospital staffing patterns. The type and array of skilled personnel utilized in academic medical centers is frequently drawn from a regional or national labor pool. For example, the University of Virginia Medical Center in Charlottesville is located in a rural area of the state and outside of an SMSA. It must, however, compete with medical centers in Richmond, Virginia, Washington, D.C., and Baltimore, Maryland for skilled personnel. Because many medical centers must recruit personnel outside of the immediate area and across state lines, the Association recommends that the legislation include a provision which recognizes the skilled labor requirements of large academic medical centers.

Sections 223 of Public Law 92-603 permitted a provider, with appropriate public notice as determined by the Secretary to charge the patient for ". . . services which are expensive than the items or services determined to be necessary in the efficient delivery of needed health services . . ." S. 3205 in replacing Section 223 does not contain this or a similar provision. Providing that consumers and medical practitioners are appropriately appraised of additional charges prior to the use of services, the Association recommends that hospitals be permitted to charge the patient above the established cost ceiling for more expensive services directly requested or authorized by the patient.

S. 3205 will allow those institutions with routine operating costs below the ceiling for their group to share in the "surplus". One concern we must raise is the manner in which hospitals will be required to handle this "surplus". Although the Association believes it may very well be inappropriate to stipulate in legislation the specific ways this money must be utilized, Congress is encouraged to provide some guidance while assuring that the institutions have flexibility in determining institutional priorities.

The Association strongly supports the case mix provision provided in S. 3205. Tertiary care/referral hospitals serve the more severely ill patients and referral of such patients from other hospitals tends to increase in times of adverse economic conditions. Recognition of these facts in the legislation should help to ensure the economic integrity of tertiary/referral centers.

Experience gained since the development and initial operation of Section 223 of the 1972 Medicare amendments has demonstrated the urgent need for a viable and timely exception and appeal process. Such an effective and equitable process has not functioned under the present Section 223 cost limitations. Therefore, the Association recommends this legislation include provisions for an exception and appeal process which provides (1) that information describing the specific methodology and data utilized to derive exceptions be made available to all institutions; (2) that the identity of "comparable" hospitals located in each group be made available; (3) that the basis on which exceptions are granted be publicly disclosed in each circumstance, widely disseminated and easily accessible to all interested parties; and (4) that the exceptions process permit the use of "per-admission cost" determinations recognizing that compressing the length of stay often results in an increase in the hospital's routine per diem operating costs but no change or reduction in the per-admission costs.

The present bill provides for the Secretary to notify the hospital of its adjusted per diem payment rate for routine operating costs no later than April first of a given year. A hospital finding that its projected costs exceed the ceiling will presumably attempt to lower its costs. To lower its costs, the hospital may have to reduce its labor force or terminate existing contracts. Employee reductions and contract alterations not only require careful planning, they frequently require significant advance notification. Because many hospitals have fiscal year and reporting periods beginning on July first, S. 3205 would provide only a 90 day notice on the ceilings. The Association recommends that the bill be changed to require at least a 120 day notification by requiring the Secretary to notify the hospitals of their routine operating cost ceiling no later than March first of a given year.

Section 10(e) provides that "nothing in this section shall be construed as otherwise limiting the authority of the Secretary to continue otherwise authorized efforts toward development of improved systems of reimbursement . . ." The Association recommends that this subsection be modified to strongly and positively encourage the Secretary to continue and, where appropriate, expand efforts to develop improved systems of reimbursement.

Assuring Medicare beneficiaries needed health care services, encouraging efficiency in the provision of health care and paying the full and fair costs of health care providers should be the guiding principals of any reimbursement system. The compatibility of the goals can be maintained under a system which accounts for the many legitimate service and case-mix differences found between hospitals. When this is done, illegitimate costs arising from inefficiency or extravagance can be isolated. However, if care is not taken to identify the costs of inefficiency, legitimate reimbursement may be threatened and consequently the hospitals' ability to provide needed health services will be reduced.

In this regard, one has to be impressed with the thought and effort that went into the provider reimbursement portion of this proposal. One is also impressed with the real complexity of implementing the proposal on a national scale. While the Association finds the proposal, with suggested amendments, worthy of support, the Association recommends that we move forward cautiously and under the review and supervision of the above recommended Technical Advisory Board.

Practitioner reimbursement reforms

The apparent purpose of Section 22(c) is to eliminate Medicare and Medicaid recognition of remuneration arrangements between physicians and hospitals in which the physician's fee-based income rate in his professional medical service practice is used as a basis for computing his compensation for Part A reimbursable services. In place of such arrangements, the subsection proposes recognition of ". . . an amount equal to the salary which would have reasonable been paid for such services . . ."

While this objective seems clear in principle, it is clouded with ambiguities in practical application. The bill includes no indication of the basis on which ". . . an amount equal to the salary which would have reasonably been paid . . ." is to be determined. Certainly the Association realizes and appreciates the

desire of the Congress to permit those developing regulations to have some flexibility in implementing this amendment; however, in recruiting and negotiating with the medical staff, the hospital chief executive officer and/or medical school dean must be able to determine the amount of compensation that Medicare and Medicaid will recognize. Therefore, the Association requests that Congress either modify the proposed amendment to incorporate some specific guidelines for regulations or so specify its intent in hearings and Congressional Reports that those preparing the regulations have a clear and consistent direction for determining a reasonable salary for physicians in employment situations.

MISCELLANEOUS REFORMS

Percentage contracts

Section 20, as the Association understands it, is designed, in part, to eliminate as reasonable charges Medicare and Medicaid recognition of expenses for services or facilities which are determined as a percentage of health service revenues. However, our discussions with many groups of individuals have indicated that there are varying interpretations for this subsection. Therefore, the Association requests that the Subcommittee clearly state the objective of this subsection in its report on this legislation.

Overhead cost controls

Section 40 will require the Secretary to establish regulations for determining the reasonable cost or charges of direct and indirect overhead expenses. This approach is one means of controlling costs; however, it seems to be in direct conflict with the philosophy and purpose underlying the cost ceilings imposed in Section 10. The direct and indirect overhead expense controls specified in this subsection are based on itemizing and controlling individual, rather than aggregate, expenses. The Association believes that simultaneous controls of individual overhead expenses and aggregate cost ceilings places management in an untenable position. To provide efficient and effective services within the cost ceilings, the hospital director needs the administrative flexibility which the overhead controls would diminish. In its consideration of changes, the Association strongly recommends that the Subcommittee adopt exclusively a cost control philosophy of cost ceilings rather than a philosophy of both ceiling and line-item controls.

Contract approval

This provision directs the Secretary to establish a program for review and advance approval of "consulting, management, and service contracts" with an annual cost of $10,000 or more. The Association believes this subsection contains several deficiencies. First, as with the overhead controls program, this contract approval amendment is an individual service control rather than an aggregate ceiling control. Once again, the hospital director must try to live within a ceiling at the same time his operational flexibility to do so is reduced. Second, by requiring advance approval of virtually all types of hospital contracts, this amendment shifts operational management authority from the hospital director to the HEW staff. The hospital director and governing board could propose and implement but not decide on courses of action. In effect, DHEW will be managing by contract review significant aspects of the nation's hospitals. Third, by requiring all contracts with an annual payment of $10,000 or more to be approved, the amendment guarantees that DHEW will have to undertake a significant bureaucratic expansion. This $10,000 threshold is so low that the number of contracts requiring approval will be significant. Bureaucracy will mushroom and the resultant costs will be an additional burden on the nation's health expenditures. Fourth, the legislation requires a procedure to determine if the services may appropriately be furnished by contract. Even if government authorities could judge the reasonableness of a contract price and could evaluate the contractor's likely ability to perform the services, the governing board of the institution should retain the right to determine whether it wants a function performed by "in-house" or contract personnel.

If this segment of the proposed Section 40 is intended to ensure that Medicare and Medicaid do not subsidize contracts of questionable value or contracts undertaken with nearly fraudulent intentions, the present provisions do not discriminate between those contracts likely to be undesirable and those which are characteristic of routine hospital operations. Therefore, the Association recommends that this section be re-written to direct the Secretary to control

only those irregular, nearly fraudulent and self-dealing contracts which may be sources of abuse.

Conclusion

In conclusion, the Association expresses its appreciation to the Committee for this opportunity to testify on S. 3205. The Association shares the Committee's objective of improving the Medicare and Medicaid programs, and the Association has offered this testimony on the legislation as a sincere effort to refine and improve the proposed amendments.

Senator TALMADGE. Our next witness is Mr. John Alexander McMahon, president, American Hospital Association, accompanied by Leo J. Gehrig, M.D., senior vice president.

Without objection, your entire statement will be inserted in the record and you may summarize.

STATEMENT OF JOHN ALEXANDER McMAHON, PRESIDENT, AMERICAN HOSPITAL ASSOCIATION, ACCOMPANIED BY LEO J. GEHRIG, M.D., SENIOR VICE PRESIDENT

Mr. MCMAHON. Thank you, Mr. Chairman. We will be very brief.

Mr. Chairman, as your introduction indicated, I am John Alexander McMahon, president of the American Hospital Association, representing more than 7,000 member institutions and 21,000 personal members.

As you indicated, Dr. Leo Gehrig, senior vice president of the Washington office, is here along with Allen J. Manzano, vice president of the association, on my right and Mr. Irwin Wolkstein, associate director of the Washington office, on my far left.

We appreciate the opportunity to present our views and recommendations and appreciate the inclusion of the entire statement in the record.

Your bill, Mr. Chairman, identifies and addresses a number of important areas, many of which provide for positive reform in the administration of medicare and medicaid. We also appreciate your understanding of the shortcomings of simplistic solutions—like arbitrary caps that have been suggested by others. The full statement indicates that there are certain sections of the bill which we support as they stand. In other areas, while we support the intent, we think that certain changes would be helpful. We have made in our full statement a number of constructive suggestions in response to your invitation for refinement and modification.

Mr. Chairman, on pages 2 to 5 of our full statement we have offered an explanation for the factors in rising health costs, including inflation, the difference in the hospitals' market basket, the effect of malpractice insurance premiums, increases in costs of food and energy in hospitals and the growing population and expanding benefits of the medicaid and medicare programs along with the statutory and regulatory requirements which often add to costs without raising benefits to patients. The statement also indicates that this system is not really out of control, as people suggest, because there are a number of controls Congress has already put in place, like the planning act and like the PSRO's, which this committee had a substantial hand in developing.

Mr. Chairman, on pages 5 and 6 we have touched on several current proposals to limit hospital reimbursement like the administration's 7-percent limit on increases and the budget resolution's reduction in the medicare and medicaid budget of $100 million. I would say we appreciate your efforts, Mr. Chairman, and those of Senator Long to restore those reductions during consideration of the budget resolution and we believe the bill that is the subject of these hearings offers a better and fairer approach to the problem.

Now, Mr. Chairman, let me address, if I may, section 10, perhaps the single most important section to hospitals, and I am going to read a paragraph at the bottom of page 6 of the full statement.

Section 10 of your bill proposes significant changes in the Federal reimbursement mechanisms for hospitals, and we have carefully studied these changes. We believe them to be a significant improvement over the existing methodology of section 223 of Public Law 92–603, which section 10 is intended to replace. Any system to classify institutions for the purpose of reimbursement on a comparative basis has its difficulties, and we certainly applaud your proposal to remove from the comparison procedure for routine per diem hospital costs a number of elements which are beyond the control of institutions. Clearly, any classification system should be sufficiently sophisticated to separate efficient from inefficient institutions, and our suggestions for modifications of section 10 are designed to protect the efficient ones while motivating the others to increase their effectiveness. We offer the following suggestions which have been set forth in detail on pages 7 to 12 which we believe are necessary to make your proposed incentive system more effective, equitable, and workable, assuring you that we stand ready to participate in further refinements toward the ends that both your committee and we seek.

I will be glad to answer any questions about the specifices in time but let me only say we think the phasein principle is most important. We hope the exception process could be broadened and we hope the bill can be amended to assure adequate payment for medicaid services.

I would like now to turn, Mr. Chairman and Senator Dole, to page 12. We have an additional, and major, change to offer to section 10. We urge that section 10 be amended to provide that where a State rate review program has been established, either by statute as in Maryland and Connecticut, or voluntarily as in Indiana, which applies to all purchasers of care other than medicare and medicaid, and which is designed to meet the full financial requirements of the hospitals covered by the program, then medicare and medicaid should be required to pay the rates so established.

I have noted at the top of page 13, Mr. Chairman, our reasons for urging this amendment. We believe they are quite simple. If State rate review programs cover all patients but medicare and medicaid beneficiaries, and the latter pay according to a different formula, it is very likely that some hospital costs will not be met. Moreover, the application of two sets of formulas to two sets of patients may well result in one set of patients subsidizing the care of the other, contrary to the long established principle of Public Law 89–97, which set up medicare and medicaid, which specifically prohibits such subsidization.

Mr. Chairman, that kind of an amendment will not operate as an open door to the Federal Treasury. As a matter of fact, the record of the State rate review programs we are describing is one of moderation of rates of increase in health care costs. We have set forth data on pages 13 to 15 in support of this point. In summary, Mr. Chairman, we believe that this proposed amendment will provide equitable treatment for all third-party payers which will avoid subsidization and will at the same time be effective in moderating increases in hospital costs. We recognize there are details of the amendment to work out and we welcome the opportunity to purchase these details with your committee staff.

Mr. Chairman, on pages 15 to 17 we made comments on sections 2, 4, 6, 7, and 8. Generally our comments are very supportive of your efforts to improve these programs.

If I may direct your attention now to the middle of page 18, I would like to say a word or two about section 12 which would increase the rate of return on net equity allowed for purposes of Federal reimbursement to investor-owned hospitals to twice the average return on the social security trust fund. We support this provision on the principle that a suitable return on investment is necessary to insure that investors will continue to advance capital for investor-owned facilities. In addition, we recommend an adequate margin of revenues over expenses for not-for-profit institutions.

We are now developing the specifics for an adequate margin and will provide these to your committee in the near future. The margin is absolutely necessary to provide working capital, the equity base for future capital expenditures and the undergirding of the risk inherent in prospective payment mechanisms. The advantage of this approach to all third-party payors, including medicare and medicaid, lies in the reduction of interest charges on money which otherwise would be borrowed at high interest rates to meet these requirements and contingencies.

Now, Mr. Chairman, I am going to summarize the comments on section 22 which we have on page 19 of our statement and I want to say that this gives us much concern. We understand the problem, but we believe it suggests the wrong solution. The section as it stands provides that hospital associated physicians would generally be paid on a fee-for-service basis for personally performed patient care services. In addition, executive, educational, and administrative functions of these physicians would be paid for in amounts equivalent to salaries customarily paid to similarly competent physicians for such services.

We oppose this approach because it would interfere with the management prerogatives of hospital administrators and governing boards. We understand that your committee has identified instances where payments to hospital associated physicians are out of line with payments to other physicians. We have tried to determine a way to deal with the problem, but have not yet been able to find a solution. We know, for example, that percentage arrangements generally provide fair compensation but we do not know how to compare these arrangements with salary arrangements, with fee for service arrangements, or with lease arrangements.

We suspect that it is not the form of the contract, Mr. Chairman, but the contracting parties that can assure fairness to physician, institution, patient, and a third-party payor. Our statement suggests, Mr. Chairman, that we need more information to determine the extent of the problem and the effectiveness of alternative solutions. Since we have no solution to offer, we can only pledge our cooperation in exploring the problem further with this committee, its staff, and other organizations. I assure you we will make available all of the information that we have, and that we have tried to summarize in the last few months.

Mr. Chairman, on page 20 we have touched on section 40, the procedures for determining reasonable costs and reasonable charges. Section 40 would vest within the Secretary of HEW authority to determine in advance the reasonableness of all hospital contracts greater than $10,000 annually and we have indicated our concerns with that section, Mr. Chairman.

Senator TALMADGE. Mr. McMahon, I hate to call time on you but your 10 minutes have expired.

First I want to thank you and the American Hospital Association for your cooperation and helpfulness in drafting this proposed legislation. It seems to me that a major deficiency in the State rate regulation is that it compares the reasonableness of the hospital costs only with other hospitals in the same State. Our sample review of routine hospital costs in Maryland which you cited as an example to the effective State review indicates that in fact those routine costs are often higher than those in reasonably comparable hospitals and in the State of Pennsylvania. In Maryland, for example, what other hospital is comparable to the Johns Hopkins Hospital?

Mr. MCMAHON. There is no other hospital. As a matter of fact, I am not sure that there is one in Pennsylvania, Mr. Chairman. You would have to go some distance from Baltimore to find a comparable hospital. But let me say that the reason that we have long espoused the principle of regulation by the State is the same reason we thought that it was appropriate for planning to take place there. The rates established, Mr. Chairman, for any hospital are largely a reflection of the services provided by that hospital and we believe a regulatory process closer to the people served will assure, for example, that the people of the State of Maryland who are referred to Johns Hopkins Hospital for treatment are going to be in a better position to determine to what extent those rates should rise which in effect means to what extent should the services rise. Therefore, a comparability from State to State, while it has its advantages, also has the difficulties, Mr. Chairman, of not giving the people of a specific State the opportunity to determine the level of rates and thus the level of service.

Senator TALMADGE. Yesterday we heard from Governors, State legislatures and counties as to the extreme difficulties they were having in meeting hospital and medical costs. All urged that the States be given greater discretion in determining appropriate reimbursement. It seems to me it might make sense to let a State determine reimbursement for medicare and medicaid where that reimbursement is on the same basis as for other patients or even just a majority of the patients. The only restriction would be a requirement in the Controller General

and the Secretary of HEW which certifies that this would not cost the Federal Government more than it would otherwise have paid under present law. Does that sound fair to you?

Mr. McMAHON. Mr. Chairman, I would suggest a couple of modifications to that suggestion. First, when you made reference to the fact that medicare and medicaid might pay where all or a majority of the patients are covered by a rate review program, we have set out in our testimony—I think it is at page 15—some comments by Mr. Elmer Smith, an associate commissioner of Social Security, and Dr. Alice Rivlin that suggests that these rate review programs ought to cover all third parties.

Now as far as the second part of your question goes, the difficulty with having anybody certify that the payment being made would be no more than what would be paid under existing medicare and medicaid is that, Mr. Chairman, once you put into place a State rate review program, clearly it is going to have its impact on the reduction of cost. One that takes place there no one can say that medicare or medicaid is not in a position to be paying less than what would be the case if that kind of process were not in place.

Therefore, we think the basic thing the committee should recognize is that once a State rate review program is put in place, then the mechanics of cost reduction or cost effectiveness, the attention of the hospital on the reduction of cost is already underway. Therefore, it would seem to us that at that time medicare and medicaid have been thoroughly protected because the decision is being made just as you heard from the Governors and the counties. The decision has been made to reduce the rate of increase in costs and medicare and medicaid will have the benefit of those activities.

Senator TALMADGE. Senator Dole.

Senator DOLE. Mr. McMahon, what measures has the Association taken to improve the surplus bed problem in rural hospitals, where we have much of the facility remaining empty while overhead continues to mount. And with reference to that, do you think we might be able to utilize some of those beds for long-term care patients?

Mr. MCMAHON. Senator, we have given our attention to that in a number of ways. We think, and my statement indicates, two things that the committee is looking at that make good sense, one of which is the opportunity to utilize some of those beds for long-term care.

In addition, we have given specific attention over on the next to the last page of the statement to S. 3661 introduced by Senator Laxalt and others. The provision that we understand the subcommittee is looking at, sometimes called the swing bed proposal, would encourage rural hospitals particularly to utilize unused beds for long-term care. In addition, we are looking at other ways to provide for the conversion of facilities not only to long-term care but to other kinds of activities and working on ways to advise hospitals of what help is available for that kind of conversion. It is really a use of the existing facilities in some alternative way that we think will provide a very useful approach to the problem.

Clearly in time, Senator Dole, and the reason why we are reluctant particularly in the rural areas to encourage closure is that population shifts are taking place and as the population grows across the country

we may come to a time in the not very distant future where we are going to find an increase in utilization not on a per patient basis but because of the addition of the total number of citizens in those areas.

Senator DOLE. With reference to your statement on the bottom of page 5 and the top of page 6 concerning Senator Long's amendment to restore the $1.4 billion cost in medicare and medicaid mandated by the Budget Committee in the First Concurrent Resolution, I might just note that I supported that effort so I am sympathetic with your concerns. But just what impact would the $700 million reduction ultimately decided on in conference have on your member hospitals?

Mr. MCMAHON. Senator Dole, our problem with it was that we have no idea because since the basic law as found in Public Law 89-97 it is a commitment by the Federal Government to pay for the reasonable cost of covered services, we don't know how the mechanics would be put into place. We assume before the Congress could live with such a reduction they would have to identify, in ways other than a limitation on costs, a way that costs might be reduced or that services might be reduced because there is not——

Senator DOLE. That would get into the program structure itself, however, which the Budget Committee does not do. We simply deal with functional categories, and in that regard the pressures to cut costs are going to remain. I just wonder, then, if you might have any recommendations in that area?

Mr. MCMAHON. No, sir, we do not. We would be glad to work with the committee toward this end. We don't know how costs can be cut for covered services. The planning bill over time will have its effect. The Professional Standards Review Organizations will have its effect but it may very well be that at some point the Congress will have to grapple with the benefit structure itself.

Dr. GEHRIG. We do believe, as was indicated earlier, and as Senator Talmadge indicated there is a need to avoid any short-term meat ax approach that doesn't pay for services provided. We really think that the thrust of the Talmadge bill is forward looking. While it does not promise you a short-term 1977 savings, it moves to the matter of cost control in a judgmental way which protects the ability of providers to render the services that are offered, so we really are looking down the road.

Senator DOLE. I agree that the bill may help contain costs, but I am not sure how far it can go in reducing them. Maybe containment is the real question, but as a member of the Budget Committee I can almost promise you we will toss out some resolution cutting Federal health programs $500 million or $1 billion, then leave it up to the authorizing committee to determine how that is going to be done while we run for cover. [Laughter.]

Senator TALMADGE. Mr. McMahon, I am somewhat surprised at your position with respect to payments to hospital associated physicians. I say that because my staff and I had many conversations and communications with the State Hospital Association executives and individual hospital administrators. They recognized the need and were generally supportive of the position. In view of this discrepancy I would be interested to know if you have polled your hospital membership with respect to this issue.

Mr. McMahon. I have not polled each of the 7,000 member institutions, Mr. Chairman, but we certainly have had broad discussions about the problem. There is no question about the fact that there is a widespread recognition that the problem exists. On the other hand, I have been able to find no specific solution. While there are some who have, I know, taken the position that section 22 as it stands would offer a useful approach, nevertheless the vast majority of the hospital people that I have talked to recognized the difficulty.

They recognized the difficulties, Mr. Chairman, because many of them have learned to live with percentage arrangements and live with them appropriately. They look at the percentage, adjust the percentage from year to year, and make sure that the percentage as it changes with respect to volume brings out an appropriate compensation that is in line with the services and compensation of other physicians on the medical staff, and often involve the medical staff in the discussion. They say, do not take away from us a useful approach to compensation which we have learned to live with and put us into another kind of mandatory compensation arrangement because there is no way that we can be sure that that itself will contain costs.

As I said in my oral statement, Mr. Chairman, we don't know how we can look at the different kinds of arrangements. We know that there are appropriate compensation arrangements under all kinds of formula arrangements and we know that there are problems under all kinds. That is the reason that in this informal kind of polling that has gone on that the only thing I can suggest to the subcommittee at this point is our willingness to continue the discussion so that we can seek an appropriate kind of solution that will work across the board.

Senator Talmadge. Do you consider a poll worthwhile?

Mr. McMahon. No, sir. In any poll you run into the difficulties of a simplistic solution. That is the reason in my approach rather than saying, "Would you prefer this to this?" I have said, "Here is the problem." First the problem exists and with some exceptions there was a recognition, though we have not seen the specifics of it, that is likely that there is a real problem in some isolated cases with these kinds of arrangements. But when we go from there, Mr. Chairman, I run into the problem that different people have learned to live with different arrangements and obviously they have a favorable attitude toward the arrangement they have learned to live with and in opposition to others.

So I think, Mr. Chairman, this is far too complex a matter to subject to simple polling techniques but I have offered in the statement and in the written testimony our full cooperation including bringing some of the people in from whatever part of the country, under whatever kind of arrangement seems appropriate to the discussion of this problem because we think it is a very complex one.

Senator Talmadge. In general is there bona fide economic competition by radiologists and pathologists competing for the monopoly situations which hospitals give them? Is this situation of such a broad and competitive nature that hospitals negotiate from a position of strength in contracting with radiologists and pathologists?

Mr. McMahon. Mr. Chairman, as attorneys we understand the words "bona fide," yet there is a good-faith approach to this. The diffi-

culty is, Mr. Chairman, that in some cases competition exists when a hospital goes out to find a pathologist or a radiologist. Clearly today with the increase in the output of medical schools there is more competition than there has been before. On the other hand, there are some places where there is very little competition because it is a place that is not attractive to physicians, but there is and there will continue to be as the output of medical schools increases—there is an opportunity for a selection process.

From the conversations that I have had I do not get the impression that the situation is so dominated by the physician that we need this kind of drastic solution to interfere with the contractual arrangement. I would ask Dr. Gehrig—himself a physician—if he would have any comments to add to that?

Senator TALMADGE. Dr. Gehrig.

Dr. GEHRIG. Senator, I think the only thing I would add, and I think Mr. McMahon did allude to it, not being a lawyer I am not knowledgable of your "bona fide" discussion, but I do think that there are areas where competition exists such as the major urban areas, but I would think that we would be less than frank to say that there is not a real problem when you get to some rural areas where there is not a pathologist. In fact, a great deal of effort has to be made to bring one in, but I think it is equally wrong to suggest that in every rural area that lacks that type of manpower that there is necessarily not a good-faith effort to make an appropriate arrangement.

Now, this may be an example where the hospital has, if you will, less leverage; but I do believe that these physicians by and large are responsible people and while they need to be reimbursed, I just think that one cannot go from a bad example to saying the same thing about all of them. In sum, I think we do have a difference in competition when you look at the Johns Hopkins Hospitals of the world versus Ravenna, Nebr., where we have difficulty getting just a general practitioner.

Senator TALMADGE. Senator Dole.

Senator DOLE. No questions.

Senator TALMADGE. In 1975 the American Hospital Association Annual Report in criticizing arrangements to give gross departmental charges states as a matter of policy, and I quote:

> This arrangement, however, provides no incentive to the physician for affecting economies and it brings about the rather incongruous situation in which any pertinent charge to patients, even one made solely to cover increased departmental operating expenses, accrues to a considerable extent to the financial benefit of the physician.

In general, the American Hospital Association policy statements are quite critical of percentage arrangements.

I have two questions. What are the advantages to the hospital of the percentage arrangements and when did the American Hospital Association change its formal policy?

Mr. MCMAHON. First, Mr. Chairman, let's be very clear about the nature of that statement. It was not a policy statement; it was a guideline statement and it is so labeled. I have the printed copy here in front of me. What we were doing in that statement through a broad consultative process was to provide information to hospitals for their

contractual arrangements with the hospital base affiliated specialist and in the general policy, for example, because what you were reading from was in the technical part of comments on certain kinds of contractual provisions, we said in the general policies part that the American Hospital Association recognizes that good medical care is being provided in hospitals by physicians under many forms of mutual agreement.

We believe it is the right and responsibility of hospitals to develop with physicians contractual terms on the basis of local factors that are fair to patients and provide high quality care.

The whole thrust of that guideline document, Mr. Chairman, is to recognize that there are all kinds of ways to deal with the compensation of hospital affiliated specialists from leases, which we did not embrace either, to percentage arrangements, either gross or net, and we attempted to point out all the way through what some of the problems were with different kinds of arrangements, even salary arrangements in areas where there is opposition by much of the medical profession to any salary arrangement whatsoever. This was an informational document provided to hospitals wherein we set out all of the advantages and disadvantages, but against a general policy that the way that a hospital deals with problems like this is a matter for the governing board, for its management and for its medical staff, to determine.

Senator TALMADGE. I am reading from page 41 of your annual report of 1975, line 3, under the lease provision. "A lease or concession arrangement is in view of the American Hospital Association generally not desirable."

Under what circumstances would lease arrangements be desirable?

Mr. MCMAHON. Well, as the thrust of the statement indicates, Mr. Chairman, our problem with the lease arrangement is that under certain kinds of leases the hospital has given up complete control over the operation of the laboratory, let's say. On the other hand, a lease might be so detailed that it would be possible to retain as a condition of termination of the lease, certain kinds of control.

I don't know what the impact of other contractual activities would be, but we are concerned and I would say this with respect to the lease, that one of the things that concerns us about section 22, Mr. Chairman, in the outlawing of percentage arrangements in any case, is that there might be a total lease of the laboratory in order to provide services not on a percentage arrangement but on an outright lease which then would avoid the restrictions of section 22 but would leave the hospital in a worse position from the managerial point of view than would the percentage arrangement that exists at the present time.

Senator TALMADGE. Earlier I indicated that we have had conversations with a substantial number of hospital administrators and others on this matter of hospital-associated physicians. The large proportion in fact indicated that they are not free to manage in their relationships, that in fact they were negotiating under the gun; have little bargaining room.

For example, in one hospital in New Jersey, the pathologist who was directly reimbursed $121,000 agreed under the terms of the con-

tract to be present and in person at the hospital during the first 2 weeks of the term of the agreement. I wonder what it would have cost to have kept him there for a month.

Is this an example of the hardnosed bargaining by hospitals?

Mr. McMAHON. Mr. Chairman, that is an example of what happens under any kind of circumstances when you are trying to cover 7,000 health care institutions. I said in my statement that there are instances which are not appropriate. I think you and I would both agree that there are instances across the spectrum where with that many institutions, things have not been done as well as they might.

I can't defend that kind of arrangement. It is the reason why we published that guideline document, Mr. Chairman, to give hospitals, their administration and their governing boards, some insight to the way that things can be done. We think there are ways to bring some arm's length bargaining into the proposition. As a matter of fact, we suggested the involving of the rest of the medical staff because the rest of the medical staff is really more the consumer of the laboratory service, for example, than the hospital itself or the patient because that is where the ordering begins.

Now, involving the medical staff in these deliberations, as we suggested, is one way to make sure that there is an appropriate tradeoff between the possible competition for availability of other kinds of services, and equity of compensation treatment among the members of the medical staff. So that while there are cases here and there, and I am surprised that with the people that have talked to you that none of them have said to me that our position is inappropriate because our position has been widely known in the hospital field for the past month or so on this section.

Nobody has come to me and said, "This is completely inappropriate. We need that kind of statutory help in order to manage our institutions."

Senator TALMADGE. Would you be agreeable to a joint poll of the hospitals?

Mr. McMAHON. Mr. Chairman, if that is the way you want to proceed to provide additional information, yes. We will offer our help, Mr. Chairman, in any way that we can help.

Senator TALMADGE. The staff?

Mr. McMAHON. Indeed we will, sir.

Senator TALMADGE. Thank you very much. We appreciate your contribution, Mr. McMahon.

[The prepared statement of Mr. McMahon follows:]

STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION

SUMMARY

I. The American Hospital Association represents more than 7,000 health care institutions, including most of the hospitals in the country. In this testimony we comment on Sections 2, 4, 6, 7, 8, 10, 11, 12, 22, 23 and 40 of S. 3205. We suggest a number of modifications to the bill as introduced and propose several additional provisions.

II. *Introduction.*—At the outset, we discuss the overall problem of rising health care costs and enumerate the major factors that have contributed to increases in the cost of hospital care. Further, we examine some short-term and long-range proposals for institutional reimbursement; we oppose arbitrary

reductions in the federal budget or limitations on hospital reimbursement which do not appropriately consider the health care promised to beneficiaries and the costs of providing the services.

III. *Section 10.*—We review proposals for hospital reimbursement outlined in section 10 and make several specific recommendations regarding them. We propose a provision for the participation of Medicare and Medicaid in certain state rate review programs.

IV. *Section 2.*—We support organizational changes along the lines contained in this Section. However, we recommend the authorization of a new position in the Department of Health, Education, and Welfare—an Under Secretary for Health to whom both the Assistant Secretary for Health and the Assistant Secretary for Health Care Financing would report.

V. *Section 4.*—We strongly support the provisions to improve administration of the Medicaid program, including federal assistance to states in this regard.

VI. *Section 6.*—The provisions of this Section would assist hospitals by easing the administrative burden of multiple reporting systems which are costly and inefficient, and we support this Section.

VII. *Section 7.*—The AHA has been concerned with the process of regulation development and implementation, particularly the provision of an appropriate opportunity for public participation and comment. We support the requirement for a minimum 60-day comment period for proposed regulations under this program.

VIII. *Section 8.*—We believe that the use of expert, nongovernmental advisors has contributed significantly to the development and implementation of these federal health programs. We therefore recommend that either HIBAC be continued with increased responsibilities, or a new health insurance policy advisory council be formed.

IX. *Section 11.*—We support the provision for transitional allowances for the conversion or retirement of underutilized facilities. However, we propose a modification for this Section which would provide a commitment by government for such assistance in advance of the conversion or retirement action.

X. *Section 12.*—The AHA supports the increase in the rate of return on net equity for investor-owned hospitals. We also recommend an adequate margin of revenue over expenses for not-for-profit institutions.

XI. *Section 22.*—The AHA opposes this section as it would interfere with and circumscribe the rights and prerogatives of hospital management and governing boards to choose the form of contract for hospital-associated physicians. We recommend the collection of relevant data in this area in order to establish and apply tests of reasonableness of the charges of these physicians comparable to the tests currently applied to all other physicians.

XII. *Section 23.*—We support the provisions of this Section which are intended to widen the access of Medicaid patients to care in physcians' offices and clinics.

XIII. *Section 40.*—We oppose this Section for the same reasons we oppose Section 22. Because of the volume of contracts that would be by this Section and the lack of detailed knowledge by government necessary to make these decisions, we believe this provision would be both costly and unworkable.

XIV. *Other considerations.*—We offer support for two additional provisions which are now pending before this Committee but are not included in S. 3205: (1) a simplified method of reimbursement for long-term care in certain hospitals; and (2) flexibility in standards and regulations for rural hospitals.

STATEMENT

Mr. Chairman, I am John Alexander McMahon, President of the American Hospital Association, representing more than 7,000 member institutions, including most of the hospitals in the country, extended and long-term care institutions, mental health facilities, hospital schools of nursing, and over 21,000 personal members. With me today are Leo J. Gehrig, M.D., Senior Vice President, Allen J. Manzano, Vice President, and Irwin Wolkstein, Associate Director of our Washington Office. We appreciate this opportunity to present the views and recommendations of the Association concerning the Medicare and Medicaid Administrative and Reimbursement Reform Act, S. 3205.

Your bill, Mr. Chairman, identifies and addresses a number of areas important to the public, providers, and government in the provision of health care services. We believe certain sections of the bill provide for positive reform in the administration of Medicare and Medicaid, and we commend you for your action, as well

as for your understanding of the shortcomings of simplistic solutions. We appreciate the situation you described on March 25, 1976, when you introduced S. 3205 and said that "we may well be confronted with the need to cut and slash payments to hospitals and doctors indiscriminately, and often inequitably. This path is exactly what this bill seeks to avoid." We accept the opportunity you offered when you stated, "I want to emphasize that none of the proposed changes are frozen in concrete. They are all intended to deal with real problems. Hopefully, the hearings process will lead to refinements and modifications enhancing equitable and effective solutions to those problems."

There are sections of your bill which we support as they stand. In other areas, while we support the intent of the provisions, certain changes are necessary in our view, and we would like to make constructive suggestions in response to your invitation for refinement and modification of the bill. Further, the AHA believes some provisions should be deleted from the bill and we wish to suggest certain additional provisions. We wish to build upon the thoughtful efforts which already have gone into this legislative proposal, and the American Hospital Association wishes to continue to cooperate with this Committee in the search for appropriate solutions to the many problems and challenges which these vast programs present.

The problem of rising health costs

Foremost among the problems addressed in S. 3205 is that of the rapidly increasing cost of hospital services under Medicare and Medicaid. The solution is made difficult by the very nature of the increase in hospital costs which is due primarily to four factors:

1. First, a portion of the increase in costs results from the rise in prices and wages in the rest of the economy which necessarily impacts on hospitals. The need to maintain competitive wage levels, particularly, has a heavy impact in a labor intensive industry such as ours.

2. Second, the hospitals' market basket is unlike that of any other sector in the general economy, and the costs of goods and services purchased by hospitals are more heavily weighted by those costs which are rising at a faster rate than the cost of living. For example, the average annual hospital liability insurance premium rose from $13,000 in 1970 to more than $110,000 in 1975. This represents a 1,000 percent increase in just five years. In Chicago during that period, according to a study conducted by the Chicago Hospital Council, hospital malpractice insurance premiums increased 200 percent, and it is estimated that the cost of such insurance for the hospitals surveyed is now between $40 and $43 per patient day. Although increases in costs of food and energy, two major staples in the hospital market basket, have not been as dramatic, they nevertheless have risen at a rate much higher than that of the Consumer Price Index. Food prices, for example, have risen an average of 8.4 percent per year over the past five years, and energy costs have risen 15.1 percent per year over that same period.

3. The third factor affecting hospital cost increases is the changing nature of the output of the hospital. As a result of continuing research and new technology, services provided by hospitals are constantly improving in terms of treatment methods and the expansion of capability for dealing with conditions previously untreatable or untreated. Renal dialysis, laser surgery, total blood replacement, cancer therapy and a host of new diagnostic approaches to disease are but a few of the many examples of the costly improvements and expansion of hospital services. From 1965 to 1975 the number of intensive care units increased by 130 percent. Further, there has been a very significant increase in the intensity of these services resulting from a variety of factors, including shortened hospital stay, increased clinical capability, defensive practice of medicine, and public demand. The American people expect these improvements in health services to be available, and their expectations intensify the use of such services and produce an increase in the costs of health care.

4. Finally, because S. 3205 is addressed specifically to the increasing costs of Medicare and Medicaid, it is important to note two special factors: (1) an ever-increasing Medicare population which is the result of increased aging in the population as a whole and (2) the special impact of the recession on the needs and numbers of beneficiaries of Medicaid. In addition, Congress has increased the scope of benefits under these programs—for example, through the inclusion of the disabled under Medicare, and the extension of Medicare catastrophic benefits to persons of all ages in need of treatment for renal failure through dialysis and organ transplantation.

If cost rises due to increases in the intensity of care, product enhancement, the hospital market basket, and the increased coverage and benefits to federal program beneficiaries were excluded from consideration, the increase in hospital costs would be reasonably comparable to price increases in the general economy, yet all too frequently these basic factors are ignored in considerations directed at getting a handle on rising health care costs.

In considering any control of the rate of increase in hospital costs, increases in the quality and quantity of services must be addressed. Congress has enacted two key measures designed to deal with these issues. Good planning for the delivery of health services through implementation of Public Law 93-641, linked with certification of need legislation at the state level, will have a positive effect in determining which services and facilities are needed. Health services planning focuses on the orderly addition and control of those services which reflect the needs of a community, and the American Hospital Association strongly supports this activity.

The Medicare Amendments of 1972, Public Law 92-603, provide for the development of Professional Standards Review Organizations (PSROs) which, coupled with institutional quality assurance programs, address the issue of quality of health care and the appropriate utilization of services. Hospitals on a voluntary basis have for many years supported this process, and in 1970 AHA developed a detailed methodology for institutional quality assurance programs. Further, the Joint Commission on the Accreditation of Hospitals has for many years required quality assurance programs as part of its standards for accreditation.

We are encouraged by the congressional actions of recent years that address factors which contribute to hospital costs rather than merely federal reimbursement for costs that are incurred in providing services to program beneficiaries. On the other hand, certain congressional actions as noted earlier have expanded benefits for federal beneficiaries and have had the direct effect of increasing federal budget outlays for health services. There also are statutory and regulatory requirements imposed by the Executive Branch which, in our opinion, have added significantly to the cost of providing services without bringing commensurate health benefits. Hospitals are very concerned with rising costs, but it is frustrating when, on the one hand, they are criticized for rising costs and on the other, they are obligated by federal mandate to take actions which increase health expenditures and do not directly contribute to the provision of patient care.

Current proposals to limit hospital reimbursement

Various short-term and long-term solutions to the rapid increase in hospital costs have been proposed. The Administration's budget proposals for fiscal year 1977 would place a 7 percent limit on the yearly increase in per diem reimbursement to hospitals for Medicare services, for example. This short-term approach would not affect the factors that produce rises in hospital costs.

Moreover, such an arbitrary limit is inconsistent with the Administration's own estimate that the rise in hospital costs for the next fiscal year will be about 14 percent. It ignores the reality that labor costs, by the Administration's own admission, are likely to rise 9 percent or more, and that the costs of other major elements of the hospital market basket—goods and services essential to the provision of care—will also rise. Imposition of a percentage cap, with the continued expectation that hospitals would continue to provide the services that have been promised to beneficiaries, places these institutions in a financially untenable position and forces them to seek to defray these unmet costs through additional charges to other payors.

As you know, Mr. Chairman, the First Concurrent Budget Resolution calls for a total reduction in the Medicare and Medicaid budget of $700 million for fiscal year 1977. The AHA appreciates your efforts and those of Senator Long to restore the proposed reductions during consideration of the resolution by the Senate. We oppose a limit on funds without simultaneous recognition that this requires a cutback in present services to which beneficiaries are entitled. Government should promise the American people only what it can realistically fulfill in terms of financing and delivery of health care services.

Mr. Chairman, the American Hospital Association agrees that there are a number of significant changes in institutional reimbursement and other administrative areas which should be made in Medicare and Medicaid. It is our intent to discuss a number of sections of your bill specifically, and provide constructive

suggestions at appropriate points in this discussion. We wish to emphasize our belief that your bill has approached many important problems in these programs in a very thoughtful manner.

Improved methods for determining reasonable costs for services provided by hospitals

Section 10 of your bill proposes significant changes in the federal reimbursement mechanisms for hospitals, and we have carefully studied these changes. We believe them to be a significant improvement over the existing methodology of Section 223 of Public Law 92-603, which Section 10 is intended to replace. Any system to classify institutions for the purpose of reimbursement on a comparative basis has its difficulties, and we certainly applaud your proposal to remove from the comparison procedure for routine per diem hospital costs a number of elements which are beyond the control of institutions. Clearly, any classification system should be sufficiently sophisticated to separate efficient from inefficient institutions, and our suggestions for modifications of Section 10 are designed to protect the efficient ones while motivating the others to increase their effectiveness. We offer the following suggestions which we believe are necessary to make your proposed incentive system more effective, equitable and workable, assuring you that we stand ready to participate in further refinements toward the ends that both your Committee and we seek.

1. The bill calls for "a uniform system of accounts and cost reporting (including uniform procedures for allocation of costs) for determining operating and capital costs of hospitals providing such services. . . ." Uniform cost allocation and reporting is obviously necessary to an adequate comparative system of reimbursement. However, we wish to be sure that the accounting requirements instituted under this provision would not extend to uniform accounting which would be likely to hamper management efficiency, and be likely to conflict with the requirements imposed on hospitals by other private and governmental programs.

2. An ongoing system of hospital classification is presented, utilizing bed size and type of facility as its basis. While these two variables are important, it would be necessary to evaluate the appropriateness of the specified breakdowns according to bed size, and to provide adequate opportunity for exceptions review. For example, a 100-bed general hospital in a rural area will not infrequently have a more complicated case-mix and a totally different mission than a similar sized general hospital in an urban area.

Similarly, while there is need to separate institutions by the types of services they provide, a comparative evaluation may be hampered by the small sizes of the groups which may result. Additionally, the category provided for hospitals which are primary affiliates of accredited medical schools appears extremely restrictive and, as the Committee knows, not infrequently a number of hospitals may be affiliated with a single medical school.

3. The bill, in defining routine operating costs, provides that such costs exclude four items which are in fact beyond the control of the administration of an institution and have in the past created difficulties in any comparative classification scheme. It is our understanding, Mr. Chairman, that you intend to include within the bill an exclusion for costs related to malpractice insurance premiums. We strongly urge and support your action in this matter, for these costs have not only risen precipitously in recent years, but their impact has not been uniform across the country. The exclusion should cover the costs of both professional and general liability insurance, which usually are sold as a unit.

Among costs excluded from routine operating costs are "energy costs associated with heating and cooling the hospital plant." However, we strongly recommend that all energy costs be excluded for two reasons: (1) There is a significant variability in types of energy sources used by hospitals and their costs in various regions of the country; and (2) the differentiation of the costs of energy by type and use (e.g., electricity, which is used for not only environmental controls, but for lighting and many diagnostic and therapeutic purposes) is very difficult, if not totally impractical.

4. The bill provides that the personnel component of average per diem routine operating costs shall be adjusted through the use of a wage index based on general wage levels prevailing in the areas in which the hospitals are located.

Here our concern is the fact that this index refers to wage levels in the general economy rather than the segment of the labor force from which hospitals recruit

their employees. It must be pointed out that the correlation between these wage levels is, at best, approximate because many hospital employees are highly specialized. Moreover, to the best of our knowledge, wage data of nonmetropolitan areas are not available on a periodic basis, and it is in these areas that approximately 50 percent of all hospitals are located. Therefore, a new wage index must be developed and maintained, and we believe it is essential that it be based on that segment of the labor market from which hospitals must recruit. Furthermore, although hospitals which have characteristically higher wages would be granted a one-year reprieve, they would be subjected thereafter to controls which fail to recognize that those higher levels of costs may be fixed, for example, by virtue of prior contractual agreements, or may well be maintained by state or local law, as in the case of public institutions.

5. Section 10 provides that ". . . at the end of the fiscal year a retrospective adjustment will be made in the amounts paid a hospital to reflect the lesser of the cost increase incurred by the hospital or the cost increase in prices which occurred in goods and services used. . ." The problem with this provision is that a hospital could be told at the beginning of the year that it would be reimbursed, say $100 per patient day, for its routine services, and budget accordingly for this expected payment—but if at the end of the year the government determines that the forecasted price increase was in error, and that the hospital should be paid $95 per patient day, the institution would incur a deficit. We do not believe that hospitals should be placed at risk in this manner which would permit a retrospective denial of reimbursement of incurred costs on the basis of an erroneous economic forecast.

We are concerned also about the specific language detailing the arithmetic to be used in arriving at the projected estimate of the average per diem routine operating costs to be applied to a given period. We are uncertain that the present language provides that the costs used in the base would be properly adjusted to take into account the fact that hospitals have varying fiscal years. A varying inflation adjustment would be needed both in the base data and in determining the projected estimate to be used for a given hospital. The estimate should vary, depending upon the date a hospital's fiscal year begins.

6. The Section further provides that hospitals may seek an exception for two basic reasons, one of which is an "unusual case-mix." This exception for case-mix deals with only one aspect of a difficult problem in evaluating the appropriateness of the cost level of a hospital. That problem is an assessment of the intensity and complexity of care provided by the institution. Intensity is affected, of course, by the case-mix of patients served. One of the problems faced by hospitals with case-mixes believe to require unusual levels of intensity of care is that they do not have the required data to prove their point. The bill should provide that the Secretary of HEW would make the needed data available to all hospitals within a classification group.

A second point in the provision for exceptions with which we would take issue is the omission of factors in addition to case-mix which affect intensity of care, for example, length of stay, which may also be valid grounds for exception. Hospitals with high patient turnover rates (shorter lengths of stay, usually a characteristic of more efficient operation, would be particularly hard hit since the per diem routine cost in such institutions is generally higher than in institutions with longer average stays. Increased costs for providing routine care not reflected in case-mix also occur in hospitals in which patients rarely employ private duty nurses. Public hospitals and other facilities providing care for many indigent patients must compensate for the absence of privately employed nurses through their own nursing staffs.

Further, patient mix alone does not necessarily reflect in full the complexity of service that may be provided in one institution as compared with another, although it has important cost implications. We recognize that the state of the art for determining and comparing this set of extremely important variables as they relate to costs is poorly developed. It is essential that considerable additional analysis and development of evaluative procedures and appeal mechanisms be undertaken as critical adjuncts to the reimbursement procedure to be sure that either the basic process or the exceptions approach covers all needed factors.

7. The bill provides that for hospitals in Alaska and Hawaii, adjustments may be made in the per diem payment rate to reflect higher prices prevailing in those states. This is an important and appropriate provision; however, prices paid by hospitals in other regions of the country do not necessarily reflect the national average, and similar allowances should be provided for them as well.

8. We are greatly concerned about the provision which would tie the incentive reimbursement formula to average per diem costs within a group of comparable institutions without provision for evaluating and altering an unwarranted, and we believe unintended, "ratchet" effect. If, as intended, the results of the incentive formula would be that each year average per diem costs would potentially be reduced, additional hospitals not previously found to have high costs would be so identified and penalized. This would be the inevitable consequence each fiscal year of cost reductions in hospitals classified in the highest category. Unless some accommodation is made to recognize this trend, the eventual result would be that high quality and complicated health services would no longer be feasible in many health care institutions. We do not believe that this is the intent of the Committee and recommend that legislative language be included to ensure that a review of this matter will be made every two years after the system is applied so that the system may be evaluated and modified accordingly.

9. The bill's provisions on Medicaid reimbursement to hospitals are limited to assuring that the reimbursement does not exceed amounts payable under Section 10 of the bill. While in your statement summarizing the bill last March 25, Mr. Chairman, you said the bill would establish a new method of reimbursement not only for Medicare but also for Medicaid, the bill does not so provide. This omission would perpetuate a very serious problem for hospitals in some states which seek to obtain hospital services for Medicaid patients at rates that are below cost and thereby are placing hospitals in financial jeopardy. We would hope that the bill could be modified to require the Medicaid payments be at an equitable level.

10. An exceedingly important issue not addressed in the provisions of Section 10 is the provision of charity care and the bad debts incurred by hospitals. The costs of providing services for needy patients who are not covered by any program are a very serious problem for many hospitals, and we would urge the Committee to consider reimbursement provisions to support the necessary care of such patients.

11. The bill wisely provides that implementation of Section 10 would occur over a period of two years with only one-half of the penalties and incentives applied during the third year after enactment. As you have recognized, Mr. Chairman, many complicated aspects of this reimbursement system fundamental to its successful development are yet to be developed and evaluated. During the period prior to the full implementation of the proposed reimbursement system, we strongly urge a full scale evaluation of its effectiveness by the Secretary of HEW who should be authorized to recommend appropriate modifications to the Congress. The soundness of the classification system and other elements of the proposed method for determining reasonable costs of hospital services should be validated so that the system appropriately identifies efficiently and inefficiently operated institutions.

And now, Mr. Chairman, we have an additional, and major, change to offer to Section 10. We urge that Section 10 be amended to provide that where a state rate review program has been established, either by statute as in Maryland and Connecticut, or voluntarily as in Indiana, which applies to all purchasers of care other than Medicare and Medicaid, and which is designed to meet the full financial requirements of the hospitals covered by the program, then Medicare and Medicaid should be required to pay the rates so established. It should be noted that this provision would not apply all state rate review programs to federal purchasers, because some state programs do not meet the requirement of covering all nonfederal purchasers of care. We understand, for example, that the programs in Massachusetts and New York do not cover all nongovernmental third parties, so they would not be covered by the amendment we propose.

Our reasons for urging amendment are quite simple. If state rate review programs cover all patients but Medicare and Medicaid beneficiaries, and the latter pay according to a different formula, it is very likely that some hospital costs will not be met. Moreover, the application of two sets of formulas to two sets of patients may well result in one set of patients subsidizing the care of the other, contrary to the long established principle of Public Law 89-97, opposing such subsidization.

We believe that this amendment will achieve equity among all third-party payors. Moreover, it should be designed to meet the full financial requirements of health care institutions, including the costs of patient care; approved educational and research programs not otherwise financed; capital expenditures con-

sistent with community planning decisions and approved through the planning controls provided in Public Law 93-641; and an operating margin to provide working capital, the equity base for future capital expenditures, and the undergirding of the risk of unforeseen contingencies.

Mr. Chairman, such an amendment as we are urging will not operate as an open door to the federal treasury. As a matter of fact, the record of the state rate review programs we are describing is one of moderation of rates of increase in health care costs. For example:

1. In Maryland, the Blue Cross Association reported on May 30, 1975, that the Maryland Health Services Cost Review Commission (HSCRC) had held hospital rate increases to a level substantially lower than similar rate increases elsewhere in the nation. Harold Cohen, director of the Maryland HSCRC, recently reported to a Senate Health Subcommittee that hospital rate increases in that state have dropped well below the national annual average since the Commission's inception. The Maryland experience is especially valuable because both Medicare and Medicaid have recently received waivers to participate in the rate review program.

2 In Connecticut, under the legislatively established Commission on Hospital and Health Care, similar comparisons can be made. John K. Kittridge, past vice president of Prudential Life, and chairman of The Council on Consumer and Professional Relations of the Health Insurance Association of America, has said that "the Connecticut experience is significant because the rate of escalation in that state similarly paralleled or slightly exceeded the nationwide experience through 1973, the year the Connecticut legislature established the Commission on Hospital and Health Care." The following table presents the comparative experiences of Connecticut and the nation since establishment of the Commission.

HOSPITAL PRICE INCREASE

[In percent]

	Connecticut	United States
1973 to 1974	6.1	11.8
1974 to 1975	8.3	13.9
1975 to 1976	9.6	14.0

These statistics reflect price increases, in percentages, for private sector patient charges. In the three years since the implementation of the state prospective rate review system, the increase for Connecticut hospitals has been 60 percent of the national average.

3. In Indiana, where a voluntary program has been in effect since 1959, a study commissioned by the Social Security Administration showed for 1972 that "for short term hospitals . . . average increase per diem operating cost was 11.3 percent compared to the national average of 13.8 percent; the per case cost increase in Indiana was 8.6 percent compared to the national average of 11.5 percent." Absolute dollar figures show the significant difference between average costs in Indiana hospitals for 1972 and average national costs:

	Indiana	United States
Cost per stay	$720.13	$826.16
Cost per patient day	89.95	105.09

Although these data relate to only one year's experience in Indiana, the rate of increase in hospital costs in that state has been consistently lower than the national rate.

The advantages of consideration of all hospital costs and reimbursement at the state level was recently discussed in testimony before the House Ways and Means Committee's Oversight Subcommittee. Elmer W. Smith, an associate commissioner of the Social Security Administration, said that in order to be successful, prospective payment systems must focus on total costs, must include all

payors, and must be mandadtory to some degree. In a statement before the Senate Committee on Labor and Public Welfare Subcommittee on Health, Alice M. Rivlin, Ph.D., director of the Congressional Budget Office, also suggested that efforts to moderate hospital costs must apply to all purchasers of care.

To sum up our arguments in support of this proposed amendment, we believe it will provide equitable treatment for all third-party payors, will avoid subsidization of one group of patients by another, and will at the same time be effective in moderating increases in hospital costs. We recognize that there are details of the amendment to be worked out, and we will welcome the opportunity to pursue these details with your Committee staff.

Establishment of Health Care Financing Administration

Section 2 of the bill would combine the Bureau of Health Insurance, Medical Services Administration, Bureau of Quality Assurance and Office of Nursing Home Affairs into a Health Care Financing Administration. An Assistant Secretary for Health Care Financing would have responsibility for the newly-created administration. The current Assistant Secretary for Health would have the responsibility for all other HEW health programs.

Although a Health Care Financing Administration would provide an organization through which greater coordination of policy and program administration could be achieved, the fragmentation within the Department with respect to overall federal health policy would still exist due to the split of health programs under two Assistant Secretaries. Therefore, we urge greater coordination of federal health programs and recommend that a new position of Under Secretary for Health be created, in addition to the development of a Health Care Financing Administration as the bill provides. Both Assistant Secretaries would report to the Under Secretary for Health and, in this way, the necessary coordination of the many unrelated HEW health programs and the policies affecting them would be enhanced. While it appears not to be feasible at this time to contemplate and recommend a separate Department of Health, the above recommended organization change would provide an identifiable top level policy official in HEW who would be responsible for all health programs.

State Medicaid administration

Section 4 of the bill would establish specific performance criteria with respect to state administration of Medicaid. Requirements related to timely determination of eligibility; prompt payment of claims; quality control in eligibility determinations; and effective claims review could result in better state administration. We strongly support such measures to improve Medicaid administration.

Claims processing and information retrieval systems for Medicaid programs

Section 6 also amends Title XIX by mandating uniformly between Medicare and Medicaid reporting systems. It would be considerably easier for hospitals to report if claims processing for purposes of Medicare and Medicaid were made uniform. We therefore support this provision.

Regulations of the secretary

Under Section 7 of the bill, a minimum of 60 days would be provided for comment on proposed HEW regulations under this provision. The AHA has always been concerned that appropriate time be provided for comment on program regulations, and we support this provision.

Termination of HIBAC

Section 8 would terminate the Health Insurance Benefits Advisory Council (HIBAC). We believe that the use of expert nongovernmental advisors, through HIBAC, has contributed significantly in the development and implementation of these federal programs, and consider it important that the major health care programs of Medicare and Medicaid be provided the advice and assistance of such an advisory group, particularly during a period of significant legislative and program changes.

HIBAC served an important and useful role in the earlier development and implementation of Medicare. As a result of changes in the responsibility of this advisory council in 1972, the evolution of the program, and the extent to which its advice has been sought and utilized in recent years, the role of this council has decreased. Such an advisory council should be available not only for its potential contributions during the reform of Medicare and Medicaid, but also for the development and implementation of any major revisions in the Social

Security health related legislation. We therefore strongly recommend that either HIBAC be continued with increased responsibility for its advisory role or, if it is discontinued, that a new health insurance policy advisory council be formed, with more adequate authority and responsibility for advice to the Secretary about these programs.

Transitional allowances for conversion of beds

AHA supports Section 11 of the bill. However, as it is presently written, the Section provides that applications for assistance would be approved only retrospectively, leaving unanswered the potential for obtaining such assistance before the conversion of beds and taken place.

We urge that an application for support under this Section be reviewed and approved prospectively so that an institution which retires or converts beds in the manner outlined in its approved application can be assured of the payment upon which it will be dependent.

Return on equity for investor-owned facilities

Section 12 would increase the rate of return on net equity allowed for purposes of federal reimbursement to investor-owned hospitals to twice the average return on the Social Security Trust Fund. The AHA supports this provision on the principle that a suitable return on investment is necessary to ensure that investors will continue to advance capital for investor-owned facilities. In addition, we recommend an adequate margin or revenues over expenses for not-for-profit institutions. We are now developing the specific for an adequate margin, and will provide these to your Committee in the near future. The margin is absolutely necessary to provide working capital, the equity base for future capital expenditures, and the undergirding of the risk inherent in prospective payment mechanisms. The advantage of this approach to all third-party payors, including Medicare and Medicaid, lies in the reduction of interest charges on money which otherwise would be borrowed at high interest rates to meet these requirements and contingencies.

Hospital-associated physicians

Section 22 would establish a mechanism whereby hospital-associated physicians would generally be paid on a fee-for-service basis for personally performed patient care services. In addition, executive, educational and administrative functions of these physicians would be paid for in amounts equivalent to salaries customarily paid to similarly competent physicians for such services.

The American Hospital Association opposes this provision since it would interfere with and circumscribe the rights and prerogatives of hospital management and governing boards to choose the form of contract into which they will enter with physicians. Section 22 is further restrictive of management discretion when tied to Section 40 which would appear to make all percentage contracts not reimbursable.

The AHA recognizes that your Committee has identified instances of payments to hospital-associated physicians which suggest that the present rules on reasonable costs and charges, as they have been applied, are not adequate. We would recommend as an orderly approach to this issue that provisions be made for the collection of data on such factors as the amounts now being paid to hospital-associated physicians; the levels of skills involved; the time and effort expended by the physician; expenses incurred by the physician in carrying out his responsibilities to the hospital; the volume and types of services provided by the laboratory; and the resulting unit costs. Using such data it would seem possible to establish and apply tests of reasonableness of the charges of hospital-associated physicians which are more comparable to the tests currently applied to all other physicians.

Such an approach would more appropriately and equitably consider the reasonableness of the totality of charges of hospital-associated physicians from the points of view of these physicians and the purchasers of care. Furthermore, while providing government a method of evaluating reasonableness of costs in this area, this approach retains for the management of hospitals the authority they must have to make decisions for which they are responsible.

Payment of physician services under medicaid

Section 23 would require Medicaid to pay not less than 80 percent of the Medicare reasonable charge for health care provided by physicians in non-

hospital settings. We support such a provision to encourage the treatment of routine illness and conditions outside of the hospital emergency room when such treatment is appropriate and could be more reasonably rendered in a physician's office or a clinic.

Procedures for determining reasonable costs and reasonable charges

Section 40 would vest within the Secretary of HEW authority to determine in advance the reasonableness of all hospital contracts greater than $10,000 annually. Furthermore, percentage contracts, as noted earlier, would not be reimbursable. We oppose this Section on the same grounds that we oppose Section 22. It would result in unwarranted interference with hospital governance and would circumscribe management prerogatives. Again, mechanisms for determining the reasonableness of costs or charges are already provided under Title XVIII and the regulations under it. Moreover, we do not believe that there is an appreciation for the vast number of hospital contracts which would be covered by this provision. The federal government does not have the ability to consider all of the necessary variables in the internal operation of each of these institutions and in their service areas that must be reflected by management in the conditions of each contract. The volume of contracts covered and the lack of necessary detailed knowledge by government would make this requirement an administrative morass that would result in bureaucratic delay, and would be both costly and unworkable.

Other considerations

We understand from discussions with your staff that you are considering adding to this bill a provision for Medicare payment for long-term care services in some hospitals that alternately use some of their hospital beds for long-term care. Such a provision would permit the more efficient use of rural hospital capacity in certain areas. Further, it would more efficiently provide additional long-term care beds in areas where frequently such resources are limited. We believe that a provision of this type could be a reform of value to both patients and government.

Finally, we would like to commend for the consideration of you and your Committee the provisions of S. 3661, introduced by Senator Laxalt and others. This bill, in addition to provisions for the long-term care usage of rural hospitals, recognizes the differences between these facilities and major urban hospitals. Small rural hospitals are providing needed quality health care to their patients within the resources available to them. However, their limitations in size, scope of services, and availability of health manpower, together with geographic isolation, give rise to the very significant problems these institutions have in dealing with rigid federal regulations which are more applicable to major urban facilities. It is necessary that federal regulations contain the flexibility to deal with the requirements that are made of these institutions.

Concluding remarks

In summary, Mr. Chairman, the hospitals of this country agree that various changes can well be made in Medicare and Medicaid. We are fully aware of the complexity of the areas which are addressed in your bill, and in the spirit of your remarks at the time you introduced it, we have offered a series of recommendations for modification of the bill, which we hope are constructive. We have appreciated the opportunity of working with you and your staff and participating at this hearing, and we look forward to continuing these efforts. I will be pleased to answer any questions you may have.

Senator TALMADGE. The next witness is Mr. John A. Bradley, Ph. D. Dr. Bradley, you may insert your full statement in the record and summarize it, sir.

STATEMENT OF JOHN A. BRADLEY, PH. D., PRESIDENT, FEDERATION OF AMERICAN HOSPITALS, ACCOMPANIED BY MICHAEL BROMBERG, NATIONAL DIRECTOR, AND ALBERT C. BAKER, DEPUTY DIRECTOR, FEDERATION OF AMERICAN HOSPITALS

Mr. BROMBERG. Mr. Chairman, I am Michael Bromberg, the national director of the federation with Dr. Bradley, on my right, who in

addition to being president of the federation is also vice president of American Medicorp, one of the largest hospital management companies in the world, owning and managing 53 hospitals with over 11,000 beds.

On my left is Albert C. Baker, deputy director of the federation and formerly hospital specialist with the Cost of Living Council.

As taxpaying institutions representing over 1,000 hospitals, we have been particularly interested in modern management of hospital facilities. Your bill S. 3205 recognizes the need to amend the medicare-medicaid programs in order to provide economic incentives to develop and implement effective and efficient management systems in participating hospitals. We commend the subcommittee chairman for his leadership in proposing meaningful incentives and we hope our suggested modifications to S. 3205 will be helpful in achieving our common objective of quality health care delivered in an efficient manner.

I would like to speak to sections 10, 12, and 40 of the bill, Mr. Chairman. Beginning on page 7 of our testimony we discuss section 10 performance-based reimbursement. Replacement of the current, highly inflationary system of retrospective reimbursement with a competitive system of prospective payment would be our primary recommendation for reforming institutional reimbursement.

The Federation of American Hospitals has long favored increased experimentation with prospective payments for hospital services based on negotiated rates or target rates established by a formula. Our association favors a major overhaul of the medicare-medicaid reimbursement system for institutional providers; however, we also believe that experimentation on a national basis involving several prospective payment methods is necessary to determine appropriate long-range systems.

However, we have been disappointed with the Department of HEW's very cautious and limited use of that authority.

We endorse the general approach of section 10 of your bill, which includes target rates and economic rewards for efficiency. By establishing a target based on average routine costs, the proposal seeks to inject competition among similar facilities. This is a much more promising approach than the arbitrary cost ceilings advocated by some of the public-utility type rate regulation proposed by others. Inflexible caps, on the one hand, would force a reduction in quality while utility type regulation protects inefficiencies by removing all competition. I also might add it would give the States the power to allocate trust fund dollars, which we do not think a wise policy.

In modifying section 10 in your bill, Mr. Chairman, we would propose that the exception procedure for those facilities with costs above 120 percent of average be more flexible. Inefficiency should be penalized but unforeseen or uncontrollable events, such as physician strikes or extraordinary increases in malpractice insurance premiums, should be recognized as justifiable causes for cost increases.

In answering Senator Dole's question, which is really crucial on what we do when we come to the point where the Federal budget just doesn't give anymore, at the bottom of page 9 we suggest that where restrictions on reimbursement are imposed the facility should be allowed to charge the program beneficiary for the difference between

program limits and actual costs. This is presently authorized under section 223, but that would be repealed by your bill.

That type of limited surcharge is quite different from coinsurance previously proposed by the administration because it would be limited to a small number of hospitals, those high-cost institutions, and therefore, a small number of beneficiaries.

In addition, the beneficiaries would, in many instances, be able to select another facility where costs do not exceed the ceiling. This would add another element of competition by encouraging patients to consider taking a more active role in selecting access to the health system and selecting this would be possible, for example, where their physician has privileges in more than one hospital.

In addition, we strongly feel there should be an exemption for new hospitals built with required planning approval to recognize the high startup costs as well as higher debt services of a new facility or wing. This exemption is needed because of initially low occupancy rates that push up the average per diem costs of new facilities making it unfair to expect those hospitals to compete with already established facilities.

We urge the committee to recommend a hardship exception for those "unforeseen and uncontrollable" events which cause significant increases in cost. The concept of phasing in section 10 is laudable; however, in this instance we would urge a faster period for implementing section 10. We believe this can be done by requiring a uniform reporting system instead of the uniform accounting system. This could save at least 1 full year in implementing section 10.

We are concerned about the fairness and cost of imposing a uniform accounting system on a universe of 7,000 hospitals which vary so in size, scope of service, and geographical area. The benefits of that system may be outweighed by the added costs and administrative problems.

On page 13 we discuss the need for continued experimentation. We believe that the performance-based reimbursement system outlined in S. 3205 represents a major step in making medicare and medicaid more cost efficient. However, section 10 is really not a system of prospective rates. We believe the Secretary should be directed by this committee to engage in a much more extensive program of experimentation along prospective lines.

At the bottom of page 15 we list a few of the types of prospective rates we would like to see experimented with, such as negotiated rate or a rate per diagnosis and others listed there.

On page 16 we discuss rate of return. We urge the committee to amend the medicare law for a more reasonable vehicle for determining rate of return.

By eliminating income taxes from the list of reimbursable costs, the Department of HEW has made the return on equity for investor-owned hospitals approximately 10 percent on a pretax basis or an aftertax return of approximately 5 percent.

Senator TALMADGE. I hate to interrupt you, but your 10 minutes have expired. Your full statement will be entered in the record.

Mr. BROMBERG. Thank you.

Senator TALMADGE. Senator Dole.

Senator DOLE. In your summary on page 2 you indicate that you oppose restrictions on contract negotiations with hospital-based physicians but would support a reasonable limit on the result of such negotiations. Would you define that "reasonable limit" and tell us what criteria might be used in reaching it?

Mr. BROMBERG. Senator Dole, I think we are saying the same thing as the last witness in our testimony, and that is that we believe that it is more important for the Government and this committee to look at the final results or bottom line, if you will, of what the program costs are instead of each line item in a hospital's budget and therefore, instead of trying to set guidelines on how we negotiate with the hospital-based physicians, we would rather look at the outcome of that negotiation.

Now our present law, for example, provides that physicians are paid on the basis of a 75th percentile of prevailing and customary charges. Perhaps that type of approach could be used to see whether a percentage arrangement or a lease arrangement or other arrangement would have exceeded that on a unit basis or on a total basis. That is one approach.

Senator DOLE. I believe there is also a reference in your statement to the fact that a greater return on equity is needed. What is it now, and what percentage are you seeking?

Mr. BROMBERG. It comes out to approximately 5 percent after taxes. Right now it is one and a half times the trust fund. The chairman's bill would increase that by a third to two times the trust fund. But as we point out in our testimony, Senator, in this country right now industry is receiving 14 percent after taxes; and even public utilities, which are monopolistic and protected, are receiving about 12.1 percent after tax return on equity.

Our industry is also receiving it, but we are receiving it from other patients. We are forced to cross subsidize by making our profit margin from nonmedicare patients since we are only getting 5 percent from medicare. We think that is not only unfair, but the medicare rate of return violates the intent of the law.

The U.S. District Court has recently held in the District of Columbia that the Secretary should review this policy and set new regulations—that kind of study was intended by Congress. That makes it quite timely for this committee to reconsider the issue.

There are several ways to make it more fair. We have listed in our testimony the two ways that would bring us up to public utilities would be either to increase the rate of return by making it three times the trust fund or putting in a provision which allows the Secretary of HEW by each year by regulation after public hearings to determine what a reasonable rate of return is compared to industries of comparable risk.

We could consider utilities, other industries, other hospitals and determine a rate each year. That kind of approach would bring us up to par; would not require that we seek a higher return from other patients.

Senator TALMADGE. Thank you very much. We appreciate your contribution.

[The prepared statement and attachments of Mr. Bradley follow:]

STATEMENT OF JOHN A. BRADLEY, PH.D., PRESIDENT, AND MICHAEL D. BROMBERG, ESQ., DIRECTOR, NATIONAL OFFICES, FEDERATION OF AMERICAN HOSPITALS

On behalf of the members of the Federation of American Hospitals, we would like to thank the Committee for this opportunity to present our views on proposed reforms of the Medicare and Medicaid programs.

The Federation of American Hospitals is the national association of investor-owned hospitals, an industry with more than 1,000 hospitals in the United States and over 111,000 beds. These facilities range from small rural hospitals to large urban and suburban medical centers, built with private capital saving billions of tax dollars.

As tax paying institutions, investor-owned hospitals have been particularly interested in modern management of our nation's health facilities. S. 3205 recognizes the need to amend the Medicare and Medicaid programs in order to provide economic incentives to develop and implement effective and efficient management systems in participating hospitals. We commend the Subcommittee Chairman for his leadership in proposing meaningful incentives and we hope our suggested modifications to S. 3205 will be helpful in achieving our common objective of quality health care delivered in an efficient manner.

MEDICARE AND MEDICAID REFORM

The lack of a general consensus as well as requisite funding have been major stumbling blocks in Congressional deliberations on national health insurance. Certainly the development of a national health insurance program is something that must be of continued concern to Congress, but in the meantime, it is critical that the Medicare and Medicaid programs be carefully scrutinized and overhauled in order for necessary reforms to be instituted. These programs have been in operation for ten years now so there has been more than enough time to evaluate their performances and pinpoint the problems areas. That is one of the major benefits of the Subcommittee Chairman's bill in that it intelligently assesses many of these weaknesses. It is crucial that the Medicare program operate at maximum efficiency and effectiveness before implementing any system of universal health insurance.

HEALTH CARE FINANCING ADMINISTRATION

We support that provision of the bill that would create a new Health Care Financing Administration by combining the Bureau of Health Insurance, the Medical Services Administration, the Office of Nursing Home Affairs, and the Bureau of Quality Assurance into a single agency. This would be instrumental in alleviating the often fragmentary nature of department policies on Medicare and Medicaid. At the present time these agencies operate as virtually autonomous units; creation of a single agency would provide more streamlined, uniform policymaking as well as enhance the efficiency and accountability of these programs.

While supporting the concept of the new Administration, we believe that it should be under the direct supervision of the Assistant Secretary for Health, rather than a new Assistant Secretary for Health Care Financing. With the exception of the Secretary himself, the Assistant Secretary for Health should be the top spokesman and policy maker for departmental health policy. Creation of this new position could serve to undermine this authority.

In addition to weakening the basic powers of the Assistant Secretary for Health, establishment of an Assistant Secretary for Health Care Financing would separate cost and quality issues, and place even more authority in the hands of health economists. We, too, support cost-consciousness, but we are concerned by the increasing preoccupation with the bottom-line that has come to characterize departmental thinking and regulation. Issues of cost and quality of care are appropriately addressed jointly. For this reason we believe that the Assistant Secretary for Health should have jurisdiction over the newly proposed agency.

The Office of Fraud and Abuse Control, as proposed in S. 3205, would be placed under the authority of an Inspector General, who would also be charged with overseeing the efficiency of the Medicare and Medicaid programs as well as their compliance with the law that governs them.

We caution against creation of such a position for several reasons. In the first place, it seems to be a duplication of already existing authority. Responsibility for these programs—and all health programs—should fall under the aegis of the Assistant Secretary for Health. However, the Inspector General would circumvent the Assistant Secretary and report directly to the Secretary. There is nothing cost efficient about establishing yet another layer of bureaucracy and we question the need for the broad powers assigned to the proposed Inspector General.

One aspect of these powers that we find particularly disturbing, however, is the power that he would be granted to confidentially expend up to $100,000 in any fiscal year to supplement inspections, audits, and reviews. No individual could receive more than $5,000 of these confidential funds.

We have already stated our support of continued attempts to eliminate fraud and abuse in the Medicare and Medicaid programs. However, the bill places no restrictions on the means which may be employed to obtain supplementary information of a "confidential" nature. Certainly investigations should be stepped up and extremely stiff penalties meted out for provider fraudulence, but we recommend that the position of Inspector General as proposed by reviewed as to need and appropriateness.

STATE MEDICAID ADMINISTRATION

We commend those provisions of the bill which seek to upgrade the State Medicaid programs by imposing on-site evaluations subject to uniform federal standards. Increasing the administrative efficiency of these programs will be of benefit to both the consumer and provider of services. The withholding of federal matching funds for a State's administrative costs pending correction of program deficiencies provides an incentive to the States without cutting off the flow of dollars for needed medical services.

In particular we support the provision that 95% of all "clean" claims be paid within thirty days of receipt from the provider. Assurance of an improved cash flow will serve as an incentive to providers to accept Medicaid patients.

SIXTY DAY COMMENT PERIOD

With few exceptions, a thirty day comment period is presently provided for public comment on proposed regulations. In order to assure that regulations affecting health care are representative of sound public policy, it is mandatory that the public and the health sector as a whole be given the time to respond with comments and constructive recommendations. However, as matters now stand, by the time that the proposed regulations reach our hospitals, particularly those in western regions, we are left with considerably less than thirty days in which to evaluate regulations that are often complex and lengthy. There is often not sufficient time available to study the regulations, gather information on their possible and probable effect, and then formulate and forward a response to the Department of Health, Education and Welfare officials. Therefore, we strongly support the provision to extend the period for public comment on proposed regulations to sixty days except in those cases where the urgent nature of the regulations demands otherwise.

HEALTH INSURANCE BENEFITS ADVISORY COUNCIL

The effective administration of Title XVIII depends in part on the cooperation—not confrontation—between government and the health industry. HIBAC was created by Congress when Medicare was first passed as a means for affirming Congressional intent that industry advice and cooperation be sought by the Department. Instead of abolishing HIBAC, as proposed in S. 3205, we recommend that the Council's role in the regulatory process by clarified and where appropriate, broadened.

We recommend that HIBAC be reconstituted as a ten member advisory body, broadly representative of health providers, consumers, and third party payors, a more workable size than the present nineteen members. HIBAC should be an advisory body of the legislative as well as the executive branch. It should meet more frequently and all proposed regulations under Title XVIII should be submitted to HIBAC thirty days prior to initial publication in the FEDERAL REGISTER. Any regulation which HIBAC determines to be contrary to the public

interest or inconsistent with sound administration of the Medicare program, should be reconsidered by the Secretary prior to initial publication.

These recommendations, if adopted, would help restore confidence and trust in the system by assuring a real dialogue between the payor and provider of program benefits.

PERFORMANCE BASED REIMBURSEMENT

We realize that much of the impetus for reform of Medicare-Medicaid stems from increasing Congressional insistence that these programs operate in a manner that is as cost efficient as possible. Replacement of the current, highly inflationary system of retrospective reimbursement with a competitive system of prospective payment would be our primary recommendation for reforming institutional reimbursement.

The Federation of American Hospitals has long favored increased experimentation with prospective payments for hospital services based on negotiated rates or target rates established by a formula. Our association favors a major overhaul of the Medicare-Medicaid reimbursement system for institutional providers; however, we also believe that experimentation on a national basis involving several prospective payment methods is necessary to determine appropriate long range systems. As you know, such experimentation is authorized under Section 222 of Public Law 92-603. However, we have been disappointed with the Department's very cautious and limited use of that authority.

We generally support the determination of a target rate for routine operating costs as outlined in Section 10 of S. 3205, but have several recommendations to make.

We endorse the general approach of Section 10 which includes economic rewards for efficiency. By establishing a target based on average routine costs, the proposal seeks to inject competition among similar facilities. This is a more promising approach than the arbitrary cost ceilings advocated by some of the public-utility type rate regulation proposed by others. Inflexible caps would force a reduction in quality while utility type regulation protects inefficiencies by removing all competition.

We recommend that the incentive features of Section 10 be broadened to provide for provider retention of savings of up to 7½% of the first $100 of a routine cost target and up to 5% of any excess. This would place even greater emphasis on efficiency by reducing the reward for high cost institutions compared to lower cost facilities. At the same time the suggested revision would prevent windfall profits. A sliding scale for incentive payments is more equitable because it would make the dollar rewards more uniform for all hospitals.

The restrictions on reimbursement for those hospitals with routine costs more than 20% above the group average should be more flexible. The exception procedure should assure that no institution is penalized for costs beyond its control. Inefficiency should be penalized but unforeseen or uncontrollable events, such as physician strikes or extraordinary increases in malpractice insurance premiums, should be recognized as justifiable causes for cost increases.

Where the restrictions on reimbursement are imposed, the facility should be allowed to charge the program beneficiary for the difference between the reimbursement ceiling and its actual costs. This is now authorized by Section 223 of Public Law 92-603; however, that provision would be repealed by S. 3205 once Section 10 becomes operational.

That type of limited surcharge is quite different from coinsurance because it would be limited to a small number of hospitals and therefore, a small percentage of program beneficiaries. In addition, the beneficiaries would, in many instances, be able to select another facility where costs do not exceed the ceiling. This would add another element of competition by encouraging patients to consider taking a more active role in selecting a hospital. This would be possible where their physician has privileges in more than one hospital as well as in situations where the hospital is the point of entry for the patient.

We also recommend the following modifications to the definition of routine costs and the exception procedure:

Malpractice insurance costs should be excluded from routine operating costs in the determination of an average per diem for each category of hospitals. The cost of this insurance can vary tremendously from institution to institution within the same category depending on geographic location. Since this factor is beyond the control of the hospital, it should not be penalized by a target rate that doesn't take into account such cost variation.

In addition, there should be an exemption for new hospitals built with required planning approval to recognize the high start up costs as well as higher debt services of a new facility or wing. This exemption is needed because of initially low occupancy rates that push up the average per diem costs of new facilities making it unfair to expect those hospitals to compete with already established facilities. We recommend that new facilities be exempt from the target rate for their first full three fiscal years.

For similar reasons we suggest an exception for sudden and uncontrollable drops in occupancy in an established facility. The Economic Stabilization Program provided such an exception for reductions in occupancy of more than 5 percent.

Another concern is that recognition needs to be given to differences in treatment modality for psychiatric facilities. The legislation should require the Secretary to take into account the treatment modality of psychiatric hospitals and give recognition to the variation in personnel needs demanded by the different programs. State, and other public institutions should be separate categories from private institutions due to differences in scope of services.

Further, there is a need to stress that even within the non public sector, the specialty hospital category, such as psychiatric, needs to take into account type of programs. For example, a psychiatric hospital that has extensive shock treatment modality will have a very different pattern of personnel requirements than a psychiatric facility that has programs which have millieu therapy treatment. Yet these are all accepted and recognized treatment modalities for mental health care.

There are two other difficulties that we foresee in the implementation of this portion of the bill. Firstly, in establishing average per diem routine operating costs, it would appear that costs are to be determined on an historical basis with no provision made for adjustment for inflation purposes during the ensuing year. Thus, depending on the fiscal year of the hospital, these figures could be almost two years in arrears by the close of the hospital's projected or budgeted year. We recommend, therefore, that an actual hospital cost inflation factor be built into the bill for that period.

We urge the Subcommittee to recommend a "hardship" exception for other "unforeseen and uncontrollable" events which cause significant cost increases.

The concept of phasing-in new systems is laudable; however, in this instance we would urge a faster period for implementing Section 10. We believe this can be done by requiring a uniform reporting system instead of a uniform accounting system. This should save at least one full year in implementing the new payment system. We are concerned about the fairness and costs of imposing a uniform accounting system on a universe of hospitals which vary so in scope of services, size, and sophistication in accounting departments. The benefits of such a system may well be outweighed by the added costs and administrative problems.

CONTINUED EXPERIMENTATION

We believe that the performance-based reimbursement system outlined in S. 3205 represents a major step in making Medicare and Medicaid more cost efficient. However, it is essentially not a system of prospective rates. We believe that if payments are to be closely related to actual costs, they should be made on a predetermined basis. Therefore, although we favor the implementation of the target rate scheme proposed in S. 3205, we recommend that the Secretary be directed to engage in an intensive program of experimentation along prospective lines. Experimentation on a national basis involving several prospective rate methods is necessary to determine appropriate long range systems.

It is important to understand that because Medicare has not paid its fair share of institutional costs for providing services to program beneficiaries, health facilities have been forced to increase charges to non-government patients. The inflationary impact of Medicare has been felt throughout the health field. By changing the payment system to a predetermined rate, we can begin to reduce the annual inflation rate, but the Medicare program must first acknowledge its obligation to pay a fair rate for services rendered. There will, therefore, be no federal budgetary savings in the initial periods of experimentation with prospective rates. There should, however, be an immediate impact on inflation rates in charges to non-government patients as well as long range cost containment for the Medicare program.

An approach which we favor would be on in which the Secretary would consider and approve or disapprove a number of prospective rate systems developed by providers, third party payors and other interested parties subject to federal guidelines. At least three or more of these payment methods should be made available to hospitals, which would then make an annual selection.

When the Secretary determines that the number of hospitals choosing a particular payment method is not adequate enough to provide a sound base for evaluating that method, then the Secretary would withdraw it and allow the electing hospitals to select another method within thirty days.

Any prospective rate method authorized by the Secretary should include at least these basic provisions:

(1) Financial incentives for efficiency of hospital operations equal to the potential difference between the prospective rate and the actual rate;

(2) Medicare and Medicaid should pay their fair share of the total financial requirements to avoid cross-subsidization of those costs by private patients; and

(3) Substantial participation by hospitals in each prospective rate method.

In addition, any approved payment methods must take into account the hospital's total costs of operation and approved capital expenditures, including the costs of financing approved capital facility or services projects.

Finally, all payment methods must include provision for a return on investment for non-profit hospitals, with the Secretary determining annually a reasonable rate after considering rates of return on investment of comparable risk.

The concept of a predetermined rate for specific treatments on a per diem or per admission basis by diagnosis is one example of the type of prospective rate system we believe should be developed and tested. Other examples include a negotiated rate with a negotiated inflation rate for the second and subsequent years of the experiment: a negotiated discount from billed charges with a negotiated inflation rate for subsequent years; a budget review process limited to facilities whose rates exceed a percentile of group charges or costs; and payment of usual billed charges in return for an agreement by the facility to freeze charges to all patients for a specified period of time.

One final note on the classification system as proposed in the bill. As long as we are only concerned with routine operating costs as defined, classifying hospitals merely by size and type is sufficient. However, looking ahead to the time when the average target rate includes ancillary services, the classification system should then be revised to include such factors as geographic location, patient mix, and the age of the facility, in order to more accurately reflect the differences among facilities within the various categories. The target rate should also be determined on a per stay rather than a per diem basis.

RATE OF RETURN

We urge the Committee to amend the Medicare law to create a mechanism for the annual determination of a reasonable rate of return on investment. The Medicare rate of return should be equal to investments of comparable risk in other industries.

An adequate rate of return is necessary for a number of reasons, most importantly to: (1) protect the hospital's financial integrity and maintain its credit; (2) to reward investors at a level commensurate with the risk assumed in making their investment; and (3) to attract new capital for maintenance and needed expansion.

In no other industry are income taxes not recognized as an operating expense for purposes of cost based reimbursement or rate of return. The after-tax rate or return in every year of the Medicare program has been an annual average rate of return on common equity of 4.4%. In marked contrast, during that same period from 1966 to 1974, privately owned electric utilities have earned 12.0% after taxes on common equity, or 273% of the allowed Medicare return. Although "reasonable cost" language in the Medicare Act is similar to the language of the Interstate Commerce Act, the Federal Power Act and the Natural Gas Act, only the latter three have consistently been construed to include normalized income taxes (both federal and state), for example, as a cost. By eliminating taxes from the list of reimburseable costs, the Department of HEW has made the return on equity for investor-owned hospitals approximately 10% on a pre-tax basis or an after-tax return of approximately 5%. This is in marked contrast to the average after-tax return on equity for all industry in the U.S. of

14% in 1973. This included an after-tax return of 14.1% in the service industry and an after-tax return of 12% for public utilities.

Investor-owned hospitals must make a fair return on investment in order to be viable, and if the federal government refuses to pay its fair share, this increases the return needed from the private patients, in order to make the overall return acceptable. This is, in effect, an indirect subsidy to the federal government at the expense or private patients needing hospitalization. Such cross-subsidization represents not only a direct violation of the Medicare law, but is a major cause of inflation in the private sector of the health industry.

Only last month, in a case filed in the U.S. District Court for the District of Columbia, *Humana of South Carolina, Inc.* v. *Mathews*, Civil Action No. 75-0302, the court ruled that the Secretary of HEW must establish new guidelines for the determination of an appropriate rate of return on equity capital for investor-owned hospitals participating in the Medicare program. Humana contended that the current formula of one and one-half times the trust fund yield does not reimburse the reasonable cost of providing services insofar as a return on equity capital is such a cost and therefore, hospitals are forced to raise the charges of private paying patients. The court held that such cross-subsidization directly violates 42 U.S.C. § 1395x(v)(1)(A), the law governing the Medicare program. The Court directed the Secretary of HEW to make "a detailed study of the various factors affecting the economics of the proprietary hospital industry" in order to enable the Secretary to determine the actual level of return needed to provide a reasonable return on equity and avoid cross-subsidization.

The issue of reasonable and just rates of return has been addressed in a number of other important court cases. For example, in *Smyth* v. *Ames* (1898), the Supreme Court determined that, "The corporation may not be required to use its property for the benefit of the public without receiving just compensation for the services rendered by it." The court decision then proceeds to set forth factors which should be considered when determining a reasonable rate; these factors all revolve around the "fair value of the property being used by it for the convenience of the public."

The inclusion of federal income taxes as a recognized element of the cost of service, aside from being addressed in principal in *Smyth* v. *Ames*, was specifically conceded in the Supreme court's ruling in *FPC* v. *Memphis Light, Gas & Water Division* (1973) and in the case of *FPC* v. *United Gas Pipe Line Company*, heard in 1967. In the latter, the decision stated in part that, "One of (the Commission's) statutory duties is to determine just and reasonable rates which will be sufficient to permit the company to recover its costs of service and a reasonable return on its investment . . . Normally included as cost of service is a proper allowance for taxes, including federal income taxes."

The Federal Power Commission, the Civil Aeronautics Board, the Federal Maritime Commission, the Interstate Commerce Commission and the Federal Communications Commission all recognize that federal income taxes represent a proper service cost in determining a just and reasonable rate of return for a public utility.

Although we are gratified to see that S. 3205 attempts to correct this inequity by raising the allowance return to twice the rate on current hospital insurance trust fund investments instead of the current 1½ times, we believe that this is still insufficient. Section 12 would in effect increase the rate of return from 5% after taxes to 7% after taxes. That proposed increase would still fail to make the rate of return equal to investments of comparable risk.

We see three possible approaches to amending the Medicare law to improve the current rate of return on investment:

(1) Provide for an annual determination by the Secretary of a return equal to rates of return on investments in industries of comparable risk;

(2) Recognize income taxes as an allowable cost of doing business, reimbursable under Title XVIII; and

(3) Increase the current formula to at least three times the trust fund yield.

It would cost more than $6 billion in public funds to replace the beds built by investor-owned hospitals. If these hospitals are allowed to earn a fair return on investment (enough to encourage further investment), they will furnish a considerable portion of the future money needed for new hospital construction, thereby freeing public funds for other uses.

BUSINESS COSTS

Aside from the matter of income taxes, the present Medicare cost reimbursement formula disallows other costs of doing business as public companies, for example, those involving stock maintenance. Investor-owned corporations, like *all* publicly owned companies incur certain regular and recurring expenses related to legislative and regulatory requirements regarding public disclosure of the activities of these companies, as well as costs related to the maintenance of ownership records. Included in these are the costs of filing registration statements, legal fees, underwriting discounts, printing costs, accounting fees, filing fees, and consolidating statements for SEC purposes, costs of annual meetings and mailing of proxies. These costs are treated as a charge against capital; they are not included in the equity base and do not earn a return, as well as not being treated as reimbursable expenses. This means that the providers' equity is being reduced inappropriately. From a review of the basic Medicare law and regulations, we do not believe that this was the intent of Congress in providing for a return on equity.

A challenge to the Department's refusal to allow stock maintenance costs as reimbursable items under Medicare has been instituted in the U. S. Court of Claims (*AMI-Chanco, Inc. v. United States of America*).

We urge the Subcommittee to reconsider the current Provider Manual provision on stock maintenance costs, particularly in light of the fact that investor-owned corporations have no control over these legally required costs of doing business.

Hospitals fulfill an absolute, necessary, and vital function in serving the needs of the public. The costs in terms of the facilities themselves of fulfilling this function are enormous and are even greater for investor-owned hospitals, which must pay both state and federal income taxes, as well as property taxes. In 1974 alone, investor-owned hospitals paid $125.8 million in combined federal-state income taxes, and $46.3 million in property taxes. Since the inception of Medicare and Medicaid, the federal government has consistently refused to recognize its share of these additional costs. We believe that numerous judicial precedents as well as Title XVIII of the Social Security Act itself, dictate that this is totally unjustified.

We urge, therefore, that the Committee mandate the reimbursement of "all necessary and reasonable expenses of a public corporation."

CONVERSION ALLOWANCE

The Federation supports that provision of the bill which encourages closing or converting underutilized beds or services by including in the hospital reasonable cost payment, reimbursement for costs associated with closure or conversion. However, in the case of for-profit hospitals, only increased operating costs would be recognized; capital costs would be disallowed.

We believe that regardless of ownership, hospitals should have both their capital and increased operating costs associated with closure or conversion recognized. To differentiate on the basis of ownership raises serious constitutional questions. If there are two hospitals located in a community—one non-profit, the other investor-owned—and the community believes that the investor-owned facility should be closed or converted to another use, the provision as presently stated provides no incentive for the investor-owned hospital to acquiesce. After all, no facility can be expected to shut down and retire its debt without benefit of patient income. The question should be "What is best for the community?" Then all costs connected with closing or converting the facility—regardless of ownership—should be recognized.

This provision is essentially experimental, limiting transitional allowances to only fifty hospitals per year for the first two years of operation. The Secretary would review all recommendations forwarded by the Hospital Transitional Allowance Board; however, there would be no appeal of the Secretary's final decision. We recommend that when the program becomes more than experimental, these decisions become subject to judicial review.

HOSPITAL BASED PHYSICIAN REIMBURSEMENT

Insofar as control of physician reimbursement is concerned, we can understand the desire to discourage potential abuse or excessive payments by limiting the

reimbursement for certain hospital based physicians. However, we believe that the actual method of payment—be it fixed fee, or percentage, lease, or direct billing arrangements—should be left to the discretion of hospital management. By restricting payments to a fixed fee, many rural areas might be unable to attract the services of these specialists.

We would not, however, be opposed to screens being applied to the final result of the hospital physician negotiations using a technique similar to the 75th percentile of the prevailing payment levels in the area.

Finally, there should be a "grandfather" clause covering all contracts made prior to enactment of S. 3205 between hospitals and hospital based specialists.

HOSPITAL CONTRACTS

The Federation strenuously opposes Section 40 of the bill. This Section authorizes the Secretary to review and give prior approval of all contracts involving amounts of $10,000 or more. In addition, reimbursement to contractors, consultants, etc. at any level would not be recognized where payment was based on a percentage arrangement.

Section 10 of the bill precludes the need for the kind of line-by-line budget examination proposed in Section 40. Under the proposed target rate, the concern is properly with the total costs, not with all the individual components that go into that final figure. Hospitals are given incentives to come in under the target rate, or at the very least make sure that their per diem routine operating costs do not exceed 120% of the average rate determined for their category. This factor in itself would serve to prohibit the negotiation of contracts that are excessive.

Furthermore, empowering the Secretary to give prior approval to all contracts involving $10,000 or more would create an administrative nightmare. The daily operation of a hospital could conceivably come to a halt while the Secretary reviews a mountain of contracts involving linens, dietary services, building maintenance, emergency room physicians, therapy services, communication systems, leases, security guards, management, etc.—the list is endless. Again, these individual components are all covered by the Section 10 target rate, and should be left to the discretion of the administrator and board governing the hospital.

CONCLUSION

In conclusion, we believe a thoughtful reassessment of the administration of the Medicare and Medicaid program is in order. We are encouraged by the development of the legislation presently before this Committee, particularly in the area of performance-based incentive reimbursement for hospitals.

Other legislation has been proposed or introduced to "reform" these programs, but from a very narrow perspective: that of mere bottom line cost control. These crude attempts seek to place flat, arbitrary limits on institutional Medicare reimbursement, without any attempt to understand the causes of rising health costs, much less furnish providers with any constructive incentives to counter this trend. The issue of quality of care, which goes hand in hand with a discussion of costs, is totally ignored.

S. 3205 is the result of a great deal of well-thought out labor on the part of the Subcommittee Chairman, the Members, and the Committee staff. On its own it may be considered a bill with a great deal of merit; compared to the arbitrary cost control schemes alluded to above, it is particularly commendable.

We do have certain objections to S. 3205, as well as recommendations that may be applied to those sections which we support. These have all been mentioned in our testimony. Working from the solid base provided by this bill, we believe that modifications may be made to improve the bill.

We commend the Committee for taking the lead in revitalizing and reforming Titles XVIII and XIX of the Social Security Act, and thank you for this opportunity to present our views, particularly in the area of performance-based incentive reimbursement for hospitals.

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We commend the Committee for taking the lead in revitalizing and reforming Titles XVIII and XIX of the Social Security Act, and thank you for this opportunity to present our views.

SUPPLEMENTAL REMARKS OF JOHN A. BRADLEY, PH. D., PRESIDENT, FEDERATION OF AMERICAN HOSPITALS

Mr. Chairman, the experience of my company, American Medicorp., Inc., demonstrates rather graphically the undesirable consequences of requiring administrative review of such contracts. Building on the expertise gained from running its own 36 acute-care hospitals, American Medicorp has been active in marketing these hospital management skills to others. The results have been dramatic. At Braintree Hospital in Braintree, Massachusetts, the census at this rehabilitation facility has doubled in the first six months of management, and the total operating cost per patient day has been reduced from $197 to $143. At Saint Mary's Hospital in Philadelphia, a non-profit facility owned by the Third Order of the Sisters of St. Francis, professional management techniques and controls saved this facility from an almost certain demise and moved it from a quarter of a million dollar annual deficit to an operating surplus of $100,000 in 1975.

These contracts are complex and were the subject of extensive negotiation. Contracts of this type often require financial subsidy by the manager, deferment of fees until the hospital is in sounder financial condition, and other provisions which are highly subjective and tailored to the situation and would make the administrative determination of reasonableness virtually impossible. Moreover, having to have such contracts reviewed and approved in advance by the Secretary would involve many months of delay and in the cases of both Braintree and St. Mary's delay would have, in all likelihood, made it impossible for them to survive.

The administrative nightmare of prior approval of literally thousands of agreements is a bureaucratic burden that we feel should not be adopted. The cost elements resulting from these contracts are all covered by the Section 10 target rate, and their reasonableness and cost effectiveness will be controlled by the proposed target rate reimbursement system.

[From the Wall Street Journal, Wednesday, July 21, 1976]

CALLING FOR HELP—MORE HOSPITALS TURN ADMINISTRATION OVER TO OUTSIDE COMPANIES

THE 19 FIRMS IN FIELD OFFER MANAGERS AND COST CUTS; IMPACT ON QUALITY CARE?

Moving Sutures to Tarzana

(By Janice C. Simpson)

LAS VEGAS.—Southern Nevada Memorial Hospital was sick. Some of the symptoms:

Four administrators, four directors of nursing and 12 controllers had come and gone in eight years at the county-financed hospital.

Billing had fallen a year behind.

Occupancy had sunk to 65% as doctors moved their patients to the city's three privately owned hospitals, which were better equipped and more smoothly run.

The hospital's cash flow had turned so weak that nurses had to run out to nearby drugstores to buy supplies.

Sixty suppliers had refused to make deliveries until the hospital could settle its overdue accounts.

Finally, last spring, the medical staff issued an ultimatum: Improve conditions at Memorial or we will walk out. Agreeing that the hospital needed professional management, the Clark County Board of Commissioners, the hospital's governing body, signed a $295,000-a-year contract for three years with Hyatt Medical Management Services Inc., of Encino, Calif.

SPECIALIST ARRIVE

Within days, 15 Hyatt people, including specialists in billing, purchasing, public relations, personnel, reimbursement procedures and housekeeping, arrived on the scene. Within two weeks they identified problems and made recommendations on how to correct them. Then they showed the Memorial staff how to put those suggestions into action. They also helped the hospital take advantage of various cost-saving plans, such as bulk purchasing, that are available to Hyatt clients.

In less than three months, the hospital was back in the black. Morale was up, supplies were coming in, bills were going out promptly and occupancy was climbing.

A few years ago, Memorial probably would have hired another hospital administrator and hoped for the best. But increased government regulation, the development of third-party reimbursement systems such as Medicare and Medicaid, and the rising costs of hospital equipment and employee salaries have made the administrator's job too much for one person to handle.

"One hospital administrator can't know everything about hospital management nor would he have the time to do everything that would have to be done," says Ellsworth Taylor, a spokesman for the American Hospital Association.

MORE SIGN CONTRACTS

For an increasing number of hospitals, an attractive alternative to the single administrator is contract management—turning day-to-day supervision over to hospital-management companies, which have sprung up over the last five years. These companies own some hospitals and manage others.

About 130 U.S. hospitals have signed contracts with such companies, according to the Federation of American Hospitals, a group that represents proprietary, or for-profit, hospitals. Fees range between roughly 3% and 8% of the hospital's gross revenues. However, more are being negotiated for flat fees.

Most of the contract hospitals are small, with fewer htan 100 beds. But Memorial has 302, and the 300-bed Tulane University Hospital in Louisiana has signed on with a management company. So has New York City's 405-bed Flower & Fifth Avenue Hospital. Hopsitals in France, Mexico, Panama and Saudi Arabia have also signed contract with U.S. companies.

Hyatt Medical Management Services is part of Hyatt Medical Enterprises, which is a subsidiary of Hyatt Corp., known mainly for its hotels. The management company is one of 19 such firms that sell modern business techniques and cost-saving services to hospitals with financial or administrative problems. The bigger ones are Hospital Corp. of America, American Medicorp, Hospital Affiliates Inc. and Hyatt.

Most of the management companies are also chains of private, for-profit hospitals. Their move into the contract management field worries some observers, who question whether absentee managers can be sensitive to local needs; whether the loyalty of the administrator, who is often placed on the management company's staff, will be compromised when he remembers who issues his paycheck, and whether necessary but unprofitable services will be dropped for the sake of balancing the budget.

"There is the hazard of overemphasizing the purely financial in the hospital at the sacrifice of quality care," cautions Richard Stull, president of the American College of Hospital Administrators.

Donald Bigler, vice president of the board of directors at Victor Valley Hospital in Victorville, Calif., agrees that contract management can concentrate too heavily on money matters. "At our local level, we know the physicians, so our decisions aren't determined by the purely financial. But for an outsider, "the business projections take priority," he says. Victor Valley terminated a contract with Hyatt when board members decided that the company's services, specifically

those involved in planning a hospital expansion program, weren't producing the expected results.

The management companies insist, however, that hospitals can be businesslike and provide quality care at the same time. They also point out that hospitals can cancel contracts, as Victor Valley did, if they aren't satisfied with the results.

Many health-care experts believe that the skills these companies can provide outweigh any disadvantages. Certainly the companies' high salaries, plus the promise of advancement, enable them to attract the kind of talent that most small hospitals can't afford. "You can get a super finance guy if you've got 50 hospitals" paying his salary, says Montague Brown, a Duke University professor of hospital administration.

A management company also can reduce hospitals' costs by negotiating group insurance rates for them, by dividing the cost of data-processing equipment among them and by setting up bulk purchase contracts with suppliers, contracts that the companies say can save hospitals up to 30% on their orders.

Managers can also provide coordination between hospitals. For example, the Hyatt inventory-control manager recently transferred $3,000 worth of sutures to the Medical Center of Tarzana, near Los Angeles, from Eastwood Hospital in El Paso, Texas. The El Paso hospital had overordered.

Not all management companies are run by for-profit chains. Nonprofit groups such as the Lutheran Hospitals and Homes Society in North Dakota offer similar services. The Lutheran Society was founded in the 1930s when a small group of nonprofit hospitals in North Dakota, each unable to afford the expertise it needed, banded together and shared the costs. The administrator flew his own plane from hospital to hospital.

Typically, the nonprofit groups don't advertise. The profit-making chains, on the other hand, advertise and recruit customers with what one client calls "a hell of a salespitch."

These chains got into the health-care business back in the 1960s when Medicare and Medicaid brought new dollars into the industry and made owning and operating hospitals look like a good investment. The chains acquired hospitals owned by small groups, usually doctors who were eager to exchange the problems of running a hospital for the pleasure of practicing medicine, and they built their own.

ACTIVITY CURTAILED

High interest rates in the early 1970s curtailed construction activity, however, and "most of the acquisitions that were to be had, were had," says a spokesman for the Federation of American Hospitals. The companies began looking into the possibility of contract management and decided they liked the idea. Fulfilling a contract, they reasoned, wouldn't involve large capital outlays, as building or buying a hospital did, so profits could start flowing faster—usually in under a year, they figured, and they figured right.

Hyatt Medical Enterprises' contribution to Hyatt Corp. earnings has increased steadily in recent years. For the fiscal year ended Jan. 31, 1976, it contributed $1.4 million, or 17 cents a share, on revenues of $58 million, greatly helping corporate earnings that sagged because of poor hotel occupancy in 1975.

Today, Hyatt Medical Enterprises employs 60 full-time professionals in the health-care field who work directly with their counterparts at the client hospitals. It own six hospitals and manages 18 others. The flagship of the managed hospitals is Las Vegas' Memorial.

Hyatt was helped at Memorial by the creation of a new board of trustees with greater powers than its predecessor—one of its first moves was to hire Hyatt—and by a $1 million bank loan that quieted angry suppliers. But most of the people who have been closely involved with the hospital agree with Ann Valder, director of public relations, who says, "If you don't have the administration and the know-how, you're still going to bumble." They credit Hyatt with preventing the bumbling.

Confidence in Hyatt wasn't always that strong. Dahl Gardner, assistant administrator, was frightened at first about his own job security and the hospital's future. "I thought, when they came, 'Oh, my God, they're going to go for the buck,'" he recalls. Now he says that while Memorial is more efficient and businesslike, "every decision doesn't revolve around the cost ratio."

A NEW ADMINISTRATOR

When Hyatt takes over management of a hospital, it either keeps the old administrator, names one of its own people to the post or brings in an administrator from elsewhere. In the case of Memorial, it took the third course: It brought in George Riesz, an experienced administrator, from the Cedars-Sinai Medical Center in Los Angeles. Mr. Riesz says he probably wouldn't have taken the Memorial job if there hadn't been a management team backing him up. (His salary, about $45,000 a year, which Hyatt pays out of its contract fee, would have priced him out of Memorial's range anyway.)

Mr. Riesz concedes that because of the presence of the Hyatt team, "in many ways I feel that I'm not chief executive officer." But he adds that there are benefits for an administrator in contract management: The Hyatt team can spot trouble early; it affords Mr. Riesz the leisure of concentrating on specific problems rather than trying to solve everything at once, and it increases his influence with the board of trustees. One trustee says, "He doesn't have to fear what he says to the board because Hyatt will take care of him. It makes him a lot more incisive and effective."

Aided by Hyatt reports and recommendations, Mr. Riesz raised Memorial wages about 9% but renegotiated lower pay scales with hospital-based physicians such as pathologists and anesthesiologists. He raised daily room rates an average of $10. He enlarged the rehabilitation center, which had had a waiting list, to 28 beds from 12.

A new controller, also recruited by Hyatt but not on its payroll, organized a billing system under which late payers were contacted within 30 days of the due date, and he developed procedures for getting Medicaid and Medicare funds due the hospital. Memorial also went on the Hyatt bulk purchasing plan, and its warehouse inventories were put on the company's computer system so that orders could be placed in advance of need.

As Memorial settles into its new routine, the Hyatt people spend less time at the hospital, although they still make regular visits. The Memorial staff doesn't seem inhibited by their presence. "They've learned the secret of being unobtrusive," one doctor says. "They're just there when you need them."

Senator TALMADGE. Next we will hear from Mr. Jeffery Cohelan.

STATEMENT OF JEFFERY COHELAN, EXECUTIVE DIRECTOR, GROUP HEALTH ASSOCIATION OF AMERICA, INC.

Mr. COHELAN. Mr. Chairman, I will make my brief statement and then I will be followed by Mr. James Lane, counsel for the Kaiser Foundation Health Plan. We are both accompanied by Mr. Gibson Kingren, vice president of the Kaiser Foundation Health Plan, Inc. After our statements, we will be pleased to respond to questions.

Mr. Chairman, members of the committee, my name is Jeffery Cohelan and I am executive director of the Group Health Association of America. GHAA is an association representing the major prepaid group practice plans and health maintenance organizations in the Nation. My statement this morning deals in the main with section 41 of S. 3205 and with the treatment of HMO's generally under medicaid and medicare.

Mr. Chairman, you, the members of this committee, and your able staff are to be commended for its surveillance of the medicare and medicaid programs. S. 3208 represents your second effort to bring these massive programs under prudent management in order to assure decent health care to the eldery and the poor. Your work in securing passage of Public Law 92-603 and in the drafting of the present amendments will go far in assuring that these programs will be administered in a manner which people have a right to expect of their Government. We support and congratulate you, Mr. Chairman.

Our main concern in S. 3205 is with section 41, which sets forth three general criteria for payments under medicaid to health maintenance organizations. First, such HMO's must meet the definitional requirements of section 1876 of the act. Second, the HMO is required to have an enrolled population at least half of which is nonmedicaid or medicare except for certain geographic areas with high medicaid-medicare populations. Third, the reimbursement mechanism must be substantially similar to those required by section 1876.

Mr. Chairman and members of the committee, we oppose the third requirement and urge amendment of medicare and medicaid to provide a fairer reimbursement to HMO's.

HMO's are now the subject of a developmental program passed by the Congress in 1973 as a result of the experience of the proven capability of prepaid group practice plans to provide high quality comprehensive health care with a great degree of economic efficiency. The thrust of the developmental program is to introduce HMO's on a broad scale as a competitive alternative to the fee-for-service system, which will serve in an appreciable measure to make medical care delivery more efficient through the operation of marketplace forces.

The health maintenance organization accomplishes these desirable results through a system of fixed prepayment on a capitation basis which obligates the HMO to render comprehensive care on a risk basis. With risk and through varied arrangements with the providers of care, the HMO has a natural incentive to operate economically and efficiently as well as render high quality care. Failure in either of these regards will either financially burden the HMO or lead to a loss of enrollees or both.

It is ironic that neither medicare nor the proposed medicaid amendment fully recognize these inherent HMO principles. Even though section 1876 does permit prepayment, the HMO must share the savings with the government.

We sympathize with the committee's desire to prevent the abuse and alleged fraud practiced by a few unscrupulous medicaid entrepreneurs in California—my State—and other regions of the country. These cases have been the subject of several investigations by the Congress, the GAO and local agencies. The findings were shocking not only because of the misuse of a federal program but also because of the hardships they cause the poor beneficiaries.

Senator TALMADGE. Your full statement will be inserted in the record. Proceed to summarize.

Mr. COHELAN. Surely these abuses must be stopped. We believe this committee, through enactment of the fraud and abuse provisions of S. 3205 as well as the first two provisions of section 41, will control them. Fraud will be treated as a felony. Medicaid contracts on a capitation basis may only be with HMO's, who are subject to Federal regulation and mandate, and HMO's themselves will have an enrollment at least half of which is drawn from the nonmedicaid/medicare sectors. A "medicaid entrepreneur" will find it virtually impossibe to operate with these new restrictions.

By comparison, these abuses are but a small percentage of the major problem, and it suggests that we really need some kind of competitive mechanism in the health care delivery system. Surely these practices must be stopped.

But we see neither the need nor logic for applying a reimbursement formula which does not fairly and equitably reimburse an HMO on the same prospective basis as it receives reimbursement for its other members. The reimbursement formula should be based on similar costs for medicare-medicaid services in the fee-for-service community with appropriate actuarial adjustments. Savings achieved by the HMO should be used by the HMO in providing additional benefits to the medicare-medicaid member. In this way, the member will be afforded the full advantage of HMO membership on the same basis as any other member. The Government in turn will have afforded the same or a fuller range of benefits than those provided in the statutes with no additional cost to it.

Mr. Chairman and members of the committee, passage of the HMO Act in 1973 amounted to a congressional ratification of the successful operation of prepaid direct delivery health systems where and when they have been tried. Indeed, most of the sponsors of the various national health insurance proposals have included the HMO alternative in their proposals. We believe this to be an expression of confidence in our system and its worth as part of health care delivery in the United States.

We ask that the medicare and medicaid programs share that confidence. An equitable reimbursement and sound HMO management with appropriate Federal oversight will indeed guarantee these results.

Thank you.

Senator TALMADGE. Thank you, Mr. Cohelan.

Senator TALMADGE. Mr. Lane, you may summarize your statement and it will be inserted in the record.

STATEMENT OF JAMES A. LANE, COUNSEL, KAISER FOUNDATION HEALTH PLAN, INC.

Mr. LANE. My name is James Lane. I am counsel for Kaiser Foundation Health Plan. As an introduction, I would say that our program now serves over 3 million members in 6 States throughout the country. We have over 125,000 medicare members and over 20,000 members receiving services under 19 prepaid contracts.

The purpose of my presentation is to discuss how S. 3205 will affect hospital-based prepaid group practice programs and to suggest appropriate amendments. The bill proposes substantial changes in the medicare and medicaid programs. Many of them, innovative but untried, merit careful study and consideration. Some would make significant improvements in the programs and should be enacted. However, others appear to offer little to the solution and should be deleted.

A major thrust of the bill is cost containment. Our program is dedicated to the effective, efficient delivery of health care services along with other prepaid group practice programs in the country.

We believe Congress should amend the law so that such programs have an opportunity to provide services and receive payment for them in a manner that emphasizes their basic strengths. For too long such programs have been forced, to the disadvantage of their members, to participate in medicare and medicaid under rules designed for fee-for-service providers.

I would like to make four basic points about the bill; the first as to the hospital reimbursement proposal. These criteria are to be added to the existing cost determining provisions and will result in a cap on allowable costs. A hospital may receive an equal to or more or less than its actual operating costs, depending upon its "adjusted per diem payment rate for routine operating costs."

However, the amount received may have no relation to what the hospital's cost should be because it will be determined in an arbitrary manner. There is no reason to believe that the routine operating costs of any hospital should be the same as the average routine operating costs of all hospitals within its classification.

A more certain relationship exists between the intensity of care provided and routine operating costs. There is little doubt that the more serious cases a hospital has, the more its routine operating costs will be. This fact presents a serious problem for hospital-based prepaid group programs. Such programs generally have hospital utilization rate—that is, hospital days per 1,000 persons—that are approximately one-half those of the traditional fee-for-service system. This is because only persons actually requiring hospital care are hospitalized and they are kept only as long as necessary. This results in more intensive cases and thus higher costs per day, but not higher costs overall. Therefore, hospitals of such programs may be unfairly penalized by the proposed system unless the provision relating to intensity of care provides an adequate adjustment, and we commend the committee for placing such a provision in the bill.

However, since the Social Security Administration has been attempting unsuccessfully for several years to devise an intensity factor for use in reimbursing hospitals for routine costs, we are apprehensive about the ability to develop a satisfactory approach to quantification of this factor.

In addition, we think three changes are necessary in the formula. First, we believe there should be a classification for HMO-based hospitals. These hospitals, as the chairman indicated, are similarly situated and should be compared with each other and not request fee-for-service hospitals.

Second, the hospital wage rate adjustment which is in the bill is a commendable feature of the bill, but is only allowed for 1 year. It should be made a permanent feature of the bill and not limited.

Third, the system should be ranged in to take true prospective payment system instead of a retrospective system, which it is at the present time.

Section 41 of S. 3205 would amend title 19 to provide that prepaid programs under medicaid must be paid substantially in the same manner as provided for under section 1876 of the Social Security Act.

As you undoubtedly know, this section should be deleted from the bill. Even though section 1876 was enacted in October 1972, it has not been implemented. It is untried and unproven.

On the other hand, a number of States have successfully implemented title 19 prepaid programs. None of these programs uses the section 1876 method of payment. Requiring States to apply section 1876 to title 19 contracts probably will result in the elimination of most prepaid programs under medicaid.

So that section may result in the termination of many prepaid programs under title 19 throughout the country because there is no section 2 at this time.

Since if you are going to tie hospital reimbursement of our hospitals to the fee-for-service system, we feel that will be a disadvantage. We request that section 1876 be modified.

Senator TALMADGE. Mr. Lane, I hate to interrupt you, but your 10 minutes have expired.

As a point of information, our data on the 10-percent sample of all hospitals covered under medicare, it seems to show that if the hospital reimbursement system in our bill were in effect, there would be no correlation between the hospital's average length of stay and whether or not it would be penalized or rewarded.

Nevertheless, if it appears that this might be a problem, we would be pleased to work with your organization and attempt to develop it. I suggest you stay in touch with our staff on the development in the legislative process.

Senator Curtis.

Senator CURTIS. I would like to ask you a question. I think it will help us to understand the problem if you would tell us what types of abuses are taking place.

Mr. COHELAN. Unfortunately, the areas in which the abuses occurred within my State of California, as you no doubt know and those organizations are not eligible for membership in my organization and never have been.

Senator CURTIS. Don't give any names, but tell us what type of an abuse exists.

Mr. COHELAN. I am just unable to do so because I am not familiar with the organizations. I only know about the newspaper accounts.

Maybe Mr. Lane can comment on it.

Mr. LANE. Most of the abuses in medicaid programs in California were associated——

Senator CURTIS. The man referred to HMO.

Mr. LANE. Yes. In California they are called prepaid health plans, and they are not HMO's under the Federal act, and most of the abuses reported in the press related to solicitation and there were allegations, many of which were proven, that they were using unethical solicitation methods to gain medicaid members. They go door-to-door. They dress in white coats. They claim they are social workers or physicians and try to sign individuals up on that basis.

Most of those abuses have been stopped at this time.

Senator TALMADGE. Senator Curtis, in further answer to that inquiry, Senator Nunn, my colleague from Georgia, will be the first witness Thursday, July 29, and I understand the standing investigation committee of the Committee on Government Operations—he has been acting chairman during this year—will have substantial light to throw on the question you asked.

Senator CURTIS. The only ones you know about are those relating to soliciting members. Are there any abuses after they get them?

Mr. LANE. There have been allegations and I believe some substantiation of lack of adequate care; not being open at the times promised to the State, not having the physicians and other individuals available at the time promised and not having the proper finances.

Senator CURTIS. What type of individual organizations sponsor these groups? Are they individual hospitals or a group of doctors? Who sponsors them?

Mr. LANE. Well, one of the problems in dealing with them are sponsored by all sorts of organizations. For example, our organization has such a contract and it has never been placed in question. They are also sponsored by county foundations, and those have never been placed in serious question. The ones that are generally placed in question are what you might call entrepreneurial models or broker models in which an individual enters into a contract with a State and then enters into contracts with individual physicians and hospitals and tries to put a package together and often does not fulfill his promises.

Senator CURTIS. Are they receiving any Federal funds?

Mr. LANE. I am not sure whether they are or not, but not to my knowledge.

Senator CURTIS. Not to your knowledge?

Mr. LANE. Well, some prepaid health plans receive Federal funds, but I am not sure the ones that are accused have funds.

Are you talking about the Federal development funds?

Senator TALMADGE. Senator Nunn says they are.

Mr. LANE. The whole purpose of the prepaid health care in California was to service health care recipients. But I don't believe they have HMO developments, the ones that are being accused of abuses.

Senator CURTIS. Did they exist before the Federal act?

Mr. LANE. Some of them did. Our program has been in existence over 30 years. Many others have been in existence for a substantial length of time. The ones that are generally accused of abuses came into existence as a result of the Medical Reform Act of 1972 and they sprang up and were sponsored by the State government and the basic government is that the State government did not fulfill its responsibility to release the Federal.

Senator CURTIS. The problem should be met by the State government?

Mr. LANE. The State government is moving to meet the problem and has solved substantial portions of it. There are now substantially fewer such programs in California than there were in the heyday, and most of the ones that have gone out of business were in bad operators.

Senator CURTIS. Do you need any more Federal legislation in order to clean up these organizations in California?

Mr. LANE. In my opinion, you don't. What you really need is some good administrators in the California system, and they are working towards getting some. It is not that easy to do.

Senator CURTIS. Are they Federal officers?

Mr. LANE. No; they are State officials.

Mr. COHELAN. Senator, I would like to make one comment. I think it is very important that they make a distinction between these kinds of entities and the kinds of entities that are eligible for membership in the Group Hospital Association of America or those that qualify under the acting 93233.

As a matter of fact, there are mandated requirements. There are some amendments pending, but even there in order to be a qualified program they would have to meet certain standards.

Senator CURTIS. What do they spend the funds for?

Mr. COHELAN. The funds that are in the bill for planning and for development.

Senator CURTIS. No; not in this bill. I mean under the current law the HMO's that you are referring to that are geting Federal funds; what are those funds for?

Mr. COHELAN. Under the Social Security Act or under the HMO?

Senator CURTIS. Anything that the HMO's get as organizations; what are those funds for?

Mr. COHELAN. Those funds are for development and for planning—planning development. There are some loans and grants in the program and then there are some funds for early operations.

Senator CURTIS. Now what is planning? Is that synonymous with promotion?

Mr. COHELAN. Well, it is to determine whether or not it is a feasible and viable program because as you know, Senator, these are very complicated systems and require a great deal of capital financing in order to launch.

Senator CURTIS. How much of the spending on that?

Mr. COHELAN. I think the bill has in it about——

Senator CURTIS. I am talking about the current situation.

Mr. COHELAN. The amounts that have been spent in the current budget, there are $26 million for the HMO general program.

Senator CURTIS. That includes planning?

Mr. COHELAN. That includes everything. In fact, it is underfunded. We asked before one of the committees of the Congress that they provide $50 million, but there were $26 million in the labor HEW bill.

Senator CURTIS. Aren't some of your best plans those that existed before this?

Mr. COHELAN. Yes, sir, that is correct. And those are the plans that we represent.

Senator CURTIS. And they are not sharing this money?

Mr. COHELAN. They are all going to qualify under the Federal act, Senator, and this is a private—no, they are not sharing in any money, that is correct. They organized before the program.

Senator CURTIS. Getting along without it?

Mr. COHELAN. They were able to finance their programs independently of Federal money, with one or two exceptions. There was some money for Hill-Burton Hospital development, but even there I think there was only one instance where the Kaiser Foundation Health Plan took advantage of those programs.

I want to say now, as the executive director of my organization, Kaiser is our largest member. We represent many others throughout the country. Many of our other organizations did in fact benefit by some of the Federal programs in the hospital area and some in the HMO program.

Senator CURTIS. That is all, Mr. Chairman.

Senator TALMADGE. Thank you very much. We appreciate your contribution, gentlemen.

[The prepared statement of Mr. Lane follows:]

STATEMENT OF KAISER FOUNDATION HEALTH PLAN, INC.

SUMMARY

Mr. James A. Lane presented the following statement regarding S. 3205 on behalf of Kaiser Foundation Health Plan, Inc., the largest comprehensive group practice prepayment program in the United States.

(1) The proposed system for setting hospital rates for "routine operating costs" would result in arbitrarily established rates. Some hospitals will be unfairly rewarded by such a system while others will be unfairly penalized. It is probable that hospitals which are essential components of hospital-based prepaid group practice programs and primarily serve their members will be unfairly penalized despite the fact that studies indicate that such hospitals and programs are saving Medicare substantial sums.

(2) Prepaid programs under Medicaid should not be required to be reimbursed pursuant to the untried provisions of Section 1876 which have not been implemented even though it is nearly four years since the section was enacted.

(3) S. 3205 should include amendments to Section 1876 that provide for fixed payments which are prospectively determined and give an HMO the option of assuming all the losses or savings of the program or sharing them with Medicare.

(4) S. 3205 should include amendments to Title 19 that require states to undertake good faith efforts to enter into contracts with prepaid programs and preclude states from imposing additional or conflicting conditions of participation upon qualified HMOs.

(5) S. 3205 should include amendments to Section 122 that eliminate HMOs from the section and thus treat HMO providers in the same manner as other providers.

STATEMENT

Mr. Chairman and Members of the Committee: I am James A. Lane, Counsel for Kaiser Foundation Health Plan.

INTRODUCTION

Kaiser Foundation Health Plan, Kaiser Foundation Hospitals, and six independent Permanente Medical Groups comprise the Kaiser-Permanente Medical Care Program. It is an economically self-sustaining, organized health care delivery system that provides prepaid health services on a direct-service basis to over 3,000,000 members in California, Oregon, Washington, Hawaii, Ohio, and Colorado. All members join voluntarily and remain members by choice. They receive covered services from 25 hospitals, 66 outpatient facilities and more than 3,000 contracting physicians.

The Kaiser-Permanente Program is the largest group practice prepayment plan in the United States. As an organized system of health care delivery, the Program accepts responsibility for organizing and providing direct health care services. The Program has pioneered many features that Congress sought to encourage by enactment of the Health Maintenance Organization Act of 1973, such as comprehensive services, an organized system of peer review, cost control, and dual or multiple choice of health benefits plans for employees.

Our Program has over 125,000 Medicare members. The Program provides services to over 20,000 Medicaid recipients under Title 19 prepaid contracts with four states. In addition, the Permanente Medical Groups and Kaiser Foundation Hospitals provide health care on a fee-for-service basis to nonmembers who are Medicare beneficiaries and Medicaid recipients.

The purpose of this statement is to discuss how S. 3205 will affect hospital-based prepaid group practice programs and to suggest appropriate amendments. The bill proposes substantial changes in the Medicare and Medicaid programs. Many of them, innovative but untried, merit careful study and consideration. Some would make significant improvements in the programs and should be enacted. However, others appear to contribute little to the solution of existing problems and should be deleted.

A major thrust of the bill is cost containment. We appreciate the Congressional concern with rising health care costs which have increased significantly Medicare and Medicaid budgets. Our Program is dedicated to the effective, efficient delivery of health care services along with other prepaid group practice programs in the country. We believe Congress should amend the law so that such programs have an opportunity to provide services and receive payment for them in a manner that emphasizes their basic strengths. For too long, such programs have been forced to the disadvantage of their members to participate in Medicare and Medicaid under rules designed for fee-for-service providers.

Congress has established a national policy of encouraging the development and growth of health maintenance organizations in order to make them available to persons throughout the country. Even where HMOs exist, they may not be available to Medicare and Medicaid beneficiaries. The amendments we are recommending would improve this situation and should be adopted.

SUMMARY OF MAJOR POINTS

This presentation emphasizes the following points:

(1) The proposed system for setting hospital rates for "routine operating costs" would result in arbitrarily established rates. Some hospitals will be unfairly rewarded by such a system while others will be unfairly penalized. It is probable that hospitals which are essential components of hospital-based prepaid group practice programs and primarily serve their members will be unfairly penalized despite the fact that studies indicate that such hospitals and programs are saving Medicare substantial sums.

(2) Prepaid programs under Medicaid should not be required to be reimbursed pursuant to the untried provisions of Section 1876 which have not been implemented even though it is nearly four years since the section was enacted.

(3) S. 3205 should include amendments to Section 1876 that provide for fixed payments which are prospectively determined and given an HMO the option of assuming all the losses or savings of the program or sharing them with Medicare.

(4) S. 3205 should include amendments to Title 19 that require states to undertake good faith efforts to enter into contracts with prepaid programs and preclude states from imposing additional or conflicting conditions of participation upon qualified HMOs.

(5) S. 3205 should include amendments to Section 1122 that eliminate HMOs from the section and thus treat HMO providers in the same manner as other providers.

THE HOSPITAL REIMBURSEMENT PROPOSAL

S. 3205 proposed additional criteria for determining the reasonable cost of hospital services. These criteria are to be added to the existing cost determining provisions and will result in a cap on allowable costs for "routine operating costs." A hospital may receive an amount either equal to, or more or less than its actual routine operating costs, depending upon its 'adjusted per diem payment rate for routine operating costs'. However, the amount received may have no relation to what the hospital's costs should be because it will be determined in an arbitrary manner. There is no reason to believe that the routine operating costs of any hospital should be the same as the average routine operating costs of all hospitals within its classification.

In addition, the bed classifications are obviously arbitrary and to the extent that bed size is relevant in determining routine operating costs, some hospitals may receive inadequate payment merely because of the number of beds they have. However, the relationship between bed size and routine operating costs is questionable.

A more certain relationship exists between the intensity of care provided and routine operating costs. There is little doubt that the more serious cases a hospital has, the more its routine operating costs will be. This fact presents a serious problem for hospital-based prepaid group practice programs such as ours. Such programs generally have hospital utilization rate (i.e., hospital days per thousand persons) that are approximately one-half those of the traditional fee-for-service system. This is because only persons actually requiring hospital care are hospitalized and they are kept only as long as necessary. This results in more intensive cases and thus higher costs per day. Therefore, hospitals of such programs may be unfairly penalized by the proposed system unless the provision

relating to intensity of care provides an adequate adjustment. Since the Social Security Administrative has been attempting unsuccessfully for several years to devise an intensity factor for use in reimbursing hospitals for routine costs, we are apprehensive about the ability to develop a satisfactory approach to quantification of this factor.

On the other hand, hospitals which have less intense cases and longer length of stays will probably be rewarded by the bonus provision in the bill. It is ironic that a proposal to contain costs will probably penalize programs that have done the most to contain total hospital costs while potentially rewarding hospitals that have done little to contain such costs.

Nevertheless, most approaches to limiting hospital payments under Medicare and Medicaid will create similar problems and it is likely that any system proposed will contain arbitrary features which result in serious inequities. If this committee decides to propose a system to limit hospital payments under Medicare and Medicaid, the proposal in S. 3205 should be improved by amendments which will be discussed later.

PAYMENTS UNDER MEDICAID PREPAID PROGRAMS

Secton 41 of S. 3205 would amend Title 19 to provide that prepaid programs under Medicaid must be paid in substantially the same manner as provided for under Section 1876 of the Social Security Act. This section should be deleted from the bill. Even though Section 1876 was enacted in October, 1972, it has not been implemented. It is untried and unproven. On the other hand, a number of states have successfully implemented Title 19 prepaid programs. None of these programs uses the Section 1876 method of payment. Requiring states to apply Section 1876 to Title 19 contracts probably will result in the elimination of most prepaid programs under Medicaid. This is an inappropirate method of controlling abuses. Qualified HMOs should be available as a choice to Medicaid recipients.

PAYMENTS UNDER MEDICARE TO HMOS

At the present time, prepaid group practice programs have only limited opportunities to participate in Medicare and Medicaid on a prepaid basis. For example, in our Program, the hospital services we provide under Part A are not paid for on a prepaid basis and only three of our six Regions have been able to negotiate prepaid contracts with four state Medicaid programs. We believe that Congress should take steps to enable HMOs to participate on a fair and equal basis in the Medicare and Medicaid programs in a amnner consistent with their basic method of operation.

We recommend that Section 1876 be amended to provide that the per capita payments be established prospectively, so that an HMO will be able to determine the resources available to provide care. Under the present section, the amount of payment will not be known until two or three years after the care is provided!

The amount of payment should be based upon the estimated costs of services from non-HMO physicians and providers in the area adjusted for age, sex and Medicare disability status. The present section also requires an adjustment for institutional status and the difficulty in determining such an adjustment is one of the reasons the section has not been implemented. Age, sex and Medicare disability status are major determinants of utilization and adjustments for them are readily determined. The bill could provide for a study of other factors (e.g., institutionalization) which could be added as adjustments when they can be readily determined.

The section should be further amended to provide that an HMO that assumes all the risks of providing care to Medicare beneficiaries should receive all the savings from its efficiencies. Under the existing section risk basis HMOs are required to assume all the risks of providing care *plus* an uncertain payment level, but any savings must be shared equally with Medicare. This is obviously unfair.

In addition, we recommend an amendment to Section 1876 to permit HMOs to share equally in both the losses and the savings of their operation with Medicare.

HMO PARTICIPATION UNDER MEDICAID

We recommend that Title 19 be amended to provide that states must undertake good faith efforts to enter into prepaid contracts with HMOs and to prohibit

states from imposing additional or conflicting requirements for participation upon HMOs qualified under the Health Maintenance Organization Act of 1973.

Congres has established a national policy of encouraging the development and growth of HMOs. One of the means of accomplishing this objective is the requirement of the HMO Act that most employers must offer qualified HMOs to their employees. We believe that offering qualified HMOs to recipients of Medicaid programs would be consistent with and would further that national policy.

In addition, states should be precluded from imposing additional requirements upon qualified HMOs. The HMO Act has established national standards for HMOs and those meeting the standards should not be confronted with additional and conflicting state requirements.

HMO CAPITAL EXPENDITURES

Section 1122 of the Social Security Act should be amended to remove HMOs as such from its coverage. It would continue to cover health facilities owned by or associated with HMOs, but not their capital expenditures for ambulatory facilities or non-health care construction such as parking lots or administrative buildings. Section 1122 discriminates aganst HMOs because it does not cover unorganized ambulatory facilities or the non-health care construction of other types of organizations.

The Senate version of the HMO Amendments removes HMOs from the certificate of need provision of P.L. 93-641. Section 1122 should be modified in the same manner so that the two provisions are consistent.

SPECIFIC PROVISIONS OF S. 3205

1. P. 15, lines 5-23.—States would be required to report on utilization of services under the State Medicaid program. This requirement should be expanded to include a report on prepaid Medicaid programs with HMO participation and utilization shown separately for group practice and individual practice plans.

2. *P. 22, lines 3-23.*—The Secretary would be required to report to Congress on the status of state Medicaid programs. This requirement should be expanded to include a report on prepaid Medicaid programs from the information provided by the states.

3. *P. 26, lines 20-25; p. 27, lines 1-2.*—We are in favor of this provision which would require the Secretary to afford interested parties the opportunity to comment on major policy guidelines before they are adopted.

4. *P. 29, lines 12-24.*—We recommend that a fourth classification be added to this subsection: "Hospitals which provide the preponderance of their services to members of hospital-based prepaid group practice programs." Such hospitals generally differ from fee-for-service hospitals in case mixes and other characteristics. If a separate classification is not established for them, it is probable that they will be treated unfairly by the proposed system.

5. *P. 30, lines 6-15.*—This paragraph defines "routine operating costs" by exclusion. We recommend that this definition be retained, but that the term also be defined affirmatively. In addition to the exclusions, the paragraph should include: "costs for regular room, dietary and nursing services, minor medical and surgical supplies, and the use of equipment and facilities for which a separate charge is not customarily made."

6. *P. 32, lines 8-25; p. 33, lines 1-9.*—This provision requires an adjustment in the personnel component of routine operating costs for differences in wage levels in different areas. It also allows the use of the wage level for hospital employees if it is significantly higher than the general wage level. This provision is necessary to reduce the arbitrary nature of the proposed system. However, the use of hospital wage levels is limited to the first year. This limitation is unreasonable and should be deleted. If it is not, it would require hospitals to bring their wage levels into line with the general wage level in the area within one year or be penalized. For most hospitals, this would be impossible.

7. *P. 34, lines 13-18.*—This provision requires a retrospective adjustment in the 'adjusted per diem payment rate for routine operating costs' at the end of the fiscal year. We recommend that this requirement be deleted. We believe that the payment rate should be fixed in advance and both hospitals and the Medicare and Medicaid programs should live with the fixed payment level. Retrospective adjustments based upon price increases create unpredictability for hospitals. A

major objective of this bill should be the establishment of prospective rates so that hospitals can plan accordingly and the programs will have more certainty in their cost estimates.

8. *P. 37, lines 1–13.*—This is a special provision for underutilized hospitals in underserved areas. We support such a provision as necessary to prevent unfairly penalizing rural hospitals.

9. *P. 37, lines 14–25; p. 38, lines 1–3.*—This provision attempts to provide for an unusual case mix in a hospital which requires greater intensity of care. This is an essential provision and we support the concept. However, it is questionable whether the provision will achieve its objective. In order to work, an accurate measure of intensity is needed. The Social Security Administration has been unable to develop such a measure for use in reimbursing hospitals for routine costs and it is doubtful if it is possible to develop a satisfactory intensity factor in the near future.

10. *P. 40, lines 9–25, pp. 41–47, p. 48, lines 1–4.*—This provision is designed to encourage the closure or conversion of unneeded hospitals. We support this objective, but it may not be accomplished by this provision. The transitional allowance can be paid only to hospitals which continue to provide services so that there is no assistance for total closure. It is not clear whether the transitional allowance would cover all added costs or only Medicare and Medicaid's share of them. In addition, the hospital must carry out the conversion or closure before it is eligible for the transitional allowance and even then, it may receive no assistance because of the 50-hospital limit on participation. We suggest that Congress might approach this problem directly by considering an experimental reverse Hill-Burton program. Under such a program, government funds could be used to purchase and close unnecessary hospitals. Such an approach has potential for containing hospital costs.

11. *P. 79, lines 17–25; p. 80.*—We have recommended the deletion of this provision which would tie payment for Medicaid prepaid programs to Section 1876 requirements. However, if it is not deleted, it should be amended to insure that existing prepaid Medicaid contracts are not jeopardized. The section should not be effective until Section 1876 is implemented and fully operational and the regulations governing this provision have been adopted. It should not apply to contracts in existence on its effective date, but only to subsequent renewals or new contracts. Moreover, the requirement for prior approval of such contracts by the Secretary (p. 80, lines 17–19) should be deleted. This requirement would serve only to further delay the implementation of prepaid contracts.

I will be pleased to respond to questions from the Committee.

Senator TALMADGE. The next witness is Mr. Charles D. Phillips, president, American Protestant Hospital Association.

Mr. Phillips, you may insert your full statement in the record and summarize it, sir.

STATEMENT OF CHARLES D. PHILLIPS, PRESIDENT, AMERICAN PROTESTANT HOSPITAL ASSOCIATION

Mr. PHILLIPS. Thank you, Mr. Chairman.

I have with me Kenneth Williamson, who is representing the association in Washington.

Senator TALMADGE. Delighted to have you, sir.

Mr. PHILLIPS. The American Protestant Hospital Association, representing some 300 hospitals, homes for the aging and other health care agencies throughout the country, as well as some 2000 personal members who are engaged in the delivery of health care services.

Mr. Chairman, we greatly appreciate the opportunity to present the position of ALPHA on S. 3205. Mr. Chairman, let me say at the outset that the members of APHA appreciate your concern about the rising costs of the medicare and medicaid programs to the taxpayers of this Nation. We are grateful for your commitment to the development of

reforms which will prevent the cutting and slashing of hospitals and physicians indiscriminately and inequitably and the imposing of arbitrary controls and indiscriminate limits on payments to hospitals such as the administration's proposed ceilings on hospital cost increases.

We are concerned, however, that the reforms which are proposed as solutions to the problems of escalating costs of hospital services be based on an awareness of the factors which are responsible for such increases and that the reforms addressed those factors rather than taking the simplistic approach of limiting reimbursement.

We believe that this bill demonstrates your awareness of the enormity of the problems faced both by the Federal Government and health care institutions of this Nation and that it is a step in the direction of addressing needed reform.

I will comment on certain sections of the bill which we feel are of more crucial significance to our members.

Section 2, establishment of Health Care Financing Administration. We believe the bill does address the current fragmentation of health programs by proposal to merge the four existing programs under one administration, and certainly we support efforts to bring about increased coordination of Federal programs. We have long been on record in favor of the establishment of Cabinet-level Department of Health as a mechanism for the most effective coordination of the setting of national health policies and the administration of medical health programs and believe that on this proposal when it gets at fragmentation, it would improve its attempt to achieve its goal by Cabinet-level Department of Health rather than the two undersecretaries.

We certainly support the section 4, the State administration medicaid improvements, because we feel that the proposal to establish the specific performance criteria for State medicare programs will result in payment of claims and a vastly improved administration of the program.

While we are not firm in opposition to section 8, we feel that HIBAC has been a source of significant contribution to the development and implementation of the programs and believe that such an advisory group is to be of potentially great importance to such programs as medicare and medicaid, especially if we are going into a period of transition in the administration and the reimbursement of these programs.

We recommend that this group be continued and utilized even more greatly as a resource by Government or if it is dissolved, that a new policy advisory counsel be established that would have authority and responsibility in advising the Secretary of HEW on health programs.

In section 10, we are concerned with the proposals of classification of institutions for the purposes of reimbursement on a comparative basis. Previous witnesses have already expressed much of our concern. We can appreciate and understand the attractiveness of such a methodology to the Federal Government. However, we feel great difficulty will be experienced in the technical aspects of devising such a methodology for classifying institutions for purposes of reimbursement. The fact that it does delete from the comparison procedure for routine per

diem hospital costs some of the elements that hospitals have little control over, we feel is a vast improvement over the section 223 of Public Law 92-603.

This association is on record as supporting a reimbursement system which includes prospective reimbursement administered on a State level with Federal guidelines. We strongly urge this proposed legislation be amended to permit such a State program as an option for determining institutional reimbursement based upon the prospective payment methodology under Federal guidelines.

Our basic reason for this is that we feel State level rate review on a prospective basis will assure that the variables among institutions which often vary locally be taken into account and therefore, the full financial requirements of institutions more adequately provided.

Although we support an amendment which provides for a State level prospective rate review option, we realize that a methodology must be devised for those states not willing or able to exercise the option. For those states a classification might be appropriate.

Our recommendation at this point is that as that classification system is developed, that you make use of an expert panel of persons from various associations, persons who have had experience over a long period of time and in the medicare program are familiar with its problems and that this council or a panel of experts discuss their basis for the classification system and the appropriateness and validity of the components now included in the bill.

We believe that would be in keeping with the openmindedness of the chairman of the committee when you introduce the bill and that it would prove a substantial assistance in performing a workable and equitable method of classification.

I want to state to the committee that we certainly are in support of an incentive reimbursement system to the medicare reasonable cost controls which is now in effect. We commend the chairman for the proposal to move from a retrospective cost reimbursement system to one of prospective reimbursement. We would hope that the bill be modified to provide for a new method of reimbursement for Medicaid which would assure that payments are made at a reasonable level so that hospitals will not be forced to provide services for those patients at rates which are below cost.

We support section 11 and feel that that would be a substantial help in getting at the problem of overbedding and utilizing beds in the country.

In section 12 we feel that the bill certainly should provide that the same principle be applied for not for profit hospitals and that they be allowed an operating margin so that they are not forced to operate just on a cost only basis.

Section 22, hospital associated physicians. We recognize that the problem with this section 10 addresses not a new——

Senator TALMADGE. I hate to interrupt you, but your ten minutes has expired. Your statement will be inserted in the record.

Senator TALMADGE. Mr. Williamson, I understand for 20 years you were deputy director of the American Hospital Association; were you not?

Mr. WILLIAMSON. I was deputy director and director of Washington activities for a period of more than 20 years, yes.

Senator TALMADGE. Would you comment on the provisions of the bill on hospital-related physicians.

Mr. WILLIAMSON. Well, the statement that the Protestant Association officially put in the record indicates questions they have in two areas of the bill. Referring to those past years and the testimony I heard earlier this morning from the American Hospital Association, it seems to me, to represent a change in position.

At the time medicare was started, I was responsible officially, of course, for urging upon the government an amendment to medicare called the Douglas amendment.

You will, I am sure remember it, and it was a strong effort to provide that medical specialist services so-called were made a part of the law as hospital services. So as to control them and protect the public. Some of the provisions that you are attempting in your bill relate to what we hoped to accomplish at that time. We made other efforts also to accomplish these results to protect hospitals and the public.

There was a long record of hospitals feeling an inability to control the cost of those specialist services. As I listened to the testimony, it suggested. I think, that the view of the hospital field, seems to have changed and as they believe apparently that the relationships have improved from those days when medicare started. They are urging, as I listen to it, greater caution in evaluating all the variety of proposals that there are in effect before jumping to one approach and that Federal intervention is not needed.

Senator TALMADGE. Have you changed your mind on the subject?

Mr. WILLIAMSON. No; I have not. From what I know about the field, the field is still pretty much at the mercy of medical specialists and for many their income sounds excessive, Senator.

I believe what I hear from around the field—I have quite a lot of contact in the field—is that hospitals have great difficulty in administering contracts with medical specialists and in rural areas this is sometimes tougher, but not always.

I hear in urban areas also that because of the very large amounts of money involved that they have equal difficult times in getting equitable arrangements. My own personal view quite apart from the official association view is that you started in the right direction by separating administrative costs of medical specialist services from the professional fees as a basic step.

I think that is a very valuable step. I think as the statement says, however, that you then leave professional fees—charges—that channel you left rather wide open. Under present circumstances I am not sure you will end up reducing or controlling medical specialist fees by the present provisions of your bill you would have to control the charges.

In fact, I believe there is a danger of increasing the cost of those services.

Senator TALMADGE. We wanted to get an adequate fee for service, and it seems to me while you guarantee a portion of the losses without any limitation at all, it is unrealistic. Do you agree with that?

Mr. PHILLIPS. Yes. I agree it is radiologists and pathologists and they generally get a cut of the charges for services rendered by other people that render services and are quite competent to render those service totally.

Senator TALMADGE. Thank you very much.

Senator Curtis?

Senator CURTIS. What is your association's recommendation about hospital-related physicians?

Mr. PHILLIPS. Again, we feel that we have no specific recommendations. We recognize the problem. We would be glad to work with the committee staff in coming up with a solution. It is the rigidity of saying that this is one contractual arrangement that will not be permitted and basically mandating that as our basic opposition.

We are looking for ways of getting at the problem, Senator, and would be glad to work with the staff as you look at some alternative ways.

Senator Curtis. Do you feel that compensation has been unreasonable?

Mr. PHILLIPS. In some cases, yes, but not in every case. We do have some of our administrators who are getting at it. They were becoming much more sophisticated, I think, in the negotiations, much more hard-fisted about the approach, and we are going to get at this problem. Our position is that we would like to see that administrators are assured the management prerogatives to manage their institutions, and that the boards and the Administrator can carry out these efforts for improved management in getting at the problem.

Senator CURTIS. What is your opinion as to what the proposed bill will do?

Mr. PHILLIPS. I am sorry, I didn't get the last part of your question.

Senator CURTIS. What recommendation do you have in reference to the bill that is before this committee in dealing with these physicians? Do you think it should be adopted or not?

Mr. PHILLIPS. We would oppose the prohibition of the percentage contract.

Senator CURTIS. You are opposed to what is in the bill that is now before the committee?

Mr. PHILLIPS. Right.

Senator CURTIS. Do you want to elaborate on that any?

Mr. PHILLIPS. Mr. Williamson has already given the two major considerations. One, it would get into the prerogatives of the management as a mandate: you cannot have that kind of contractual arrangement. No. 2, we are not sure that we will get at the problem that you are seeking to address of the abuse in costs, that it could be that once you separate out the administrative teaching, those kinds of services, and give a reasonable salary for that and then let him build the direct billing on a fee service basis for patient services, we are just not sure that the bill would attain its objective.

We agree with the objective of controlling excessive income of hospital-based physicians, but we are saying we don't believe that is necessarily the one and only way as the bill proposes, Mr. Chairman.

Senator CURTIS. Are you saying it is excessive compensation?

Mr. PHILLIPS. In some cases, I agree that there is excessive compensation. We believe that in many cases there are good contracts that have established or determined that the compensation is reasonably in line with others.

Senator CURTIS. Is that the majority of the cases?

Mr. PHILLIPS. I would think so, yes.

Senator CURTIS. Then you are saying in the majority of the cases of these pathologists and radiologists, there is no major problem that calls for Federal legislation?

Mr. PHILLIPS. Correct.

Senator CURTIS. That is all.

Senator TALMADGE. Do you think there should be a ceiling on reimbursement, Mr. Phillips?

Mr. PHILLIPS. I am always bothered by ceilings, arbitrary ceilings. I think it is that guidelines of reasonableness can be determined and then let that be the proceeding instead of being arbitrarily fixed in amount.

Senator TALMADGE. It is for a reasonable guideline, is that your response?

Mr. PHILLIPS. Yes.

Senator TALMADGE. Thank you.

Have you surveyed your members on this issue?

Mr. PHILLIPS. The members of my Council on Government Relations, which helps to establish the association policy, and some of the officers of the association, while agreeing with the effort to get at those isolated cases that are unreasonable compensation, the general feeling was that the bill as proposed is unacceptable.

Senator TALMADGE. Thank you very much, gentlemen. We appreciate your contribution, and the committee will stand in recess——

Senator CURTIS. May I ask one more question.

Were these specialists making a contribution in getting patients well?

Mr. PHILLIPS. Do they make a contribution in getting the patients well?

Senator CURTIS. Yes. Is it something important, in your view, in the process of administering good medicine; in the role of the pathologist, for instance?

Mr. PHILLIPS. The role of the pathologist?

Senator CURTIS. The role.

Mr. PHILLIPS. The role, yes.

Mr. WILLIAMSON. Yes, I would say, Senator, they make an enormous contribution to patient care within the areas that they function.

Senator CURTIS. In the long run isn't the least expensive medical treatment the one that does the most to make people well?

Mr. WILLIAMSON. That does not mean most treatment?

Senator CURTIS. No.

Mr. WILLIAMSON. That means the most of the best treatment?

Senator CURTIS. Yes; the best treatment.

Mr. WILLIAMSON. Yes.

Senator CURTIS. The accurate treatment?

Mr. WILLIAMSON. Yes.

Senator CURTIS. Sometimes the treatment might aggravate them. I am disturbed about the fact that doctors in hospitals have to gear all of their operation to Government regulations and requirements and plus the other fear that now exists over the last few years of malpractice. That is taking a lot of time and energy that could well be devoted to making patients well. If they make them well and make them productive citizens, that is the least expensive medicine. You might have an operation that will cost less, but if it was not in the best medicine, it would be very expensive in the long run.

Mr. PHILLIPS. That gets also into the ever-increasing burden of regulation where other people have to be employed on the staff to interpret to implement regulations which adds again to the cost of care.

Senator CURTIS. That is all, Mr. Chairman.

Senator TALMADGE. Thank you very much.

[The prepared statement of Mr. Phillips follows:]

STATEMENT OF THE AMERICAN PROTESTANT HOSPITAL ASSOCIATION

Mr. Chairman, I am Charles D. Phillips, President of the American Protestant Hospital Association, representing some 300 hospitals, homes for the aging and other health care agencies throughout the country, as well as some 2000 personal members who are engaged in the delivery of health care services. With me is Kenneth E. Williamson, the Washington Representative of the Association.

We greatly appreciate the opportunity to present the position of APHA on S. 3205. Mr. Chairman, let me say at the outset that the members of APHA appreciate your concern about the rising costs of the Medicare and Medicaid programs to the taxpayers of this nation. We are grateful for your commitment to the development of reforms which will prevent the cutting and slashing of payments to hospitals and physicians indiscriminately and inequitably and the imposing of arbitrary controls and indiscriminate limits on payments to hospitals such as the administration's proposed ceilings on hospital cost increases.

We are concerned, however, that the reforms which are proposed as solutions to the problem of escalating costs of hospital services under Medicare and Medicaid be based on an awareness of the factors which are responsible for such increases, and that the reforms address those factors rather than taking a simplistic approach of limiting reimbursement. We believe that this bill demonstrates your awareness of the enormity of the problems faced both by the federal government and the health care institutions of this nation and that it is a step in the direction of addressing needed reform.

Mr. Chairman, we will comment on only certain sections of this bill which we feel are of more crucial significance to our members.

SEC. 2. ESTABLISHMENT OF HEALTH CARE FINANCING ADMINISTRATION

The bill addresses the current fragmentation of health programs by proposing to merge four existing programs under one administration. We favor efforts to bring about the increased coordination of federal programs. However, we feel that fragmentation and a lack of uniformity in federally financed health programs is likely to be perpetuated if the proposal for two assistant secretaries is enacted. The separation of the administrations for financing and for delivering health care is not in the best interest of the health care services of this nation. Therefore, we support the creation of a cabinet-level Department of Health rather than as a mechanism for the most effective coordination of the setting of national health policies and administration of federal health programs.

SEC. 4. STATE MEDICAID ADMINISTRATION

This section reflects the awareness of the Chairman of the problems besetting hospitals because of the performance of states in administering Medicaid. We support the proposal to establish specific performance criteria for state administration of Medicaid which will result in more prompt payment of claims and vastly improved administration of the program.

SEC. 8. TERMINATION OF HEALTH INSURANCE BENEFITS ADVISORY COUNCIL

APHA believes that the use of expert non-governmental advisors through HIBAC has been the source of significant contribution to the development and implementation of federal programs. Such advisory group appears to be of potentially great importance to such major programs as Medicare and Medicaid, especially during a period of transition. APHA recommends the continuation of HIBAC and a greater utilization of this resource by government, or, in the case of its dissolution, the formation of a new policy advisory council with added authority and responsibility in advising the Secretary of HEW on health programs.

SEC. 10. IMPROVED METHODS FOR DETERMINING REASONABLE COSTS OF SERVICES PROVIDED BY HOSPITALS

The APHA is concerned with the proposal for the classification of institutions for the purposes of reimbursement on a comparative basis. We can understand the attractiveness of such a methodology to the federal government. However, we feel that great difficulty will be experienced in the technical aspects of devising such a methodology for classifying institutions for purposes of reimbursement. The fact that S. 3205 deletes from the comparison procedure for routine per diem hospital costs some of the elements over which an institution has little or no control is a vast improvement over Section 223 of P.L. 92-603.

APHA is on record as supporting a reimbursement system which includes prospective reimbursement administered on a state level under federal guidelines. We strongly urge that this proposed legislation be amended to permit a state administered rate review option for the determination of institutional reimbursement based upon prospective payment methodology under federal guidelines. State level rate review on a prospective basis will assure that the variables among institutions, which are often very local, are taken into account and that the full financial requirements of institutions are provided. Therefore, we urge you consider amending the proposed legislation by permitting as an option to a classification system of hospitals a state prospective rate review system involving all payers.

Although APHA supports an amendment which provides for a state level prospective rate review option, we realize that a methodology must be devised for those states not willing or able to exercise the option. For those states a classification system would be appropriate. We are greatly concerned that the classification system be devised with full consultation from the field of health care and government agencies. We therefore recommended that this committee bring together a group of technical experts who have been involved in Medicare-Medicaid reimbursement matters over the years. Representatives should include persons from associations of providers, Social Security Administration, health care institutions, congressional staff, Blue Cross Association, and etc. These experts would discuss in depth the basis for the classification system and the appropriateness and the validity of the components now included in this bill. We believe that the formation of such a panel of experts would be in keeping with the spirit of open-mindedness expressed by the chairman when you introduced the bill and that it would prove to be of substantial assistance in forming a workable and equitable method of clasification.

Further I want to state that we concur with the addition of an incentive reimbursement system to the Medicare reasonable cost controls which is now in effect. We commend the chairman for his proposal to move from a retrospective costly reimbursement system to one of prospective reimbursement. We also urge that the bill be modified to provide for a new method of reimbursement for Medicaid which would assure that payments are made at a reasonable level so that hospitals will not be forced to provide services for those patients at rates which are below cost.

SEC. 11. INCLUSION IN REASONABLE COST OF HOSPITAL SERVICES ON ALLOWANCE FOR RETIREMENT OR CONVERSION OF UNDERUTILIZED FACILITIES

We support the demonstration project proposed in Section 11 by which federal financial support would be provided institutions which apply for such support on the basis that their operations would be made more efficient or cost-effective by

the closing or conversion of underutilized beds and that they would also become eligible for positive incentives under the provisions of Section 10.

SEC. 12. RETURN ON EQUITY TO BE INCLUDED IN DETERMINING "REASONABLE COST" OF SERVICES FURNISHED BY PROPRIETARY HOSPITALS

APHA supports the principle implemented in this section—that an adequate return on investment is a reasonable expectation in business. By the same principle, we urge the Committee to amend this section to provide for an adequate operating margin on reimbursement by Medicare and Medicaid to not-for-profit institutions, since no institution can continue to operate only on the basis of costs.

SEC. 22. HOSPITALS—ASSOCIATED PHYSICIANS

We recognize that the problem which this section attempts to address is not a new one for hospitals or the government. We express grave concern, however, over the proposal that the federal government involve itself with such specificity in determining the types of contractual arrangements between hospitals and physicians. We recognize that cases of unreasonable compensation can be documented, but believe that to enact legislation prohibiting a specific type of contract removes decision making from its proper authority—management and the governing boards—and places it in Washington. This eventuality serves neither the best interest of the community or the government.

We are concerned further that the language of the bill will not accomplish the intended result of reducing hospital costs. There are those who have studied this proposal who are convinced that the aggregate costs resulting from categorizing the various services of these physicians and the mandating of a fee-for-service basis of reimbursement for personal patient services will be greater than those now being experienced.

SEC. 40. PROCEDURES FOR DETERMINING REASONABLE COST AND REASONABLE CHARGES

APHA vigorously opposes this section. The Medicare law already contains adequate provisions to determine reasonable costs. Further, the proposal is a gross infringement on the management prerogative of individual institutions.

SUMMARY OF RECOMMENDATIONS

Mr. Chairman, in conclusion we would like to summarize some of the recommendations that we have made here today.

1. We support efforts to end the current fragmentation of federal health programs. However, we recommend, consistent with our previous position, the creation of a cabinet-level Department of Health as a mechanism for the coordination of the administration of all federal health programs.

2. We recommend the continuation of a Health Insurance Benefits Advisory Council, and a greater utilization of the resources by government. However, in the case of its dissolution, we recommend the formation of a new policy advisory council with added authority and responsibility in advising the secretary of HEW.

3. We recommend that Section 10 be amended to permit as an option to a classification system of institutions for the purposes of reimbursement on a comparative basis a reimbursement system which includes prospective reimbursement administered on a state level under federal guidelines.

4. We recommend that the committee in devising the classification system to determine reimbursement for institutions in those states not able or not wishing to adopt state administered prospective reimbursement under federal guidelines, consult in depth with a panel of experts drawn from association providers, hospital executives, Social Security Administration, Blue Cross and Other third party payers, congressional staff and etc.

5. We recommend that the bill be modified to include a new method of reimbursement for Medicaid to require that these payments be made at a reasonable level.

6. We recommend that Section 12 be modified to assure an adequate operating margin on reimbursement for Medicare and Medicaid for not-for-profit institutions in recognition that no facility can continue to operate only the basis of cost.

7. We recommend that Section 22 be modified so that these specifics of contractual arrangements between hospitals and physicians are left to the management prerogatives and that further studies be conducted to determine more appropriate ways of assuring the accomplishment of the objective of controlling excessive compensation to hospital based physicians.

8. We recommend the deletion of Section 40 in its entirety.

Mr. Chairman, we thank you and members of this committee for considering these views and for giving us this opportunity to appear before you. Thank you.

Senator TALMADGE. The committee stands adjourned until 8 tomorrow.

[Whereupon, at 10:10 a.m., the subcommittee recessed, to reconvene at 8 a.m., Wednesday, July 28, 1976.]

MEDICARE-MEDICAID ADMINISTRATIVE AND REIMBURSEMENT REFORM

WEDNESDAY, JULY 28, 1976

U.S. SENATE,
SUBCOMMITTEE ON HEALTH OF THE
SENATE FINANCE COMMITTEE,
Washington, D.C.

The committee met at 7:59 a.m., pursuant to recess, in room 2221, Dirksen Office Building, Senator Talmadge, chairman of the subcommittee, presiding.

Present: Senators Talmadge, Bentsen, and Dole.

Senator TALMADGE. The committee will come to order. Our first witness this morning is the distinguished Senator from Utah, who has done a great deal of investigatorial work in the field of health delivery services and so forth.

I am sure he will speak from a great deal of experience. We are delighted to have you with us, Senator Moss.

Senator Moss. Thank you very much, Mr. Chairman.

STATEMENT OF HON. FRANK E. MOSS, A U.S. SENATOR FROM THE STATE OF UTAH

Senator Moss. I am pleased that I have the chance to testify this morning in favor of S. 3205, the Medicare-Medicaid Administrative Reimbursement and Reform Act.

Senator TALMADGE. I neglected to state that you were cosponsor of this bill and we are grateful for your support.

Senator Moss. I thank you. I am indeed pleased that I could join the chairman in the introduction of this bill. I am hopeful that we can move it along through the Senate.

As chairman of the Subcommittee on Long-Term Care of the Senate Committee on Aging, I have enjoyed working with the staff and members of the Senate Committee on Finance. I want to say how effectively they are working on this piece of legislation and others that come within their jurisdiction.

I marvel at your ability to get through an incredible workload each year and to do so in such grand style. Through the years, we of the Committee on Aging have perceived our role as aiding this and other legislative committees by providing in-depth research relating to problems of the elderly.

In this connection, most of you know I have chaired more than 40 hearings in the past six years relating to various aspects of the medicare and medicaid programs.

Many of the hearings I conducted related exclusively to nursing home problems. We have produced a 12-volume report and I have introduced a number of bills that I would like to urge you to incorporate into S. 3205.

In September of last year, Senator Edmund Muskie and I held joint hearings on what I call the real crisis in health care, that is, the widespread fraud and abuse which robs the taxpayer of both his tax dollars and the health care needs of the indigent.

These hearings related to practitioners in the medicaid program associated in one way or another with long-term care. The problems disclosed were so serious that in October of last year, I summarized our preliminary findings in a speech.

I ended by declaring war on fraud and abuse. I must say I was delighted to find that Senator Talmadge and others of you in this committee are in the trenches with me.

The phase of our intensified investigation related to fraud and abuse among clinical laboratories and to related fraud by physician-practitioners in so-called medicaid mills, small clinics which checker the ghettos of our major cities, catering to those who walk in off the street with medicaid cards.

As many of you remember, working together with the Better Government Association, we rented a storefront in Chicago, pretending to be a group of practitioners opening for business. A sign in the window and a telephone number announced: "Professional Inquiries Invited."

It was not long before our telephone started ringing off the hook. Twelve laboratories appeared at our storefront, and offered investigators kickbacks ranging from 25 to 55 percent if we would agree to send all of our laboratory business to that particular laboratory.

Armed with information that 12 laboratories gave kickbacks and the general amount that was offered, investigators sifted through paid billings in the Illinois Comptroller's Office and constructed a profile of each laboratory.

We knew precisely which physicians used each of the 12 laboratories. We then selected 50 physicians for interview from this list.

The physicians which our investigators found were primarily foreign medical graduates working out of medicaid mills. When confronted with our information, they readily admitted receiving kickbacks from the laboratories as well as from other providers.

However, in at least half of the interviews, the foreign-trained physicians were not the recipients of the kickbacks. We learned that the illegal rebates were being paid to the businessmen who owned the medicaid mills.

We were amazed to learn that many of these physicians were working essentially on commission. They were allowed to keep only 20 to 40 percent of the moneys they generated from seeing medicaid patients.

Clearly, the incentive is to "optimize patients", that is, to see as many patients as possible and to order as many tests as possible. Our financial analyses found that some medicaid mills received over a million dollars from medicaid each year.

Of this amount, more than 50 percent is going to a businessman who owns or rents the real estate.

The report drafted by our committee staff called attention to these matters, adding a number of startling conclusions. For example, the report concluded that $1 out of every $5 paid for clinical laboratory services is fraudulent.

It concludes that a small number of laboratories control the bulk of medicaid business. In New York, 17 labs control 70 percent of the medicaid business. In New Jersey, 12 labs control nearly 60 percent of medicaid payments, and in Illinois, 26 labs control over 90 percent of the medicaid business.

The report concludes that, at least in the States which came under investigation, kickbacks are widespread among labs specializing in medicaid business. In fact, it appears to be necessary to give a kickback in order to secure the business of physicians or clinics who specialize in the treatment of welfare patients.

The average kickback to physicians or medical center owners in Illinois was 30 percent of the monthly total of the lab received for performing tests for medicaid patients. Kickbacks took several forms including cash, furnishing supplies, business machines, care or other gratuities as well as paying part of a physician's payroll expenses.

Most commonly it involved the supposed rental of a small space in a medical clinic.

The report concludes that it is apparent that the law passed by the Congress in 1972 prohibiting kickbacks and mandating a $10,000 fine and a year in jail upon conviction is not being enforced.

When I was confronted with an early draft of this report, I was shocked by the conclusions that the staff reached in their work with Chicago's Better Government Association. I decided to go to that city and see things for myself, accompanied by Senator Pete V. Domenici of New Mexico.

I saw the proliferation of so-called medical clinics spreading like mushrooms all over Chicago; I saw their glaring signs beckoning medicaid patients to utilize health care services.

I visited a postage-stamp size clinical laboratory which billed medicaid for almost $200,000 last year. There was little in the way of equipment and no lab technicians in evidence. While the owner assured us as to the quality of the work performed, I heard from the owner himself that he chose to send his wife's blood test to another laboratory.

I visited the sparkling new Laboratory of Illinois Masonic Hospital and saw its sophisticated new machines only to learn that the hospital could not obtain much medicaid lab business because of its refusal to offer kickbacks.

I interviewed a physician who received over $100,000 from medicaid last year. I asked him to check nine lab invoices presented to Medicaid for payment by D. J. Clinical Laboratory of Chicago against his records.

The doctor told us that he had not ordered 55 percent of the $259,000 total in lab tests for which D.J. had billed that Illinois medicaid program on these nine invoices.

This same doctor told us that he received a rebate of $1,000 per month from the laboratory in exchange for sending that laboratory all this medicaid business. The kickback was disguised as rent for a 6- by 8-foot room in the physician's office.

The doctor's rent for the entire suite was $300 a month and yet he received $1,000 per month for the "rental" of a 6 by 8 room.

Finally, I interviewed a businessman who owns two medical clinics employing foreign-trained doctors who received about $300,000 in medicaid payments last year. This man admitted sending all of his lab business to one company in Chicago.

He told us he received a rebate of 50 percent of the amount of medicaid paid for laboratory tests which physicians in his clinics ordered for welfare patients.

I cite these facts to you in support of the content that fraud and abuse is rampant in the medicaid program. In my view, this is because of the bifurcated nature of the medicaid program.

Both the States and the Federal Government are looking to each other to prevent fraud and abuse. Technically, the States are responsible, at least that is my reading of title 19.

It was established as a State-administered program. The problem is that most States have abdicated this responsibility. One need look no further than the statistics maintained by HEW's Social Rehabilitation Service to see that the majority of our states are inactive from the point of view of locating and preventing fraud.

For example, in the quarter ending June 30, 1975, there were a total of 1,394 medicaid fraud cases pending. Some 1,119 of these were in four States: Michigan, 318; Pennsylvania, 137; Massachusetts, 125; and Ohio, 539.

The State of California was not included in the totals, but it is the fifth State that has a fairly aggressive fraud prevention unit. On the opposite end of the pole is the State of New York which despite receiving almost one quarter of the $14 billion we paid out in medicaid payments had a total of 30 fraud cases pending.

The provider abuse and surveillance activities in the city and State of New York are in a shambles.

I will skip a little, Mr. Chairman, I realize time is limited. I hope that my entire statement will be in the record.

Senator TALMADGE. The statement will be inserted in the record, Senator.

Senator Moss. I do not mean to suggest that there are not a great many qualified people in New York, and elsewhere who are working hard to change these problems. I simply offer my view that most States are failing to make an acceptable improvement.

Nor am I impressed by the recent decision of our well-meaning Secretary of Health, Education, and Welfare to employ the bulk of the some 100 new medicaid investigators in a series of lightning raids on various States to root out evil and then to move on.

I suggest we need an aggressive and continuous pressure exerted against those who abuse the system rather than this kind of transitory foot patrol.

At this time, I would like to provide this committee with a quick overview of the next report to be released by my subcommittee. It is entitled, "Fraud and Abuse Among Physicians Participating in the Medicare Program."

I emphasize, that this report represents, in part, our analysis of the medicare program because up to now I have been speaking about

medicaid. I should like to begin by reading quotations which have been excerpted from an investigative tape made by law enforcement officials in the southern district of New York.

I include this to show the degree of sophistication of those who would abuse the program. I will skip over these but simply say that they are on tape physicians talking between themselves about how the system is viewed in New York.

In the preparation of our report on physician abuse in the medicare program, we received invaluable assistance from Mr. James Cardwell, Commissioner of Social Security, who allowed us to examine medicare fraud cases maintained by the Bureau of Health insurance's program integrity unit.

We found the work of this unit effective nationwide, efficient in sharp contrast to the administration of the medicaid program. The principal problem we found with medicare's administration is that the program integrity unit is too small to do what is expected of them.

Second, their hard work is often lost on U.S. attorneys who relegate medicare fraud cases the very lowest possible priority.

In the course of preparing our report, we reviewed every case referred to the Justice Department for prosecution from the following 25 States: Arkansas, California, Colorado, Connecticut, Florida, Illinois, Indiana, Iowa, Maryland, Massachusetts, Mississippi, Nebraska, New Mexico, New Jersey, New York, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Washington, and West Virginia.

Since it was organized in 1969, the program integrity unit has handled over 20,000 cases of fraud and abuse. Some 49 percent of all the fraud cases and 73 percent of all the abuse cases related to physicians.

Most of the cases come to the attention of the program integrity unit as a result of a beneficiary's complaint. Medicare, unlike medicaid, sends a carbon copy of every paid bill to the beneficiary.

Many patients complain to medicare that they did not receive the services indicated or did not see the physician on a particular day. While most beneficiaries complain directly, sometimes they channel their complaints through their Senators and Congressmen.

A second source of cases is the carriers and fiscal intermediaries employed by medicare. These insurance companies are hired by medicare to screen and pay bills. When they uncover suspicious practices by physicians and others who exceed statistical norms, they refer such providers to the program integrity unit.

Other sources of cases include the news media in the five States mentioned above who have active medicaid investigative units, referrals to medicare from medicaid are quite common.

At the present time there are 123 people in medicare's program integrity unit located in each of the 10 regional offices and in the headquarters office in Baltimore. Since there were 107.9 million claims presented to medicare for payment in fiscal 1975, and $14.2 billion paid out, this means that there is one program integrity specialist for every 878,048 claims received.

Similarly there is one program integrity specialist for every 195,000 medicare beneficiaries and for every $115.5 million in payments under the program.

Most of the cases these investigators receive are resolved or settled by BHI. Only the most serious cases can be pursued with existing manpower by the program integrity staff. Of the almost 10,000 cases against physicians only 400 were referred to the Justice Department.

Upon receiving a complaint, medicare investigators take a valid sample of the providers paid billings. Approximately 30 bills are selected at random. Beneficiaries are then interviewed and asked if they received various services.

If a high percentage of these patients deny receiving services, the provider is marked for more intensive investigation. Formal affidavits are taken and all the facts are turned over to the U.S. attorney holding jurisdiction with a recommendation for prosecution.

Medicare investigators include two figures, one relating to actual provable fraud from among the 30 cases they selected. A second figure is an extrapolation from the provider's total billings. It is essentially an educated estimate of amount of total fraud.

I listed a number of kinds of common abuse in medicare and several case histories, Mr. Chairman.

Since 1969, there have been a total of 459 cases out of a total of 20,219 processed by program integrity which have been referred for prosecution. Of the 459 cases, some 400 relate to physicians.

Of the total 459 cases referred to Justice, 210 have been accepted for prosecution. Of the 210 cases, there have been 140 convictions; 22 acquittals, 18 dismissals, and 20 indictments are still pending.

In addition to the 210 accepted cases, 149 were declined for prosecution. The remaining 100 cases were pending in the offices of U.S. attorneys with no determination having been yet made as to whether they will be accepted or rejected.

Only 10 percent of the 150 providers convicted of medicare fraud actually served any time in jail. The range is from two years in jail, received by three providers, to 15 days in jail.

In addition, two providers were given 1 year sentences, two were sentenced for 6 months, one received a 4-month sentence, four received 60-day sentences, one received a 45-day sentence, and one received a 30-day sentence.

The National District Attorney's Office provides the information that 13,943 defendants were sentenced in fraud cases by the Federal district courts for the period 1970 to 1975. Some 33 percent were imprisoned. The average sentence was 20 months.

By contrast, 10 percent of medicare convictions, which are felonies, resulted in imprisonment but the average monthly sentence was statistically zero.

U.S. attorneys refuse to take medicare cases for many different reasons, ranging from a heavy workload to the difficulty of transporting witnesses to and from court. The principal reasons seems to be that the beneficiaries who complain are the key witnesses in the case against physicians who are well thought of in the community in general.

Medicare, by definition, is limited to the aged and disabled. Quite often, beneficiaries are ill or have died before cases can be made. But more often it appears that U.S. attorneys and their staff do not regard medicare cases as glamorous and that dealing with the elderly is viewed as difficult and unpleasant.

Some of the reasons for declining cases from the files we viewed include: "the witnesses are elderly. They make poor witnesses. They can't remember the exact nature of services they received."

"The witnesses are aged and senile."

I would like to close by offering a few conclusions: one, the medicare program is light years ahead of medicaid from the point of view of fiscal integrity. While a significant amount of fraud continues to haunt the medicare program, it exists first, because there are too few people in the medicare program integrity unit to handle the massive caseload, and second, because of the lack of responsiveness for the Federal judiciary.

By contrast, the medicaid program is, with the exception of the five states I have mentioned, completely without controls. As we stated many times, fraud in medicaid is massive and widespread. We know this from actual experience.

Two, my estimate of fraud in the medicare program would be about 10 percent of the entire program or $1.5 billion out of the $15 billion we spent last year. Speaking specifically of physician fraud, we estimate that $300 million is ripped off by physicians each year out of the $3 billion paid by medicare to them.

Three, this massive amount of money, $300 million, is stolen by comparatively few physicians. About 10 percent of the 250,000 physicians who participate in the medicare program have been accused of fraud and abuse of the medicare program over the past 5 years.

Speaking more specifically, there have been 20,219 cases of fraud investigated by the Program Integrity Unit of the Bureau of Health Insurance, about 49 percent or 9,907 involved physicians.

Of the 19,084 cases of abuse instituted by medicare investigators, 73 percent of 13,921 cases involved physicians.

Using these numbers in yet another way, the 9,907 cases of physician fraud in the medicare program represent only four percent of all doctors participating in that program. The 13,931 cases of abuse represent about 6 percent of all doctors participating in medicare.

In short, the $300 million in fraud is perpetrated by only 4 percent of the medical profession and care should be used to make it clear that only this small minority is involved.

If I had to summarize my presentation before you this morning, in a couple of paragraphs, I would say the following. Everything I am about to say about medicare goes double for medicaid.

The chances that a physician will be caught cheating the medicare program are very slim indeed, even given the good work of medicare's program integrity unit. The chances that a case will be developed are slimmer still; most of the existing cases relate to charging for services not rendered, that variety of fraud which is the easiest to prove.

The odds that a case will be referred to the Justice Department for prosecution are extremely small, only 400 cases of physician fraud have been referred to Justice since 1969 or roughly 4 percent of all physicians' fraud cases.

The chances of being found guilty are infinitesimal, since less than 1½ percent of all accused in physicians' fraud cases have been found guilty. The chances of a physician going to jail for medicare fraud are less than infinitesimal, only 15 doctors have served some time in

jail as a consequence of medicare fraud since the very beginning of the program 10 years ago.

The chances of having a license revoked or being terminated from the medicare program are nonexistent, we found only two physicians who had their licenses revoked and none have been terminated from the medicare program since its beginning in 1965.

It is obvious that the great majority of physicians who are caught abusing the system are simply asked to pay back the money, or some portion of it, that they have stolen. Even those that are indicted on as many as 60 or 70 felony counts are allowed to plead guilty to 1 or 2 misdemeanor counts upon a promise to repay moneys fraudulently obtained.

In some cases minor fines are involved. Significantly both these repayments and many fines leveled at the practitioner for fraudulent practices are almost invariably paid out of future medicare earnings.

The long and short of it is that the message that we have given physicians is, "Go ahead and steal. The worst thing that can happen to you is that will will be asked to pay some of the money back.

"The odds are you will never be caught. And if, by some accident, you are caught, you have had the use of all this money for several years."

It is a strange sort of punishment, a Government subsidized, interest free loan for physicians.

Under these conditions it is a bit curious to me that more physicians do not choose to cheat the system. Like the doctor I quoted when I began my remarks, the only thing they are afraid of is the Internal Revenue Service, and, fortunately for them, the IRS has been singularly inactive when it comes to pursuing the leads referred to it by the Program Integrity Unit of the Bureau of Health Insurance.

The Department of Justice and the various U.S. attorneys office, with the exception of the southern district of New York and middle district of Pennsylvania, have given medicare cases absolutely the lowest priority.

Since by definition, these cases involve the sick and elderly, time is of the essence. In such cases, justice delayed is truly justice denied. The great number of cases that are declined for prosecution each year largely result from the death or disability of crucial witnesses.

Unfortunately, these cases languish in the offices of U.S. attorneys for years. It is apparent that medicare cases are not considered glamorous; that there is resentment in having to work with the elderly.

It seems that before the bar of justice, as in every other aspect of human life, the elderly are relegated to the rock bottom priority.

Yet another measure of the effects of this delay is the fact that 320 civil fraud counts with a value of over $1 million have been lost to the medicare trust fund by the running of the statute of limitations.

Cases simply sit around until they expire. Undoubtedly, all this fraud and lost money has its effects in terms of higher medicare costs and reduced medicare coverage for the elderly.

Finally, a word should be added about the permissive judges who refuse to give physicians jail sentences in the face of 50 or 60 felony

counts against them. As noted above, the average sentence in all fraud cases in Federal district court is 20 months while medicare convictions are statistically at zero.

This situation can no longer be tolerated. Nor should we tolerate the curious twist of logic which sentences those who have been found guilty of defrauding the sick and the elderly to do several months community work with the sick and aged.

There comes a certain point when physicians, like other lawbreakers, must be put in jail. To do otherwise, is to make a mockery of the laws we have enacted and to ridicule the great majority of honest physicians who observe the law.

I recommend therefore the immediate enactment of S. 3205. A fraud and abuse unit is important now and will be even more so in the future. At the present time, there is little exchange of information between medicare and medicaid.

It is imperative that the Inspector General be given subpena powers as well as access to all medicare-medicaid and State files.

The Internal Revenue Service should begin a systematic review of all medicare and medicaid providers whose billings exceed statistical norms. By law, States now report to IRS the names of all physicians making $500 or more from the medicaid program.

Similarly, the Postal Service should work out a cooperative agreement to work with medicare and medicaid personnel.

The Department of Justice must undertake procedures to bring medicare and medicaid violators quickly before the bar of justice. Consideration should be given to expanding the number of U.S. attorneys with the thought of designating a certain number of assistants in each region to handle prosecution of medicare and medicaid cases.

Medicaid forms should bear the warning that fraud of the program is a Federal crime because of the large share of funds coming from the Federal Government. Many violators now contend that they do not violate Federal law by stealing from medicaid.

Medicaid regulations now require the release to the public of the names of all physicians making more than $100,000 from that program. Inexplicably, medicare regulations prohibit a similar disclosure of the names of providers over $100,000.

I believe this committee should intervene to make the medicare list available in view of the strong public interest and our desire to make medicare and medicaid consistent.

In the nursing home context, I have several bills which I will not discuss at this point. I will have my staff sit down with the staff of this committee and express my thoughts along these lines.

I must apologize for the length of the statement but it is something on which our committee has been working for a number of years.

Senator TALMADGE. Thank you, Senator Moss. That is one of the best statements I have seen in this area since I have been in the Senate. It is concise, goes into detail, particularity. You and your subcommittee are to be commended and the taxpayers of this country owe you and your subcommittee a great debt of gratitude for what you have done, in bringing this matter to a head.

Incidentally most of the recommendations you have made, I believe, are included in the bill, specifically making it a felony instead of a

misdemeanor in these particular cases which we hope will be a deterrent to further fraud and abuse.

You are probably aware of the fact that in 1970, we started turning over to IRS a report on the amounts physicians had received in payments.

IRS has collected countless millions and millions of dollars in additional tax payments from people who have abused this program and failed to report their income. You went into great detail about errors and fraud which your subcommittee uncovered in respective States.

Was that submitted to the Department of Justice for appropriate prosecution?

Senator Moss. Yes; we did submit those cases that we uncovered.

Senator TALMADGE. Did the Department of Justice proceed to prosecute in those areas?

Senator Moss. The two districts that I mentioned, central Pennsylvania and the southern district of New York, have been very cooperative. We turned over our report to Mr. Richard Thornberg, Chief of the Criminal Division, Department of Justice here in Washington.

Mr. Skinner of the attorneys for the northern district of Illinois has been very cooperative as well.

Senator TALMADGE. Has Mr. Thornberg stated why the other assistant attorney general, or prosecuting attorneys in the respective districts have not taken action?

Senator Moss. He has not furnished us with any explanation or reason.

Senator TALMADGE. I hope you will pursue further why they are effective in some areas and ineffective in others.

I think the greatest deterrent to violating the law is the certainty of swift and sure punishment. That is a matter for the Justice Department to proceed with.

As you are a former prosecuting attorney yourself, do you not agree that is a great deterrent in violating the law?

Senator Moss. Indeed it is. The thing I mentioned here were the number of cases, they sit and just get so old that finally the statute is run and nothing is done on them. It is an intolerable thing not to proceed.

Senator TALMADGE. As you know this bill not only includes the appointment of inspector generals on fraud and abuse but also authorizes HEW to prosecute cases themselves. Would you concur in that?

eSnator Moss. Yes; I am aware of that. I think that is an excellent idea. We constantly get into the question of whether the Justice Department is being bypassed in any manner when the investigative arm is right there and when the responsibility for protecting that money is lodged in one of the departments of our Government, I think it is the legal division who can proceed to recover money or to punish those who commit criminal offenses more directly and with less likelihood of delay than we have been encountering by going to Justice.

The usual provision—I could not remember for sure the bill—the provision that comes to my mind is of course Justice may always opt to take it but when Justice does not opt to take it, HEW may.

Senator TALMADGE. If they fail to act, then HEW can act on their own, that is the provision in this particular bill.

Senator Moss. I do not believe that Justice ought to be cut off if they want to take it.

Senator TALMADGE. I agree. I do not think they should be preempted if they perform their duties, but if they drag their feet, as you say in many instances you reported, then I think HEW must be empowered to act.

I read your entire statement, Senator, and some of it you did not—I believe you stated that the fraud was limited to only some 4 or 5 percent of the doctors.

Senator Moss. That is true, about 4 percent. I wanted to make that clear because when you bring out criticism of course it spreads across the whole thing. I did not want to indicate——

Senator TALMADGE. You certainly did not want to blacken the entire profession.

Senator Moss. No; I do not.

Senator TALMADGE. Governor Busbee of my State testified Monday in behalf of the National Governors Conference and made somewhat the same statement. He stated, however, that over-utilization, in his judgment, was three times as great in its expense as fraud and abuse.

Did your subcommittee find something similar to that?

Senator Moss. I do not know about percentage but there is over-utilization, yes. That is something that great attention should be given to.

Senator TALMADGE. I believe you stated that outright fraud amounted to about 10 percent of the total medicaid payments which was $14 billion last year. If we could eliminate the fraud, it would save some $1½ billions in the item alone?

Senator Moss. That is correct. That much is being lost.

Senator TALMADGE. So if overutilization is three times as great as the fraud you are talking about $5 or $6 billion annually that is wasted in this program?

Senator Moss. That is true.

Senator TALMADGE. That is unnecessary.

Senator Moss. Yes, sir.

Senator TALMADGE. As you know, the rate of expense has gone up, some 20 percent annually, some $30 billion in 1 year to some $37 or $38 billion this year. That would slow the rapid escalation if we could eliminate the fraud and abuse?

Senator Moss. Yes.

Senator TALMADGE. Did you find kickbacks almost 100 percent prevalent on these laboratories you talked about?

Senator Moss. Yes; they were. On all of these store front laboratories, kickbacks was the way they live. The thing I have pointed out, we saw sitting right in this area, this great hospital, this Masonic Hospital with one of the finest laboratories mentionable, very modern and they said we cannot get any of this business because we will not make any kickbacks.

Senator TALMADGE. These kickbacks are not only violative of the law but they violate the standards of ethics of the medical profession, do they not?

Senator Moss. They surely do. It is amazing how readily a number of the physicians talked with us about it.

Senator TALMADGE. Thank you, Senator Moss. You were very, very helpful. I hope that you disseminate your remarks as widely as possible in Congress and among the people generally so that they will understand what is going on.

Senator Moss. Thank you very much, Mr. Chairman.

[The prepared statement of Senator Moss follows:]

TESTIMONY OF SENATOR FRANK E. MOSS, CHAIRMAN OF THE SUBCOMMITTEE ON LONG-TERM CARE, SENATE COMMITTEE ON AGING

Mr. Chairman and Members of this Committee: It is a pleasure for me to be here this morning to testify in favor of S. 3205, the Medicare-Medicaid Administrative Reimbursement and Reform Act as introduced by the distinguished senior Senator from Georgia. I am pleased to be a cosponsor of this bill.

As Chairman of the Subcommittee on Long-Term Care of the Senate Committee on Aging, I have enjoyed working with the staff and members of the Senate Committee on Finance. I marvel at your ability to get through an incredible work load each year and to do so in such grand style. Through the years, we of the Committee on Aging have perceived our role as aiding this and other legislative Committees by providing in-depth research relating to problems of the elderly. In this connection, most of you know I have chaired more than 40 hearings in the past six years relating to various aspects of the Medicare and Medicaid programs.

Many of the hearings I conducted related exclusively to nursing home problems. We have produced a 12-volume report and I have introduced a number of bills that I would like to urge you incorporate into S. 3205.

In September of last year Senator Edmund Muskie and I held joint hearings on what I call the real crisis in health care, that is, the widespread fraud and abuse which robs the taxpayer of both his tax dollars and the health care he needs. These hearings related to practitioners in the Medicaid program associated in one way or another with long-term care. The problems disclosed were so serious that in October of last year, I summarized our preliminary findings in a speech. I ended by declaring war on fraud and abuse. I must say I was delighted to find that Senator Talmadge and others of you in this Committee are in the trenches with me.

The first phase of our intensified investigation related to fraud and abuse among clinical laboratories and to related fraud by physician-practitioners in so-called Medicaid mills, small clinics which checker the ghettos of our major cities, catering to those who walk in off the street with Medicaid cards.

As many of you remember, working together with the Better Government Association, we rented a storefront in Chicago, pretending to be a group of practitioners opening for business. A sign in the window and a telephone number announced: Professional Inquiries Invited. It wasn't long before our telephone started ringing off the hook. Twelve laboratories appeared at our storefront, and offered our investigators kickbacks ranging from 25 to 55 percent if we would agree to send all our laboratory business to that particular laboratory.

Armed with information that twelve laboratories gave kickbacks and the general amount that was offered, investigators sifted through paid billings in the Illinois Comptroller's Office and constructed a profile on each laboratory. We knew precisely which physicians used each of the twelve laboratories. We then selected 50 physicians for interview for this list.

The physicians which our investigators found were primarily foreign medical graduates working for Medicaid mills. When confronted with our information, they readily admitted receiving kickbacks from the laboratories as well as from other providers.

However, in at least half of the interviews, the foreign-trained physicians were not the recipients of the kickbacks. We learned that the illegal rebates were being paid to the businessmen who owned the Medicaid mills. We were amazed to learn that many of these physicians were working essentially on commission. They were allowed to keep only 20 to 40 percent of the monies they generated from seeing Medicaid patients. Clearly, the incentive is to "optimize patients"—that is, to see as many patients as possible and to order as many tests as possible. In our financial analyses we found that some Medicaid mills receive over a million from Medicaid each year. Of this amount, more than 50 percent was going to various businessmen who owned or rented the real estate.

The report drafted by our Committee staff called attention to these matters, adding a number of startling conclusions. For example, the report concluded that one dollar out of every five paid for clinical laboratory services is fraudulent. It concludes that a small number of laboratories control the bulk of Medicaid business.

In New York, 17 labs control 70 percent of the Medicaid business. In New Jersey, 12 labs control nearly 60 percent of Medicaid payments. In Illinois, 26 labs control over 90 percent of the Medicaid business.

The report concludes that, at least in the States which came under investigation, kickbacks are widespread among labs specializing in Medicaid business. In fact, it appears to be necessary give a kickback in order to secure the business of physicians or clinics who specialize in the treatment of welfare patients.

The average kickback to physicians or medical center owners in Illinois was 30 percent of the monthly total the lab received for performing tests for Medicaid patients. Kickbacks took several forms including cash, furnishing supplies, business machines, care or other gratuities as well as paying part of a physician's payroll expenses. Most commonly it involved the supposed rental of a small space in a medical clinic.

The report concludes that it is apparent that the law passed by the Congress in 1972 prohibiting kickbacks and mandating a $10,000 fine and a year in jail upon conviction is not being enforced.

When I was confronted with an early draft of this report, I was shocked by the conclusions that the staff reached in their work with Chicago's Better Government Association. I decided to go to that city and see things for myself. Accompanied by Senator Pete V. Domenici of New Mexico;

I saw the proliferation of so-called Medical Clinics spreading like mushrooms all over Chicago;

I saw their glaring signs beckoning Medicaid patients to utilize health care services;

I visited a postage-stamp size clinical laboratory which billed Medicaid for almost $200,000 last year. There was little in the way of equipment and no lab technicians in evidence. While the owner assured us as to the quality of the work performed, I heard from the owner himself that he chose to send his wife's blood test to another laboratory.

I visited the sparkling new Laboratory of Illinois Masonic Hospital and saw its sophisticated new machines only to learn that the hospital could not obtain much Medicaid lab business because of its refusal to offer kickbacks.

I interviewed a physician who received over $100,000 from Medicaid last year. I asked him to check 9 lab invoices presented to Medicaid for payment by D. J. Clinical Laboratory of Chicago against his records. The doctor told us that he had not ordered 55 percent of the $259.00 total in lab tests for which D. J. had billed the Illinois Medicaid program on these 9 invoices. This same doctor told us that he received a rebate of $1,000 per month from the laboratory in exchange for sending them all this Medicaid business. The kickback was disguised as rent for a 6 x 8 foot room in the physician's office. The doctor's rent for the entire suite was $300 a month and yet he received $1,000 per month for the "rental" of a 6 x 8 room!

Finally, I interviewed a businessman who owns two medical clinics employing foreign-trained doctors who received about $300,000 in Medicaid payments last year. This man admitted sending all of his lab business to one company in Chicago. He told us he received a rebate of 50 percent of the amount Medicaid paid for laboratory tests which physicians in his clinics ordered for welfare patients.

I cite these facts to you in support of the contention that fraud and abuse is rampant in the Medicaid program. In my view, this is because of the bifurcated nature of the Medicaid program. Both the States and the Federal government are looking to each other to prevent fraud and abuse. Technically, the States are responsible, at least that is my reading of Title 19.

It was established as a State-administered program. The problem is that most States have abdicated this responsibility. One need look no further than the statistics maintained by HEW's Social and Rehabilitation Service to see that the majority of our States are inactive from the point of view of locating and preventing fraud. For example, in the quarter ending June 30, 1975, there were a total of 1,394 Medicaid fraud cases pending. Some 1,119 of these were in four States: Michigan (318), Pennsylvania (137), Massachusetts (125), and Ohio

(539). The State of California was not included in the totals, but it is the fifth State that has a fairly aggressive fraud prevention unit. On the opposite end of the pole is the State of New York which despite receiving almost one-quarter of the $14 billion we paid out in Medicaid payments had a total of 30 fraud cases pending.

The provider abuse and surveillance activities in the City and State of New York are in a shambles. Despite the fact that Federal funds have been made available at the rate of 90 percent for development and 75 percent of the operating costs of automated data systems, the management systems at the State and county level have not been modified since the start of the Medicaid program 10 years ago. New York City, despite an impressive computer capability, does not have such rudimentary fraud detection aides as provider, vendor, and recipient profiles. All of its files beyond the past 3 months are stored in pasteboard boxes in a warehouse in Ryerson Street in Brooklyn. Efforts to prosecute cases have been hampered by the inability to retrieve the original invoices submitted by providers which are in these cardboard boxes, often broken open and scattered about. One city employee on the scene told us that "if we can recover 50 percent of the invoices we want, we're lucky."

I do not mean to suggest that there are not a great many qualified people in New York and elsewhere who are working hard to change these problems. I simply offer my view that most States are failing to make an acceptable improvement. Nor am I impressed by the recent decision of our well-meaning Secretary of Health, Education, and Welfare to employ the bulk of the some 100 new Medicaid investigators in a series of lightening raids on various States to root out evil and then to move on. I suggest we need an aggressive and continuous pressure exerted against those who would abuse the system rather than this kind of transitory foot patrol.

At this time, I would like to provide this Committee with a quick overview of the next report to be released by my Subcommittee. It is entitled, "Fraud and Abuse Among Physicians Participating in the Medicare Program." I emphasize, that this report represents, in part, our analysis of the medicare program because up to now I have been speaking about Medicaid. I should like to begin by reading quotations which have been excerpted from an investigative tape made by law enforcement officials in the Southern District of New York. I include this to show the degree of sophistication of those who would abuse the program. Names have been withheld as both doctors are being held for trial. Dr. B. is the owner of several clinics in New York City. He was caught indulging in massive fraud and agreed to assist in the investigation, implicating other providers. At his request, he was fitted with a hidden tape recorder and instructed to let the subject of the investigation, Dr. S., do all the talking. There has been some editing on our part for clarity. Portions are condensed. The tape in its entirety runs nearly an hour. But the quotations are exact.

Dr. B.: "How many of us do you think are involved?"

Dr. S.: "We are all involved. As far as getting caught, they only have the paper to go on. You gotta know how to read the paper. When they confront me with a billing I presented, I just don't remember. All you tell them is, 'We're interested in good medicine,' that is all you have to say."

Dr. B.: "How many people have you got working for you?"

Dr. S.: "The only people I got was to chart an invoice. Once the chart is all made up and the invoice is all made up, I put in the patient's number down and submit a bill. Who is there to dispute this. Whether you did anything for the patient or not, who is going to see?"

Dr. B.: "Hum."

Dr. S.: "You see the trick is never to put down or to charge for a patient you didn't see. When I billed for a sed (sedementation) rate or a CBC (complete blood count), or whatever, I always drew blood. Where the blood went I did not know."

Dr. B.: "One of the most common thing is to bill each patient as if it was his first visit to get the higher rate. Suppose they hit you with that one?"

Dr. S.: "My attorney says I don't remember—I don't even remember what I put down for 95 percent of my patients. He also says, 'You're close to the statute of limitations, so stall. They are going to run out of time unless you give them the nails they need to drive into your coffin'."

Dr. B.: "Suppose they bring in one of their house doctors to examine your bills?"

Dr. S.: "I don't know what you did in your practice. You don't know what I did in mine. So what can the expert tell them? He'll say, 'He is a good doctor so far as I know.' The nurse, is she going to argue? She wasn't even in the room with you when you saw the patient. So you come down to the patient. He is going to say what? 'I only saw the doctor ten times in three years'? You see there are only three parties. Doctor, nurse, and patient. The doctor is easy to wrap up, the nurse doesn't know and the patient isn't going to remember. If the patient walks in here and I bill him for a vaginal smear, what is he going to say? How is he going to describe what I did and didn't do? How is he going to know how long it should take or what the procedures are?

If they ask you did you ever put down for a patient you didn't see, you say, 'I don't recall.' If they ask you, 'Would you do that?' You say, 'No, that is dishonest, I wouldn't even think about it.' 'Did you do these procedures?' 'I wouldn't even think about it.' 'Is this your signature?' 'Yes, but that's not my writing. The girl did the work. I should read it more carefully, they must have made a mistake'."

Dr. B.: "I see."

Dr. S.: "I am trying to tell you doubts. You create doubts. Who can disprove it? The nurse? Do you think she can remember any better than you? The nurse is out. The doctor is out. I am not going to cast mud on anyone. The patient, that's where it's at, that's the one they are interviewing. Patients from three to four years ago. And you know the type of intellect patients have to begin with. This is why I never put down for a CBC or a sed rate or whatever if I don't draw blood. They remember if you give an injection. I don't like going through the routine of doing it but it must be done."

Dr. B.: "Yeah."

Dr. S.: "There is no way to prove a thing. Even if they show you the worst piece of paper you ever wrote, there is no way to prove a thing. You never put through for a patient you didn't see, the patient might have been on vacation or in the hospital. That's the only way that they can hang you. I'm not that stupid. It is stupid to write bills on patients you didn't see on dates you weren't in your office. Other things (kinds of fraud) are all right. But if you put down anything strange, you'd better set a date or a note explaining it. Those are the things they look for."

Dr. B.: "What about Medicare?"

Dr. S.: "I am very careful about Medicare. I do not want to take too much money from Medicare. I know they are going to investigate. I never wanted to earn more than $40,000. I drop it in the summer and pick it up in the fall."

Dr. B.: "Do you manipulate that program?"

Dr. S.: "Did we do something wrong. Yes, of course, we did. But they can't prove it. Can they prove we didn't do this or that procedure? It all comes down to memory. I am telling you I don't remember. Remember and all you do is create problems for everyone. Who is going to know what goes on in my office? Unless they investigate me personally, they are never going to know.

"So the nurse maybe put down the wrong date. What nurse?

"I don't remember, if they ask you a specific question beginning with did you ever ——, you say 'no.' If they ask, would you consider writing ——, You say, 'I wouldn't do that, that's wrong, that's illegal.'

"The best they've got is the patient's word against yours which always leaves room for doubt and a good attorney will tear them to shreds."

Dr. B.: "What about kickbacks?"

Dr. S.: "A million guys a year ask me for kickbacks. They can't prove it."

Dr. B.: "Uh-huh."

Dr. S.: "The next thing from here is income tax. That they can prove. From that, they investigate you personally. They do a cost of living on you and you've got trouble. We are all looking for an angle but get involved with the IRS and they have got you. There's no statute of limitations. Whatever there is to find, they are going to find. They'll stay with it for years and you've got big trouble."

In the preparation of our report on physician abuse in the Medicare program, we received invaluable assistance from Mr. James Cardwell, Commissioner of Social Security, who allowed us to examine Medicare fraud cases maintained by The Bureau of Health Insurance's Program Integrity Unit. We found the work of this unit effective nationwide, efficient in sharp contrast to the administration of the Medicaid program. The principal problem we found with Medicare's administration is that the Program Integrity Unit is too small to do what is

expected of them. Secondly, their hard work is often lost on United States Attorneys who relegate Medicare fraud cases the very lowest possible priority.

In the course of preparing our report, we reviewed every case referred to the Justice Department for prosecution from the following 25 States: Arkansas, California, Colorado, Connecticut, Florida, Illinois, Indiana, Iowa, Maryland, Massachusetts, Mississippi, Nebraska, New Mexico, New Jersey, New York, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Washington and West Virginia.

Since it was organized in 1969, the Program Integrity Unit has handled over 20,000 cases of fraud and abuse. Some 49 percent of all the fraud cases and 73 percent of all the abuse cases relates to physicians.

HOW ARE CASES GENERATED?

Most of the cases come to the attention of the Program Integrity Unit as a result of a beneficiary's complaint. Medicare, unlike Medicaid, sends a carbon copy of every paid bill to the beneficiary. Many patients complain to Medicare that they did not receive the services indicated or did not see the physician on a particular day. While most beneficiaries complain directly, sometimes they channel their complaints through their Senators and Congressmen. A second source of cases is the carriers and fiscal intermediaries employed by Medicare. These insurance companies are hired by Medicare to screen and pay bills. When they uncover suspicious practices by physicians and others who exceed statistical norms, they refer such providers to the Program Integrity Unit. Other sources of cases include the news media in the five States mentioned above who have active Medicaid investigative units, referrals to Medicare from Medicaid are quite common.

HOW MANY PEOPLE ARE THERE IN MEDICARE'S PROGRAM INTEGRITY UNIT AND HOW DO THEY OPERATE?

At the present time there are 123 people in Medicare's Program Integrity Unit located in each of the ten regional offices and in the headquarters office in Baltimore. Since there were 107.9 million claims presented to Medicare for payment in fiscal 1975 and $14.2 billion paid out, this means that there is one Program Integrity specialist for every 878,048 claims received. Similarly there is one Program Integrity specialist for every 195,000 Medicare beneficiaries and for every $115.5 million in payments under the program.

Most of the cases these investigators receive are resolved or settled by BHI. Only the most serious cases can be pursued with existing manpower by the Program Integrity Unit. Of the almost 10,000 cases against physicians only 400 were referred to the Justice Department.

Upon receiving a complaint, Medicare investigators take a valid sample of the providers paid billings. Approximately, 30 bills are selected at random. Beneficiaries are then interviewed and asked if they received various services. If a high percentage of these patients deny receiving services, the provider is marked for more intensive investigation. Formal affidavits are taken and all the facts are turned over to the United States Attorney holding jurisdiction with a recommendation for prosecution. Medicare investigators include two figures, one relating to actual provable fraud from among the 30 cases they selected. A second figure is an extrapolation from the provider's total billings. It is essentially an educated estimate of amount of total fraud.

United States Attorneys then accept or decline cases for prosecution.

WHAT ARE THE MOST COMMON KINDS OF MEDICARE ABUSE?

As noted, the great bulk of Medicare fraud and abuse cases relates to physicians. Most common cases include:

(1) Charging for servives not covered under the Medicare Act.

(2) Charging for services not rendered.

(3) Charging for work performed by others unqualified to reecive Medicare payments.

(4) Soliciting, offering or receiving kickbacks.

(5) "Upgrading" of claims, that is, charging for major surgery when minor work was done.

(6) Unnecessary surgery.

(7) Gang visits to nursing homes—walking through a facility and billing every patient in the home for a visit and examination.

(8) Overutilization, that is, bringing patients back to the office again and again absent medical necessity.

(9) Brokering or laboratory procedures—billing as if laboratory tests were performed personally and by hand when, in fact, they were performed at an automated laboratory for a fraction of the cost.

(10) Charging patients for service after accepting Medicare assignment.

CASE HISTORIES OF MEDICARE FRAUD

The following case histories are provided by way of illustrating the kinds of rip-offs that occur. Medicare regulations bar the release of names.

Case 1

Medicare investigators charged these two New Jersey osteopaths with a variety of abuses including double billing, charging both Medicare and Medicaid for the same services, collecting illegal cash fees from Medicare patients who had assigned their Medicare claims to them, filing false statements, destruction of records to avert accountability and billing for tests not performed. Two indictments were handed down against the doctors.

The first charged that they were illegally dispensing narcotics (not in pursuance of their medical practice). Allegedly, the defendants would talk briefly with persons coming into their offices requesting narcotics and would write prescriptions for drugs without conducting an examination. For a fee the prescription would be given to the persons requesting the drugs who would then take the prescription to a pharmacy.

The second indictment alleged conspiracy to file false claims. Some 22 instances were given where the osteopaths billed Medicare for electrocardiograms, urine tests and blood sugars which the patients said they did not receive. In still other instances, patients were requested to return to the office every two weeks for additional check-ups. As a consequence, additional bills were submitted to the program with no sound medical reason for doing so.

A press release issued from the U.S. Attorney's Office in 1974 reads: "If convicted on all counts of this, the first indictment, each defendant faces a maximum sentence of 205 years imprisonment and a $210,000 fine.

"If convicted on all counts (of the second indictment) each defendant faces a maximum sentence of 25 years imprisonment and a $40,000 fine."

The doctors pleaded guilty and, despite the massive evidence, received a suspended sentence. There is no record of any fine being imposed against them or any funds having been recovered. They were ultimately reinstated in the Medicare program.

Case 2

Medicare learned that this New Jersey physician was billing for surgery, specifically the removal of cancerous lesions, which he did not perform. In most cases he was removing small warts and growths when no malignancy was involved. He also charged for the removal of large lesions for which Medicare pays a higher rate because more time and surgery is involved; in this procedure, stitching is required to close the wound.

The investigation focused in on these complicated procedures: the removal of what was described as large lesions requiring many stitches. Of the 24 beneficiaries interviewed, 21 substantiated that no stitches were needed or provided following surgery. As an example, the doctor submitted a bill for the removal of "two basal cell carcinomas requiring 14 subticular and 28 silk sutures." The beneficiary said the doctor removed two small warts and that no stitches were required. The doctor merely applied a salve to the wound instructing the patient to bathe it in witch hazel every four hours. It was his practice to call back each patient one more time to look at the wound.

Pathology reports confirmed that growths this doctor removed were not malignant. The 42 claims occasioned by the fraud resulted in an overpayment of $5,255.59. While Medicare investigators could only prove some $5,000 in fraud they extrapolated and projected $14,677.31 as the approximate amount of fraud committed in one year.

The doctor pleaded no defense to one of 13 felony counts. He was fined $1,000 and placed on two-year probation. He made a civil restoration of $14,033.31.

At the time of sentencing, the Judge said: "It is astonishing that a man of your standing in this community, whose income is many times that of the average citizen, should stoop to this theft of the United States government. It is unbelievable. I will not sentence you to a prison term although I have thought about it for some time."

Case 3

Investigators working with California's Medicaid program (Medi-Cal), called this case to the attention of Medicare. It involved a physician who was billing more than $60,000 a year from Medicare, claiming 8 or 9 visits each month to his patients in various California nursing homes. He even continued to bill over a three month period while he was outside the continental limits of the United States on vacation. His technique consisted of making multiple entries in the doctor's progress notes, placing the entries in brackets, making one entry as to the patient's condition after each bracket. A nurse witnessed these procedures and called authorities. She stated that the doctor visited this one particular nursing home only once a month. She charged that he filled out the charts and left without ever seeing any of the patients. The doctor was charged with 39 felony counts and convicted on all counts by a jury. While he faced a maximum 5 years imprisonment on each of the 39 felony counts and a maximum fine of $390,000, he actually received a 3 years suspended sentence and a $58,500 fine.

Case 4

Investigators found that a California podiatrist was trimming toenails and billing for more extensive services. This practice is called "upgrading" of claims. The podiatrist allegedly visits patients in nursing homes. A review of the charts at the nursing homes he visited show an abnormal concentration of nail infections, abscesses, fissures, hematomas, and sub-ungual infections. In a singe day he charged for visits to 45 patients. On another day he charged for 47 patients. The average fee per visit was $25.

In this case Medicare investigators has six beneficiaries who would dispute false claims made by the podiatrist regarding surgeries. The evidence included bills submitted to the government, the doctor's operative reports, hospital pathology laboratory reports, and x-rays of patients' feet.

Three podiatrists were willing to testify that the x-rays show that the bones which the podiatrist said he removed are still in the feet of the six patients. These are bones which do not grow back if they are surgically removed.

All of this evidence was given to the U.S. Attorneys Office in Los Angeles in December of 1973. After having the case for two years, the Criminal Division of the U.S. Attorney's office formaly declined prosecution of the case on December 22, 1975. The rationale was that there is no use prosecuting the doctor absent new evidence that he continues to commit such violations.

Case 5

The Fiscal intermediary did not make payments in this Missouri case because they established that the doctor who allegedly treated the beneficiary for a prostate condition was a dentist. The amount of the fraud was $200. The U.S. Attorney declined to prosecute the case because the money involved was small and the dentist admitted his guilt. When questioned the dentist said that he had gotten into this mess because he had a wife who wanted more than he could provide and that he had been sniffing cocaine. He said this had resulted from his occasional use of marijuana which gave him delusions of grandeur. The case was settled with the dentist paying Medicare back the $200 fraudulently obtained.

Case 6

The beneficiary reported that a Texas physician had billed Medicare for services she never received. It would have been impossible for the doctor to bill on her behalf since she had not been to him in over 4 years. Moreover, even in her previous visits which were long ago, she had not received X-ray or blood tests. Finally, she was in the hospital being treated by another physician on one of the dates for which the doctor had billed Medicare. Some 90 percent of the beneficiaries contacted alleged that the doctor had billed Medicare for services not rendered. Some 61 false claims submitted on behalf of 25 beneficiaries totaling $9,248 were involved. During the course of the investigation the doctor visited all 42 of his Medicare patients in an effort to get them to sign a statement

that they had been coerced to sign statements against him. Several of the complaining parties notified Medicare and refused to sign the deposition the doctor wanted. The case was postponed several times because of Court backlogs but ultimately came to trial on January 27, 1975. The doctor pleaded guilty to 2 counts of fraud. He received 5 years probation, a $10,000 fine, and repaid the program $9,248.

Case 7

An analysis of 39 beneficiaries selected at random disclosed the Colorado doctor had billed 20 of them for services not rendered. The doctor was charged in a 42 count indictment and found guilty of 32 counts of fraud including 1) charging Medicare for visits that never took place; 2) charging Medicare more than was actually billed to the patient; 3) intentionally omitting information or making false statements on request for payment; 4) misrepresenting the amounts already paid by patients on his request for payment forms. At the trial, the physician's bookkeeper testified that she was asked to add extra costs to the Medicare payments in order to "pay for the high overhead" of the doctor's office. She added that she was asked to submit bills for drugs such as B12 and estrogen that are not covered by the Medicare program and that she was asked to represent these as kinds of the limited number of drugs covered by Medicare. The doctor was given one year probation and a $48,000 fine.

HOW MANY CASES HAVE BEEN REFERRED TO THE DEPARTMENT OF JUSTICE AND WHAT HAS BEEN THE OUTCOME?

Since 1969, there have been a total of 459 cases out of a total of 20,219 processed by program integrity which have been referred for prosecution. Of the 459 cases, some 400 relate to physicians.

Of the total of 459 cases referred to Justice, 210 have been accepted for prosecution. Of the 210 cases, there have been 150 convictions; 22 acquittals, 18 dismissals and 20 indictments are still pending.

In addition to the 210 accepted cases, 149 were declined for prosecution. The remaining 100 cases are pending in the offices of United States attorneys with no determination having yet been made as to whether they will be accepted or rejected.

HOW MANY OF THE 150 CONVICTIONS RESULTED IN JAIL SENTENCES?

Only 10 percent of the 150 providers convicted of Medicare fraud actually served any time in jail. The range is from 2 years in jail (received by 3 providers) to 15 days in jail. In addition 2 providers were given one year sentences, 2 were sentenced for 6 months, one received a 4 month sentence, 4 received 60 day sentences, one received a 45 day sentence and one received a 30 day sentence.

HOW DO THESE SENTENCES COMPARE WITH OTHER FRAUD SENTENCES IN FEDERAL DISTRICT COURT?

The National District Attorney's Office provides the information that 13,943 defendants were sentenced in fraud cases by the Federal District Courts for the period 1970 to 1975. Some 33 percent were imprisoned. The average sentence was 20 months. By contrast, 10 percent of Medicare convictions (which are felonies), resulted in imprisonment but the average monthly sentence was statistically zero.

WHY ARE SO MANY CASES DECLINED FOR PROSECUTION BY THE DEPARTMENT OF JUSTICE?

U.S. Attorneys refuse to take Medicare cases for many different reasons, ranging from a heavy workload to the difficulty of transporting witnesses to and from court. The principal reasons seems to be that the beneficiaries who complain are the key witnesses in the case against physicians who are well thought of in the community in general and Medicare, by definition, is limited to the aged and disabled. Quite often, beneficiaries are ill or have died before cases can be made. But more often it appears that U.S. Attorneys and their staff do not regard Medicare cases as glamorous and that dealing with the elderly is viewed as difficult and unpleasant.

Some of the reasons for declining cases from the files we viewed include:

"The witnesses are elderly. They make poor witnesses. They can't remember the exact nature of services they received."

"The witnesses are aged and senile. They are at a disadvantage in testifying against an articulate and well educated physician."

"The lawyers the physician has hired are strong and there is little likelihood we can win the case given the current nature of our proof."

"There is no way to disprove the diagnosis which prompted the doctor's treatment. We can't find anyone who will question his medical judgment."

"The medical profession is held in high esteem. To overcome a doctor's favorable image, in a passive crime such as this the case must be fairly aggravated, which is not shown in this case."

"There is no evidence the physician is continuing to engage in fraudulent practices."

CONCLUSIONS

I would like to close by offering a few conclusions:

(1) The Medicare program is light years ahead of Medicaid from the point of view of fiscal integrity. While a significant amount of fraud continues to haunt the Medicare program it exists, first, because there are too few people in the Medicare Program Integrity Unit to handle the massive caseload, and, second, because of the lack of responsiveness of the Federal Judiciary. By contrast the Medicaid program is, with the exception of the five States I have mentioned, completely without controls. As we stated many times, fraud in Medicaid is massive and widespread. We know this from actual experience.

(2) My estimate of fraud in the Medicare program would be about 10 percent of the entire program or $1.5 billion out of the $15 billion we spent last year. speaking specifically of physician fraud, we estimate that $300 million is ripped off by physicans each year out of the $3 billion paid them by Medicare.

(3) This massive amount of money, $300 million, is stolen by comparatively few physicians. About 10 percent of the 250,000 physicians who participate in the have been accused of fraud and abuse of the Medicare program over the past five years. Speaking more specifically, there have been 20,210 fraud cases investigated by the Program Integrity Unit of the Bureau of Health Insurance, about 49 percent or 9,907 involved physicians. Of the 19,084 abuse cases instituted by Medicare investigators, 73 percent or 13,931 cases involved physicians.

Using these numbers in yet another way, the 9,907 cases of physician fraud in the Medicare program represent only 4 percent of all doctors participating in that program. The 13,931 cases of abuse represent about 6 percent of all doctors participating in Medicare.

In short, the $300 million in fraud is perpetrated by only 4 percent of the medical profession and care should be used to make it clear that only this small minority are involved.

(4) If I had to summarize my presentation before you this morning in a couple of paragraphs, I would say the following. Everything I am about to say about Medicare goes double for Medicaid.

The chances that a physician will be caught cheating the Medicare program are very slim indeed, even given the good work of Medicare's Program Integrity Unit. The chances that a case will be developed are slimmer still; most of the existing cases relate to charging for services not rendered—that variety of fraud which is the easiest to prove. The odds that a case will be referred to the Justice Department for prosecution are extremely small (only 400 cases of physician fraud have been referred to Justice since 1969 or roughly 4 percent of all physicians' fraud cases). The chances of being found guilty are infinitesimal (since less than 1½ percent of all accused in physicians' fraud cases have been found guilty). The chances of a physician going to jail for Medicare fraud are less than infinitesimal (only 15 doctors have served some time in jail as a consequence of Medicare fraud since the very beginning of the program ten years ago). The chances of having a license revoked or being terminated from the Medicare program are non-existent (we found only 2 physicians who had their licenses revoked and none have been terminated from the Medicare program since its beginning in 1965).

It is obvious that the great majority of physicians who are caught abusing the system are simply asked to pay back the money (or some portion of it) that they have stolen. Even those that are indicted on as many as 60 or 70 felony

counts' are allowed to plead guilty to one or two misdemeanor counts upon a promise to repay monies fraudulently obtained. In some cases minor fines are involved. Significantly, both these repayments and any fines leveled at the practitioner for fraudulent practices are almost invariably paid out of future Medicare earnings.

The long and the short of it is that the message that we have given physicians is, "Go ahead and steal. The worst thing that can happen to you is that you will be asked to pay some of the money back. The odds are you will never be caught. And if, by some accident, you are caught, you have had the use of all this money for several years." It is a strange sort of punishment—a government subsidized, interest free loan for physicians.

Under these conditions it is a bit curious to me that more physicians do not choose to cheat the system. Like the doctor I quoted when I began my remarks, the only thing they are afraid of is the Internal Revenue Service and, fortunately for them, the IRS has been singularly inactive when it comes to pursuing the leads referred to it by the Program Integrity Unit of the Bureau of Health Insurance.

(5) The Department of Justice and the various United States Attorneys Offices (with the exception of the Southern District of New York and Middle District of Pennsylvania) have given Medicare cases absolutely the lowest priority. Since by definition, these cases involve the sick and elderly, time is of the essence. In such cases, justice delayed is truly justice denied. The great number of cases that are declined for prosecution each year largely result from the death or disability of crucial witnesses. Unfortunately, these cases languish in the offices of United States Attorneys for years. It is apparent that Medicare cases are not considered glamorous; that there is resentment in having to work with the elderly. It seems that before the bar of Justice, as in every other aspect of human life, the elderly are relegated to the rock bottom priority. Yet another measure of the effects of this delay is the fact that 320 civil fraud counts with a value of over one million dollars have been lost to the Medicare Trust fund by the running of the statute of limitations. Cases simply sit around until they expire. Undoubtedly, all this fraud and lost money has its effects in terms of higher Medicare costs and reduced Medicare coverage for the elderly.

Finally, a word should be added about the permissive judges who refuse to give physicians jail sentences in the face of 50 or 60 felony counts against them. As noted above, the average sentence in all fraud cases in Federal District Court is 20 months while Medicare convictions are statistically at zero. This situation can no longer be tolerated. Nor should we tolerate the curious twist of logic which sentences those who have been found guilty of defrauding the sick and the elderly to do several months community work with the sick and aged. There comes a certain point when physicians, like other lawbreakers, must be put in jail. To do otherwise (as we have been) is to make a mockery of the laws we have enacted and to ridicule the great majority of honest physicians who observe them.

RECOMMENDATIONS

(1) I recommend the immediate enactment of S. 3205. I feel that its central fraud and abuse unit is necessary now and will be even more important in the future. At the present time there is little exchange of information between Medicare and Medicaid. It is imperative that the Inspector General be given subpoena powers as well as access to all Medicare, Medicaid, and State files.

(2) The Internal Revenue Service should begin a systematic review of all Medicare and Medicaid providers whose billings exceed statistical norms. By law, State now report to IRS the names of all physicians making $500 or more from the Medicaid program. Similarly, the Postal Service should work out a cooperative agreement to work with Medicare and Medicaid personnel.

(3) The Department of Justice must undertake procedures to bring Medicare and Medicaid violators quickly before the bar of Justice.

Consideration should be given to expanding the number of United States Attorneys with the thought of designating a certain number of Assistants in each region to handle prosecution of Medicare and Medicaid cases.

(4) Medicaid forms should bear the warning that fraud of the program is a Federal crime because of the large share of funds coming from the Federal government. Many violators now contend that they do not violate Federal law by stealing from Medicaid.

Medicaid regulations now require the release to the public of the names of all physicians making more than $100,000 from that program. Inexplicably, Medical regulations prohibit a similar disclosure of the names of providers over $100,000. I believe this Committee should intervene to make the Medicare list available in view of the strong public interest and our desire to make Medicare and Medicaid consistent.

(6) In the nursing home context, I have several bills which I will not discuss at this point. I will have by staff sit down with the staff of this Committee and express my thoughts along these lines.

Senator TALMADGE. In opening the hearings today, I would like to remind witnesses once again, all presentations and testimony are limited to not more than 10 minutes as I have stated.

The full statement will be made a part of the record, and carefully reviewed.

The next witness is Mr. Edward Beddingfield, medical doctor, chairman of the council on legislation, the American Medical Association. Dr. Beddingfield, we are honored indeed to have you with us.

Your entire statement will be inserted into the record.

STATEMENT OF EDGAR T. BEDDINGFIELD, JR., M.D., CHAIRMAN, COUNCIL ON LEGISLATION, AMERICAN MEDICAL ASSOCIATION, ACCOMPANIED BY HARRY N. PETERSON, DIRECTOR, DEPARTMENT OF LEGISLATION, AMERICAN MEDICAL ASSOCIATION

Dr. BEDDINGFIELD. Mr. Chairman and members of the subcommittee. I am Edgar T. Beddingfield, Jr., M.D., a physician in the active practice of medicine in Wilson, N.C. I serve as chairman of the Council on Legislation of the American Medical Association, and I am pleased to present to this subcommittee the views of the association on the important legislation, S. 3205, before you. With me is Harry N. Peterson, the director of the AMA Department of Legislation.

At the outset I would like to state that this subcommittee is to be commended for these hearings on S. 3205 with its review of certain areas of the medicare and medicaid programs. Major amendments to these programs were adopted in 1972. Subsequent to that time only relatively limited hearings have been held concerning implementation and development of these programs. It is evident that there has been substantial dissatisfaction with major provisions of these laws as well as with regulations promulgated pursuant to the laws.

Dissatisfaction has been voiced by providers and physicians, as evidenced by numerous lawsuits, by Congressmen, as well as by Medicare-Medicaid patients—the beneficiaries of those programs. It is indeed timely that this committee, through its hearings, review these programs as to issues in S. 3205.

However, Mr. Chairman, in considering any changes to medicare and medicaid, it is of paramount importance to consider possible effects upon patients in those programs, and it is equally important to measure the impact of program changes upon those who are not

Federal program beneficiaries—the private patients. We perceive in the amendments before this committee, as proposed in S. 3205, a very strong potential for a continued shifting of segments of health care costs to private patients—costs which are properly the obligation of the Federal program on behalf of its beneficiaries. When this shifting occurs, it not only has ramifications relating to availability of care for medicare-medicaid patients, but it also affects quality of care for all patients.

As to S. 3205, an overview of the modifications this bill would make indicates clearly that the major thrust is cost containment.

The American Medical Association fully supports measures which can properly contain costs so long as such measures do not impair the quality and availability of care for beneficiaries. The medicare and medicaid programs were intended to provide for their beneficiaries the same kind of care received by other segments of our population.

Unless it is now the intent of Congress to alter the status of availability of care and quality of care for medicare and medicaid beneficiaries, it is imperative that any cost containment measures be imposed cautiously so as not to have unintended effects.

We are, of course, aware that Congress faces "hard decisions" in attempting to maintain these health programs at a high standard of quality care while struggling with a means to fund properly all of the obligations assumed by the Government, relating not only to these programs, but also to all other programs.

It must be recognized that the increased demands which have flowed from increased care made available through Government programs have added to the marked increase in total cost of these programs. It should additionally be recognized that health care costs are not immune from natural increases during a period of high inflation as we have been experiencing recently. And it must be recognized that increased expenditures resulting from increased services and resulting also from inflationary costs do not of themselves warrant the imposition of arbitrary cost controls.

We have submitted for your consideration a more detailed and extensive discussion on major provisions of S. 3205. We have indicated our support—and our opposition—to provisions of the legislation. As to some provisions we have suggested amendments. We urge your careful examination of that statement. In the remaining portion of the brief period allotted us during these hearings for oral presentation, I will quickly summarize our recommendations with respect to elements of the bill.

ADMINISTRATION

Under the category of administrative reforms, we recommend that the sections relating to the establishment of a health care financing administration, an office of central fraud and abuse, and the appointment of an inspector general for health administration not be adopted. In our opinion, these provisions are unnecessary, because sufficient

authority is provided in current law to accomplish the goals sought by these provisions. In fact current initiatives are now underway and are being pursued vigorously to accomplish the objectives. With respect to establishment of a separate health care financing administration, we recommend that overall direction of health care programs not be so divided.

We support the principle underlying the provisions establishing procedures for more timely and accurate determinations relative to eligibility and administrative procedures under medicaid. The provisions enabling States to verify medicaid services on a sample basis would also be beneficial.

Concerning the provisions relative to promulgation of regulations, we are firmly on record for modifications of the Administrative Procedures Act to correct abuses which have occurred in the promulgation of regulations. Modifications are needed in order to afford proper opportunity for all interested persons to have meaningful input into the regulation process. Following the promulgation of a proposed rule there should be a minimum comment period of 60 days, with additional time being provided thereafter for the assimilation of comments before the rule is published in final form.

We recommend for your consideration the elements of the proposal developed by the American Medical Association, S. 3358, which is now pending before the Congress. In that bill we addressed certain of the same issues involved in S. 3205. Our bill for administrative rulemaking reform, in addition to providing for an expanded comment period on proposed regulations, would in part also make modifications to require major policy statements, which often affect substantive provisions, such as benefits and eligibility, to be published in the Federal Register. Too often agencies will circumvent the Federal Register process by directives issued through guidelines or policy statements. Our reform proposal also covers many issues not addressed by S. 3205.

As to the last item of proposed change in the section pertaining to administration, we recommend not only a continuation of HIBAC but also a strengthening of its role through proper independent staffing.

PROVIDER REIMBURSEMENT

S. 3205 provides a new methodology for determination of hospital reimbursement. We have strong concerns with respect to this proposal. It would, in effect, classify hospitals and create for each classification an average daily rate—for routine operating costs—which would determine reimbursement under the medicare program. In some respects this provision may ameliorate some of the problems which have developed in implementation of section 223 of Public Law 92–603, upon which similar methodology was imposed. However, we find this averaging of hospital costs to be undesirable. This method, even with the variances allowed in S. 3205, still retains the seeds for reduction of

quality of care. It also creates the probability that costs properly attributable to government programs will be shifted to the private sector. The proscription in medicare law against such shifting would be violated.

We do support in principle the provisions which encourage the closure or conversion of underutilized facilities. We suggest, however, that assistance for these purposes might more appropriately come from funds which have not been earmarked for the direct delivery of health care services.

PRACTITIONER REIMBURSEMENT

A series of provisions under this section of the bill have special applicability to physicians.

The provisions establishing a new statewide prevailing charge level and restricting the applicability of the economic index are objectionable and should not be enacted. Current medicare reimbursement formulas are themselves discriminatory and arbitrary. Now to impose further limitations that would have the effect of denying even the restricted increases allowable by the economic index is most unjustifiable and the proposal should be rejected. Unrealistic and arbitrary ceilings could unfortunately reduce physician participation in medicare.

The provisions requiring physicians to designate themselves as either a participating physician or as a nonparticipating physician, with the undesirable consequences dictated by the bill, would vitiate a fundamental concept upon which the medicare program was premised. These provisions would remove the present option of the physician to accept an assignment or to bill directly on a patient-by-patient basis. They would require physicians to enter into an agreement with the Secretary of HEW to accept assignments from all patients as participating physicians, otherwise they, as nonparticipating physicians, would not be allowed to accept assignments from any.

To support a medicare mandated division of physicians would be both unwise and unrealistic. The proposal is unrealistic in that it would fail to recognize the present appropriate practice of a case-by-case determination as to whether an assignment should be taken. To label a physician as participating only on the basis of whether he accepts a restricted reimbursement is to denigrate the services of other physicians who actually provide treatment for medicare patients, but who would be deemed nonparticipating solely because they chose not to accept assignment for all their medicare patients far in advance of treatment. In our opinion, although the cost to the program would be relatively unchanged, the result would very likely be a decrease in assignments.

The proposal is unwise because, by disallowing assignments on a case-by-case basis, some patients will not seek services of physicians of their choice. This effect would be contrary to the intent and language of the Medicare Act itself.

These provisions offer certain new entitlements to participating physicians, those who must accept assignments for all patients. Certain of the so-called benefits, those calling for more timely payments, are no more than those to which the physician is entitled now. If the medicare administration could in fact fulfill a new mandate of Congress to expedite payments to physicians, as held out in the bill, such a system should, in all fairness and equity, be initiated immediately. It is disheartening, indeed, if advantageous administrative aids are presently available and they are not being used now. The $1 per claim offered as an inducement for physicians to take assignments is an inducement in name only since it is coupled with the requirement that payment in full as determined by medicare must be accepted thus depriving physicians of other appropriate reimbursement procedures. The foregoing provisions, intended to increase the use of assignments, instead only emphasizes the need for examination of the basic reasons why assignments are being shunned.

In our view the provisions as to hospital-associated physicians exceed the proper bounds of Federal action. It is not the role of the Federal Government to specify elements which constitute the practice of medicine generally or in any of its specialty fields. Nor should Federal legislation, by statutory definition, attempt to divide or specify the role of the physician in the practice of medicine. Accordingly, the provisions as to anesthesiology services and pathology services should not be adopted.

Moreover, the section entitled "Hospital Associated Physicians" is not in fact so limited and accordingly is misleading. In modifying the general definition of physicians' services, section 22 of S. 3205 would apply to the entire spectrum of physicians' services in the medicare program. We strongly object to any application of any provision which would limit recognition of what constitutes physicians' services in the communities across our Nation. This section would disregard normal professional relationships and establish as the proper recognition of certain physicians' income only that level which would be received by a salary. We find this premise untenable. These provisions should be rejected.

Concerning the provision which would tie medicaid reimbursement levels to the reasonable charges allowed under medicare, we have strong concerns, and recommend that this provision not be adopted. The medicare level is itself arbitrary and discriminatory, and to peg medicaid reimbursement at a percentage of such an unfair figure should not be countenanced in statute. Moreover, to do so would give an illogical approval for different levels of reimbursement by separate Federal programs for the same services.

We support section 24 to provide payment for furnishing antigens prepared by allergists for medicare beneficiaries.

We support section 25 to facilitate medicare payments in the administration of the estates of medicare beneficiaries.

The prohibition against assignment of physicians' accounts, as proposed, is too broad and should not be adopted.

LONG-TERM CARE

We disapprove of the provision under which the Secretary may overrule the certification by a State agency of a facility for participation in the medicare program.

We support the provision permitting more flexibility in patient absences from skilled nursing facilities.

MISCELLANEOUS

The bill also relates to miscellaneous reforms. We object strongly to section 40 of the bill in several particulars. We find unacceptable the provision which restricts recognition by medicare of certain contractual relationships entered into by the hospitals and professionals. While some individual contracts are not to be condoned, hospital management and physicians should be free to enter into various arrangements in the interests of patient care, with hospital management and physicians remaining accountable to the public. The action of prohibiting any percentage arrangement, however, should not be countenanced.

The additional provision requiring Secretary approval of almost every hospital contract is extreme to say the least. We doubt the feasibility of the proposition just based on volume of contracts involved. But more importantly, we are not convinced that government agencies can exercise the apparent wisdom which is accorded them by this proposal. Government agencies have not demonstrated any special acuity which would warrant its employees passing upon the necessity and propriety of hospital contracts.

We support the provisions relating to contracts with health maintenance organizations. We also approve the provision for expanded recognition of ambulance services with the modifications that we have proposed.

CONCLUSION

In conclusion, Mr. Chairman, we have indicated our support for some proposals and our objections to others. Taken as a whole, this bill should not be enacted unless substantially modified. It would not be in the best interests of medicare and medicaid patients.

We would now be pleased to respond to any questions which the committee may have.

Senator TALMADGE. I have looked over your statement and have studied it in great detail. I do appreciate your contributions. I know that you have testified against the provisions in section 22 relating to the reimbursement of hospital related physicians.

We of course welcome your testimony and the testimony of all other concerned groups on this point. I would like for the record to show at this point statements received by the subcommittee from the American Society of Anesthesiologists, College of Radiologists.

Those are three organizations directly involved, acknowledged the problems, worked with the committee in developing section 22 and are generally supportive of its provisions and several State medical societies provided advice and assistance in the drafting of the section of the bill designed to encourage acceptance of assignments under medicare.

They were not as negative as you foresee the potential of this section. I thought—they thought this might do some good in a noninflationary way. Do you have any comment on that?

Dr. BEDDINGFIELD. I would like to respond in this fashion Mr. Chairman. Of course we acknowledge they are proper, these physicians are members of their specialty society organizations and are likewise part of our constituency in the American Medical Association.

Some of those physicians and those of us in the AMA, while acknowledging that there may be problems, we do not feel the solution to these problems is to set into Federal law definitions of what constitutes the practice of medicine, practice in the various specialties within the medical field by statutory delineation of the elements of medical practice.

We think that this is the thing that should be left to the States in their medical practice. It should be left, as it has been traditionally, to the policing of medicine by itself.

Senator TALMADGE. Radiologists and anesthesiologists are reasonably satisfied and they helped draft the section, Doctor.

Dr. BEDDINGFIELD. I believe they have to speak for themselves. I think there is going to be some subsequent testimony that may not be quite as enthusiastic as that which the Chair suggested.

Senator TALMADGE. Nobody objects to a fee for service. They do render an outstanding service and you cannot run a hospital without radiologists and pathologists and anesthesiologists.

I can appreciate your urging that the Government pay doctors more money in order to solve some of our medicare and medicaid problems, but on Monday the Secretary of HEW, at the Governor's Conference of State Legislatures and the National Association of Counties testified as to their inability to cope with the rapidly increasing costs of the care.

I think it is fair to say that given the State and county financial problems and the Federal budget deficit, it is highly unlikely that significant increases will be made in the payments of doctors.

The fact that some of us may have to work to prevent cutbacks given that background, what specific and I repeat specific recommendations does the AMA have to moderate the high cost of medical care and hospital care.

As you are probably aware, the Budget Committee mandated a $700 million cutback on existing programs. That probably is—that is a problem to me so what specific recommendations do you have?

Dr. BEDDINGFIELD. I would specifically recommend that the Government decide exactly what it wants to purchase in health care for governmental beneficiaries. If the Government wants to purchase first class medical care, high-quality care, accessible around the clock in every geographical area, the Government is going to have to pay for it.

The Government is you, the Government is me, we recognize that. We are fully aware, of course, that there is a limit beyond which Government can go. I think we have to delineate exactly what the Government is going to provide.

Is it going to provide a basic health care program under medicare-medicaid? Or is it going to provide an all inclusive comprehensive program, no holds barred and embracing all the new technology, with good access and high quality as to general good health, and with malpractice lawyers looking over the providers' shoulder, and still expect to get it at bargain basement rates?

Sir, there is no way.

Senator TALMADGE. You are saying that the only way we can reduce the costs is to reduce the benefits?

Dr. BEDDINGFIELD. I think you have to describe reasonably what the benefit package is and then pay a reasonable price per unit of service for getting that package.

Senator TALMADGE. Did you hear Senator Moss' testimony?

Dr. BEDDINGFIELD. Yes, sir, I listened attentively to that.

Senator TALMADGE. Do you have any comment on that?

Dr. BEDDINGFIELD. I do. No. 1, certainly we in the AMA and in the medical profession, do not, will not, condone fraud and the abuse that the Senator was describing.

We question and would like to know more about his figure of even 4 percent. Four percent fraud, what does it mean? Is that alleged fraud, purported fraud? Certainly with the number of convictions, it sounds like this is alleged fraud.

I believe every witness who has appeared before this committee has emphasized and talked about fraud, that the number of physicians involved in contrast to the total population of physicians is very small indeed.

We would like to be able to identify the bad apples. We would like to be able to report them to the local medical society. We, in the AMA, have drafted model State legislation and sent it to all of the States. Passage of that legislation would provide the medical examining boards and licensing boards with stronger tools in dealing with this type of question.

We want them out as much as you.

Senator TALMADGE. That is exactly the thrust of this bill, doctor. What we are trying to do is eliminate fraud, abuse, try to correct all

of the maladministration that we would have in HEW, where there is conflicting-contradictory regulations confusing doctors, hospitals, nursing homes, and everyone else dealing with the program.

I would hope that the American Medical Association would be more constructive and more helpful in trying to help us draft a bill to get these problems that nearly every witness has pointed to that has appeared before our committee in this 3 days.

Dr. BEDDINGFIELD. I think we have been constructive. I reported just a moment ago about some drafts of state legislation that have been disseminated, as a matter of fact has already been in use in several States.

I have two sentences here of an action of our house of delegates that was taken earlier this month. If I may, I would like to read those two sentences.

Senator TALMADGE. Sure.

Dr. BEDDINGFIELD. This was adopted by the AMA House of Delegates in its annual convention in Dallas earlier this month in this regard. "The American Medical Association condemns and deplores all acts of fraud and wrongdoing, including in particular any wrongful acts as recently reported in the medicaid and medicare programs.

"We urge that responsible Government agencies proceed with all due speed in the prosecution under the provisions of due legal process of all who are charged with fraudulent misconduct.

"We will continue to offer our cooperation and assistance in bringing to an end such activities."

Senator TALMADGE. Do you support the provision in the bill making a fraud a felony?

Dr. BEDDINGFIELD. I have no objection to that.

Senator TALMADGE. Senator Dole?

Senator DOLE. I have not been here to listen to your summary remarks and have not had a chance to read your entire statement, but I would be interested in your reaction to testimony we have had from Governor Busbee, and I understand Senator Moss and others, that the problem has not so much been fraud and abuse as it has overutilization.

I think a major concern has been over the practice of pingponging patients around to several doctors for treatment under medicaid for the same condition. What can physicians do to curtail some of this?

Dr. BEDDINGFIELD. The last time that I appeared in this room was during the PSRO hearings. I believe that provided a mechanism for controlling utilization. I do not believe that program has yet been adequately funded by the Congress and adequately cranked up in enough jurisdictions to become effective as a tool to control this problem.

That, I would submit, is the most readily apparent solution of the issue. I believe that overutilization is much more of a problem than fraud in terms of actual dollars and cost savings to the problem.

I believe that as to overutilization, that criticism is not only to be self-imposed in the medical profession but also should be imposed on the beneficiaries of the program and, indeed, at some time on requirements to comply with various governmental types of quality control.

Mr. PETERSON. I would invite the committee's attention to amendments which the AMA has suggested which are pending before the committee to amend the PSRO program with the intent that it would become more effective in its operation.

Senator DOLE. You mention on the bottom of page 17 your reservations with respect to the "participating" and "nonparticipating" provisions of S. 3205. Do you have any feedback from your State medical societies as to how many physicians would support the assignment program contemplated by this bill?

Dr. BEDDINGFIELD. Contemplated by this program?

Senator DOLE. Yes.

Dr. BEDDINGFIELD. No, sir. I have a feeling from talking with physicians around the country. I talked with physicians in every State but I do not have any quantified polling or anything like that to report.

Senator DOLE. What is your personal feeling?

Dr. BEDDINGFIELD. My feeling is that this compulsion to be either 100 percent participating or 100 percent nonparticipating is going to get people away from participating. If I might reflect a personal experience, I practice in a group of 21 physicians in Wilson, North Carolina.

We take assignments up until now 100 percent of the time. We have taken a very careful look at this and are wondering if we are pursuing the right course. We have been proud of the fact that if and when the medicare reimbursement formula becomes so oppressive that we can no longer stay in business with what medicare will pay us at that point, we would like the option to go into selective direct billing.

Now that we have the option patient-by-patient, we have not exercised that option, however, if we were told that we had to go 100 percent in or out, we would go out tomorrow. We still treat medicare people, we would still try to charge reasonable fees, but when medicare gets to where they will not pay those reasonable fees and we cannot receive a reasonable payment—you would be forcing us out.

I do not believe that the incentives, so-called, that are in this bill would be sufficient to keep people in.

I think the net effect would be to drive them out. I think that is the feeling of most doctors across the country.

Senator DOLE. You responded, I think, to a question about getting a handle on the costs of medicare and medicaid by suggesting that Congress consider "whacking" the benefit package. I sit on the Budget Committee as well as the Finance Committee, and since we did, earlier this year, vote out a cut of $1.4 billion in these programs, I am certain these pressures are going to continue.

Accordingly, I wonder if you might have some thoughts on policy changes or methods other than benefit reductions—which are probably not very realistic, politically—for responding to the dilemma?

Dr. BEDDINGFIELD. I believe that is not quite my word, to cut the benefits. I think the Government is trying to describe what the scope of the benefits is, what the duration of its benefits is, and whether you

are going to have a full service kind of program or other—I do not think you can have any kind of open-ended program whether it is health care or anything else. You cannot have a completely open-ended program and talk about getting controlled cost in these inflationary times.

I think to be more positive, we should take a new look at these programs; for example, saying this is how much hospitalization we are going to pay for, this is how much we are going to pay for in physician's services—I think this would be a more realistic way to have people participate, to have physicians participating in this. To say you are going to have cut in half what you are paid and you are going to have inspector generals looking over your shoulder to see if you really did it, is not realistic. It is like being encouraged to participate in the program with a gun at your head.

Senator TALMADGE. I assume you noticed the GAO testimony concerning physician markups on laboratory work which was done out of their offices. This apparently is a rather widespread practice and one which we have been told is contrary to AMA's statement of ethics.

Have you taken steps to remind your membership of their responsibility in this regard?

Dr. BEDDINGFIELD. Yes, sir. We do frequently, by every available communication, remind our members of their responsibility under the medical code of ethics.

I would point out to you that I have not seen the final GAO report. I understand it has just been released. We were given an opportunity to review an early draft of the report and we responded to Mr. Hart, the director of the General Accounting Office, in regard to that. We had several questions about the methodology employed, the size of the sample, the method of selecting that sample, none of which was satisfactorily presented in the document handed to us for review.

There are only a very small number of doctors cited in your own State of Georgia, for example. It talked about only 29 services ordered by 11 physicians in Georgia. Conclusions should not be extrapolated from such small data bases. We have to know more about it.

Certainly we do not condone profiteering off laboratory work, whether it is performed in the physician's office or sent out to a mail-order laboratory, commercial laboratory or somewhere else should also not be condoned.

I would like to hold off comment until we get more details. We are against profiteering.

Senator TALMADGE. If you do not have a copy of the report, I would be glad to provide one to you.

At the bottom of page 5——

Dr. BEDDINGFIELD. May I ask that in response to your question a copy of our letter sent to GAO on the early draft be made a part of the record?

Senator TALMADGE. Without objection, it will be inserted at this point.

[The letter follows:]

AMERICAN MEDICAL ASSOCIATION,
Chicago, Ill., June 17, 1976.

Mr. GREGORY J. AHART,
Director, U.S. General Accounting Office,
Washington, D.C.

DEAR MR. AHART: This is in response to your submission to us for review of a draft GAO report entitled "Need for Improved Controls Over Costs of Laboratory Services Under Medicare and Medicaid." We appreciate having the opportunity to review the document.

The draft report raises concerns inasmuch as the findings of GAO suggest that some physicians have billed for laboratory services in excess of proper charges. To the extent that any charges are improper, the AMA deplores such practice. As you know, this Association has long had a policy viewing such practices as unprofessional.

Our policy was well stated during the Annual meeting of the House of Delegates in 1969 in both a Judicial Council Report and in a Resolution of the House of Delegates, both of which statements were adopted by the House of Delegates.

The Resolution adopted at that time set out the AMA policy and view that it is preferable that the laboratory, and not the attending physician, bill and collect from the patient or third party payor for laboratory services. It did, however, recognize that "where circumstances make this impractical or where increased costs to the patient would result, the bill submitted by the attending physician to his patient or third party payor should state the name of the laboratory performing the services for his patient and the exact amount of the charges paid or to be paid by the physician to the laboratory." The policy statement also recognized that the attending physician is entitled to "fair compensation for the professional services he renders."

As to laboratory services which the physician performs for his own patients, his bill should provide information to show where such services were performed, as well as an adequate description of the services provided and the specific charges made.

That policy as adopted does not, however, contemplate that a physician forwarding a sample to a laboratory should not be entitled to a fair charge for his own professional service, which may include an interpretation of results of the laboratory tests, and does not preclude any proper handling charges for collecting and forwarding samples.

As to the draft GAO Report, we note that it is based on an extremely small sample of physician charges for laboratory services. For example, statistics cited are based upon: 78 services ordered by 7 physicians in Florida, 29 services ordered by 11 physicians or physician groups in Georgia, 50 case in California from two different carriers (only 28 cases were cited as involving 10 physicians and were the cases cited as excessive), 23 cases pertaining to 13 physicians in Arizona, and 10 procedures ordered by 12 physicians or groups in the Washington, D.C. metropolitan area.

It is obvious from even a cursory reading of the Report that the numbers of physicians and cases cited is extremely small. Moreover, the total group sampled, if there in fact was a true sampling process, is not identified.

The fact that the numbers cited are very small in terms of the total number of physicians in any area and in terms of the total number of laboratory procedures performed in each area does not condone improper activities. However, it is equally improper to cite significantly few statistics to support the conclusions of the draft report that "Medicare and Medicaid often pay substantially more for laboratory services than the prices charged for such services by independent laboratories" (emphasis ours). Moreover, there is nothing in the report which would deny justification for the "markup" or any portion thereof. As a matter of fact the Report specifically acknowledges that the findings were not discussed with physicians "who marked up on laboratory services." We believe that unsubstantiated general conclusions give an unfair impression that the Report identified widespread abuse.

We are also concerned that the limited data cited spans a period of three years (1972–1974).

As to Section 224 of P.L. 92–603, implementation of which is cited by the Report as necessary, we are concerned that an overly strict interpretation of its

provisions by Medicare and Medicaid would result in its imposing upon laboratory reimbursement a level which corresponds to the lowest cost for which a laboratory service has been offered in the area without any proper determination of whether such services are "widely and consistently available in a locality."

If section 224 is interpreted solely in terms of cost, we are concerned that the imposition of "lowest level" (determined on the basis of statistics alone) will not properly consider availability, continuity, and quality. Cost, although of a concern, must be secondary to quality. Beneficiaries of federal programs should not be denied services which are, in the judgment of the attending physician, most appropriate for the patient.

We would therefore urge caution in strict and over-zealous imposition of Section 224 on laboratory service reimbursement.

In conclusion we would like to point out that the AMA supports proper reimbursement for physicians performing professional services. We also support reasonable, necessary actions taken to assure that possible fraud or abuse in health programs will be prevented. It is necessary, however, to recognize that the overwhelming proportion of physicians practice in a responsible manner.

In our view the draft Report lacks proper balance and lacks clear identification of a proper methodology. Accordingly, we would urge that the Report not be issued in the present form.

We would again express our appreciation in having the opportunity to review the draft Report.

Sincerely,

JAMES H. SAMMONS, M.D.

Senator TALMADGE. At the bottom of page five in your statement, you say that it is unnecessary to enact legislation establishing an Office of Central Fraud and Abuse Control because HEW already has authority to investigate fraud and abuse.

You say you are indeed impressed with the recent activities of HEW and its fraud and abuse activities. Could you tell us exactly what achievements have impressed you the most?

Dr. BEDDINGFIELD. This increase—I think these numbers are approximate—but the increase in the number of investigators who are working on this, I believe, has gone from 2 to 78 in recent months.

Senator TALMADGE. In your statement on page 25, you discussed payments to hospital associated physicians on a percentage basis. You state, that it should be recognized that such contractual arrangements involve some element of financial risk for the physicians involved.

What specifically is the risk assumed by the pathologists or radiologists under the percentage gross revenues contract?

Dr. BEDDINGFIELD. The risk assumed would be that the percentage arrangement might not net him the income that he would make under an otherwise salaried arrangement.

Senator TALMADGE. All of the data we have seen indicates that a percentage arrangement is far higher than any salaried doctor. Have you found that to be correct?

Dr. BEDDINGFIELD. I would suspect that this is generally true but there is nonetheless the inherent element of this against percentage.

Senator TALMADGE. Is it not true that Blue Shield, the doctors plan, has for many years used the concept of participating physicians.

Dr. BEDDINGFIELD. Yes.

Senator TALMADGE. Do not participating physicians agree to accept Blue Shield allowances as payment in full for most classes of subscribers?

Dr. BEDDINGFIELD. Yes, most of them do that.

Senator TALMADGE. With most doctors, I understand even the AMA agrees that there should be some ceilings or—for prevailing charge limits on reimbursements. Are you contending that there should be no limits supplied to the hospital associated specialist, such as pathologists other than whatever the traffic will bear?

Dr. BEDDINGFIELD. Of course not.

Senator TALMADGE. Senator Dole?

Senator DOLE. No questions.

Senator TALMADGE. Thank you very much, Doctor, we appreciate your contributions.

Dr. BEDDINGFIELD. Thank you, Mr. Chairman.

[The prepared statement of Dr. Beddingfield follows:]

STATEMENT OF THE AMERICAN MEDICAL ASSOCIATION,
BY EDGAR T. BEDDINGFIELD, JR., M.D.

Mr. Chairman and Members of the Subcommittee: I am Edgar T. Beddingfield, Jr., M.D., a physician in the active practice of medicine in Wilson, North Carolina. I serve as Chairman of the Council on Legislation of the American Medical Association, and I am pleased to present to this Subcommittee the views of the Association on the important legislation, S. 3205, before you. With me is Harry N. Peterson, the Director of the AMA Department of Legislation.

It is indeed timely that important areas of the Medicare and Medicaid programs should be the subject of hearings by this Subcommittee. Extensive changes in those programs were made through enactment of P.L. 92-603, the Social Security Amendments of 1972, and more recently through P.L. 94-182. While not all provisions of those laws have as yet been implemented, a great number are being implemented; and many of the basic provisions in the law, as well as regulations based on them, have understandably proven to be highly controversial. Dissatisfaction has been evidenced in recent lawsuits, brought in unprecedented numbers, by various program providers. Dissatisfaction has been evidenced by an Administration dilatory in regulation promulgation and reluctant to enforce certain provisions it felt to be inimical to the interests of program beneficiaries. Dissatisfaction has been voiced by Congressmen in Committee hearings called to review the status of programs and their implementation. Increasing dissatisfaction of beneficiaries is also evident.

In view of this impressive record of dissatisfaction, and by virtue of the fact that some provisions of the earlier laws were enacted without comprehensive hearings, it is incumbent that adequate provision be made, in consideration of S. 3205, to receive the comments of all persons desiring to submit views.

Mr. Chairman, this Subcommittee is to be commended for these hearings and its review of Medicare and Medicaid at this time. Foremost, of course, in any consideration of changes in the Medicare-Medicaid laws, is the basic question of the effect of such changes on beneficiaries. Of equal importance is a consideration of their effect upon other patients, and the general availability of health services. This latter statement is emphasized because we perceive in a strict application of provisions in this bill a shifting of a portion of the health care costs of Medicare-Medicaid patients to private patients. When quality of care for Medicare-Medicaid is maintained, this shifting of costs to private patients is a natural result when government fails to meet its assumed obligations in financing Medicare-Medicaid costs.

S. 3205 would provide substantial and fundamental modifications in Medicare and Medicaid affecting providers and beneficiaries, as well as private patients. The changes relate to such significant areas as administration, provider reimbursement, practitioner reimbursement, long-term care, and miscellaneous areas. We will now review sections of the bill proposed under each of these categories.

ADMINISTRATION

Under the general category of "Administrative Reforms" S. 3205 provides for several extensive changes in the present administration of Medicare and Medicaid.

Health Care Financing Administration (Sec. 2)

The bill directs the Secretary of HEW to combine into a single unit within HEW the functions and personnel of the Bureau of Health Insurance, the Medical Services Administration, the Bureau of Quality Assurance, and the Office of Nursing Home Affairs. This unit would be designated the Health Care Financing Administration. The new Administration would be headed by an Assistant Secretary having policy and administrative responsibility for Medicare and Medicaid, the PSRO program, and the renal disease program under the Social Security Act.

We believe that a new Health Care Financing Administration should not be created. The effect of this proposal would be to divide the present responsibility for financing and health services into different departmental activities. The health programs of HEW would be split and come under the direction of separate Assistant Secretaries with the possible result of compromising quality under financial pressure. We believe such a division and fragmentation of responsibility should not take place and that all HEW health programs should be under the same administration. We recommend that this change not be made in present law.

The legislation would also establish within HEW an Office of Central Fraud and Abuse Control under the direction of an Inspector General for Health Administration. This new Office would have the overall responsibility for monitoring activities which are designed to deal with fraud and abuse in programs under titles V, XVIII, XIX, Part B of title XI, and the renewal disease program established by section 226 of the Social Security Act. It would also have the responsibility of initiating and conducting direct investigation of alleged, actual, or potental fraud or abuse in any of these programs.

There must be no doubt as to Medicine's unequivocal opposition to fraud and abuse on the part of any health care providers in governmental programs. In May of this year a representative of the AMA testified at an HEW meeting in Washington at which HEW undertook to explain its "Fraud and Abuse Initiative" to a select group of representatives of health care providers. While this 'Initiative" is directed more at a federal-state cooperative investigation of the extent of fraudulent and abusive provider practice under Medicaid, the AMA pledged its full cooperation in uncovering all instances of provider fraud and abuse, regardless of the program.

An observation made at this HEW meeting bears repeating here in regard to S. 3205. An over-enthusiastic approach could adversely reflect on innocent providers. Furthermore, since 70% of Medicaid expenditures, nationally, are for institutional services while only 10% are for physician services, the maximum fiscal effect might be attained by concentrating on a review of institutional services. Notwithstanding that observation, Medicine is resolute in its commitment to assist in the identification of all providers who may be abusing these governmental programs.

This commitment was most recently reaffirmed by the AMA House of Delegates at its Annual Convention in Dallas, earlier this month, when it adopted the following statement:

"The American Medical Association condemns and deplores all acts of fraud and wrongdoing, including in particular any wrongful acts as recently reported in the Medicaid and Medicare programs. We urge that responsible government agencies proceed with all due speed in the prosecution under the provisions of due legal process of al who are charged with fraudulent misconduct. We will continue to offer our cooperation and assistance in bringing to an end such activities."

There can be no question that program fraud and abuse by providers must be eliminated. However, the statutory creation of a "special office" is not necessary or desirable. HEW currently has clear authority to investigate fraud and abuse, and is currently embarking upon a concentrated program without the necessity of special legislation. We are indeed impressed with the recent activities of HEW in its fraud and abuse activities.

It is not, therefore, understandable to us why there is felt to be a need which would justify the enactment of this duplicative authority.

Inspector General (sec. 3)

We are, for the same reasons, puzzled by the proposal for creation of a similarly unnecessary Office of Inspector General. It would seem to us to be counterproductive to create a separate Inspector General for the purpose of reviewing

and investigating health programs and thereby diluting the present responsibility for the management of these programs. The functions envisioned for the Inspector General can be carried out under current authority without creating this new formal investigative unit.

Finally, in regard to further administrative reforms, we would urge that the General Counsel of HEW not be given the proposed authority to prosecute fraud cases directly. Such authority could result in a double standard for prosecution of fraud, one established by HEW and one established under the existing authority vested in the Justice Department. A far better course in our opinion would be to provide the Justice Department with adequate resources so that it can more fully carry out its present responsibilities for prosecuting fraud cases.

Mr. Chairman, we would urge that this entire section relating to the establishment of a Health Care Financing Administration, an Office of Central Fraud and Abuse, and the appointment of an Inspector General for Health Administration, not be adopted. These provisions are duplicative of present authority, and, as pointed out in recent testimony of HEW on separate legislation to create the Office of Inspector General, could be counterproductive to the efficient and economic administration of the various health programs.

State Medicaid Administration (Sec. 4)

Under this proposed change in existing law, additional criteria would be added to State Plan requirements under Medicaid. The State Plan would require that Medicaid eligibility determinations be made for all applicants receiving payments on the basis of disability within at least 60 days, and for applicants receiving assistance on the basis of age or blindness, within 30 days. Redetermination of eligibility for the two above categories would have to be made within 30 days after the State received information which would change a recipient's eligibility and in any event at least every 6 months.

In addition, other provisions are proposed which are designed to more easily and quickly determine the acuracy of data, coverage of services, eligibility, recipient claims, charges, billing procedures, and possible fraud under Medicaid. We are in support of the principle that a more timely determination of eligibility under Medicaid should be made and that incentives should be provided for more accurate determinations.

Claims Processing and Information Retrieval Systems for Medicaid Programs (Sec. 6)

The legislation modifies the present requirements in the law that each State Medicaid plan include a mechanism by which each individual covered would be provided prompt written notice of the specific services covered and rendered, the name of the provider of services, the dates on which the services were rendered, and the amount of payment made. As proposed in S. 3205 this requirement could be satisfied by sending such notices to a sample group rather than to each recipient who received services. We believe that this change is reasonable and would reduce costs as well as improve the administration of the program at the State level. Accordingly, we support this modification in the law.

Regulations of the Secretary (Sec. 7)

One of the more vexing problems which confronts the medical profession in the implementation of all Federal health programs, but particularly in Medicare and Medicaid, is the promulgation of regulations. This is addressed in Section 7 of the legislation before you. The provision indicates that a proposed rule or regulation generally shall become "effective not less than sixty days after publication."

Under present procedures Regulations are proposed in the Federal Register, and there is rarely adequate time provided to submit appropriate comments. The promulgation of final regulations presents an additional distinct problem.

It is not entirely clear from the language in Section 7 of S. 3205 how the 60-day period proposed would be applied. It would appear that the 60-day period would run from the date of promulgation of the rule as a proposed rule. In such case the period (even though longer than currently provided in the Administrative Procedure Act) would clearly still be inadequate. Such 60 days should constitute a minimum *comment* period, and additional time would be needed before promulgation of the rule in final form. If, on the other hand, the 60 days would run from the date of publication as a final regulation until its effective date, a 60-day interval can be supported as to such period.

In testimony which the AMA has previously offered to this Congress during hearings on various proposed changes to the Administrative Procedure Act, we urged a major restructuring of the Administrative Procedure Act so as to better enable the public to respond meaningfully to proposed regulations, and to require that Federal Agencies accurately reflect the intent of the law and be more responsive to the comments received from the public. In response to repeated Agency abuses, the AMA developed its own legislative proposal, now pending before the Congress, and we commend S. 3358 for your consideration.

A second modification in present law, as it relates to promulgation of regulations, is also proposed by Section 7 of S. 3205. It directs that generally any regulations necessary to implement the provisions of the bill, or any provision of law enacted or modified by the bill, shall be promulgated so as to become effective within one year after enactment of S. 3205.

While we are certainly in favor of prompt promulgation of rules, the broad mandate of this section cannot be supported inasmuch as it would surely result in the publication of hastily conceived and developed regulations which would not be in the best interest of a proper and orderly development of programs established under the law. The concept of requiring prompt promulgation of regulations is salutary; however, the statutory mandate, even with the exception provided through action of the Comptroller General, does not in our opinion provide an appropriate solution to a situation widely recognized as being in dire need of remedy.

The third change suggested in regrad to regulations addresses itself to the issuance of major policy guidelines by the Secretary. As proposed, the Secretary would be required to provide a "reasonable opportunity" for comment by interested parties prior to the time such guidelines become final. The legislation is silent as to what constitutes a "reasonable opportunity" for comment.

While on its face this requirement would appear to have merit we must interject a note of extreme caution. The provision would give statutory approval to a process currently being widely abused. It would recognize that "major policy" guidelines should be published other than through promulgation in the Federal Register. We would therefore urge that the Secretary be required to publish any proposed policy statement in its entirety in the Federal Register with an opportunity of at least 60 days for public comment. Once again we would urge that such a requirement should be a part of an overall revision of the Administrative Procedure Act. Mr. Chairman, our bill, S. 3358, would correct this abuse and require substantive policy statements to be published for comment in the Federal Register.

HIBAC (Sec. 8)

Section 8 of the legislation mandates the dissolution of the Health Insurance Benefits Advisory Council originally enacted under P.L. 89-97. When the 89th Congress provided (as part of the original Medicare and Medicare enactment) for the creation of HIBAC, it was not its intent to establish this as an "ad hoc" or temporary advisory body. Congress envisioned an active and constructive advisory role for HIBAC and expected that the Secretary would take full advantage of it.

We recognize that HIBAC has not been, perhaps, as active or contributory as it might have been. However, the fault lies not with the body itself, but rather with its use—or disuse—and to the staffing—or lack of staffing—it has received. In our view the Congress, rather than mandating dissolution of HIBAC, should strengthen it by requiring that it receive the independent support necessary to permit it to carry on a proper and effective advisory role to the Secretary.

We therefore urge that Section 8 be rewritten to strengthen HIBAC and to make it a truly effective body.

PROVIDER REIMBURSEMENT

Reasonable Cost Determinations for Hospitals Under Medicare (Sec. 10)

We are deeply concerned that the quality of patient care will be sacrificed to the proposed methodology in Section 10 for the determination of reimbursable hospital cost. Under such methodology a hospital could be paid more or less than its actual costs, depending on the relationship of its actual costs to average costs for its hospital classification. Formula determinations for hospital reimbursement

would not be operative as a guide to the reasonableness of each hospital's costs; they would constitute restrictions, based on statistics, on the reimbursement of costs to a hospital, whose actual costs might be in excess of the average for its classification.

Section 10 would establish a uniform system of accounts and cost reporting for hospitals in arriving at operational costs. All hospitals would be categorized according to size, type of hospital, and such other criteria as the Secretary might select. The routine operating costs would be determined, according to hospital classification, by averaging the costs of all hospitals in a category and adjusting for price increase percentage. For hospitals whose actual operating costs exceeded the average, payment could not exceed 120 percent of the adjusted average per diem payment rate for such hospital. Hospitals with below-average operating costs could receive an incentive allowance. Special provisions would provide exemptions for hospital "hardship cases", and cost adjustments could be made for certain hospitals in underserved areas and for hospitals which have an unusual case mix.

Reimbursement ceilings for individual hospitals, as set by Section 10, are not based on an actual assessment of what it costs to provide hospital services. The leeway permitted hospitals whose actual costs are above average, the special allowance for those which are below average, and any special consideration for hospitals which are understaffed or which have special cost problems or serve needy areas are commendable. But clearly, as an end result, the payment of actual and necessary costs of providing hospital care is no longer the controlling factor; instead a system is created for setting arbitrary statistical limits on hospital reimbursement.

The proposal provides no assurance that inefficiency will be corrected. The prescribed methodology simply creates a pressure to reduce costs to a set dollar amount without regard to how such reductions may be attained. If a hospital is forced to treat Medicare and Medicaid beneficiaries at a loss, its ability to retain needed employees and to maintain a level of expenditures necessary to provide quality services will be reduced. This in turn will lead to reduction of the range of services available from a given provider and will significantly alter the quality of patient care. Moreover, failure by Medicare and Medicaid to compensate a hospital for its actual costs can only result in additional inequitable shifting of program costs to private patients in further violation of statutory proscriptions in the Medicare law.

We recommend that section 10 not be adopted. Medicare and Medicaid are represented to provide health care in the mainstream for their beneficiaries. The federal government must meet this commitment. We cannot subscribe to or condone "average" health care services for our elderly and disadvantaged in order to accommodate payment "on the average".

Inclusion in Reasonable Cost of Hospital Services an Allowance for Retirement or Conversion of Underutilized Facilities (Sec. 11)

Section 11 would authorize increased payments from Medicare, Medicaid and Maternal and Child Health Care funds to cover a "reimbursement detriment" as a result of a qualified conversion or closure of underutilized facilities. This would authorize an increase in payment as recommended by a national board and finally determined by the Secretary, when such conversion or closure resulted in a reduction in capital-related reimbursement or in costs above those reimbursable under the "reasonable cost" determination formula.

We support the principle of providing assistance to hospitals which would suffer a "reimbursement detriment" as a result of voluntary conversion of closure of facilities which are underutilized and for which adequate alternative sources of care are available in the area. This could encourage a more effective use of hospital facilities. Initiating this support on a limited basis, as provided in the bill (for 50 hospitals), will enable an assessment to be made of this mechanism before more widespread application is attempted. We view this innovation as an experimental program.

We do have some reservation concerning the use of Social Security health care funds for a program of assistance for the conversion or closure of facilities. In effect this would be devoting Social Security health care funds for other than direct health services. In our view, funding for the conversion or closure of facilities might more properly be provided from other sources.

PRACTITIONER REIMBURSEMENT

Criteria for Determining Reasonable Charge for Physician's Services (Sec. 20)

Section 20 would significantly change determinations of reasonable charges under Medicare. At the present time prevailing charge levels are set in localities so that the prevailing charge level would cover 75 percent of the customary charges made for similar services in that locality. Certain additional limitations are imposed so that the charge level for any fiscal year beginning after June 30, 1973 would not exceed the level determined during the fiscal year ended on that date, except to the extent that a higher level is justified by economic changes determined to be acceptable by the Secretary on the basis of appropriate economic index data.

Under the bill, however, a new prevailing charge level would be determined for each state which has two or more "localities" within it. For such a state, a statewide prevailing charge level shall be determined, and the bill specifically provides that the prevailing charge level shall cover 50 percent (instead of the current 75 percent) of the charges made for similar services in the state. Based on this determination of the statewide prevailing charge level, a new limitation is then imposed through operation of the Economic Index. As to the prevailing charge level for a service in a locality, any increase permitted by the Economic Index cannot be applied if, and to the extent that, the resulting prevailing charge level for such service or procedure would exceed the statewide prevailing charge level by more than one-half.

This procedure could, in many cases, result in a diminution in the reimbursable amount which physicians would receive by virtue of future increases provided under current law. In no case, however, would section 20 provide to any physician more than the increases which the current law would allow. It appears that the real effect of the new methodolgy would be to cause a leveling of reimbursement payments. This leveling would be accomplished, however, through a reduction (particularly in metropolitan areas) of increases which otherwise generally would be due under the economic index and to which physicians currently are entitled under Medicare. While the reimbursement levels in non-urban areas might for a period of time undergo normal increases which could be higher (at least percentagewise) than those to be recognized in metropolitan areas under the Economic Index, this stifling of proper fee recognition for all physicans would be detrimental to maintaining a proper level of care under the program.

Discrimination in the application of the economic index in states with two or more localities would result. Some physicians would receive the full amount allowed by the index, others would not. Further discrimination would result because the index would apply fully to all physicans in states constituting a single locality. The artificial ceiling imposed on Medicare reimbursements under Section 20 could affect participation by physicans and affect the availability of care for Medicare patients. This type of limitation would also further aggravate the shifting of expenses under Medicare and Medicaid to patients under private programs.

In our opinion reimbursement levels imposed upon physicans are currently substandard by virtue of existing controls. Section 20 of S. 3205 would materially further reduce even this standard and would thus adversely affect Medicare patients. We recommend that Section 20 not be adopted.

We note that one provision in this section is intended to permit greater flexibility in recognition of charges in shortage areas under special circumstances.

The intent of this provision is salutary. Its objective is to induce physicians to enter shortage areas to establish medical practice. However, the methodology set out and the effects of permitted variations must be examined very carefully. The allowance for a physician to enter a shortage area and establish Medicare reimbursement levels higher than those currently recognized under the Medicare program in such circumstances may in fact cause inequities in reimbursement recognition in that area. As we understand the provision, it would be possible for a physician establishing a practice in a shortage area to establish fee reimbursement levels at charges higher than some physicians who already may be in practice in that same area. This type of disparity could cause undesirable results. This could occur particularly if physicians who had established practices in the shortage area were required to perform services at rates which are

less than those charged by new physicians coming into the area. The potential effects of the proposed change should be analyzed very carefully.

As indicated above, section 20 should not be adopted as proposed.

Agreements of Physicians to Accept Assignment of Claims (Sec. 21)

Section 21 of S. 3205 would create two classes of physicians under Medicare: "Participating" physicians and "non-participating" physicians. A participating physician would be one who entered into an agreement with the Secretary in which the physician agreed to accept Medicare reimbursement as payment in full for his services on the basis of an assignment for all his Medicare patients. A non-participating physician would not be eligible to accept assignment with respect to any patient.

Certain entitlements are provided under the bill to induce physicians to sign up as participating physicians. As one inducement the participating physician would be permitted to submit claims on a multiple listing basis (rather than on an individual patient basis) and would be allowed $1.00 as "an administrative cost-saving allowance" for each patient listed. In addition, at least 50% of the estimated amount due on each multiple listing claim form would be paid within five days of receipt of the physician's claim (subject to later adjustments).

It is specifically provided that no "cost saving allowance" would be payable for physician services performed in a hospital (whether on an inpatient or outpatient basis) unless the physician ordinarily bills directly and (1) such services were in the form of surgical procedures or anesthesiological services, or (2) such services were performed by a physician whose office or regular place of practice was at a locality other than the hospital.

No cost saving allowance would be allowed on account of services consisting solely of laboratory or X-ray services performed outside the office of the physician claiming payment therefor.

Mr. Chairman, this provision would vitiate fundamental principles of payment for physician services upon which the Medicare program has been premised since its beginning. A physician may now accept an assignment or bill directly for reimbursement and he may do so on a patient by patient basis. There is no requirement currently that physicians enter into any formal agreement with the Secretary whatsoever. Under the new proposal, however, the physician would have to determine his method of reimbursement and this would apply to all his Medicare patients without exception. It undoubtedly will be argued by some that the course to be undertaken is still optional with the physician; however there is no justification for the strict limitations contained in the proposal. Moreover, it is indeed ironic that in order to entice physicians into a participating agreement Medicare should have to offer so-called "benefits."

As to the multiple list billing mechanism, one should assume there would be administrative advantages for Medicare and for the physician. There is no reason why this payment system should not be put into effect immediately under the current billing and payment procedures, if in fact it would operate as an aid in the administration of the program. The one dollar per listing inducement will have little persuasive effect when measured against any losses from eliminating the direct billing option. The provision for early—or more appropriately, timely—payment is certainly no more than physicians are entitled to and should receive at the present time, without the necessity of statutory mandate. If it would be within the capability of Medicare to achieve the early payment procedures projected under the bill, the same energies ought to be channeled today into achieving that same goal. It would be disheartening if convenient administrative aids are now available—but are not being utilized.

It is obvious that the goal sought to be accomplished by section 21 is to achieve an increase in the assignment use rate.

The fact that inducements are necessary in order to buttress a sagging assignment rate should cause an examination of basic factors involved. Without question the current system, with its insufficient reimbursement rate, is the major deterrent to assignments. The artificial and discriminatory payment mechanism under Medicare has caused a rejection of the assignment method for receiving payment. The 75th percentile formula, based on old and unrealistic data (at times almost two years old) and further curtailed through application of the Economic Index, has caused the great disenchantment of many physicians with the assignment method. It should be observed that in seeking to foster acceptance of assignments S. 3205 is dichotomous. In one section it seeks to provide induce-

ments for assignments, while in another it discourages such use through imposition of further discriminatory payment mechanisms.

Rather than seek to initiate new devices to bolster the current assignment levels based on a perpetuation of artificial and arbitrary payment levels, it is time to examine and to make realistic the basic Medicare reimbursement formula and payment mechanisms. If indeed it is the intent of Section 21 to achieve more widespread acceptace of assignments, it would be better accomplished by making the reimbursement level under that system more acceptable and in accord with usual and customary practices. Medicare limitations, as through application of the Economic Index, are discriminatorily imposed, and should be removed.

Section 21, as proposed, should not be adopted.

Hospital-Associated Physicians (Sec. 22)

Section 22 would establish, by law, a stringent definition of "physicians' services"; would enact statutory definitions of which services performed by anesthesiologists and pathologists are "physicians' services"; would establish ceilings on payment to physicians paid on a basis related to hospital income; and would reduce the Medicare payment for radiology and pathology services if the physician providing them did not accept assignment.

Medicare law now defines "physicians' services" in general terms as "professional services performed by physicians". S. 3205 would specifically exclude from that definition those services the physician performs as an educator, an executive, or a researcher and would exclude even patient care services unless "personally performed by or personally directed by a physician" for the benefit of the patient and unless the service is of such a nature that its performance "by a physician is customary and appropriate."

At the outset it should be made clear that although this amendment is carried in the bill under the heading "Hospital-Associated Physicians" the amendment is not so limited, and the placement of this amendment under that heading is misleading. In fact this amends the general definition of "Physicians' Services" in section 1861(q) and consequently the new limitations created would apply to all "physicians' services" throughout the Medicare law and program. Consequently we object strongly to this modification. All services of physicians as recognized within the geographical area of the physician's practice should be recognized as "physicians' services" under Medicare. A strict application of the bill language would have dire consequences with respect to proper recognition of, and payment for, all services of physicians under Medicare.

Even if the provision was intended to affect only the inpatient services of "hospital-associated physicians" and it were so stated, the modification would be nonetheless objectionable.

The writers of regulations, armed with the proposed statutory language which includes as "physicians' services" only patient care service which is "personally performed" or "personally directed" and "of such a nature that its performance by a physician is customary and appropriate," could arbitrarily change the practice of medicine as fully recognized in communities today. For example, would Medicare now refuse a physician's claim because the service is provided by a nurse or a physician's assistant?

Whatever its intent, a legal definition which states that a physician acts as a physician only when directly treating a patient and when performing services only a physician can perform can only lead directly to confusion in the Medicare program and further dismemberment of health care.

Furthermore, the physician as educator, researcher or administrator does not cease to be a physician; indeed, since the earliest days of the medical profession, teaching and research have been recognized as intrinsic parts of the practice of medicine and, as medicine has become more organized and technologically sophisticated, administrative tasks have developed which can be performed most effectively only by a practicing physician.

We protest strongly any artificial division of the physician's role.

We further protest, therefore, the attempt to define precisely what are "personally performed" or "personally directed" services in the fields of anesthesiology and pathology. Medicine is a living science, which changes from year to year—sometimes from day to day—while laws may take years to change. Even the regulatory process, as this Congress is well aware, can be dilatory and insufficiently flexible. The language of these sections goes further in limiting medical practice than the laws under which physicians are licensed to

practice. Its restrictions on anesthesiology and pathology are not only unwise legislation in themselves, but tend to undermine the very legislation passed by this Congress in 1972 intended to improve care under Medicare, Medicaid, and Maternal and Child Health programs. Congress has established PSROs to determine whether patients under the three programs are receiving care which meets appropriate professional standards of quality.

The bill would superimpose on PSRO deliberations specified standards as to how many patients a physician could personally treat or personally direct treatment for and still have the treatment considered a "physician's service". It would say which services of pathologists are "physician's services" and which are not.

Congress cannot, and should not attempt to, direct physicians' actions nationwide by statute, and should not enact laws directing what services will be recognized as physicians' services. PSROs were given the charge to determine the property of medical services and when they met proper professional standards.

We would suggest that this Committee consider very carefully the limitations this law would set on care recognized as properly provided by anesthesiologists. It would state, for purposes of the program, that an anesthesiologist can "personally perform" physicians' services for only two patients at a time, and can only "personally direct" care for four patients at a time, and that the "reasonable charge" for "personally directed" care will be half that for "personally performed" care.

By this standard, an anesthesiologist will receive the same payment for two patients for whom he provides all the listed services as for four patients for whom he provides all but one of the listed services, and for whose care he remains legally liable. This change will probably result in a reduction in the anesthesiology services available to Medicare, Medicaid, and Title V patients.

The Congress should not set in inflexible statutory provisions what elements will be required to constitute acceptable performance of practice by anesthesiologists or pathologists.

We oppose also the attempt to establish specific statutory limits on physician charges "related to the income or receipts of a hospital". It cannot be assumed that such contractual arrangements necessarily result in excessive fees, nor can it be assumed that equating the physician's "customary charge" with a "reasonable salary" plus additional necessary hospital and physicians costs will be an equitable approach. It should be recognized that such contractual arrangements involve some element of financial risk for the physicians involved, which a salaried arrangement obviates. For the same reasons we object to limitations on arrangements with hospitals or medical schools whereby payment for physician services are limited to a salary equivalent.

Finally, in Section 22, the bill would enact an approach which is intended to "encourage" physician acceptance of assignments—but it does so by penalizing the patients if they do not. Under present law, pathology and radiology services to hospital inpatients are paid from Part B at 100 percent of the "reasonable charge", whether the physician has accepted assignment or not. S. 3205 would change the amount of Medicare payment to the usual 80 percent of the "reasonable charge" only when the physician does not accept assignment, and permits crediting of the patient's 20 percent of the "reasonable charge" towards the annual Part B deductible. We point out that the Medicare "reasonable charge" for pathology and radiology services remains the same, whether or not the physician accepts assignment.

The Association questioned whether the coinsurance factor should be eliminated for specific segments of medical care during the discussions prior to passage of PL 90-248. We question even more strongly the establishment of different rates of payments by Medicare for services provided on assignment and for the same services when billed to the patient. We believe that this approach violates basic principles of equity to the Medicare beneficiaries, who pay the same out-of-pocket premium but would receive different degrees of coverage as a result of factors over which they have little or no control.

We wage strongly that Section 22 not be adopted.

Payment for Physician Services Under Medicaid (Sec. 23)

Under this section the Medicaid law would be revised to provide, effective July 1, 1977, that the amount payable for physician services performed outside

a hospital would not be less than 80% of the Medicare reasonable charge. In our view this provision should not be adopted. On its face it would appear that the provision would cause an upgrading of fees in some states, and we recognize the intent is to provide a payment rate which will encourage a higher level of participation by physicians in the Medicaid program. We recognize also, however, that it could operate as a ceiling above which the states would feel no need to provide levels of payment.

Most importantly, there is a fundamental issue involved here. There can be no logical justification for statutory recognition of a differential in payment levels for the two federal programs. To peg one at a percentage of the other places the issue in clear focus. Moreover, as we have indicated above, the basic medicare reimbursement level is itself an artificial and discriminatory one. To base the Medicaid payment at a percentage of that arbitrary level would only further the discrimination between programs and their beneficiaries. This should not be given the cloak of approval by the Congress.

Moreover, during a time when States are withdrawing services because of lack of funds, it would be naive not to anticipate the irresistible pressures from the states which would be exerted to lower the Medicare rate and which would result in a further reduction of the Medicare reimbursement structure.

Section 23 does not portend well for Medicare and Medicaid beneficiaries and should not be adopted.

Payment for Certain Antigens Under Part B of Medicare (Sec. 24)

There would be added to the definition of "medical and other health services," under Medicare, provisions to include antigens (as limited in quantity by the Secretary) prepared by an allergist for a particular patient. Included also would be antigens prepared and forwarded to another qualified person for administration to the patient by or under the supervision of another physician.

We believe that this provision is a beneficial one. It would relieve questions concerning payment that have been raised with respect to antigens prepared by allergists. Providing payment for these necessary services will be beneficial for many elderly beneficiaries. We recommend support for section 24.

Payment Under Medicare of Certain Physicians' Fees on Account of Services Furnished to a Deceased Individual (Sec. 25)

Provisions allowing Medicare payment to a physician for services rendered to a person who died prior to payment to, or acceptance of an assignment by, a physician presently may occur only if the physician agrees later to accept payment under the terms of an assignment.

This new provision would enable a spouse or other legal representative of the deceased person to authorize payment to the physician under Part B without regard to the acceptance of an assignment by the physician.

We believe this provision would be beneficial in the orderly adminstration of the Medicare program and would be of benefit to the heirs and representatives of deceased Medicare beneficiaries in the administration of their estates. We are in support of this provision.

Prohibition Against Assignment of Fees (Sec. 26)

This section would amend Medicare and Medicaid to limit the circumstances under which a payment for services provided by a physician or other person could be assigned to a third party. Such assignment could only occur pursuant to an agreement with an agent under which the compensation to be paid to the agent for his services was not dependent either upon the amount of the billing or payment, or upon the actual collection of any such payment.

In our view this provision is too broad in its effect and should not be adopted. While the amount of the charge made by the physician should not be related to any assignment of billing to a third party for collection, the prohibition contained in the section is much too broad. In the absence of any surcharge, in effect, being made on the patient to allow for an anticipated assignment, the physician should be free to enter into contracts under which his accounts are properly processed. In our view this provision would act as an unreasonably broad restraint and should not be adopted.

LONG-TERM CARE REFORM

Medicaid Certification and Approval of Skilled Nursing Facilities (Sec. 31)

This section provides that the Secretary would enter into an agreement with any State able and willing under which the services of the State health agency

or other appropriate State or local agencies would be utilized by the Secretary for the purpose of determining whether an institution in such State was qualified as a skilled nursing facility for purposes of the Medicaid program. Notwithstanding certification by the State agency, however, the Secretary is empowered to accept or reject such certification. The Secretary would thus approve or disapprove facilities for participation in the Medicaid program.

In our opinion this section of the bill would create confusion and uncertainty, and constitute an unnecessary and unwarranted involvement of the Federal government. The present procedure which grants recognition to certification by the state agency as the criterion for eligibility for Federal Medicaid payments to the states should be retained. The proposed section 31 should not be adopted.

Patient Absences from Facility (Sec. 33)

We support Section 33 of the bill on "Visits Away From Institution by Patients of Skilled Nursing or Intermediate Care Facilities."

This section would provide that under Medicaid an inpatient of a skilled nursing or intermediate care facility could make visits outside the institution and that such visits would not be regarded as conclusively indicating that such individual was not in need of the facility services.

This provision provides desirable flexibility in the course of treatment for skilled nursing and intermediate care facility patients. Such flexibility could produce positive results in patient care.

MISCELLANEOUS REFORMS

Procedures for Determining Reasonable Cost and Reasonable Charge; Disclosure of Ownership and Financial Information (Sec. 40)

We are opposed to the provisions of the bill in Section 40 relating to "Procedures for Determining Reasonable Cost and Reasonable Charge." We do support the principle of proper disclosure referred to in those provisions of Section 40 relating to "Disclosure of Ownership and Financial Information."

Section 40 of the bill provides that commissions, finder's fees, or similar arrangements, or amounts payable for any facility under a rental or lease arrangement which was determined as a per centum, fraction, or portion of the charge or cost attributable to a health service would not qualify as a reasonable cost or charge under Medicare, Medicaid or Maternal and Child Health. In addition, the Secretary would have to establish procedures whereby there would be review and advance approval of any contract which constituted an element of cost of any health service, was a consulting, management, or service contract, and involved payments of $10,000 or more in one year.

This section would thus in effect prohibit certain contractual relationships between hospitals and professionals involving any percentage lease or rental arrangements. In our view this provision should not be adopted. Physicians and hospitals should have full freedom of contract in order to assure that services will be readily available in their communities. This is not to say that contractual arrangements which disregard the proper interests of patients should be condoned. Hospital management, whether through the office of the Administrator or the Board of Trustees, as well as the physicians or other providers of services, must exercise prudence and be accountable in the public interest. Excessive profits must be questioned and improper contracts not recognized within the reimbursement structure. The action in not recognizing any percentage lease or percentage arrangement, however, is extreme and should not be countenanced.

As to the provision in this section which would grant the Secretary prior approval power over most contracts involving health services, including professional services as well as other services furnished to the hospital, we find this equally objectionable and should be rejected.

The mood generally prevailing today is for less government, and the wisdom of decreasing the interference of the Federal government in the lives of the citizens of this country is widely recognized. We believe it would be most inappropriate to provide in law for interference by the Federal government in contracts between private parties for professional and other health services furnished to hospitals. Aside from the lack of feasibility of the proposal based on the sheer volume of contracts involved, we are not impressed with the record of government in the handling of its own contractual obligations and opportunities. Governmental agencies have not demonstrated any special acuity which

warrant its employees passing upon the necessity and propriety of hospital contracts.

This section would also provide for certain disclosure of business dealings of any officer, director, partner, or any person having an ownership interest (1% or more) in an entity that was a provider of services. Other provisions would require an independent pharmacy or laboratory to permit the Secretary to have access to its books or records pertaining to billing and payment for goods and services.

With regard to those provisions relating to disclosure of ownership and financial information for officers and certain other persons connected with entities that are providers of services, we support the principle of proper disclosure. Disclosure, for instance, should be made to a Board of Trustees by any of the members thereof who have an interest in matters coming before the Board. However, it is felt that the provision of section 40 could also be detrimental to beneficial facility operation. For instance, a qualified member of the Board of Trustees of a hospital may be reluctant to serve in such capacity where he has an interest in a business providing services to the facility where such relationship is required to be made public. Inferences could be disparaging of character and integrity and inhibit beneficial participation. Very frequently special benefits, financial and otherwise, redound to the facility by virtue of special affiliation of members of Boards of Trustees, etc. Thus the facility could be denied the benefit of valuable services.

It should be kept in mind that our comments here are aimed only at mandatory publication of such relationships, and are not intended in any way to restrict the disclosure of such information to other hospital board members or to the institution's administration. Disclosures of information to the hospital's governing body or administration concerning disclosure of financial information are in some cases required by specific statute or in others under general principles of law regarding a corporate director's fiduciary duties.

The provisions of section 40 should not be adopted.

Standards for Payments Under Medicaid to Health Maintenance Organizations (Sec. 41)

This section provides that payments under Medicaid for the provision of medical assistance could be made on a per capita or similar basis only if (1) such payment was made under a contract or other arrangement that had been approved in advance by the Secretary; (2) payment was made to a health maintenance organization (as defined under Medicare); and (3) a specified per cent (not less than 50% except in special circumstances) of the enrolled members in the HMO were not individuals entitled to Medicare or Medicaid.

In our opinion, this provision could be helpful in reducing or eliminating improper practices such as those which have recently come to light with respect to some HMOs. Accordingly we support the provisions of section 41.

Ambulance Service (Sec. 42)

We recommend a slight modification of Section 42 relating to "Ambulance Service", and offer our support for this section as modified.

Under this section of the bill, Medicare would be extended to provide for ambulance service to the nearest hospital which was both adequately equipped and had medical personnel qualified, in the opinion of the hospital, to deal with, and available for the treatment of, the individual's illness, injury, or condition.

Improved ambulance coverage for Medicare patients is highly desirable. The provision for determination by the hospital of adequacy of personnel and facilities should be modified to provide for this determination to be made by the medical staff of the hospital. We would recommend that Section 42 be changed to provide for this role of the medical staff.

CONCLUSION

Mr. Chairman, we have discussed many of the provisions of S. 3205. As seen from this review, this bill would have serious and far-reaching ramifications with respect to services furnished under the Medicare, Medicaid, and Maternal and Child Health Programs. While in the main thrust of the bill is aimed at cost containment, the full effects would be broader and affect the quality and availability of care under those programs.

In view of the continuing inflationary pressures in our economy, we are indeed sympathetic with the intent of this legislation to seek limitations upon the in-

creasing costs of these health programs. It must be recognized, however, that arbitrary curtailments of increases in costs will have natural consequences with respect to maintaining quality and availability of care. Each element cannot be treated separately without expectation of impact on the others.

In our foregoing discussion we have indicated those provisions which we believe will have harmful consequences and not be in the interest of program beneficiaries. We have also indicated our support for other provisions. Taken as a whole, the bill should not be enacted as it would not be in the best interests of Medicare-Medicaid patients.

As the Subcommittee explores the effects of the provisions of this bill, we continue to offer our assistance to the Subcommittee.

Senator TALMADGE. The subcommittee is indeed honored to have the Honorable Lloyd Bentsen, Senator from Texas.

STATEMENT OF HON. LLOYD BENTSEN, A U.S. SENATOR FROM THE STATE OF TEXAS

Senator BENTSEN. Thank you very much, Mr. Chairman, I appreciate this opportunity to present my views on S. 3205, the Medicare-Medicaid Administrative and Reimbursement Reform Act. This is an impressive piece of legislation and shows the insight of the chairman of the committee into the complexities of this Nation's health financing programs.

After 2 days of hearings I am sure I do not need to mention to this committee the enormous increase in the cost of health care nor the concomitant increase in Federal dollars allocated for health financing that has been one of the major catalysts to the development of this bill.

I will, therefore, limit my remarks to specific sections of the bill.

Of all forms of medical services, inpatient hospital care is the most expensive to both the Federal financing programs and the consumer. Section 10 of S. 3205 marks yet another step in the development of Federal reimbursement to hospitals in an attempt to encourage efficiency and, therefore, reduce costs.

However, this section does not go far enough. It will only subject about 35 percent of the hospital's costs to the limits it proposes. However, of even greater concern to me is the basic structure of Federal reimbursement which this section would perpetuate, that is, reimbursement on the basis of unit costs.

When the medicaid and medicare programs were first developed, one of the objectives was to design a reimbursement method that would have as little effect as possible on the existing health care system.

Thus, a system based on the cost incurred by the hospital of providing a day of service made sense. However, with 90 percent of hospital reimbursement now based on this method, the system has proven itself unduly inflationary.

In effect, what we have is a cost plus system. What we need to build back into this system is an incentive on the part of those administrative programs in the various hospitals to try to bring about some efficiencies of service and have some rewards for doing so.

Section 223 of the 1972 amendments to the Social Security Act was enacted in recognition of this inflationary trend. This section was an attempt to slow the trend by imposing limits on those hospital costs which were the least variable, routine costs.

No effort was made to reform the structure of the reimbursement system at that time. It was understood that HEW would try to extend the 223 limitations to hospitals' ancillary costs as soon as a workable approach was found.

As you are well aware, no approach to limit ancillary services, and thus their costs, in an equitable manner has been found.

Moreover, since the enactment of section 223, we have not seen any dampening of the inflationary spiral in hospital costs.

Mr. Chairman, the problem with our past attempts to limit costs is that we have attempted only to further refine the current system without facing up to its basic structural inadequacy.

Our efforts to tighten the definitions of the basic units of cost have led to one of the most expensive and burdensome set of regulations of any Federal program. Yet we have not altered the incentives in the current system that encourage hospitals to provide more days of care in order to receive higher payments.

This is one of the basic problems we have in the insurance business, in trying to carry out hospitalization insurance. Patients are checked in that really do not need hospital care; however, their insurance coverage is based on being in the hospital.

Doctors check them into hospitals, hospital administrators desire to keep them in the hospitals— this is a problem.

The most obvious example of the structural inadequacy of the reimbursement system is its failure to recognize that small increases in the number of days of care a hospital supplies incurs only a marginal increase in cost to the hospital.

We reimburse the hospital as if the cost incurred were the full cost.

Your hospital costs do not go up proportionately as you increase the occupancy rate of the hospital.

I can recall one instance in the insurance business where we had an administrator of a small hospital who checked in his janitorial staff and all of their families and they all supposedly had the flu and he kept them all in there for 10 days.

We ended up having to pay that claim, we could not figure out any other way to do it.

Senator TALMADGE. We had some testimony Monday where a couple decided they wanted to go to Florida on a vacation, the mother was somewhat elderly so they checked her in the hospital.

Senator BENTSEN. We had one case where they decided they wanted to go to the Cotton Bowl to see the New Year's Day game and just hauled the kids into the hospital, said they had the flu.

Currently if a hospital's utilization increases by 3 percent, its reimbursement is also increased by 3 percent. Yet, even small hospitals do a large enough volume of business to achieve economies of scale.

As long as we fail to recognize these economies of scale, we also fail to encourage efficiency. As long as we continue to apply limitations to only some units of a hospital costs and not to others, we encourage hospitals to allocate their costs to areas not curbed by Federal limitations.

In my opinion, we do not have the fiscal leeway to continue to make only marginal changes in a system based on unit costs that has, over the past decade, proven itself highly inflationary.

It is time to take a gross revenue approach to hospital payments, to provide hospitals with lump sum payments on a prospective basis. This

kind of system is being tested on a limited basis in several States and has been endorsed by both public and private organizations as a method of encouraging hospitals to budget their resources and then manage efficiently.

I am delighted to see that you built some strong audit processes into this piece of legislation, I think that is very important. If you allocate somebody's payments on a prospective basis, then go back and audit them at the end of the year, and do your spot check audits, that is one of the ways to encourage some of the efficiencies.

One of the things I learned in business is that you can expect what you inspect. If you go back and do spot check audits, you will find just what the true costs are.

The hospital administrator has a better idea of how best to manage his own business than does the Federal Government.

Let us give him the incentives to do the best job he can within a specific budget. Prospective lump-sum payments not retrospective unit cost payments can provide this kind of incentive.

Mr. Chairman, there is one other section of S. 3205, that I would like to comment on briefly. Section 40 of this bill would require HEW to review and approve tens of thousands of contracts above $10,000 that are negotiated by hospitals and other health care institutions each year.

Senator TALMADGE. That really was to flag a probem, that $10,000. We had considerable criticism of that figure and I concur with the criticism that it is being corrected.

Senator BENTSEN. You just finished my speech for me then. I never argued with the Chair when I found we were in agreement.

Senator TALMADGE. That was my practice when I was practicing law too, Senator.

Senator BENTSEN. Thank you very much.

Senator TALMADGE. I want to compliment you on your statement. This bill tries to give incentives for efficient performance. Heretofore, we have had penalties for inefficient performance, but no incentives for efficient performance.

As I read your statement and listened to it, that was the total thrust of your argument and this bill is aimed at exactly that direction. I hope it can become law and I believe that it would ameliorate this fantastic increase in expenses for medical care and deliveries.

As you know, it has been increased from $30 billion this past year to $37 or $38 billion this year and the Budget Committee on which Senator Dole sits has mandated a $700 million decrease in expenditures.

This committee, as I see it, is confronted with some decisions it must make. First, we can cut back services; I do not think anybody wants to do that. Second, we can continue to let the law run as it is now, open ended, the sky is the limit, bill whatever you want, kickback whatever you want, put patients in the hospital for no reason at all and keep them there as long as you want.

It is intolerable the way it is working. Every witness we have had to date has complained about it. There are practically no exceptions, so we are going to have to take action to correct it and I believe this Congress or next Congress will.

Senator Dole?

Senator DOLE. No questions, thank you.

Senator BENTSEN. Thank you. What we have seen operating in Texas in nursing homes on the medicaid, they will bring in the nursing home operators at the end of the year, the Department will look over their costs they have had during the year, then they will go in and do spot audits to determine the validity of those costs and then make a cost effective allocation for the forthcoming year.

Then they also go back and spot them with an audit for services to see that they are really doing the job in the services for the people. Something like this for hospital and medicare, I would like to see given consideration.

Senator TALMADGE. Thank you, very much, for a helpful statement. We greatly appreciate your contribution, Senator Bentsen. When I introduced S. 2305, I referred to the desirability of the subcommittee examining the potential legitimate role of relative value guides or scales in determining appropriate reimbursement of physicians under medicare and medicaid.

Since that time, at my request, the staff of the subcommittee has been engaged in discussions on this subject, both with some representatives in the medical profession and with officials of various Federal agencies.

As a result of these discussions, the staff has prepared a working draft of specifications for legislative provisions. It is designed to authorize Federal medical insurance programs to use relative value to the extent the programs determine themselves to be useful, appropriate, and noninflationary.

I would like to submit this working draft to the record and I am hopeful that it will receive the careful attention of members of the subcommittee as well as witnesses appearing before today and during the remainder of these hearings.

Relative value guides can play a legitimate role in assisting the Bureau of Health Insurance in its various intermediaries in determining appropriate physician reimbursement levels.

I am hopeful that these hearings will provide the basis for inclusion in the bill of a specific provision which will better take the use of these guides in appropriate circumstances.

[The working draft follows:]

RELATIVE VALUE GUIDES

When I introduced S. 3205, I referred to the desirability of the subcommittee examining the potential legitimate role of relative value guides or scales in determining appropriate reimbursement of physicians under medicare and medicaid. Since that time, at my request, the staff of the subcommittee has been engaged in discussions on this subject, both with some representatives of the medical profession and with officials of various Federal agencies.

As a result of these discussions, the staff has had prepared a working draft of specifications for a legislative provision. It is designed to authorize Federal medical insurance programs to use relative value guides to the extent the programs determine them to be useful, apppropriate and non-inflationary. I would like to submit this working draft for the record, and I am hopeful that it will receive the careful attention of the members of the subcommittee, as well as the witnesses appearing before us today and during the remainder of these hearings.

Relative value guides can play a legitimate role in assisting the Bureau of Health Insurance and its various intermediaries in determining appropriate physician reimbursement levels. I am hopeful that these hearings will provide the basis for inclusion in the bill of a specific provision which will validate the use of these guides in appropriate circumstances.

Amend title XI of the Social Security Act to provide that, to assist in determining payment for physicians' services covered under any title of the act, the Secretary may authorize the use of studies, guides, scales, or tables formulated and adopted by a bona fide national, State or local professional society or association of physicians or health benefit organization, the purpose or effect of which is to establish, on the basis of complexity of procedure, time or effort necessary for completion, and/or other relevant medical considerations, a relative value for one or more medical procedures of the type normally performed by the members of such a society or association in relation to or compared with other medical procedures of the type normally so performed: *Provided*, That such study, guide, scale or table does not assign a monetary value to the procedures covered thereby or to the unit employed in establishing relative value.

In determining whether such authorization will be given, the Secretary shall take into account such evidence as the sponsoring organization shall provide concerning its impact on program costs as well as the appropriateness, clarity and usefulness of the proposed system. The formulation adoption, dissemination or use of such a study, guide, scale or table, whether or not authorized by the Secretary for use under the Act, shall not in itself be deemed a violation of any antitrust law. Nothing herein shall be construed as compelling any person to use such a study, guide, scale or table in connection with either the seeking of, or the making of, payment or reimbursement for physicians' services under the Act, or otherwise.

Senator TALMADGE. The next witness is Dr. John M. Dennis, president of the American College of Radiology, accompanied by Dr. Frederic D. Lake, M. I., chairman, board of chancellors and Otha W. Linton, director, governmental relations.

At this time, Dr. Dennis, I want to thank you and the American College of Radiology for your very helpful contribution in drafting this bill.

STATEMENT OF DR. JOHN DENNIS, PRESIDENT, AMERICAN COLLEGE OF RADIOLOGY, ACCOMPANIED BY FREDERIC D. LAKE, M.D., CHAIRMAN, BOARD OF CHANCELLORS, AND OTHA W. LINTON, DIRECTOR, GOVERNMENTAL RELATIONS

Dr. DENNIS. Thank you, Senator. These comments on Senate bill 3205 are offered on behalf of the 12,000 members of the American College of Radiology. I express their gratitude to the chairman and members of the subcommittee for this opportunity.

I am Dr. John M. Dennis, of Baltimore, president of the American College of Radiology. I am accompanied this morning by Dr. Frederic D. Lake of Chicago, chairman of the college board of chancellors, and by Otha W. Linton, director of Government relations for the college.

The American College of Radiology is the major national professional society of physicians who use X-rays and other forms of energy to diagnose disease or who utilize high energy radiation for the treatment of cancers.

The college has a range of activities which support our obligation to provide the radiologic services needed by Americans. Since provisions of S. 3205 would have an effect upon the circumstances in which radiologists provide their services, to beneficiaries of Federal programs, we offer any possible assistance.

Almost all of the members of the college are also members of the appropriate local and State medical societies and of the American Medical Association. In what follows here, we will attempt to limit

our remarks to those elements of S. 3205 which are of primary concern to radiologists.

We are grateful to the subcommittee chairman and his staff for the opportunity to discuss S. 3205 during its formative stages. We appreciate his kind remarks about our cooperation on several occasions, including his visit with our board of chancellors and council.

We recognize the need for the Congress to seek improvements in programs through which Federal funds are used to pay for health care. The outlines of S. 3205 were shared with the Senate on June 20, 1975, in the chairman's speech.

Following that, the American College of Radiology responded to an invitation to comment. In a letter to the chairman, we pointed out that the projected provisions dealing with mechanisms for compensation of radiologists who serve Federal health care program beneficiaries were consistent with the policy of the American College of Radiology since 1965.

While a majority of college members now practice independently in voluntary hospitals, perhaps a third or fewer are still engaged with hospitals under arrangements which would be unacceptable for Federal programs under certain sections of S. 3205.

Thus, in supporting the change which the bill would require, we caution against any presumption that these contractual arrangements which we regard as less desirable for all concerned, have necessarily been abusive of patients, physicians, or hospitals where the parties directly involved have been fair and conscientious.

The circumstances of the practice of radiology in hospital departments under previous medicare and medicaid legislation is contained in the college letter. Rather than repeat it here, we submit the letter for the record.

Senator TALMADGE. Without objection, it will be inserted in full at this point, Doctor.

[The letter follows:]

AMERICAN COLLEGE OF RADIOLOGY,
Chicago, Ill., July 7, 1975.

Hon. HERMAN E. TALMADGE,
Chairman, Subcommittee on Health, Senate Finance Committee, Dirksen Senate Office Building, Washington, D.C.

DEAR SENATOR TALMADGE: The following comments are offered on behalf of the 12,000 members of the American College of Radiology who constitute nearly 90 percent of the nation's specialists in the uses of radiologic procedures for the diagnosis and treatment of disease. Our observations are a response to the invitation contained in your June 20 speech in which you announced your intention to introduce legislation which would, among other things, affect the payment by Medicare and Medicaid for the services of radiologists to beneficiaries of those programs.

The principal suggestion with regard to the practice of radiology in hospitals, that radiologists not be compensated by federal programs if they practice under a percentage arrangement, is consistent with policy of this organization adopted in October 1965.

That statement, approved by the College's Board of Chancellors, asserted that:

"It is the policy of the American College of Radiology that members of the College shall separate their professional fees from hospital charges and present their own bills to patients."

The full College policy statement contained a paragraph noting that in those institutions where the entire medical staff practiced on a basis other than that of fee-for-service, it would be considered appropriate for the radiologist to share the common status.

Prior to the adoption of that policy, the American College of Radiology had requested the Congress to cover radiology within the Medicare and Medicaid programs as physician service under the Part B section. When this was done in PL 89-97, the College undertook a vigorous campaign to assist radiologists then working under hospital contracts to alter their practice arrangements and bring them into conformity with legal requirements and with the ACR policy stand.

In some areas, the change was relatively quick and easy for most radiologists. In others, it was opposed strongly by hospital groups and certain insurance carriers. Some radiologists lost their appointments because of efforts to separate their professional income from that of their hospital.

In the intervening years, the College has continued its campaign to persuade and assist radiologists to attain an independent, fee-for-service basis of practice in voluntary hospitals. As a professional organization, the College exercised no sanctions against members who disagreed with that policy or who found themselves unable, because of local circumstances, to bring their arrangement into compliance.

In any event, a survey just completed of College members indicates that 64 percent of those practicing in hospitals in which patients are expected to pay for services now bill and collect their own fees. We attach the summary of that survey for your review.

The position of the College favoring fee-for-service was taken in 1965 for several reasons. One was the recognition that the establishment of separate parts A and B of Medicare made it necessary to categorize the professional services of radiologists in one part. The overwhelming preference of radiologists was for a definition as physician services. This would appear to be retained and emphasized within the implementation of the language in your June 20 speech.

A second reason for the College's current policy was the recognition that percentage contracts, the dominant arrangement in 1965, contained the seeds for abuses of several kinds. Many radiologists and hospitals have continued to function with amicable and apparently equitable contracts, with radiologist incomes comparable to those of other physicians. In some instances, there have been abuses which have seemed as obvious to members of the ACR as they may have seemed to federal investigators. In some of these situations, percentage contracts have resulted in unusually high incomes to radiologists. In others, they have resulted in the retention by the hospital of a substantial proportion of funds allegedly charged as the physician's fee and collected by the hospital under its percentage agreement.

Turning to the paragraph of your speech (p S11124) in which you discuss "hospital-based specialists," we would welcome some of the concepts and express caution about others. As might be perceived from our comments above, we do appreciate and accept a premise to compensate radiologists for patient services on a fee-for-service basis. The College and its members would hope that such a fee-for-service basis would be identical to regulations and protocols for the fee-for-service reimbursement of other physicians for services to patients in Medicare and Medicaid.

We must recognize also that there are situations in which radiologists accept salary arrangements for their services to patients. Thus, it is appropriate for legislation to recognize and accept that such institutional relationships can allow for food radiology services. It has been the College's preference that salary arrangements be applied only in circumstances where patients are not billed for physician or institutional services.

Continuing through your paragraph, we commend your recognition of circumstances in which physicians directly perform services and those in which technical personnel perform certain elements under physician supervision. In radiology, for example, technologists may work with patients to produce the images from which the radiologist makes his diagnosis. In all instances, the critical diagnostic decisions are made by the radiologist and provided to the patient's attending physician in a written or oral consultation. When the radiologist treats patients, most commonly for some form of cancer, he normally sets up the treatment protocol and supervises each session.

The question of compensating radiologists for administrative and supervisory functions is one which has arisen in good part because current Medicare regulations made it desirable for hospitals to be able to attribute certain professional expenses to departmental costs. In most voluntary community hospitals, radiologists feel that their role in administering radiology departments is akin

to that of other chiefs of medical service. Over the past decade, we have observed a trend for hospitals to provide an x-ray department administrator. These x-ray administrators usually are not physicians. They are charged with the logistical management of the department, relieving the physicians to concentrate on providing patient service. Ordinarily, in community hospitals, the radiologists have no source of income other than patient fees and reject any extra payments from the hospital if allowed to practice on a fee-for-service basis.

Conversely, there are large public and academic hospitals in which the chief of radiology and his staff carry burdens of administration, teaching and research which account for significant portions of their time. In such institutions, it is felt proper for there to be arrangements for institutional compensation for such non-patient care.

It should be noted that where a radiologist or group of radiologists hold responsibilities for activities other than patient care, their volume of patient services is diminished proportionately by comparison with a group undertaking only patient services. Thus, we would urge that care be taken to avoid differentiating the basis for compensation the individual patient services of radiologists who also administer or teach or do research from the straightforward fee-for-service to be allowed for their colleagues who spend full time on patient service.

In that same paragraph of your speech, there is a sentence which reads, "No percentage, lease or direct billing arrangements would ordinarily be recognized for Medicare or Medicaid purposes." This sentence introduces two new concepts which should receive serious thought.

Over the years, a relatively small minority of radiologists have practiced in hospitals under a variety of lease arrangements. Some leases were based upon the volume of practice, amounting to an inversion of the percentage contract in which the hospital divided a joint fee with the physician. The majority of leases known to the College represented situations in which the radiologist purchased space, equipment and supportive services from the hospital, usually for a fixed annual fee. The radiologist, in turn, charged patients on much the same basis as he might have billed in a private office not located physically within a hospital.

The lease basis for practice has not been a popular one for hospitals. In some states, attorneys general have ruled that a non-profit institution cannot lease a portion of its facilities without jeopardizing the status of the whole. However, the lease does not necessarily share the same attributes of a percentage contract.

The subsequent phrase in your sentence, "direct billing arrangements," represents what we would hope is a semantic misunderstanding. Within the common usage of that phrase by physicians and health insurers, this refers to the sending of a bill by a physician to a patient for services rendered. We would use the term similarly whether the physician sends it only to the patient or whether he accepts assignment and sends it to a health care insurer. In that context, direct billing is the opposite of arrangements under which a hospital bills for physician services by combining the physician charge with hospital service charges. To us, direct billing and fee-for-service mean the same thing.

If the phrase is meant to prohibit the sending of bills to patients or their insurers by radiologists, then it would negate the fee-for-service basis promised above. If the phrase means that radiologists would be required to accept assignments of benefits for Medicare and Medicaid patients, this would constitute discriminatory treatment and surely would be opposed by those radiologists who refuse assignments and, on principle, by many who accept assignments.

If the phrase could be deleted from further discussions and from legislative language, it would resolve the problem we have suggested and would leave clear your intent to cover radiology services on a fee-for-service basis. If the phrase means something else, we respectfully request further explanation.

In the paragraph in your speech following the one just discussed, we applaud your understanding of the need to cover outpatient diagnostic services in an equitable way to avoid the large movement of patients in covered programs away from physician offices. Such an unchecked movement can only add to the public expenditures involved in expanding hospital facilities and, at the same time, represent an economic waste of private office facilities. We have held that there should be no discrimination in the payment for ambulatory services according to site, i.e., office or hospital outpatient department.

We have written at considerable length about what we perceive as the implications and impact of your words, once translated into legislation. Your legislative

Intentions are of the utmost concern to the nation's radiologists. They need to be clear enough to avert regulatory distortion. We are grateful for your recognition of our basic desire to continue practicing on a fee-for-service basis with Medicare and Medicaid patients. We would hope that you would continue to consult with our legislative counsel, J. T. Rutherford, and with the officers and staff of the College as you develop this legislation.

Sincerely,

JOHN M. DENNIS, M.D.,
Chairman, Board of Chancellors.

Dr. DENNIS. In reviewing S. 3205, we offer some general comments about the issues addressed and then specific comments upon sections of the bill. The bill contains no references to the specialty of radiology.

There were such references in the introductory and explanatory material which accompanied it. However, several sections clearly influence the practice of radiology. We are apprehensive about the specificity of definitions in legislation, as exemplified in Section 22 of S. 3205.

Some of the distinctions stated therein are difficult to establish in real-life situations. They will impose substantial difficulties upon the Federal programs, their carriers, health care institutions and physicians.

We have no quarrel with the intent to have Federal programs pay equitably for health services received by their beneficiaries. We recognize the difficulties which have been overcome as well as those remaining in distinguishing between those physicians services which benefit one patient and the services which benefit all patients and the health care institution.

We do not have the answers to this problem. However, definitions of health services for purposes of payment categorization have much broader applications than may be intended. For example, medicare provisions to compensate beneficiaries through receiving various diagnostic ultrasound procedures have led to current definitions not in keeping with this new modality.

The definition of categories of service, such as cancer therapy, "institutional services" has a kind of impact which would go beyond the immediate congressional intent. We urge language in the legislative history to make clear the context and limitations of such definitions.

It might be helpful to urge in that legislative history that the administrative agencies consult with the provider groups before the issuance of regulations, as the subcommittee is now doing prior to legislation.

We confess to an inherent apprehension about legislation which speaks to the terms, arrangements and limitations under which we offer our professional services. This is not an immediate problem for radiology in S. 3205.

However, the precedent is certain to be utilized by others for legislative or regulatory purposes. We would urge that the legislative history express the extent of the committee's proposals.

A second general point deals with the need for relief from a situation in which efforts to be responsive to some Federal agencies place us in jeopardy with others. We are encouraged to raise this by the chairman's inclusion of it in his speech to us.

Our reference is to current efforts of the Department of Justice, and the Federal Trade Commission to impute that the contrivance and distribution of standard terminologies and relative value scales by medical groups represent violations of antitrust laws.

The college's first relative value scale was prepared in response to a request from the CHAMPUS program during the 1950's. It has been welcomed enthusiastically in its several versions by third-party carriers and by the Federal agencies.

Such information may be used to develop a fee schedule by individual physicians, by hospitals or by health insurance carriers. Indeed, some such exercise must be undertaken by anyone with a need to develop a fee schedule or a profile.

The position asserted by the FTC that the preparation and distribution of a relative value scale with appropriate disclaimers by a medical group is a per se violation would make it impossible for such professional societies to cooperate with the Federal health agencies.

It could make it difficult for us to assist committees of the Congress by gathering and providing information. We urge strongly that the subcommittee add language which would amount to a limited antitrust exemption for medical societies which had created these nomenclatures, coded terminologies and relative value scales.

We do not suggest that medical societies be immunized against penalties for misuse of such materials. Rather, we request that your language require that an organization which has prepared a relative value scale be proven to have misused it to restrain trade.

In this fashion, badly needed relief could be granted without opening a much broader issue of antitrust laws. We offer possible language to accomplish this limited exemption.

The remainder of our prepared testimony consists of specific comments upon sections of S. 3205 as written. We would request that the statement, in its entirety, plus two attachments, be attached for the record.

Senator TALMADGE. Without objection, so ordered.

Dr. DENNIS. We again express the appreciation of the American College of Radiology to the committee for our opportunity to express our opinion on S. 3205. If we can be responsive to questions now or later, as the committee deliberates further, please call upon us.

I have instructed our legislative counsel, Mr. J. T. Rutherford and our Washington staff to provide any desired assistance.

Senator TALMADGE. Thank you very much, Dr. Dennis, for your helpful and constructive testimony. Your recommendations will be carefully considered by the staff and also the members of the subcommittee.

It is not the intention of the subcommittee to tell doctors how to practice their profession, only doctors know how to practice their profession, politicians do not. I hope you and the college will continue to work with our staff as this legislation progresses.

Any helpful suggestions you may have, we will receive and give careful consideration. Senator Dole?

Senator DOLE. As I understand it, the radiologists would be relatively satisfied with a fee for service arrangement rather than percentage compensation. Is that correct?

Dr. DENNIS. Yes.

Senator DOLE. Why it is that you would have one view in that issue and the pathologists another?

Dr. DENNIS. The pathologists will speak for themselves, I believe.

[The prepared statement of Dr. Dennis follows:]

STATEMENT OF JOHN M. DENNIS, M.D., PRESIDENT, THE AMERICAN COLLEGE OF RADIOLOGY, FREDERIC D. LAKE, M.D., CHAIRMAN, BOARD OF CHANCELLORS

SUMMARY OF TESTIMONY ON S. 3205

The thrust of the testimony on behalf of members of the American College of Radiology is directed to concepts and specific provisions of the proposed bill which would in some way affect the practice of radiology.

The testimony points out that provisions to eliminate certain forms of contract practice for radiologists and other physicians by which a total fee is shared between the physician and his hospital are compatible with ACR policy since 1965. It notes that most radiologists who practice in voluntary hospitals have now separated their professional fees from hospital charges and are, in fact, practicing independently.

The testimony expresses concern about the degree of specificity in legislative language embodied in S. 3205 as to definitions of certain types of medical practice. While recognizing the intent to prevent bureaucratic alteration of congressional intent, the ACR urges that the bill and the accompanying committee report make clear the context and limitations of its actions.

The ACR also urges that the committee give favorable consideration to legislative language to relieve medical organizations which devise nomenclatures, coded terminologies and relative value studies from an imputation or action by federal and state agencies that the creation of such documents represent per se violations of anti-trust and fair trade acts. The College suggests that proof be required that the nomenclatures, coded terminologies or relative value studies have been used in a manner to restrain trade or otherwise be in overt violation.

The testimony also requests clarification of the committee's intent and makes suggestions for specific language changes in several sections of the Senate bill.

These comments on Senate bill 3205 are offered on behalf of the 12,000 physician and physicist members of the American College of Radiology. I express their gratitude to the chairman and members of the subcommittee for this opportunity.

I am Doctor John M. Dennis of Baltimore, president of the American College of Radiology. I am accompanied this morning by Dr. Frederic D. Lake of Chicago, chairman of the College Board of Chancellors, and by Otha W. Linton, director of government relations for the ACR.

For the record, the American College of Radiology is the major national professional society of physicians who specialize in the use of X-rays and other forms of energy to produce diagnostic images of patients or who utilize high energy radiation for the treatment of diseases, mostly cancers. The College is charged by its members with a range of activities which support their obligation to provide the scope and quantity of radiologic services needed by Americans. Since provisions of S. 3205 would have an effect upon the circumstances in which radiologists provide their services to beneficiaries of federal programs, we feel obliged to offer any possible assistance in its consideration.

Almost all of the physician members of the College are also members of appropriate local and state medical societies and of the American Medical Association. In what follows here, we will attempt to limit our remarks to those elements which are of primary concern to radiologists.

We are grateful to the subcommittee chairman and members of his staff for opportunities to discuss the substance of S. 3205 during its formative stages. We appreciate his kind remarks about our cooperation on several occasions, including his visit with our Board of Chancellors and Council to explain the bill shortly after its introduction. As citizens and taxpayers, we recognize the need for the Congress to seek improvements in programs through which federal funds are used to pay for health care.

The outlines of S. 3205 were shared with the Senate on June 20, 1975 in the chairman's speech. Following that, the American College of Radiology re-

sponded to an invitation to comment and raise questions. In a letter to the chairman from me, then chairman of the ACR Board of Chancellors, we pointed out that the projected provisions dealing with mechanisms for the compensation of radiologists who serve federal health care program beneficiaries were consistent with the policy of the American College of Radiology since 1965. We also noted that while a majority of College members now practice independently in voluntary hospitals, perhaps a third or fewer are still engaged with hospitals under arrangements which would be unacceptable for federal programs under certain sections of S. 3205.

Thus, in supporting the change which the bill would require, we caution against any presumption that these contractual arrangements, which we regard as less desirable for all concerned, have necessarily been abusive of patients, physicians or hospitals where the parties directly involved have been fair and conscientious.

The background of the circumstances of the practice of radiology in hospital departments and its handling under previous Medicare and Medicaid legislation is contained in the College letter to the chairman. Rather than repeat it here, we submit the letter with a request that it be made part of the record.

In reviewing S. 3205, we offer some general comments about the issues addressed and then a series of specific comments upon sections of the bill. The bill contains no specific references to the specialty of radiology, though there were such references in the introductory and explanatory material which accompanied it. However, since several sections will clearly influence the practice of radiology, we will address them with brief explanations.

We are apprehensive about the specificity of definitions in legislation, as exemplified in section 22 of S. 3205. Some of the distinctions stated therein are most difficult to establish in real-life situations and will impose substantial difficulties upon the federal programs, their carriers, health care institutions and physicians. We have no quarrel with the intent to have federal programs pay equitably for those health services received by their beneficiaries. We recognize the difficulties which have been overcome as well as those remaining in distinguishing between those physician services which benefit one patient and those services which benefit all patients and the health care institution.

By no means do we suggest that we have the answers to this problem. However, definitions of health services for purposes of payment categorization have much broader applications than may be intended. For example, Medicare provisions to compensate beneficiaries receiving various diagnostic ultrasound procedures have led to current definitions not in keeping with the growth of this new modality and difficult to correct. The definition of certain categories of service, such as forms of cancer therapy, as "institutional services" has a kind of impact which would go well beyond the immediate congressional intent. At the very least, we urge language in the legislative history to make clear the context and limitations of such definitions. Perhaps it might be helpful to urge in that legislative history that the administrative agencies which implement this bill consult with the provider groups before the issuance of regulations, as the subcommittee is now doing prior to legislation.

We confess to an inherent apprehension about national legislation which speaks to the terms, arrangements and limitations under which we are to offer our professional services to patients. This is not an immediate problem for radiology in S. 3205. However, the precedent which is established here is certain to be utilized by others for legislative or regulatory purposes. Thus, again, we would urge that the legislative history express the extent of the committee's proposals.

A second general point deals with a need for relief from a situation in which efforts to be responsive to some federal agencies place us in jeopardy with others. We are encouraged to raise this by the chairman's inclusion of it in his speech to us. Our specific reference is to current efforts of the Department of Justice and the Federal Trade Commission to impute that the contrivance and distribution of standard terminologies and relative value scales by medical groups represent violations of anti-trust laws.

The College's first relative value scale was prepared in specific response to a request from the CHAMPUS program during the 1950s. It has been welcomed enthusiastically in its several versions by third party carriers and by the federal agencies charged with administering Title 18 and Title 19 health benefit programs. Such information may be used to develop a fee schedule by individual physicians, by hospitals or by health insurance carriers. Indeed, some such ex-

ercise must be undertaken by anyone with a need to develop a fee schedule or profile.

But to take the position asserted by the FTC that the preparation and distribution of a relative value schedule or scale with appropriate disclaimers by a medical group is a per se violation would make it impossible for such professional societies to offer cooperation to federal health agencies and could perhaps make it difficult for us to assist committees of the Congress by gathering and providing information about our specialties and practices.

We urge strongly that the subcommittee consider adding language which would amount to a limited anti-trust exemption for medical societies which have created these nomenclatures, coded terminologies and relative value scales. We do not suggest that medical societies be immunized against penalties for misuse of such materials. Rather, we request that your language require that an organization which has prepared a relative value scale be proven to have misused it to restrain trade. In this fashion, badly needed relief could be granted without opening a much broader issue of anti-trust law. We offer as an attachment to this testimony possible language for a section to accomplish this limited exemption.

We proceed now to specific comments upon sections of S. 3205.

As the subcommittee is aware, appeal mechanisms for physicians under Part B from adverse decisions of intermediaries have been inadequate. Thus, in section 3, we suggest the addition of language as a new paragraph to follow paragraph (c)(2)(C) which would direct the establishment of a mechanism for receiving complaints from beneficiaries or physicians for whom routine channels provide no relief. In section 4, we salute the directive to state Medicaid programs in section 1902(a)(39) which would require payment of 95 percent of "clean claims" within 30 days. The implementation of this section should relieve an inflationary burden upon physicians and other providers. If a radiology group, for example, must borrow working funds against several months delay in accounts receivable from Medicaid, the immediate result is to add unproductively to their cost of practice. These costs ultimately are borne by patients.

We commend the specification of 60 days as a basic period for public comment upon preliminary publication of regulations and other administrative rulings by the agencies charged with implementing federal programs. We also applaud the stipulation that these agencies be required to communicate proposed changes in policy guidelines to interested parties in a timely manner prior to promulgation. Over the decade of Medicare administration, for example, we have learned repeatedly of the issuance of intermediary letters affecting the coverage of radiology only when their implementation by a carrier presented a problem. While we would hasten to add that we have had prompt and sympathetic responses to these problems from the staff of the SSA Bureau of Health Insurance, many of the dilemmas could have been averted by prior consultation.

Turning to section 20, we are uncertain about the extent of applicability of the language in section 1842(b)(3A)(iii)(C) to "medical services, supplies and equipment" if the term "medical services" is not distinguished from provisions for "physicians' services" which are contained in preceding paragraphs. Perhaps the simplest way of making what we deem an essential clarification would be the insertion of a parenthetical phrase in subparagraph (C) ". . . medical service (not including physician services as defined elsewhere in PL 89-97, as amended), supplies and equipment. . . ."

It seems to us that elsewhere in section 20 might be an appropriate place to insert the limited exemption from anti-trust violations for efforts by medical societies to assist federal programs and insurance carriers to determine reasonable charge levels and ranges.

In section 21, we note the contrivance of incentives for physicians to accept assignment of their fees for services to federal program beneficiaries. Among these incentives would be prompt reimbursement of simplified batch billings. This provision is particularly applicable to radiology groups. We urge that the legislative history emphasize the intent of the Congress to require that administrators and intermediaries for these programs implement this provision immediately and effectively. As we noted above with respect to similar directives for Medicaid administrators, current delays in reimbursement by intermediaries represent a strong disincentive for physicians to accept assignment of benefits.

Also in the proposed section 1868(b)(2) we emphasize the necessity of retaining an option for physicians to opt in or out of "participating status." The desire of physicians to have this option is as strong as it was at the time of considera-

tion of the original Medicare legislation. If the intent of the several sections of S. 3205 to make the federal programs and their fiscal intermediaries more responsible is implemented successfully, then few of us would opt out of participating status. If the intent of the Congress is not executed effectively, then many more will wish or need to opt out. In either case, the preservation of this right of the physician to elect his own status is most important to us.

In the same section 21, paragraph (e)(1)(B) we interpret the cost saving incentive to be applicable to radiologists who bill beneficiaries for services performed in their private offices and not applicable to radiologists who bill beneficiaries for services performed in hospital X-ray departments. This is a discriminatory provision which would affect in particular the billing of radiation therapy services for cancer patients, most of which are provided in centralized facilities in hospitals or community centers.

In section 22(a)(1) the definitions of "physician service" to be added to section 1861(q) are compatible with those which we commonly use with regard to diagnostic and therapeutic radiology. We would note that in the production of diagnostic images by means of X-rays, isotopes, ultrasound or body infra-red emissions that the supervising radiologist need not be physically present during the exposure. However, he must exert continuing supervision over the technologists who make the exposures and he must personally inspect the images produced by them to render a diagnostic opinion.

With that understanding, our only problem in this section, as expressed above, is the great difficulty in categorizing physician activities which achieve more than one objective with the same effort.

We note in the definition of pathology services in paragraph (3) of this section a reference to the application of isotopes as being physician service. We concur with this understanding, again with the caveat that radioisotopes are used both in certain types of in vitro laboratory tests commonly regarded as pathology and also in dynamic imaging procedures clearly regarded as radiology. Thus, there should be no negative inference that the applications of isotopes are limited to pathology or are physician services only when performed within that discipline.

We addressed above and in our appended letter the general status of contract practice by radiologists in hospitals under contracts stipulating a percentage of billing or lease basis for compensation. While we have emphasized that these arrangements are, in our opinion, less desirable than physician independence, and yet are not necessarily abusive of patients or their insurers, we here address a technical point raised by language in paragraphs (b)(2)(G) and (c)(8)(A) referring to ". . . an amount equal to the salary which would reasonably have been paid for such services (together with any additional costs that would have been incurred by the hospital) to the physician performing them if they had been performed in an employment relationship with such hospital. . . ."

Our problem and that of program administrators and carriers will be with the determination of ". . . salary which reasonably would have been paid for such services . . ." In one sense, this is a mandate for the federal programs to fix, or at least to review and approve, the levels of physician salaries in those institutions where physicians must change to that arrangement to be in compliance with these portions of section 22.

In regard to those radiologists, and perhaps other physicians, whose contracts with hospitals are based upon a lease arrangement, we would point out that the termination of such leases can be a complex legal and financial transaction which might require more time than the cancellation of percentage contracts. While the terms of leases vary widely, they often involve the radiologist employing technical and clerical personnel and owning the equipment in the hospital's department. Changing personnel over to a hospital payroll and arranging for the hospital to purchase capital equipment can be complex. We urge the committee to recognize these problems and to allow an appropriate time period for their resolution.

In our opinion, it would be desirable and appropriate to indicate in the legislative history that such an obligation is not intended on a priority basis. Rather, we would suggest that the applications of the hospital accounting protocols stipulated in section 10 of S 3205 would be adequate to detect unacceptable variations from "reasonable salaries."

Further on this point, it would be our understanding that nothing in S 3205 is intended to prevent physicians and hospitals from altering or terminating or commencing contract relationships on an acceptable basis after enactment of this bill.

In section 23, we applaud the requirement that Medicaid programs must reimburse beneficiaries or providers at no less than 80 percent of Medicare UCR schedules for physician services in a non-hospital setting. Along with previous stipulations for prompt payment, this should serve to relieve physicians of current financial disincentives to serve Medicaid patients.

In section 42, we urge expansion of proposed coverage of ambulance service. In a growing number of communities, expensive facilities for radiation therapy for cancers are being centralized in a community-sponsored facility. This may be attached to a hospital, or it may be organizationally and physically separate. There are not current provisions to cover expenses of ambulances for those patients whose condition as a hospital or home care patient requires such transportation to and from a free-standing treatment center. Radiation therapy must be given in daily increments which may require 15 to 40 separate visits to the treatment facility. Thus, ambulance charges can become a significant financial burden upon patients if not covered by the program which covers the treatment.

We have commented at length and in specific detail because of our belief in the importance of thorough discussion of legislation as significant to health care as is S 3205. We repeat the willingness of College members and staff to assist the subcommittee in its further deliberations. And we again thank the members for their consideration of our viewpoints here.

LIMITED ANTITRUST EXEMPTION

Section 1—Policy

In the public interest of enabling physicians to establish charges for medical services which have a reasonable relationship to the comparative difficulty, risk and degree of skill required by such services, and to enable federal and state health agencies, fiscal intermediaries and insurance companies to estimate realistically the costs of health care delivery and to determine the reasonableness of particular charges for medical services, it is hereby declared to be the public policy of the United States to permit individual physicians or representative groups of physicians to study, establish or revise codes, indices, standard terminologies and relative value scales for particular medical services.

Section 2—Definitions

1. The term "anti-trust laws" means the Federal Trade Commission act and each statute defined by section 44 of title 15 of the United States Code as "anti-trust laws" and all amendments to such acts and to such statutes and to any other acts in pari materia.

2. The term "representative group of physicians" means a state, regional or national association of physicians described in section 501 (c)(3) or (c)(6) of the Internal Revenue Code.

3. It shall not be unlawful under any anti-trust laws for any person or representative group of physicians to create, publish or revise any code, index, standard terminology or relative value scale for particular medical services if such code, index, standard terminology or relative value scale reasonably relates the comparative difficulty, risk and the degree of skill required in rendering such medical services.

Senator TALMADGE. Thank you very much, gentlemen. The next witness is Ruth B. Ecklund, president-elect, American Association of Nurse Anethetists, accompanied by Nancy Fevold, acting executive director, and Kenneth Williamson—consultant.

We are delighted to have you with us.

STATEMENT OF MS. RUTH ECKLUND, PRESIDENT-ELECT, AMERICAN ASSOCIATION OF NURSE ANESTHETISTS, ACCOMPANIED BY NANCY FEVOLD, ACTING EXECUTIVE DIRECTOR, AND KENNETH WILLIAMSON, CONSULTANT

Mr. Chairman, I am Ruth B. Ecklund, CRNA, president-elect of the American Association of Nurse Anesthetists and chief nurse anesthetist, Family Hospital, Milwaukee, Wis. Accompanying me are

Nancy A. Fevold, CRNA, who is acting executive director of the association, and Kenneth Williamson, who is the Washington consultant for the association. We appear here today in behalf of the association.

The American Association of Nurses Anesthetists (AANA) is a professional organization whose membership is comprised of certified registered nurse anesthetists, CRNA's, practitioners, and educators who are engaged in anesthesia practice. The association's two major goals, both of which serve the public interest, are, first, to promote the continued existence of quality education in the schools of nurse anesthesia and, second, to enhance and further develop the clinical skills of individual nurse anesthetists to provide quality care for patients.

Nurse anesthetists are a major group in the delivery of anesthesia services. There are 13,522 practicing CRNA's and there are approximately 11,800 anesthesiologists —MD's. The largest percentage of anesthetics given to patients in the United States is provided by nurse anesthetists. For the approximately 16,486,045 surgical procedures in 1974, CRNA's provided the anesthesia services in 48.5 percent of these cases. In 40 percent of the hospitals in the United States a nurse anesthetist is the sole provider of the anesthesia service, working as a member of the operating team along with the surgeon in performing a highly essential service to hospital patients.

CRNA's are officially recognized by the U.S. Department of Education, the federation of specialty nursing organizations and the American Nurses' Association, the American Society of Anesthesiologists, the American Hospital Association, the American College of Surgeons, and by the Joint Commission on the Accreditation of Hospitals. The performance of CRNA's and the quality of the services they render is attested to by their widespread use in university medical centers, community hospitals, the Veterans' Administration and the armed services. CRNA's by their education are fully prepared and competent to provide anesthesia services utilizing the various anesthetic agents. Both CRNA's and anesthesiologists are interested in rendering quality anesthesia services. Attached for your information is a copy of the standards for nurse anesthesia practice which gives a good indication of the preparation of the certified registered nurse anesthetist and the guidelines by which they practice.

On August 21, 1975, we wrote you, Mr. Chairman, reviewing the whole question of reimbursement for anesthesia services. In our letter we made a number of recommendations intended to achieve cost savings in the provision of anesthesia services, eliminate abuses in the present system of reimbursement and to bring about some fairness and greater equity in the payment for services rendered by different providers. Copies of all of this material were sent to each member of the committee and we shall, therefore, not repeat that information.

We wish to direct our comments to S. 3205 and limit our remarks to those provisions of the bill dealing with anesthesia services for which we have a special competency and particular interest. The provisions we are concerned with are discussed beginning on page 58 of the bill under section 22. The provisions dealing with anesthesia services in S. 3205 are quite disappointing to us as they do not appear to change the existing and very unfair treatment accorded nurse anes-

thetists under medicare/medicaid. The bill perpetuates the same limiting definitions that appear in the present law. At a time when some form of a national health program is being considered, it would appear to be essential to consider fully the potential of all health care providers and to remove definitions and designations which seriously limit the potential of numerous providers and, thereby, substantially increase the cost of health services.

Section 22 would amend the present law and it enumerates six specific activities which must be "personally performed" or "personally directed" by a physician. Though we shall discuss several specific questions as to the intent of some of the language, we commend the committee for this attempt to assure quality in the provision of anesthesia services.

Of the six activities listed, (A) is quite clear and needs no comment.

Activity (B) is seriously in need of clarification and, we believe, change. Under medical practice acts, generally, only a physician can write a prescription. Therefore, the use of this term in this case would seriously harm the orderly process of providing anesthesia. In those millions of cases where no anesthesiologist is present or available, the person qualified and competent to formulate the anesthesia management care plan is the nurse anesthetist. Generally speaking, the physician available, the surgeon, is less qualified to do so. Additionally, in great numbers of cases where anesthesiologists are present in the institution, the activities under (B) are provided by a nurse anesthetist. The paragraph commencing on line 9 of page 59 bears out this fact.

I. We recommend, therefore, that the language for activity (B) appearing on line 22 of page 58 be amended to read: "writing an anesthetic management care plan."

Activity (C) needs clarification and specificity we believe.

II. We recommend, therefore, that the language of activity (C) appearing on line 23 of page 58 be amended to read as follows: "personal participation in the induction, maintenance, and emergence;"

The suggested change would assure the continued presence of the individual responsible for the anesthetic throughout the course of the procedure which is essential to quality of care.

We believe the language in activity (D) at present will not accomplish the intended purpose, nor will it assure the necessary protection to the patient.

Recognition of the essentiality of the words "remaining physically available" is included in the definition of activity (E). It is our belief that such physical availability is equally essential during the course of the anesthetic as covered under activity (D).

III. We recommend, therefore, that the language of lines 1 and 2 of page 59 be amended to read as follows: "remaining physically available during the course of anesthesia administration."

Commencing on line 6 of page 59 with the words "*Provided however*," the language of the bill appears to substantially diminish the quality assurances proposed in activities (A) through (F) and may be seen, therefore, as vitiating the commendatory steps to assure quality of anesthesia services. The language of the bill commencing on line 6 through line 18 of page 59 is unclear.

Is this language limited only to reimbursement procedures or is it inclusive of quality of practice? If the statement refers to the quality of practice, certified registered nurse anesthetists are fully educated and trained to function as independent anesthesia practitioners under the direction of a physician. It is noted 40 percent of the hospitals in the United States do not have the services of an anesthesiologist available.

The present language may be read as permitting a physician to be responsible in whole or in part for the anesthetic being administered to six different patients simultaneously. In only one of these is he actually required to personally provide the anesthetic. Some other person is permitted to provide the anesthetic for a second patient for which the physician may make his reasonable charge, and he may receive one-half of his reasonable charge for four other patients whose anesthetic is being given by another person. Thus, the physician is assured payment for the anesthetic provided to six patients only one of which he personally gave. This is not recognized as good practice nor would it assure quality of anesthesia service. If this is not intended then the language needs to be much more specific.

We wish to point out that most of the activities [(A) through (F)] referred to in this section are frequently performed by nurse anesthetists. In a great many instances these activities are performed with no anesthesiologist present or available. We believe activity (C) to be the most crucial. Activity (C) presently states "personal participation in the induction and emergence."

The present language provides that this activity may be provided by an individual other than the physician.

IV. We recommend, therefore, in order that quality of care is assured and patients receive the protections they are entitled to, the words "another individual" appearing on line 11, page 59, be deleted and the following words inserted: "a qualified Nurse Anesthetist."

As we have pointed out, the language in this section of the bill recognizes that individuals other than physicians are fully qualified to provide the various activities deemed to be essential in the field of anesthesia. However, though the bill deals with the question of reimbursement of physicians for the provision of anesthesia services, we do not find any language which gives consideration to the reimbursement of nurse anesthetists for similar services.

We wish to reiterate that: CRNA's provide 48.5 percent of all anesthesia services for surgical procedures in the United States, and CRNA's provide anesthesia services both in urban and rural areas, in university medical centers, community hospitals, the Veterans' Administration, and the armed services.

Thus the existing very discriminatory provisions of medicare/medicaid remains. In order that true recognition is given to the services of nurse anesthetists we recommend that they are accorded some genuine equity. Definitive changes must be made in the medicare/medicaid law.

FREELANCE NURSE ANESTHETISTS

Freelance nurse anesthetists are called upon by hospitals or members of the surgical staff of hospitals in a great many areas where

there are no anesthesiologists (M.D.'s) or where nurse anesthetists are not employed by the hospital. At the present time, freelance nurse anesthetists must resort to a variety of subterfuges to collect for their services. Thus, they are subject to the rankest sort of discrimination. We are not suggesting that nurse anesthetists generally move to a fee-for-service system of reimbursement. At the present time, 69 percent of CRNA's are hospital employed. We are saying that those nurse anesthetists, who wish to practice their profession as individuals without seeking hospital employment, should be able to do so and the Government should, in all fairness, make it possible for them to be paid for their services. Simply put, the question is: "Why should a physician be assured payment as an individual practitioner and a nurse anesthetist who is fully qualified and renders the service be prohibited from billing and receiving payment for this service." Our study of the bill does not indicate to us that the freelance nurse anesthetist's situation is improved.

In summary, hundreds of nurse anesthetists across the country have written to their Senators and received many expressions of understanding of our position and indications that every consideration would be given to our recommendations with support to bring about some real fairness and equity in the treatment of nurse anesthetists. We believe these statements were made in all good faith. We, therefore, urge your full consideration of the views we have expressed.

We recognize that S. 3205 is intended as amendments to the medicare and medicaid laws. However, it is our belief that these amendments may well form the basis of language and approaches which may be picked up in legislation providing for a national health program. Thus, we believe that the actions taken in S. 3205 in respect to providers of anesthesia services are of utmost importance for the future. We hope our comments and recommendations are helpful, and we ask that they be made a part of the permanent record.

We appreciate this opportunity of bringing our views to you and would be pleased to be of all possible assistance in working with the committee and its staff to attain the very laudable goals set forth by the chairman of the committee in the statement he made upon the introduction of the bill.

[The attachment previously referred to by the witness follows:]

STANDARDS FOR NURSE ANESTHESIA PRACTICE

INTRODUCTION

The American Association of Nurse Anesthetists (AANA) is a professional organization whose membership is comprised of Certified Registered Nurse Anesthetists (CRNA's), practitioners and educators who are engaged in anesthesia practice. The Association was organized to fulfill two basic goals. First, the AANA is involved in activities which assure the continued existence of high quality, professionally competent schools of nurse anesthesia. This activity is accomplished through the formulation and review of Standards for the Accreditation of Schools of Nurse Anesthesia and through curriculum reviews for such institutions seeking initial or renewed accreditation by the AANA. The American Association of Nurse Anesthetists is recognized by the United States Commissioner of Education as the accrediting agency for educational programs in nurse anesthesia.

The second primary goal of the AANA is to enhance and further develop the clinical skills of individual nurse anesthetists to assure the rendering of excellent anesthesia care by its members. This purpose is accomplished initially through

certification of its members. The result is that the Association assures employers and the public that its members have met certain enumerated Standards. Among these Standards are the member's current and continued registration as a professional, registered nurse as required by the state in which the member practices; graduation from a school of anesthesia accredited by the AANA; and passing a rigid qualifying examination for membership. In addition, the Association requires annual affirmation of the member's status with regard to the law. All members are required to give evidence of compliance with the laws of the individual states where they are practicing anesthesia.

After initial certification, the AANA sponsors and conducts an extensive program of continuing education to update and improve the skills and techniques of its member anesthetists. A Certificate of Continuing Professional Excellence is awarded by the AANA to its members who, within a five-year period of time, meet the Standards for Continuing Education as established by the Association.

The specific objectives of the Association, as contained in its Articles of Incorporation filed with the Secretary of State of the State of Illinois on October 17, 1939 are:

A. To advance the science and art of anesthesiology.

B. To develop educational standards and techniques in the administration of anesthetics.

C. To facilitate efficient cooperation between nurse anesthetists and the medical profession, hospitals, and other agencies interested in anesthesiology.

D. To publish periodicals and to issue bulletins from time to time to aid in the general purposes of the organization.

E. To establish and maintain a central bureau for information, for reference and assistance in matters pertaining to the science and art of anesthesiology.

F. To promulgate an educational program with the object of disseminating, through proper channels, the importance of the proper administration of anesthetics.

WHAT IS A CERTIFIED REGISTERED NURSE ANESTHETIST?

A CRNA is a health care practitioner who renders anesthesia care. First and foremost, a CRNA is a graduate of an approved school of nursing who has met state requirements and earned registration by state licensing authorities as a Registered Nurse. Further, a CRNA is a registered professional nurse who has graduated from a school of nurse anesthesia accredited by the American Association of Nurse Anesthetists. After graduation, each anesthetist must evidence individual competency by passing a rigid qualifying examination administered by the AANA. Upon successfully passing this examination, the graduated nurse anesthetist is eligible for certification as a certified nurse anesthetist by the AANA.

PURPOSES OF STANDARDS FOR NURSE ANESTHESIA PRACTICE

As an organization comprised of health care practitioners, the AANA recognizes that the general principles of quality anesthesia care should be clearly delineated to maintain and improve the delivery of excellent anesthesia care. These Standards, as published herein, are intended as a general guide for the rendering of optimum anesthesia care and are not intended as fixed criteria or requirements in any particular situation. It must be recognized that anesthesia practice will vary considerably from one geographic location to another or from one state to another because of the requirements or limitations imposed by local law as well as the characteristics of the institution in which the CRNA practices. Among the factors which must be taken into consideration within each hospital institution are: (a) the requirements or limitations imposed by state law, (b) the sophistication and availability of anesthesia equipment within the institution, (c) the quality and availability of medical staff personnel and other allied health professionals within the institution, (d) the degree of medical specialization within the community, and (e) the availability of anesthesia personnel within the community. Therefore, these Standards are not intended to be interpreted as criteria for the performance of anesthesia care, but rather as guides for the formulation of criteria on a local or regional level.

STANDARD I

Nurse anesthesia practice is dependent upon a knowledge of the fundamental sciences, anatomy, physiology, and pharmacology to predict and control the effect of the anesthetic agent on the physiological condition of the patient.

Interpretation

Anesthesia practices are characterized by the administration of anesthetic agents to a patient to achieve a desired physiological result. Therefore, a knowledge of anatomy and physiology, of the body reactions to various types of anesthetic agents as well as a familiarity with the symptoms and treatment for untoward effects are essential. The CRNA must have a basic understanding of the science of chemistry, physics, physiology, as well as pharmacology. Pharmacology is defined as a science of natural phenomena dealing with measurable, predictable, and therefore, reproducible effects of drugs on the functions and cellular structures of animals and humans. Pharmacological considerations in anesthesia practice include the inherent characteristics of the drug, the dosage to be administered, and the characteristics of the patient.

(The intent of this provision is to include a technical statement on the interrelation of the various disciplines which must be utilized for competent administration of anesthesia.)

STANDARD II

Because of the inherent nature of anesthesia, certain risks to the patient are always present when an anesthetic agent is administered. Therefore, only those nurse anesthetists who are competent and well trained should be permitted to administer anesthesia.

Interpretation

The purpose of anesthesia is to reversibly depress bodily functions, or otherwise desensitize a patient to permit the performance of medical or surgical procedures. Whenever the bodily functions are reversibly depressed or desensitized, there are certain inherent risks to the patient which must be recognized. Therefore, an anesthetic agent should be induced and maintained only by well-trained personnel who are capable of recognizing and managing untoward reactions which may develop. CRNA's are trained professionals who have had specialized training in anesthesia and have demonstrated competency in this area. They are licensed by the state as registered nurses and further have graduated from an accredited school of nurse anesthesia and have successfully completed a requisite examination for certification. Their course of study, and certification are effective indicators regarding their competency to administer anesthesia.

STANDARD III

Nurse anesthesia practice is characterized by continually questioning assumptions and techniques upon which the practice is based and retaining those which are valid and adopting and using new techniques and knowledge to continue upgrading the practice.

Interpretation

The study of anesthesia is a science in which constant innovation and improvements are being made. It is the obligation of the CRNA to participate in the improvement of the science by questioning the appropriateness or accuracy of current assumptions and techniques being employed within the practice. Furthermore, a nurse anesthetist continually should improve skills and knowledge by reading journals and pursuing continuing education to assure excellent anesthesia care. A bimonthly journal of the American Association of Nurse Anesthetists is one source from which practicing nurse anesthetists can obtain knowledge of new developments and techniques employed within their practice. In addition, the AANA continually sponsors educational programs by which practicing nurse anesthetists can remain current on new developments and techniques. CRNA's, who within a five-year period, meet the Standards as established by the Education Committee of the AANA, may earn a Certificate of Continuing Professional Excellence.

STANDARD IV

All patients shall receive a thorough and complete preanesthesia inspection.

Interpretation

The responsibility of a CRNA begins before the actual administration of the anesthetic. It is the duty of the attending physician to make a preanesthetic examination in every case, not the duty of the nurse anesthetist. The nurse anesthetist does have an obligation to ascertain that an appropriate preanesthesia exami-

nation has been made by a physician. An examination of the patient's chart will indicate whether the necessary routine examinations and tests have been made. A thorough and complete inspection of the patient prior to anesthesia is imperative to ascertain certain physiological and psychological factors which influence the selection of the anesthetic agent and the formulation of the plan of anesthetic management. This examination will help determine not only whether the patient should be subjected to anesthesia, but the suitability of the agent or method for both minor and major surgery. The nurse anesthetist should know the nature of the anesthetic agent, its effects, and the proper agent to use in case of a typical cardiovascular, renal, respiratory, or other pertinent conditions.

The mental attitude of the patient has a profound influence on the course of the procedure. Therefore, the psychological condition of the patient must be determined in advance and efforts made to ease any fears. In making a preoperative visit, the psychological powers of the nurse anesthetist can be exerted. A preoperative visit, by the nurse anesthetist who will administer the anesthesia is recommended on the day before elective surgery. The preanesthetic visit serves several purposes. It enables the patient to become acquainted with and talk to the person who will administer the anesthesia. This meeting, combined with a proper psychological approach that includes sympathetic understanding and consideration for the natural anxiety and apprehension on the part of the patient, serves to facilitate the entire anesthetic procedure.

A preanesthetic examination can ascertain additional details concerning the patient's medical history which may have a direct influence on the selection and management of anesthesia for the patient. Previous anesthetic experiences, the patient's personal preferences, the specific details concerning the types and dosages of medication which recently have been taken by the patient, along with other pertinent points should be covered. The history of unusual sensitivity to drugs and the presence of allergic conditions are also of special concern.

The nurse anesthetist should ascertain that the laboratory procedures which are routinely performed prior to surgical procedures have been performed and duly noted on the patient's chart. Furthermore, the nurse anesthetist should ascertain whether studies of the respiratory, cardiovascular, metabolic, digestive, genitourinary, and nervous systems have been made for purposes of evaluating the performance of the major physiological component, with particular regard for the conditions and deficiencies which have anesthesia implications.

In addition, the preanethesia evaluation should reflect the choice of premedication to be prescribed as well as the selection and utilization of equipment available. Pertinent information relative to the choice of anesthesia should be recorded.

STANDARD V

Anesthetic management includes the administration of the anesthetic agent as well as the professional observance of vital signs and the providing of resuscitative care to maintain or stabilize the patient's physical condition.

Interpretation

A CRNA should be competent to induce and maintain anesthesia at required levels as well as to manage any untoward reactions which may develop. The anesthetist practitioner must monitor, chart, and report the patient's vital signs and other appropriate indicators as well as provide resuscitative care that includes fluid therapy, maintenance of an airway which may necessitate intubating the trachea and providing assisted or controlled ventilation.

The nurse anesthetist is responsible for the proper care and inspection of the selected anesthetic equipment. Modern anesthesia machines are precise instruments. The finest details of the machine and engineering are incorporated to insure that the nurse anesthetist will have accurately measured amounts of gas according to the prescription at the moment. The nurse anesthetist selects not only the proper agent but the amount desired. It is therefore necessary that the nurse anesthetist fully understands the particular machine being used. Safety regulations concerning the handling of flammable agents and the labeling of gas cylinders should be strictly followed.

It is the function of the nurse anesthetist to monitor the patient in the operating room and to evaluate the physiological condition of the patient. This monitoring is not confined to clinical observation of vital functions alone, although this is a fundamental requirement and well serves the overall purpose.

The scope of the actual monitoring and the varieties of methods available may be utilized as the circumstances require.

STANDARD VI

The nurse anesthetist is responsible for the prompt, complete, and accurate recording of anesthetic information on the anesthesia chart.

Interpretation

The observation and charting of the vital signs and other pertinent anesthesia data is the direct responsibility of the attending anesthesia practitioner. The course of the anesthetic management must be charted to afford a permanent record both as an aid to the retrospective review of the quality of the patient care rendered and further as a data basis from which analysis and innovation can be formulated. Recording of all events taking place during the induction of, maintenance and the patient's emergence from anesthesia, including the dosage and duration of all anesthetic agents, other drugs, intravenous fluids, and blood or blood fraction must be made.

Accurate and relevant records are essential to the development of any science. This principle particularly applies to anesthesia practice. The primary step in the evaluation of a situation and in assessment of the patient is a record of the events. Hence, the anesthesia record is an integral part of the patient's clinical hospital chart. All vital function measurements, all procedures, all drugs should be charted in time sequences. The quality and sufficiency of these recorded observations will influence the accuracy of clinical anesthesia diagnosis. Among the purposes for which anesthesia records are kept are:

1. To facilitate the care of patients:
   (*a*) By insuring the frequent attention to the patient's condition.
   (*b*) By providing information regarding the patient's general condition.
   (*c*) By establishing the sequence of events leading to reactions and complications.
2. To provide material for teaching, for study, and for statistical information.
3. To establish a medical-legal record.

The anesthesia records should be vital, available, and accurate. To be vital and representative of the actual progress of a particular anesthesia and surgical operation, a record must display several characteristics. It must be complete. It must be a stark observation picture of the situation. Every physiological parameter possible should be measured continuously and recorded. Change in technique, in agents, in position, in surgical procedure should be noted. All complications should be identified and the final condition assessed.

To be available, the records should be kept from moment-to-moment to serve as a possible diagnostic and prognostic element in the operative course. Delays between observation and recording lead to errors; immediate notation is desired. The records must be neat and legible.

To be accurate the data should be obtained from observation of the patient and should be recorded immediately.

STANDARD VII

Nurse anesthetists must be competent to terminate anesthesia and must report the patient's condition and other essential information to the personnel responsible for post-anesthesia care.

Interpretation

The CRNA in attendance must be competent to terminate the anesthesia and report all essential data regarding the emergence from anesthesia to the personnel in charge of the post-anesthesia care.

STANDARD VIII

The anesthetized patient should receive competent and continuous post-anesthesia care by designated personnel.

Interpretation

Complete recovery from surgical anesthesia is dependent upon an essential property possessed by all anesthetic drugs, namely reversibility of the pharmacological action. As the concentration of an anesthetic drug within the blood

stream and brain tissues or nerve fibers dwindles from the levels required to maintain anesthesia down to levels approaching zero, the normal reactivity of the nerve tissue is resumed.

Partially-conscious patients must be cared for until full consciousness has returned and protective reflexes have been regained. The ultimate objective of a well-planned and carried-out anesthesia procedure is to interfere as little as possible with the essential bodily processes, thus insuring an uneventful recovery of the patient from the combined surgical and anesthetic undertaking.

A nurse anesthetist, if so designated, shall remain with the patient as long as necessary to stabilize his condition. The recording of post-anesthetic visits that include notes describing the presence or absence of anesthetic-related complications must be made.

STANDARD IX

Appropriate safety precautions shall be taken to insure the safe administration of anesthetic agents.

Interpretation

Safety precautions and controls, as established within the institution, should be strictly adhered to, so as to minimize the hazards of fire and explosion in areas where flammable anesthetic agents are used. Anesthetic apparatus should be inspected and tested by the anesthetist before use. If a leak or other defect is observed, the equipment should not be used until it is repaired. The CRNA shall check the readiness, availability, cleanliness, and working conditions of all equipment to be utilized in the administration of the anesthetic agent. Proper clothing and footwear should be utilized in accordance with the established rules and regulations at the health care institution in which the anesthesia is administered.

STANDARD X

The practices employed in the delivery of anesthesia care must be consistent with the policies, rules and regulations of the medical staff of the institution in which the anesthesia care is rendered.

Interpretation

The conduct of the CRNA is governed by the policies, rules, and regulations as established in the health care institution in which the anesthesia care is being provided. These policies, as well as the extent of the responsibility delegated, should be closely adhered to.

STANDARD XI

Compensation for the rendering of anesthesia care must be made within the norms established by the code of ethics of the American Association of Nurse Anesthetists and the general rules and standards adopted by the profession within each locale.

Interpretation

The CRNA must assiduously guard against exploitation of the patient of any participation in practices which would be contrary to the best interest of the public. General rules and standards regarding remuneration may be adopted by the profession within each locale which are to be governed by policies and laws of that locale. The right to be adequately remunerated for the services rendered is recognized as well as the counterbalancing obligation to protection the patient from economic exploitation. Nurse anesthetists are free to render gratuitous services.

Senator TALMADGE. Thank you very much, Ms. Ecklund for your helpful and constructive suggestions. We will review them carefully, the recommendations you have made, and urge you and your associates to continue to work with the staff of the committee and members of the committee in trying to develop this legislation as constructively as possible.

Next and the final witness for the day is Dr. John W. Ditzler, president, American Society of Anesthesiologists, and Michael Scott, counsel.

Doctor, I want to thank you and the organization you represent for your very helpful and constructive suggestions that you have made in trying to develop this legislation and urge you and your society to continue to work with the staff and members of the committee in developing it as it goes through the legislative process.

STATEMENT OF DR. JOHN W. DITZLER, PRESIDENT, AMERICAN SOCIETY OF ANESTHESIOLOGISTS, ACCOMPANIED BY MICHAEL SCOTT, LEGAL COUNSEL

Dr. DITZLER. Mr. Chairman, I am Dr. John Ditzler, an anesthesiologist from Chicago, Ill. I am a professor of anesthesiology, Northwestern University School of Medicine, and am, in addition, the Chief of Staff of the Veterans' Administration, Lakeside Hospital, Chicago, from which I am on annual leave to make this presentation.

I speak today as the president of the American Society of Anesthesiologists, a physicians' organization.

Senator TALMADGE. I am the ranking member of the Veterans' Affairs Committee. I hope it is not necessary for you to take annual leave to testify before a committee of the Congress. As I understand the Constitution of the United States, every citizen in America has an inalienable constitutional right to petition his Government for redress of grievances. You may proceed.

Dr. DITZLER. I am accompanied by Mr. Michael Scott of the firm of Cox, Langford & Brown, the society's legal counsel in Washington.

I would make it clear at the outset that our testimony addresses itself solely to the portions of the bill which specifically relate to anesthesiology and the delivery of anesthesia care for the American people.

The primary goal of the members of our society is the delivery of superior anesthesia care. We believe that such care is optimally provided by a well-trained physician working with one patient, a ratio of one to one.

We have believed in that concept and have implemented many of our policies with this in mind ever since the inception of the American Society of Anesthesiologists nearly 40 years ago.

We have had problems with sufficient qualified anesthesia manpower, and would, only incidentally, call to your attention the need for special consideration for specialties such as anesthesiology when considering the overall United States manpower needs for physicians.

The American Society of Anesthesiologists realizes that it has an obligation to all of the American people, and, that with well over 16 million anesthetics given per year, our current society strength of approximately 10,000 active members cannot provide the optimal one-to-one care, especially since anesthesiologists are now increasingly also engaged in intensive care units, pain centers, and pulmonary therapy support.

In many areas of the country there are a variety of methods of delivery of anesthesia care, some of them historical, some of them new and innovative, and others bringing with them some concerns.

We believe, therefore, that Senate bill S. 3205 is commendable in that it recognizes that in order to provide superior care to the American public, one must not only continue to recognize the optimal one-

to-one relationship of the anesthesiologist to his patient—one must also provide for proper and appropriate medical direction of the nonphysician anesthetist.

The definition of proper and appropriate recompense for anesthesiologists' services has been a subject of concern within our society for over 20 years. Contrasted with those individuals who believe that optimum care involves a one-to-one relationship, there have been others who have proposed that the physician need only be responsible for the medical direction of nonphysician anesthetists and that they, therefore, could appropriately provide unlimited supervision.

This latter attitude has led to practices which we as a society do not regard as optimal patient care nor perhaps in some cases adequate patient care.

It seems to us that for medicare purposes section 22 of the bill does provide a reasonable solution under these difficult circumstances. The bill permits reimbursement to physicians for anesthesia care services both in the context of the one-to-one relationship and also in the context where it is clear that medical direction of nonphysician anesthesia personnel is medically proper.

By negative implication, however, the bill disqualifies for reimbursement those physician services where personal performance or personal direction cannot, as a medical matter, be accomplished.

We thus support that portion of section 22 dealing with anesthesia services as long as it is also recognized that section 22 does not enumerate all of the circumstances in which an anesthesiologist performs legitimate patient care services.

You will find attached to our written statement a proposed revision of the pertinent portion of section 22 dealing with practical problems of anesthesia care, to which we hope the subcommittee and its staff will give serious consideration.

I would like finally to turn to a subject not directly raised by the bill itself but which has been raised by you, Mr. Chairman, in your speech on the Senate floor, introducing the bill, as well as this morning a few moments ago.

We firmly support the use of professionally prepared relative value guides or scales as one valuable mechanism for determining appropriate physician reimbursement, and further support the notion that development and use of such guides or scales should be validated as a part of the legislation now under consideration.

As the subcommittee is aware, our society is currently engaged in litigation with the U.S. Department of Justice over our development and dissemination of a relative value guide. Briefly stated, this guide attempts to establish, on the basis of complexity of procedure, time or effort necessary for its completion, and other medical considerations, a relative value in unit terms, not in monetary terms, for a variety of medical procedures of the type performed by members of our society.

We understand that your chairman's legislative proposal would validate the use of such a guide as long as it is not stated in monetary terms and as long as it is only what it purports to be—a guide.

As a practical matter, a well-developed and thoughtful guide would prove extremely valuable to all concerned.

The society strongly supports your chairman's effort in this respect and urges the members of the subcommittee and its staff to give it most serious consideration.

We believe that contrary to the position which will apparently be taken by the Department of Justice, dissemination and use of relative value guides will have a salutary rather than an adverse effect.

Mr. Chairman, this completes my oral testimony, and I will be pleased to answer your questions.

Senator TALMADGE. Thank you very much. We appreciate your very constructive suggestions and they will be considered carefully by members of the subcommittee. Again, I want to repeat, I hope you and your organization will continue to work with the staff and members of the subcommittee as we work toward a legislative solution for this very difficult and complex problem. I have only one question.

Did you hear Ms. Ruth B. Ecklund testify in behalf of the American Association of Nurse Anesthetists? Were you in the audience?

Dr. DITZLER. Yes; I heard it.

Senator TALMADGE. Would you care to comment on her statement?

Dr. DITZLER. I would care to comment in one area particularly. The statement has been made that the nurse anesthetist provides the coverage in perhaps 40 percent of the hospitals in this Nation.

I think one has to also take into account that this represents perhaps only 10 percent of the anesthetics administered in the Nation. This is in large part due to many of our hospitals being of 50-bed capacity or less.

I think in part this reflects the deficiency of our health care delivery system in the country rather than relating to a national problem of anesthetic administration.

The second part of the testimony as I heard it, related to the changing of wording indicating "any individual," and I would require closer reading to understand what the intent was, but surely it is correct that an anesthesiologist is not present in every situation where anesthesia must be administered.

I would call to your attention that by law in all of the States, a physician must be responsible for the administration of the anesthetic even though it may be administered by a nonphysician. It is a physician and in those cases, it certainly would be the surgeon or obstetrician or other qualified physician to whom the ultimate responsibility for the anesthetic must rest.

I have no other comments.

Senator TALMADGE. If you have any further comment, after reading the statement in detail, we would appreciate your information. The subcommittee will stand in recess until 8 a.m. tomorrow morning.

[The prepared statement and letter of Dr. Ditzler follow:]

STATEMENT OF THE AMERICAN SOCIETY OF ANESTHESIOLOGISTS

SUMMARY

1. The use of the term "hospital associated physicians" in Section 22 is misleading and should be changed.

2. Optimum anesthesia care involves a one-on-one relationship between anesthesiologist and patient. Anesthesiologist manpower limitations may, however, necessitate patient care in less than optimum conditions, in which event ethical principles require that medical direction of non-physician providers be given.

3. While raising certain negative implications concerning right to reimbursement for legitimate anesthesiologist services, Section 22 as it relates to anesthesiology is generally in accord with the Society's ethical guidelines.

4. Prohibition in Section 26 against use of certain percentage of collection billing practices, through use of independent billing organizations, is too broadly stated.

5. Proposed validation of dissemination and use of professionally-developed relative value guides is entirely meritorious and in the interest of all concerned with Government-financed medical insurance.

STATEMENT

My name is John W. Ditzler, M.D. I am a practicing anesthesiologist in Chicago, Illinois. I am a Professor of Anesthesiology at Northwestern University School of Medicine and in addition am Chief of Staff of the Veterans Administration, Lakeside Hospital, in Chicago.

I testify today on behalf of the American Society of Anesthesiologists, an organization of physicians of which I am the current President. My testimony represents the position of the Society, approved in principle by our Administrative Council, on those issues raised by S. 3205 which are of particular interest to the Society and its members. With minor exception, I do not intend to deal with those aspects of S. 3205 which concern organized medicine generally, as I anticipate that these subjects will be covered by testimony of the American Medical Association and others.

The membership of ASA consists of over ten thousand licensed physicians engaged in the recognized specialty practice of anesthesiology. While, as is commonly understood, anesthesiologists are principally concerned with the administration of anesthetic agents as a part of surgical or obstetrical procedures, they also engage in an increasing variety of related medical activities, particularly including pain therapy, respiratory therapy, and intensive care. We are indeed today witnessing the development, within anesthesiology, of various subspecialties: a development which I fully endorse in light of the increasing complexity of our profession.

In S. 3205, anesthesiologists are referred to as "hospital associated" physicians—essentially, I assume, because most of the medical services of anesthesiologists are performed within the physical confines of a hospital. Unfortunately, however, this term carries with it another connotation or implication, that is, that anesthesiologists are in some form of employment or agency relationship with the hospital. This implication is misleading: with only minor percentage exception, anesthesiologists perform their services as independent medical professionals, and are compensated for these services on the basis of a fee charged to the individual patient. They are no more "hospital associated"—or to use another misleading expression: "hospital-based"—than for example are the surgeons or obstetricians who form a part of the medical care team with which the anesthesiologist is most frequently involved. If then the Subcommittee finds it necessary to refer generically to certain medical specialties practiced in the hospital setting, the Society believes it far more appropriate, and not misleading, to use the expression: "certain physicians' services normally performed in a hospital."

The Subcommittee may well wonder why I choose, in testimony with respect to an important piece of proposed substantive legislation, to pause at the outset over what appears to be a minor definitional problem. To the members of our Society, the answer is quite simple: use of the terms "hospital-based" or "hospital associated" in relation to anesthesiologists, and for that matter, pathologists, radiologists and others, connotes that somehow these specialists are less independent than, or somehow different from, other independent professional specialists who perform in a hospital setting but as to whom, for reasons not clear, the terms are never employed.

This differentiation causes the average anesthesiologist to see "red". Anesthesiology has emerged in the past three decades as a recognized and vitally important field of independent medical specialization and practice. Many operative procedures performed in 1976, that could not have been performed in 1956 or 1966, are possible not so much because of new surgical techniques, but because of the enormous strides which have been made in the science and art anesthesiology. Our members are proud of these accomplishments and of their independent status in the profession and in relation to the individual patient. They are thus

sensitive to any legislative appellation which tends to derogate from this independent status.

As the Subcommittee is aware, S. 3205 contains certain express provisions relating to reimbursement under Part B for anesthesiology services. Your Chairman has already indicated, upon introducing the Bill, that these provisions were prepared after consultation with representatives of our specialty. Quite frankly, valuable communication between the Subcommittee and its staff, on the one hand, and practicing anesthesiologists on the other hand, was possible because many of the so-called "abuses" under Medicare, with which Senator Talmadge is concerned as an economic or social matter, are practices with which, to the extent they may exist, our Society should also be concerned as an ethical matter. Specifically, it is the formal position of the Society that anesthesia care of a patient should ethically be performed either by, or under the actual direction of, an anesthesiologist, and that compensation for anesthesia care under these circumstances should ethically be on a fee-for-service basis to the patient. As we view the provisions of S. 3205 dealing specifically with anesthesiology services under Medicare, they are fundamentally consistent with these ethical principles.

Before discussing these provisions in some greater detail, I should like to make two points. While we as a Society have strong views as to what is, and what is not, ethical as a professional medical matter for anesthesiologists, we do not suggest that these ethical guidelines are necessarily applicable across the medical profession as to their specialties.

When thus we state that patient anesthesia care services may ethically be performed only by or under the actual direction of an anesthesiologist, we do not claim that these ethical guidelines are necessarily required elsewhere in the profession. I speak for anesthesiology today, for anesthesiology only.

My second point is that without qualification, optimum anesthesia care involves a one-to-one relationship between anesthesiologist and patient. While both the ASA ethical guidelines and Section 22 of the Bill clearly contemplate the possibility for medical direction by the anesthesiologist of nurse anesthetists or other non-physician members of the anesthesia care team, we do not as a Society believe that there is any medical substitute for the one-on-one relationship. Personal physician direction of others may in many circumstances be medically acceptable, but in our view only personal performance represents the optimum.

Section 22 of the Bill contains the essential requirement of either personal performance or personal direction by a physician, in order to qualify for reimbursement under Part B, and insofar as that requirement relates to anesthesiology, we support it with the qualification just stated. We also support the concept contained in the Bill that "physicians' services", reimbursable on a fee-for-service basis, do not include work as an executive or a researcher. We are, however, concerned by the apparent general disqualification in Section 22 of services as an "educator" from reimbursement on a fee-for-service basis.

An anesthesiologist, during the course of rendition of an identifiable patient service, may very well be engaged, simultaneously, in an education function with respect to, for example, a resident physician also present in the operating suite. It seems unrealistic to attempt to separate out this educational function from the physician service being rendered, appropriately, to the patient on a free-for-service basis.

We agree, as an ethical matter, that physician reimbursement arrangements, based upon a percentage of hospital income or receipts, are inappropriate. In general, we are also supportive of the provisions of Section 22 dealing particularly with reimbursement for anesthesiology services, although we have certain specific suggestions for clarifying or improving these provisions.

As to anesthesiology services, Section 22 sets forth certain criteria on the basis of which, for reimbursement purposes, an anesthesiologist is deemed to have "personally performed", or "personally directed" the rendition of, such services. These criteria are determined by reference to a statement, set forth in the Bill, of the various steps which normally comprise the totality of anesthesia care rendered to a patient—from pre-anesthetic evaluation, through the administration of the anesthetic, to the rendition of indicated post-anesthesia care. The enumerated steps are drawn from ASA's 1975 Guidelines for Ethical Practice.

While we are gratified by the inclusion of our ethical guidelines in the Bill, we are at the same time concerned about the potential rigidity inherent in the

specification, in a Federal statute, of those individual items of anesthesia care which will form the basis for reimbursement unless and until the statute is amended. The science of anesthesiology is evolutionary, in terms of development of new techniques, and individualistic, in terms of patient need. As a result, ASA would strongly have preferred that the Bill confine itself to statement of principle concerning personal performance and personal direction of anesthesia care, and left to the Bureau of Health Insurance the enumeration of acts, or combination of acts, which would provide basis for reimbursement. Our experience is that while always difficult, the amendment of Medicare regulations is far easier to accomplish than amendment of a Medicare statute.

We are also concerned by certain negative implications created by the wholesale inclusion of the ASA ethical principles in the Bill. There are many valuable and important medical services performed or directed by an anesthesiologist that are not explicitly or implicitly covered by the Bill's statement of anesthesia care services. Two of the fastest-developing areas of anesthesia care are in the fields of pain therapy and respiratory therapy. The services comprising these courses of patient care simply do not follow the pattern of anesthesia care related to the operating or obstetrical suite. Yet the Bill as worded implies, unintentionally I am certain, that these important services are not reimbursable under Part B. Again, I believe, appropriate forms of reimbursement mechanism for these services are best established by regulation, rather than statute.

If the Subcommittee determines, despite the problems that I have suggested, to attempt legislatively to deal with the details of anesthesia services under Part B, then at the least I believe that the language and intent of Section 22 must be clarified. Attached to my statement is a suggested revision of Section 22—insofar as it specifically covers anesthesia care—which makes more clear that legitimate anesthesiology services continue to be covered under Part B, notwithstanding the fact that they are not among those services, or combinations of services, expressly referred to in Section 22.

In closing my discussion on Section 22, I should like to come back in part to a point I made earlier: medically, the one-on-one relationship between anesthesiologist and patient is the optimum. Section 22 contemplates reimbursement of an anesthesiologist when he medically directs up to four nurse anesthetists or other nonphysicians simultaneously. In my view, this limitation has two faces: on the one hand, the limitation goes far to prevent the purported exploitation of nurse anesthetists with which the American Association of Nurse Anesthetists appears to be in some cases legitimately concerned; on the other hand, I wish to make clear that in my view, it is only under certain narrow circumstances that an anesthesiologist can properly direct four procedures simultaneously.

Many respected anesthesiologists, while recognizing the one-on-one patient relationship as the optimum, will also say that the medical direction of two, or perhaps three, highly skilled nurse anesthetists simultaneously is the maximum reasonably possible from a medical point of view. In this sense, we find that the Bill's limitation of four to be somewhat liberal, but appropriate when as is necessary in legislation, coverage of generalized circumstances is required.

I should say at this point that in preparing for this presentation, I caused summaries of S. 3205, prepared by our counsel, to be circulated widely within our membership. As you might anticipate, the Bill received extensive comment by a number of practicing anesthesiologists. While most of this comment related to the subjects I have already discussed, I would be remiss in my responsibility if I did not cover one additional point which received substantial attention: specifically, concern has been expressed that the proposed prohibition contained in Section 26 against assignment of Medicare and Medicaid fees under a power of attorney may tend to throw out the baby with the bathwater.

In our experience, many anesthesiologists in various parts of the country—and particularly those who practice individually or in very small groups—find that the least expensive and only practical method of billing for their services—whether to a private or a Medicare patient—is under a contractual arrangement with an independent billing organization. Many of these organizations do tend to operate on an across-the-board percentage of collection basis, and some of our members doubt strongly that if this percentage basis were eliminated (as the Bill proposes to do) for reimbursement purposes, Medicare and Medicaid costs would be lessened. It would seem to us that much of the potential adverse effect, apparently of concern to the subcommittee staff would be eliminated if another exception to the general rule, contained in proposed Section 26, were made for the use

of a billing service organization on a percentage of collection basis, when a physician used that service organization for all his services to patients, and not just for Medicare or Medicaid patients (or Government reimbursement with respect thereto). This exception would, I believe, tend to legitimatize the true and comprehensive billing service, while at the same time substantially eliminating the potential for abuse in the factoring of Medicare and Medicaid claims.

Finally, I turn to a subject only tangentially related to S. 3205, but nonetheless one of major importance to our Society. Specifically, we have noted with obvious interest your Chairman's proposal to include in the legislation being considered a provision which would give statutory sanction, in a limited context, to the use of relative value scales. I say "obvious" because it is well known that despite the fact that the Department of Health, Education and Welfare has encouraged the formulation of such scales and in fact depends upon such scales in administering the Medicare Program, another executive department (the Department of Justice) has sued our Society for its adoption and publication of a relative value guide. It seems entirely appropriate for Congress to resolve this administrative ambivalence.

Because of the multiplicity of factors which an individual anesthesiologist considers in determining his fee for particular services, health insurance carriers and various governmental agencies involved in paying or reimbursing for anesthesiologists' fees have historically had considerable difficulty in formulating fair, reasonable and administratively feasible methods of payment and reimbursement, consistent with applicable statutory and regulatory requirements yet related to the specialty's mode of practice.

Many insurance carriers and governmental agencies, including the Bureau of Health Insurance and its intermediaries, have found relative value guides, including our Society's Relative Value Guide, a reasonable solution to the problem of constructing rational and workable payment and reimbursement schedules and resolving disputes as to particular claims. The policy of the Bureau of Health Insurance as to the use of relative value scales generally, and the ASA Relative Value Guide in particular, is stated in an August 1975 revision to its Part B Intermediary Manual, a copy of the pertinent portions of which is attached to my written statement.

In formulating and publishing its Relative Value Guide, the ASA has sought to respond to the needs of their third party payers, including Medicare intermediaries, in a manner which preserves the right of the individual practitioner to establish his own fees and the right of the particular payer to establish its own schedule of payment or reimbursement. Only the prevailing expert medical opinion as to the relationship between medical procedures in terms of relative complexity, time or effort necessary for completion and other relevant medical considerations is reflected in the Guide. No dollar amount of fees or conversion factors are specified. Indeed, except as an individual practitioner may be required by third party payer regulations, no one is under any compulsion to use the Guide itself.

We believe that relative value scales or guides are useful in the administration of health care payment and reimbursement programs. They are useful, however, only to the extent that they reflect the realities of medical practice. Certainly bona fide associations such as ASA should not be precluded from offering their expert opinions on the medical considerations involved in developing relative value scales and guides.

We thus strongly support the proposal of your Chairman, which we understand was presented to the Subcommittee at the outset of these hearings, to provide legislative validation to the use of relative value scales in connection with Medicare and otherwise. We believe this to be an intelligent and practical approach, of benefit alike to the medical profession, medical insurance intermediaries, the Government and the patient.

PROPOSED AMENDMENT SECTION 22, S. 3205

Sec. 22. (a)(1) Section 1861(q) of the Social Security Act is amended by adding "(1)" immediately after "(q)" and by adding, immediately before the period at the end thereof, the following: "; except that such term does not include any service that a physician may perform as an [educator,] an executive or a researcher; *or as an educator when such educational function is not performed simultaneously and in connection with the personal performance or*

personal direction of an identifiable patient care service; or any patient care service unless such service (A) is personally performed by or personally directed by a physician (*or, in the case of physicians associated in physician group practice, by one or more physician members of the group*) for the benefit of such patient and (B) is of such a nature that its performance by a physician is customary and appropriate."

(2) Section 1861(q) is further amended by adding the following new paragraphs at the end thereof:

"(2) In the case of anesthesiology services, a procedure *related to surgical or obstetrical care of a patient* would be considered to be 'personally performed' in its entirety by a physician [only], where the physician performs *for the benefit of one individual patient* the following activities:

"(A) preanesthetic evaluation of the patient;

"(B) prescription of the anesthesia plan;

"(C) personal participation in the most demanding procedures in this plan, including those of induction and emergency;

"(D) following the course of anesthesia administration at frequent intervals;

"(E) remaining physically available for the immediate diagnosis and treatment of emergencies; and

"(F) providing indicated postanesthesia care:

Notwithstanding the foregoing, a physician shall also be considered to have "personally performed" such a procedure in its entirety for an individual patient if [provided, however, that] during the performance of the activities described in subparagraphs (C), (D) and (E), such physician is [not] responsible for the care of *not* more than one other patient. Where a physician performs the activities described in subparagraphs (A), (B), (D), and (E) and another individual participates in the activities described in subparagraph (C), such physician will be deemed to have personally directed the services if he was responsible for no more than four patients while performing the activities described in subparagraphs (D) and (E) and the reasonable charge for such personal direction shall not exceed one-half the amount that would have been payable if he had personally performed the procedure in its entirety.

In the event a physician or group of physicians associated in group practice for the benefit of a patient, the reasonable charge for which has not been expressly provided for in this paragraph (including without limitation personal performance or direction of one or more of the individual activities enumerated above relating to surgical or obstetrical care or personal performance or direction of the rendition of pain therapy, respiratory therapy, intensive patient care) such physician or group shall be entitled to payment of a reasonable charge for such physicians' services which charge shall be fairly related to the reasonable charges expressly provided for in this paragraph.

6707.1: REASONABLE CHARGES—CRITERIA

6707.1: Use of Relative Value Scale and Conversion Factors.—The use of relative value scales in estimating customary charges and prevailing charges should be restricted to situations in which the carrier does not have sufficient data or to procedures that are performed only infrequently. In addition, the relative value scales used for the Medicare program should, to the extent possible, be those that are used by the carrier in its own programs. Relative value scales developed by the carrier or by medical societies for States other than those in which the carrier's Medicare service area is located should be carefully reviewed and validated before they are used. The carrier has a responsibility for ensuring that a relative value scale, which is used to estimate customary charges or prevailing charges, accurately reflects charge patterns in the area serviced by the carrier. Similarly, the conversion factor used with the relative value scale should reflect the known customary charges of the physician or other person for whom a customary charge is being estimated, or the known prevailing charges for services in the locality, as appropriate.

Customary and/or prevailing charge conversion factors used with relative value scales to fill gaps in carrier reasonable charge screens should be calculated as outlined in A and B below.

(Separate customary charge conversion factors should be developed for each physician or supplier from his known customary charges in the same category of service, e.g., medicine, surgery, radiology, etc. Similarly, separate prevailing

charge conversion factors, by locality and specialty or groups of specialties, should be calculated based on the known prevailing charges, by locality and specialty, or groups of specialties within the same category of service.)

A. *Customary Charge.*—The following formula should be used for the calculation of a customary charge conversion factor:

C/F=Customary charge conversion factor.

CHG=The physician's customary charge for a procedure.

SVC=Number of times the physician performed the procedure.

$1\text{-}n$=The different procedures the physician performed within a category of service.

RVU=The relative value unit assigned to a procedure.

$\sum$=Sum of—

$$C/F=\frac{\frac{CHG_1}{RVU_1}\times SVC_1+\frac{CHG_2}{RVU_2}\times SVC_2\cdots\frac{CHG_n}{RVU_n}\times SVC_n}{\sum SVC_{1-n}}$$

Example

Compute a customary charge conversion factor for a physician with the following charge history: (May be for medicine, surgery, radiology, pathology)

Procedure	Frequency	Customary charge	Relative value
1	3	$5	1.0
2	7	12	2.0
3	5	35	4.0
4	4	20	3.0
5	6	8	1.5
Total	25		

Method

(1) For each procedure, divide the customary charge by the relative value and multiply the result by the frequency of that procedure in the physician's charge history.

(2) Add all the results of these computations.

(3) Divide the result by the sum of all the frequencies.

Solution

$$\frac{\left(\frac{5}{1}\times 3\right)+\left(\frac{12}{2}\times 7\right)+\left(\frac{35}{4}\times 5\right)+\left(\frac{20}{3}\times 4\right)+\left(\frac{8}{1.5}\times 6\right)}{25}=$$

$$\frac{(5\times 3)+(6\times 7)+(8.75\times 5)+(6.67\times 4)+(5.33\times 6)}{25}=$$

$$\frac{15+42+43.75+26.68+31.98}{25}=$$

$$\frac{159.41}{25}=\$6.38=\$6.40 \text{ (Rounded to nearest 10 cents)}$$

To determine a physician's customary charge for a particular procedure where there is no reliable statistical basis, multiply the relative value of the procedure by the physician's customary charge conversion factor for the appropriate category of service (e.g., radiology, medicine, surgery).

6708: REASONABLE CHARGES—CRITERIA

B. *Prevailing charges.*—The prevailing charge conversion factors to be used with the appropriate relative value scale will be developed from the same formula used for customary charge conversion factors, except that

CHG=The established prevailing charge for a procedure by locality and specialty or group of specialties

SVC=The number of times the procedure was performed by all physicians in the same specialty or group of specialties and locality

1-n=The different procedures within a category of service for which prevailing charges have been established by specialty or group of specialties and locality

The conversion factors calculated for any fiscal year should reflect customary and prevailing charges calculated on the basis of charge data for the preceding calendar year. Also, reasonable charges established through the use of a relative value scale and conversion factors, in effect, consist of two components. Consequently, the conversion factors used must be recalculated when there is any change in the relative value units assigned to procedures (as may occur if the carrier begins to use a different or updated relative value scale) in order to assure that the change(s) in unit values do not violate the integrity of the reasonable charge screens.

6818: REASONABLE CHARGES—SPECIAL SITUATIONS AND INSTRUCTIONS

6818: Reasonable charges for anesthesiologists' services.—The manner in which a carrier applies the reasonable charge criteria in processing claims for anesthesiologists' services should be consistent with the predominant billing methods of such physicians in its service area.

For example, where the majority of anesthesiologists bill dollar amounts for services without any indication of the relative value units associated with their services, the carrier should establish customary and prevailing charge screens for such services in the same manner as for other physicians. This approach to determining reasonable charges takes into account the fact that a physician's charges for a particular service may, for a variety of reasons, vary from one instance to another. Therefore, under this approach, any extra amounts charged by a physician using a relative value scale and a dollar conversion factor to set his fee (e.g., the time, risk, age, etc.) will not ordinarily be a basis for allowing amounts above the applicable customary or prevailing charge. However, the provision in the regular Medicare reasonable charge methodology for allowing higher amounts when they are justified by unusual circumstances or medical complications (§ 6708) does apply in appropriate instances.

However, in many parts of the country, carriers have adopted the use of relative value scales and conversion factors in establishing reasonable charge screens for anesthesiologists' services as an accommodation to such physician's traditional use of this methodology in setting their fees and in billing for services.

The American Society of Anesthesiologists and many State medical societies have developed relative value guides from which an anesthesiologist may determine his fee for a given service. These guides generally assign base unit values to the different surgical procedures and services listed and provide for additional units taking into account such factors as time, risk, age of the patient, etc. Each anesthesiologist may apply a dollar conversion factor that he has set for himself or he may use a conversion factor that his local medical society considers to be reasonable. Where (1) this is the predominant billing practice among the anesthesiologists in a carrier's service area, and (2) where their billings include the necessary information about the unit values they have used in setting their fees for a particular service, the carrier should take this practice into account in establishing reasonable charge screens. It should, based on actual charge data, establish a customary charge conversion factor for each anesthesiologist and, from all such conversion factors, develop a prevailing charge conversion factor using the following suggested approach. (Deviations from this suggested approach must have prior BHI approval.)

A. Establish the conversion factor the anesthesiologist has used in each billing during the year. For example, where the physician has billed $54 for an anesthesia service and the total of the relative value units for the service rendered (base, time, and other modifier) was 9, he has in effect used a $6 conversion factor.

B. Determine the anesthesiologist's customary charge conversion factor by determining the median of the conversion factors he has billed during the year. (Where the actual median falls between two items in the array of conversion factors, use the next highest conversion factor in the array.) For example:

Procedure	Billed charge	Total relative value units (time, base, other modifiers)	Conversion factor
A	$120	20	$6
B	72	12	6
B	60	10	6
C	48	8	6
D	84	14	6
E	150	25	6
A	140	20	7
B	77	11	7
D	120	15	8
D	96	12	8
D	104	13	8
E	176	22	8

In the above example, the actual median of the conversion factors would fall between $6 and $7. Therefore, the customary charge conversion factor is $7. A prevailing charge conversion factor should also be computed for anesthesia for each locality, by specialty, by arraying the anesthesia customary charge conversion factors in ascending order and weighting each by the frequency of services on which it was based. An actual amount in the array which is high enough to include the customary charge conversion factors of the anesthesiologists who performed at least 75 percent of the cumulative services should then be identified as the prevailing charge conversion factor.

The conversion factors calculated for any fiscal year should reflect the charges made by the anesthesiologist(s) during the preceding calendar year. Also, the conversion factors must be recalculated where there is a change in the number of relative value units assigned to procedures or to modifying factors such as time, age, risk, etc., (as may occur if the carrier begins to use a different or updated relative value scale). This is necessary to assure that the carrier's reasonable charge screens are unaffected by such a change.

THE AMERICAN SOCIETY OF ANESTHESIOLOGISTS,

Park Ridge, Ill., August 4, 1976.

Hon. HERMAN E. TALMADGE,
Subcommittee on Health, Senate Finance Committee, Everett McKinley Dirksen Office Building, Washington, D.C.

DEAR SENATOR TALMADGE: I am writing to respond to your request, made at the close of my testimony before your Subcommittee on Health last week, for comment on the testimony presented to the Subcommittee by Representatives of the American Association of Nurse Anesthetists (AANA).

As an introductory statement, I should reiterate the undoubted fact that appropriately-trained and otherwise qualified nurse anesthetists perform in this country a valuable and essential role as members of the anesthesia care team. Fundamental to the team concept, however, is the principle that both as a matter of law and as a matter of proper medical practice, the team must be headed, whereever possible, by a trained anesthesiologist and, where that is not possible because of existing manpower limitations, by an otherwise qualified physician—normally the surgeon or obstetrician involved in the particular procedure.

It appears that the concept which underlies most of AANA's testimony, both to the subcommittee and in other recent forums, is either a reluctance to embrace the basic principle of physician direction of the anesthesia care team, or a desire medically to equate the qualifications of nurse anesthetists, on the one hand, and anesthesiologists or other qualified physicians, on the other hand. The suggestion that technicians without the knowledge of the human body (and particularly its respiratory systems) and related pharmacology provided by medical school and residency training should have unsupervised responsibility for prescribing and administering the lethal drugs essential to anesthesia, is disturbing at best. We do not believe that it is either appropriate or medically proper to predicate legislation on any concept other than physician direction of anesthesia care. As you know, the focus of our assistance to the subcommittee's staff and our testimony to the subcommittee itself has related to providing assurance, for all con-

cerned, that reimbursement of anesthesiologists under medicare and medicaid would remain consistent with this basic principle of proper medical care practice.

Turning now to the specific comments contained in AANA's statement of July 28, 1976, we offer the following:

1. We believe in general, as we have already testified, that the requirement of personal physician performance or personal physician direction of anesthesia care, contained in section 22 of S. 3205, assures to the Government and to the public that reimbursement of physicians for these services will be both appropriate and not excessive. Correlatively, we believe the limitations on reimbursement contained in section 22 should provide substantial assurance to the members of AANA that physician "exploitation" of nurse anesthetists, to the extent that it may have existed in the past, will no longer be possible under medicare.

2. AANA criticizes the language appearing on line 22 of page 58 of S. 3205, which set forth "prescription of the anesthesia plan" as one of the elements of personal performance or personal direction of anesthesia care by a physician. AANA would change this language to read: "Writing an anesthetic management care plan." We believe this suggested change is inappropriate, inasmuch as the language of S. 3205 as now written is directly responsive to the legal requirement in all or virtually all of the States, that a physician prescribe the anesthetic. In effect, by indirection, AANA argues in favor of allowing a nonphysician to prescribe the anesthetic. As we understand your intentions in introducing S. 3205, they do not include a desire to alter legal definitions of the practice of medicine, but rather are oriented toward assuring appropriate physician reimbursement. We thus do not believe that their suggested change is constructive or desirable.

3. With reference to lines 23 and 24 on page 58, AANA proposes to require that the anesthesiologists, in order to be deemed to have personally performed the anesthesia care service, must personally participate in the maintenance of anesthesia, as well as the induction thereof and the emergence therefrom. In effect, AANA would apparently require that "personal performance" by the anesthesiologist be equated with personal execution by him of every facet of anesthesia care in the operating suite. In our statement to the subcommittee, we made clear that ASA regards to "1 to 1" relationship of physician to patient as representing optimum anesthesia care. In the sense of optimum care, therefore, we fully agree with AANA. One is forced to recognize, however, that given existing anesthesiologist manpower limitations, it is not possible in every hospital in every part of the country to achieve the optimum, and one must therefore also recognize the necessity for an anesthesiologist to be medically and legally responsible for the direction of nonphysician anesthesia personnel maintaining anesthesia simultaneously in more than one operating or delivery room. The change proposed by AANA appears designed to undercut legislative recognition, for reimbursement purposes, of this practical necessity, and in effect to emasculate all of the provisions of section 22 which would permit a physician to be responsible for procedures in more than one operating room as long as he is in close physical proximity thereto. Acceptance of the AANA approach, we believe, would tend severely to limit the opportunity for medical direction by an anesthesiologist of more than one simultaneous procedure—to the detriment, we believe, of medically proper anesthesia care delivery to all possible patients.

4. AANA's suggestion that the language appearing in lines 1 and 2 on page 59, which requires the physician to follow the course of anesthesia administration at frequent intervals, be change to require the physician to remain physically available during the course of administration. Given the language which immediately follows this provision in S. 3205, requiring the physician to remain physically available for diagnoses and treatment of emergencies, we are not certain that the AANA proposal produces, as a practical matter, any substantive change. Again, the orientation of the AANA comment appears to be directed toward preventing an anesthesiologist from assuming responsibility for medical direction of qualified personnel in more than one operating room simultaneously, and while again we agree that optimum care involves the 1-to-1 relationship, we nonetheless support the pragmatic orientation of the Bill as now written, which contemplates physician responsibility, under medically sound circumstance, for more than one room at the same time.

5. We believe that the AANA proposal to change in line 11 on page 59, the reference to "another individual," to read "a qualified nurse anesthetist," is also inappropriate. In effect, this change would mean that physician "personal

direction" reimbursement would be keyed to direction of a "qualified nurse anesthetist" only. In fact, the development of and standards of training of non-physician anesthesia personnel in this country is in an evolutionary state, and it is entirely possible (if not probable) that several classes of non-physician members of the anesthesia care team are now emerging. To limit physician reimbursement to direction of a nurse anesthetist (whatever that term may legally mean) only, appears to ASA to be an unnecessarily limited course. It is also not one which is within the scope of a proposed statute designed to eliminate alleged abuse in Medicare reimbursement, as distinct from a proposal (as AANA would apparently like S. 3205 to become) designed to solidify the status of nurse anesthetists.

6. AANA reads the proviso contained in Section 22 as authorizing reimbursement to a physician when he personally performs anesthesia care as to one patient, and at the same time is responsible for that care to five other patients. We do not read the proviso in these terms. As we understand your intent, it is to permit an anesthesiologist to be reimbursed for two simultaneous "personal performances", or for four simultaneous "personal directions"—with the language of the proviso setting forth appropriate limitations in both instances. As a practical matter, it would appear impossible under the language of the Bill for a physician to claim reimbursement for personal performance of two procedures, and also claim reimbursement for personal direction of any other procedures taking place at the same time. We do agree, however, with AANA's characterization of the proviso as somewhat unclear, when one reflects on the various simultaneous combinations of anesthesia care which are possible and which are medically proper. It is for this reason that we suggested in our testimony that the proposed statute confine itself to the essential reimbursement concept of personal physician performance or personal physician direction, and leave to regulations a definition of reimbursement of procedures consistent with that basic principle. We are interested to note that on page 22 of its testimony, the Blue Cross Association—a major Medicare intermediary—agrees with our conclusion in this latter respect.

7. As you know, we have taken no position on the appropriate method of reimbursement under Medicare for the so-called free lance nurse anesthetist. We agree with AANA that some appropriate method of compensation for the services of these individuals should be found, commensurate with the value of the service they render to the patient, and the responsibility they properly assume.

Very truly yours,

JOHN W. DITZLER, M.D., *President.*

[Whereupon, the subcommittee was recessed until 8 a.m., July 29, 1976.]

MEDICARE-MEDICAID ADMINISTRATIVE AND REIMBURSEMENT REFORM

THURSDAY, JULY 29, 1976

U.S. SENATE,
SUBCOMMITTEE ON HEALTH OF THE
SENATE FINANCE COMMITTEE,
Washington, D.C.

The subcommittee met, pursuant to recess, at 8 a.m. in room 2221, Dirksen Senate Office Building, Hon. Herman E. Talmadge presiding.

Present: Senators Talmadge, Curtis, and Dole.

Senator TALMADGE. The subcommittee will please come to order.

Senator Nunn, my colleague from Georgia, has been delayed. We will hear from him as soon as he arrives.

The first witness this morning will be Mr. Bert Seidman, director, Department of Social Security, AFL–CIO. We are happy to have you with us, Mr. Seidman. You may insert your statement in full in the record and summarize it.

Because of the multiplicity of witnesses and the fact that the Senate is going in at 9 a.m. it is necessary for us to restrict our testimony in chief to 10 minutes.

STATEMENT OF BERT SEIDMAN, DIRECTOR OF THE DEPARTMENT OF SOCIAL SECURITY, AFL–CIO; ACCOMPANIED BY ROBERT McGLOTTEN, LEGISLATIVE REPRESENTATIVE OF THE AFL–CIO AND RICHARD SHOEMAKER, ASSISTANT DIRECTOR OF THE DEPARTMENT OF SOCIAL SECURITY OF THE AFL–CIO

Mr. SEIDMAN. Thank you, Mr. Chairman.

My name is Bert Seidman, director of the Department of Social Security of the AFL–CIO. With me, to my right is Robert McGlotten, who is a legislative representative of the AFL–CIO and to my left is Richard Shoemaker, assistant director of the Department of Social Security of the AFL–CIO and our expert in the field of health.

I should say I am testifying, of course, on behalf of the AFL–CIO. I happen also to be a member of the Health Insurance Benefits Advisory Council, the advisory body of medicare and medicaid. I have been a member for the past 4 years. My term is about to expire.

I would appreciate it, Mr. Chairman, if our full statement could be inserted in the record.

Senator TALMADGE. It will be, sir.

Mr. SEIDMAN. I will simply summarize it.

I appreciate the opportunity to appear on behalf of the AFL–CIO before this Health Subcommittee with respect to the Medicare-Medicaid Administrative and Reimbursement Reform Act.

Medical care costs continue to escalate at about twice the rate of all goods and services as measured by the Consumer Price Index. The impact of these rising costs on the Federal budget is substantial.

In fiscal year 1975, 42 percent of health expenditures came from public funds. Federal payments for medicare and medicaid totaled about $22 billion. The combination of direct and indirect Federal, State, and local government payments to the health industry makes the health industry one of the most heavily subsidized industries in the country.

According to the Council on Wage and Price Stability, this subsidy amounted to over $55 billion in fiscal year 1975.

There is no way to control these escalating costs until Congress enacts a comprehensive national health insurance program such as the health security bill, S. 3. Under health security, the Congress would establish a budget for health services and provide the financial resources to pay for these services. Medical societies would be obligated to negotiate realistic fee schedules so that the budget for physician services could not be exceeded. Likewise, hospitals and other health institutions would have to negotiate their budgets so that total expenditures for hospitalization could not exceed the amount of funds allocated for institutional care.

Moreover, a budgeting system of cost control can allocate funds based on the need of people for health care rather than upon their ability to pay. A budgeting system of cost control is far more flexible than regulation and is less costly as well. Budget allocations under Health Security would not be determined unilaterally by Government as is frequently alleged. Such allocations would be made in accordance with the Health Planning Act of 1974 which provides for consumer, provider and governmental input into the planning process.

Over the long run, the health security program is the least costly of all national health insurance proposals that have been introduced into the Congress. Under health security and only under health security, could costs be held to a constant percentage of the gross national product which is, currently, 8.3 percent of the GNP.

Other national health insurance bills split up the funding of NHI between the Government and the private sector with the sources of funds for the private sector being divided between Blue Cross-Blue Shield and about 1,000 private insurance carriers. Under such proposals, the providers of health care would continue to dictate their remuneration. There would be no outside limits to the amount of money the health industry could absorb.

The bill introduced by the distinguished chairman of this subcommittee is a step in the right direction but does not go far enough. There are three main thrusts in the bill:

One, it would establish a fraud and abuse unit in HEW.

Two, it would establish a single prospective reimbursement system for hospitals.

Three, it would attempt to induce physicians to accept usual and customary fees under medicare.

The AFL–CIO supports the fraud and abuse provisions of S. 3205. However, fraud and abuse are not the major causes of escalating health care costs. Other reasons are the ability of physicians to control the demand for health services for their patients including the choice of hospitals, nursing homes, laboratories and drugs.

There is an inherent conflict of interest where physicians own hospitals, nursing homes, laboratories and drug repackaging firms to which they refer or provide services for their patients. Substantial funds would have to be provided to police fraud and abuse effectively.

Only one form of prospective reimbursement is provided in the bill. Prospective reimbursement can take many forms and we do not yet know what will work and what will not work. Moreover, the upward trend of average hospital costs would continue because the organization of hospital services would not be altered and the growth in utilization of new services and technology would continue unabated.

We find particularly objectionable the provisions of S. 3205 which would, in effect, establish a system of wage control. Hospital wages are too low in most communities. We think wages and salaries should be negotiated and not mandated by formula.

In our opinion, a negotiated budget is a far more effective and flexible tool for controlling hospital costs than what is provided in S. 3205.

However, hospital budgets would have to be negotiated "across-the-board" and not just for public patients. Otherwise, costs could too readily be passed on to private patients whose premiums are paid by negotiated health benefit packages, group insurance and individual health insurance policies.

The bill treats physicians very gently. Physicians would be induced to accept assignments by a possible $2 per encounter increase in their income from medicare patients if they agreed to become participating physicians.

This simply will not work because nonparticipating physicians in the medicare program would make more than $2 extra per encounter from their over-65 patients.

The AFL–CIO strongly recommends a negotiated fee schedule for physicians. Such a fee schedule should be applied across-the-board and not just for medicare patients. Physicians should be free to elect payment by capitation. It is even possible that some physicians would prefer this method of reimbursement since it provides improved continuity of care for the patient and almost complete elimination of paperwork for the physician.

The AFL–CIO opposes elimination of the Health Insurance Benefits Advisory Council. HIBAC has the potential of making a major contribution to the medicare and medicaid programs.

We oppose increasing the rate of return of for-profit health institutions. For-profit hospitals and nursing homes have a documented record of exploiting sick patients—particularly in the nursing home field.

The AFL–CIO supports provisions of the bill which deny recognition to percentage or lease arrangements for hospital based physicians. Radiologists and pathologists have made excessive profits from such arrangements.

Medicaid and medicare patients should be treated the same. We cannot accept lower levels of physician reimbursement for the under age 65 poor than for medicare beneficiaries.

We support making the Secretary of HEW the final certifying officer for both skilled and intermediate nursing home facilities. Substandard nursing homes have been able to operate by restricting their patients to medicaid beneficiaries.

The 1973 amendments to medicare provided two unworkable methods of reimbursement for health maintenance organizations. We oppose extension of these unworkable reimbursement methods to medicaid.

In conclusion, we believe the most effective way in which to achieve control over escalating health care costs is to budget health expenditures for hospital and physician services along the lines of the health security bill.

We hope the Health Subcommittee will give consideration to our views and that the bill reported out will launch a much-needed effort to restrain the runaway escalation of medical costs.

That concludes a summary of my statement, Mr. Chairman, but my colleagues and I would be very happy to answer any questions.

Senator TALMADGE. Thank you very much, Mr. Seidman.

In your discussion of hospital reimbursement, I was intrigued by the statement on page 8 where you said in this respect, "it should be noted that the closer hospitals come to the 120 percent ceiling, the tougher management would have to be."

The AFL–CIO seems to be saying that the Government is responsible for managing hospitals and should do everything to control hospital cost increases except for hospital wage increases. In other words, control everything but us. Is that not almost exactly what is being said?

Mr. SEIDMAN. That is not what we think we are saying, Mr. Chairman. What we are saying is that we think that the hospitals should be held to prospective budgets. These should be negotiated, and that the level of wages would be one of the items in the budget.

This is not the same as putting a fixed ceiling on the cost, which would, as your bill would do, relate this to wages in such a way that the average wage in the area, high or low, would become the ceiling, and this would mean that in areas where hospitals have refused to negotiate with unions and which have predominantly low wages, the low wages would continue to be frozen and in such areas, even if a hospital does have higher than average wages, which may be still low compared to other areas, it would have to cut them to the average level within 1 year.

This really provides a kind of wage control in an industry which has had in the past notoriously low wages and still, in many areas of the country, has not begun to catch up with the level of wages of other workers.

This has been generally recognized. It is not just the labor movement who has said this. This has been a low wage industry.

We think that it would be most unfortunate to place a ceiling on the low wages of hospital employees. Incidentally, there would be no such ceiling on the level of renumeration of doctors, only the order-

lies and practical nurses and others who are being paid very low wages in many of these hospitals and nursing homes.

Senator TALMADGE. It provides that they cannot escalate greater than the wages in the local area except in increased productivity. You cannot have a contract with a hospital without assuming what the wage level is going to be, can you?

Mr. SEIDMAN. That is correct. That does not mean if you do have such a contract you would not, for example, take account of the fact that the wages are already low in that area, therefore that is an area where there ought to be some catch-up.

Senator TALMADGE. Senator Curtis?

Senator CURTIS. Do you have any evidence, based upon your study, that the arrangement under which hospital associated physicians operate has any significant effect on the fees charged to patients?

Mr. SEIDMAN. In the first place, Senator, I cannot claim we have made independent studies of these matters. We are cognizant of studies that others have made that seems to indicate that where there is a utilization of such services it does have the impact on the amount that does have to be paid for the overall hospital services.

In other words, where there are these arrangements, it is our impression that the payments are too high and this is reflected in the overall bills people pay.

Mr. SHOEMAKER. I will just make a comment.

My father-in-law died a little over a year ago. He was in the hospital for 10 days. It was a known terminal illness and the pathology amounted to $2,500, and I talked to a pathologist and he said, "They must have examined every tissue in the man's body."

This is probably a good example.

Senator CURTIS. That is not responsive to my question. I think that the rank and file who follow this as well as people in Government recognize that there are very severe problems. Some of them have been written about.

It seems to me that the question faced by this committee is, what is the right answer to the problem. I think that you people have the staff and the resources that it might be well to conduct an independent, objective study on how much these particular ranges, how significant they are in meeting the problem.

It is entirely possible that the wrong answer may be applied or proposed to a problem that is admitted to exist.

Mr. SEIDMAN. As I already indicated, we have already studied the surveys that others have made of these problems. I do not want to disillusion you, Senator. We do not have the kind of resources that you are talking about.

Mr. Shoemaker, he is not in a position to make that kind of a survey. It is our impression—it is just not our impression, but those whose judgments we respect have the same impression, that under the present arrangements the remuneration of these hospital-based physicians is, in many cases excessive and that is why these proposals are being made for changing these arrangements.

As I understand it, some of the organizations with which we are not always in agreement, also are in agreement with us that these changes should be made.

Senator CURTIS. I know that it has been alleged—it may be true, but I think we need the help of the most objective sources to establish that fact.

Thank you.

Senator TALMADGE. Senator Dole.

Senator DOLE. I do not have any specific questions; however, I find it curious that at the outset of your statement you talk about the need to contain health expenditures or get a handle on spiralling costs. I agree with that statement, but am puzzled by your suggested method of enacting some vast national health insurance plan. Do you actually believe we could save money by having such a comprehensive program?

Mr. SEIDMAN. We certainly do. We think the only way to get a handle on costs is to have a comprehensive national health insurance program and then allocate the costs for that program year by year and to build into that program as the health security bill does, the kinds of cost controls, both direct and by encouraging the improvement of the organization and delivery of medical care, so that in the future we can hold down the rise in medical costs to a degree that we have not been able to do under the present system or that we think would not be possible under other so-called national insurance proposals.

Mr. SHOEMAKER. I think it is important to understand that the health security bill provides the single source of funds so that you can negotiate with the providers. They provide the services, you provide the money. They want the money, we want the services, so you are in a negotiating position. Under the fragmenting system we have, there is absolutely no way you can get any handle on these costs.

Incidentally, the total national health expenditures budget would be fixed.

Senator DOLE. Do you have any idea what that price tag would be?

Mr. SHOEMAKER. It depends on how you figure it. If the program had been in effect in 1975, the total net additional costs in general revenues would be approximately $25 billion. That would absorb $12 to $13 billion in State and local expenditures for health services I think it is important to recognize that there is an awful lot of talking by the opponents of a comprehensive national health insurance program with respect to cost. They do not make clear whether they are talking about total costs, additional tax revenues through social security or the net additional cost from general revenues.

I would assume that the House Ways and Means Committee and the Senate Finance Committee would primarily be interested in net additional cost in general revenues.

Mr. SEIDMAN. I should add, as far as total costs are concerned, we are not talking about a new cost. We are already paying $118.5 billion in 1975—$118.5 billion—for health care costs. This is a different way of financing health care costs and of us getting a handle on future health care costs. We do not think it is possible in any other way.

Senator DOLE. The $118 billion—that is in your statement—I assume that is at all levels of government, VA, medicare, and medicaid as well as all private expenditures?

Mr. SEIDMAN. Yes, plus all private expenditures through their private insurance system. I am talking about the total health care costs

of the American people in 1975. This is not our figure; it is the HEW figure.

Senator DOLE. Thank you, Mr. Chairman.

Senator TALMADGE. Thank you very much, Mr. Seidman, and your associates. We appreciate greatly your contribution.

[The prepared statement of Mr. Seidman follows:]

STATEMENT OF BERT SEIDMAN, DIRECTOR, DEPARTMENT OF SOCIAL SECURITY AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS

The AFL-CIO appreciates the opportunity to appear before this subcommittee today to present our views with respect to S. 3205, the Medicare-Medicaid Administrative and Reimbursement Reform Act introduced by the distinguished Chairman of this subcommittee.

The time is ripe for Congress to take action to control the unconscionable escalation in medical care costs. For the calendar year 1975, the Consumer Price Index excluding medical care rose 6.8 percent. Hospital service charges increased 13.0 percent or almost double the CPI (less medical care). Moreover, the figures for the first six months of 1976 indicate these trends are continuing. In this six month period, the overall cost of medical care increased 10.6 percent on an annual basis while the CPI for all items increased 4.5 percent annually. The figures for medical services for the first six months of 1976 are not yet available, but for the first five months of 1976, they rose at an annual rate of 11.7 percent in comparison to an annual rate of 4.2 percent for all items in the same period.

The impact of these escalating costs on the federal budget is substantial. According to the Council on Wage and Price Stability, in fiscal year 1975, 42.2 percent of health expenditures came from public funds. Federal payments for Medicare and Medicaid totaled $21.8 billion. Total federal payments, including Veterans Administration and Department of Defense hospitals, construction and research, came to $33.8 billion. State and local government outlays for health were $16.1 billion and tax subsidies for health purposes amounted, conservatively, to $5.6 billion. The combination of direct and indirect federal, state and local government payments to the health industry makes this one of the most heavily supported industries in the country. The total annual subsidy to this industry amounts to $55.5 billion.

It is disturbing that in the ten years that have elapsed since Medicare was implemented, Congress has yet to take effective action to control health care costs. The AFL-CIO, therefore, congratulates you, Mr. Chairman, on your initiative in introducing S. 3205.

COMPREHENSIVE NATIONAL HEALTH INSURANCE

It is our opinion that there is no way to control these escalating costs until Congress enacts a comprehensive national health insurance program such as the Health Security bill (S. 3) which channels all funds through a single government agency so that agency will have the power to review hospital budgets and negotiate with them as to the amount of their total reimbursement. The give and take of such negotiations is far more flexible and effective than regulations. Similarly, medical societies should have the opportunity to negotiate fee schedules with the responsible government agency and doctors should be required to accept fees in full payment for services rendered. Doctors could participate or not participate in the program, but non-participating physicians would have to confine their practices to the few wealthy patients who could afford to pay their excessive fees.

Briefly this is how the Health Security bill (S. 3) would work. The Health Security bill would establish a national health expenditures budget comprised of Social Security type taxes earmarked for health matched by federal general revenues. The only way in which providers could increase their revenue as a percentage of wages and salaries would be to come before the Senate Finance Committee and the House Ways and Means Committee and justify an increase in taxes. Thus, Congress would decide what percentage of the gross national product should be allocated for health care.

The budgeting of health expenditures as provided by Health Security would not alter the present ownership of hospitals or the private practice of medicine. The delivery of health services would remain in the private sector.

The national budget for health expenditures would be a set amount in any given year. This national budget would be allocated to health regions and in turn to health services areas. The allocation would be based primarily, on two factors:

Expenditures for the prior year adjusted for inflation and productivity;
The need for health services.

For example, for physician services over-doctored health service areas would receive a somewhat lower budget, on a per capita basis, than under-doctored areas, clearly an incentive for better geographical distribution of physicians. Similar considerations would apply to facilities.

Because of built-in cost controls in a budgeting system, detailed regulation is not needed to control costs. Essentially, providers would have far more freedom to experiment and innovate under a budgetary system than under a regulatory system. Moreover, the budget approach provides incentives for physicians to become involved in better organizational arrangements for the delivery of care.

In a budgeted system of cost control, due weight would be given to historical costs. That is, due weight would be given to the prevailing pattern of hospital and institutional charges. Due weight would also be given to current fees for physicians and other provider services. However, allocations for institutional and practitioner services would be adjusted to take into account the need of patients for medical care.

For example, suppose that a community hospital had an open heart surgery unit that performed one heart operation a month but that across the street, or within a short distance, a teaching hospital performed heart surgery twenty times a month and had the capacity to perform such surgery twice a day. Then, those budgetary line items that pertained to heart surgery would be eliminated or curtailed in the community hospital. This would not just cut costs. It would also improve the quality of care since the institutions best qualified to perform the surgery would have that responsibility.

This is the approach of the Health Security bill (S. 3).

It should be emphasized that these decisions with respect to the allocation of funds for health services would not be made unilaterally by the federal government. The Health Security bill provides for the allocation of money in conformity with state and local planning. The Health Systems Agencies (HSAs), the State Health Planning and Development agencies (SHPDAs) and the state advisory councils, Statewide Health Coordinating Councils (SHCCS), have been or are now being organized under the National Health Planning and Resources Development Act of 1974. This law provides for consumer, governmental and provider participation in the planning process. Decisions with respect to resource allocation would not be dictated by the federal government as is so often alleged by the opponents of Health Security.

HEALTH SECURITY LEAST COSTLY OF ALL NHI PROPOSALS

The escalating federal expenditures for health services should bring into perspective the cost of the Health Security Program. Health Security has been the object of a propaganda attack that it costs too much. The fact is that Health Security over the long haul would be the least expensive of all national health insurance proposals. With Health Security, the national health expenditures budget could be held at the present 8.3 percent of the Gross National Product.

Had Health Security been in effect in fiscal year 1975, its total cost would have been $62.5 billion, but half of this sum would have been met through Health Security taxes so that the impact on federal general revenues would have been about $32 billion. Since Health Security would have absorbed Medicare and most Medicaid expenditures and some other health costs, the net additional cost in general revenues would have been in the neighborhood of $22 billion. Moreover, the $22 billion would have absorbed most of the $16.1 billion spent by state and local governments for health care. Health Security would be a very effective form of revenue sharing. On the other hand, without any action by Congress on national health insurance, the Congressional Budget Office projects federal expenditures for Medicare and Medicaid alone at $48 billion in fiscal year 1981.

There is no question that the health industry can absorb virtually unlimited amounts of money. One unique aspect of medical care is the degree to which

physicians control the demand for health services. Yet, physicians seldom think about the cost of the care they engender.

After the first contact with the physician, which is initiated by the patient, the doctor establishes the patient's course of treatment. The doctor advises the patient when he or she should come back for a follow-up office visit—next week, in 10 days or next month. The doctor orders the lab tests and x-rays. If the doctor deems it advisable, he or she hospitalizes the patient and decides when the patient can be discharged. The doctor writes the prescriptions, usually for costly trade name drugs, and gives instructions to interns, residents and nurses.

Another unique aspect of medical care is that the training of a physician emphasizes that any medical expense is justified. Thus, marginal improvements in the quality of care, even if achieved at substantial cost, can always be supported.

S. 3205

Considering the magnitude of the problem, S. 3205 is a step in the right direction but it is our view that it does not go far enough. The bill's principal thrust is in three directions: it would establish a fraud and abuse unit in HEW to police the medical profession and institutional providers; it would establish a single prospective reimbursement system for hospitals; and it would attempt to induce physicians to accept usual and customary fees under Medicare.

There are numerous other provisions, but we propose to limit our comments to the following sections:

Sec. 8—Termination of the Health Insurance Benefit Advisory Council.
Sec. 12—The increase in the rate of return for for-profit hospitals and nursing homes.
Sec. 22—Reforms in reimbursement of hospital-associated physicians.
Sec. 23—Physician reimbursement under Medicaid.
Sec. 31—Certification of nursing homes under Medicaid.
Sec. 41—Payments to Health Maintenance Organizations.

S. 3205 is a very complex bill which essentially relies on detailed regulation. Its implementation would require a large number of investigators. Unless sufficient funds were provided to police the providers there would, undoubtedly, be widespread evasion of its provisions.

Nevertheless, the sections of the bill that are designed to prevent fraud and abuse have our support. However, fraud and abuse are by no means the major causes of the escalating cost of health care. For example, many physicians have invested in proprietary hospitals and nursing homes to which they admit their own patients. They invest in medical laboratories to which they send their specimens. Some even buy generic drugs and repackage them under a private trade name and prescribe their own trade name drug to their patients at substantially higher cost.

S. 3205 only requires disclosure of such conflict of interest transactions. If the Employment Retirement Income and Security Act (ERISA) can prohibit trustees of health, welfare and pension plans from engaging in conflict of interest transactions, so should doctors be prohibited from engaging in such activity. Doctors would still be free to invest in hospitals, nursing homes and in medical laboratories, but should be prohibited from investing in facilities to which they refer, or which provide services for, their own patients.

HOSPITAL REIMBURSEMENT

A major thrust of the bill would be to establish an incentive reimbursement method rewarding hospitals whose routine operating costs are less than average and penalizing hospitals whose routine operating costs are more than 20 percent above average. While some high cost hospitals would have to become more efficient, or be phased out, the upward trend of average hospital costs would continue because the organization of hospital services would not be altered and the growth in utilization of new services and technology would continue unabated.

We have concern that S. 3205 would legislate a single form of prospective reimbursement. We simply do not yet know what would work and what would not work with respect to prospective reimbursement of hospitals but, in any case, the guidelines in the bill fail to attack the problem of inappropriate use of expensive, high cost hospital facilities for both outpatient and inpatient care.

We find particularly objectionable Section 10(aa)(3)(E) of the bill which, in effect, would establish a system of wage control. It would limit wages and sal-

ary increases for hospital employees, but not for doctors, in areas where wages and salaries are generally low. Paradoxically, in highly organized areas where wages were already at more adequate levels but where wages in some hospitals lagged behind the average, some hospital wages would be allowed to rise to the average wage level provided the hospitals were not in the high cost bracket. But high cost hospitals, at or close to, the 120 percent ceiling would not be able to raise the wages and salaries of their employees even if they were below the average in a given area. In this respect, it should be noted that the closer hospitals come to the 120 percent ceiling, the tougher management would have to be.

Another weakness of the bill is that the reimbursement method would apply only to Medicare and Medicaid payments. Obviously costs could be shifted to private patients whenever a hospital reached the 120 percent ceiling.

Instead of the complicated reimbursement scheme proposed in S. 3205, we would like to suggest a method like that proposed in the Health Security bill (S. 3). This is a system of prior budget review.

Budgetary controls would be most effectively achieved through a program such as Health Security. This is because the program would use the leverage of payment to achieve cost control and, at the same time, allocate funds to meet the health care needs of the American people in accordance with comprehensive planning goals.

In the absence of this leverage, legal sanctions could be used. While not as effective as the control over payments which Health Security would provide, hospital and other institutional providers could be required to submit their budgets in advance to a federal agency. The budget would then be reviewed and evaluated with respect to increased labor and material costs, effectiveness and efficiency in the delivery of services, quality of services, duplication of services in the area served and other relevant factors. The budget could, of course, be adjusted retrospectively upward or downward to the extent that ulitization varied from anticipated patterns. Such a prospective budgeting system appears to be working well in the state of Connecticut and could be extended nationally.

Such a budget system would have to be applied "across-the-board" and not just to Medicare and Medicaid patients because costs not reimbursed by Medicare and Medicaid could be shifted to private patients.

Such a budgetary review process would rely primarily on negotiation and not regulation. The process would be far more flexible and less costly than the method proposed in S. 3205.

With respect to physician reimbursement, the bill treats doctors very gently. Under the bill there would be "participating" and "nonparticipating" physicians under the Medicare program. A participating physician would be one who agrees to accept assignments in full reimbursement for services to Medicare patients.

Participating physicians would be allowed to submit their claims on a simplified, multiple-listing basis rather than submitting individual claim forms. The nonparticipating physician would be required to submit individual claim forms. It is estimated that the simplified multi-listing form would save $1 in administrative expense which would be passed on to the participating physician. In addition, it is claimed that the simplified multi-listing forms would also save the participating physician another $1 in billing, collection and office paperwork costs and thereby result in an extra $2 of income for the participating physician.

While we find the $1 reduction in Medicare administrative costs creditable, the experience of the United Mine Workers of America with their simplified multi-listing claim forms for their participating physicians indicates the doctor does not save anywhere near an additional $1 in his office costs.

But even if participating doctors could save $1 in their office expense by using simplified multi-listing claim forms, this together with the extra $1 allowed by Medicare would come to an increase in income of $2 per patient encounter for the participating physician. Most doctors who refuse to accept Medicare assignments charge more than the $2 over the usual and customary fee allowed by Medicare. For example, we have examined a bill for two encounters in one week including some laboratory tests which came to $161.00. Medicare approved $137.70. Thus, the bill was for $23.30 more than the reasonable charges allowed by Medicare. Even if there had not been any diagnostic tests, the bill for a routine office visit was $18.00. Medicare allowed $15.00. So this particular doctor would be giving up $21.30 ($23.30 minus $2) to be a participating physician in the first instance and would be giving up $1 for a routine office visit in the second instance.

As an alternative to the bill's approach, we recommend a negotiated fee schedule in the various Medicare reimbursement areas for Part B of Medicare.

Physicians should then be required to accept such fee schedules in full payment for services rendered. However, to be fully effective such fee schedules should be applied across-the-board, not just to Medicare. Otherwise physicians would likely raise their fees for private patients, thereby creating two levels of care: one level for private patients and another level for Medicare and Medicaid beneficiaries.

Physicians should also be free to select payment by capitation for patients who choose to receive all of their primary care from such physicians. Physicians who elect capitation as a method of reimbursement for their services might well discover that such a payment mechanism results in better continuity of care for the patient and almost no paperwork since a separate claim for each service is unnecessary.

The experience of HMOs has shown that capitation payments reverse the incentives of physicians. Under fee-for-service, doctors make more money for treating sick patients; and the sicker the patient, the more the doctor makes. Under capitation, the doctor makes more money if he keeps his patients well.

Capitation is the way in which medical groups are generally reimbursed in prepaid group practice plans. This is the primary reason hospital use in such plans is two to two and one-half times lower than in fee-for-service reimbursement by Blue Cross-Blue Shield and commercial insurance plans. Health Maintenance Organizations serving federal employees had to increase their premiums this year by an average of 19.3 percent, but the traditional insurance plans increased their premiums by 35 percent. Costs averaged 37 percent less for Medicaid patients enrolled in a prepaid group practice plan than for those under fee-for-service care. One way in which to control costs would be for Congress to appropriate more money for prepaid group practice plans under the existing HMO Act.

OTHER PROVISIONS

Section 8 of S. 3205 would terminate the Health Insurance Benefits Advisory Council (HIBAC). The AFL–CIO deplores this provision. While we are quite critical of the treatment HIBAC has received from the Nixon-Ford Administration HIBAC does provide some measure of public accountability in the administration of Medicare and Medicaid and with an HEW Secretary who wanted to use it effectively, could make a major contribution to these programs. The advisory council should be continued.

Section 12 of the bill increases the rate of return on net equity of for-profit hospitals and skilled nursing homes to two times the average rate of return on Social Security investment from the present one and one-half times. We feel this is unconscionable since investigations by the Subcommittee on Long-Term Care of the Special Committee on Aging of the Senate have revealed deplorable and exploitive conditions in the for-profit nursing home industry. We oppose this provision.

The AFL–CIO strongly supports Section 22 of the bill which would deny Medicare and Medicaid recognition to percentage or lease arrangements for radiologists. These hospital based physicians are reaping excessive profits from such arrangements.

Section 23 of S. 3205 would require the states to pay not less than 80 percent of the Medicare reasonable charge for non-surgical care for Medicaid patients provided by physicians outside of a hospital. While we recognize that some states pay even less for Medicaid patients, the standard should be 100 percent of Medicare reasonable charges. Otherwise there will be two standards of care—one for the poor and another for the Medicare population.

The AFL–CIO strongly supports Section 31 of the bill which would make the Secretary of HEW the final certifying officer for skilled nursing and intermediate care facilities under both Medicare and Medicaid. Present law gives the Secretary this authority with respect to skilled nursing facilities participating under Medicare only, or both Medicare and Medicaid, but not where they participate only under Medicaid. Thus substandard nursing homes have continued in operation by accepting only Medicaid patients.

Section 41 of the bill extends the unworkable methods of reimbursement for HMOs that were enacted in 1973 for Medicare and Medicaid. Two methods of reimbursement were provided—a cost-plus reimbursement and a so-called incentive reimbursement method. In order to understand why these methods are unworkable for HMOs, it is necessary to understand how HMOs operate. The

big advantage of capitation payments for a defined population as a means of paying for HMO services is that the HMO can plan and budget on the basis of the medical care needs of the defined populated served. Part of the payments can be utilized to provide incentives to the medical staffs to be efficient and to utilize facilities wisely. Cost reimbursement destroys this incentive mechanism. The other "so-called" incentive reimbursement method under Medicare destroys the ability of the HMO to budget prospectively since it cannot know in advance what it is going to receive in payments. The fee-for-service system pays bills retrospectively and the two Medicare formulas confuse prospective and retrospective reimbursement insofar as they apply to HMOs. Thus, this is an example of an attempt to apply concepts developed under fee-for-service to capitation systems.

In conclusion, Mr. Chairman, we believe the cost control provisions of Health Security—that is, a budgeting system for institutional services—would be the most effective way by which the escalation of hospital costs could be contained. Admittedly, such a control would best be carried out if all payments for health services were channelled through a single agency of government such as in Health Security. However, there remains the possibility that legal sanctions could be applied in place of control over payments.

In order for such a program to work, it is quite clear, in our opinion, that the budget review must encompass the hospital's total budget and not just that part of the institution's budget that would apply to Medicare and Medicaid beneficiaries. In short, we would reject ceilings or caps on federal payments alone as has been proposed by the Administration. Caps on part of the hospital budget for federal and state beneficiaries would leave health care institutions free to raise charges to private patients. This merely shifts costs but does not contain them. The premium cost to collectively bargained health plans would increase, along with all other premiums, to cover any shortage of payments for Medicare and Medicaid beneficiaries.

For physicians, we would support negotiated fee schedules which should be accepted by doctors as full payment for services rendered. These fee schedules would also have to be applied across-the-board. Capitation payments should be an alternative method of reimbursement for those practitioners who elect this method of payment.

We favor more stringent controls over fraud and abuse. We also support Sections 22 and 31 of the amendments but oppose enactment of Sections 8, 12, 23 and particularly Section 41 of S. 3205. We hope the Health Subcommittee will give consideration to our views and that the bill reported out will launch a much needed effort to restrain the runaway escalation of medical costs.

Senator TALMADGE. The next witness is Beverly Fiorella, president, American Society for Medical Technology, accompanied by Nancy Preuss, immediate past president.

We are delighted to have you with us. I enjoyed being at your national convention in Chicago several weeks ago.

STATEMENT OF BEVERLY FIORELLA, PRESIDENT, AMERICAN SOCIETY FOR MEDICAL TECHNOLOGY; ACCOMPANIED BY NANCY PREUSS, IMMEDIATE PAST PRESIDENT; L'NORA WELLS, PRESIDENT-ELECT; AND DENNIS WEISSMAN, DIRECTOR, OFFICE OF GOVERNMENT RELATIONS

Ms. FIORELLA. I am Beverly Fiorella, president of the American Society for Medical Technology. With me is Nancy Preuss, immediate past president of the Society.

We are pleased that the Medicare-Medicaid Administrative and Reimbursement Reform Act is being considered, and would like to comment on four major areas.

On the establishment of the Health Care Financial Administration, ASMT endorses the intent of this legislation towards medicare-medicaid reform through reorganization within HEW. However, we do

question the proposal for a separate HCFA to be directed by another assistant secretary reportable to the Secretary of HEW.

Performance records, documented in our written testimony, demonstrate that HEW has been hampered in fulfilling its laboratory administration responsibilities by self-ackwnowledged jurisdictional disputes between involved agencies.

The source of these problems seems to be the lack of top management accountability in HEW for coordination of its laboratory related functions.

ASMT feels the appropriate position towards the consolidation and coordination of the Department's health care program and their finances would be to place the authority under a single Assistant Secretary for Health. Without such consolidating and coordinating efforts, laboratories and practitioners are faced with the distinct possibility of the continuation of conflicting decisions as well as the unfortunate situation of expanded periods of time lapsing between resolution of issues.

These occurrences are detrimental and jeopardize quality functioning of laboratories. Therefore, we would strongly recommend that the committee consider amending the bill and place the proposed HCFA under the authority of the Assistant Secretary for Health, who would be the single federal official accountable for the administration and financing of Federal health programs.

Regarding the proposed termination of the Health Insurance Benefits Advisory Council, ASMT believes that the advice and information from professionals and consumers is the only way in which those responsible for title XVIII can obtain the sufficiently broad understanding of the challenges and issues to assure final program decisions which are in the best interests of the patient-public and the health care system.

We feel that the abolishment of HIBAC would create a void in professional and consumer input.

Senator CURTIS. What is HIBAC?

Ms. FIORELLA. Health Insurance Benefits Advisory Council. The abolishment of this Council would create a void of professional and consumer input that unquestionably would be detrimental to the future of the health care system.

The consumer has the right to formal and direct input. The Federal Government should not be denied the opportunity to enhance its own ability to reach decisions which will impact favorably upon the health care system.

Therefore, ASMT would like to go on record as opposing the abolishment of HIBAC, particularly without establishing an alternative mechanism as a conduit for formal and informal input from the private sector.

Consistent with our viewpoint concerning professional and consumer input, ASMT further endorses the requirement of a 60-day comment period for regulations under the proposed legislation.

Mrs. Preuss?

Ms. PREUSS. I would like to comment on the Office of Central Fraud and Abuse Control. Consistent with ASMT's historical concern regarding adequate control of reimbursement mechanisms, we endorse

the provisions in this legislation for the establishment of an Office of Central Fraud and Abuse Control.

Although ASMT has been painfully aware of certain fraudulent practices concerning laboratory testing, charges and reimbursement, we are rather shocked to learn that fraud exists within the industry to the extent emphasized in recent governmental reports.

We realize that even under closely monitored conditions, there will be those who will elect to violate commonly accepted practices. However, if we are to believe the available reports, we find that we are not faced with a situation where the violations are rare, but rather a situation where there appears to be a rampant widespread fraud and abuse.

Those of us who are in the health care profession would indeed be abrogating our responsibility if we did not publicly deplore the current situation and aggressively seek to effect a solution.

We, as professionals, find the current situation to be disgusting, disheartening, and discouraging. We do our best to assure quality service for the patient, only to find that those with the authority to assure appropriate reimbursement control mechanisms have neglected to assume this most important role.

One way in which ASMT can assist in resolving the problem is to assist in achieving passage of this legislation. We therefore endorse the establishment of the Office of Central Fraud and Abuse Control under the direction of an inspector-general.

However, for such an office to function effectively, everyone in the health care industry will have to assume a personal responsibility for the recognition and bringing to the fore fraud and abuse when it occurs. Such a responsibility cannot be exercised without incurring certain risks, such as loss of employment, suppression of career advancement, internal ostracization or failure to find subsequent employment in other institutions.

Potential loss of economic and job security can serve as a powerful deterrent to disclosure of fraudulent and abusive practices. It does not take but a cursory review of like-situations in other industries to recognize that reprisals for such disclosures are indeed predictable.

We are convinced that unless this legislation is amended to include an employee protection provision that the best-conceived Office of Central Fraud and Abuse cannot achieve what is necessary.

We propose an amendment which would protect all practitioners in the health care industry—and I emphasize all practitioners in the health care industry—from discrimination with respect to compensation, terms and conditions and privileges of employment. Such an amendment is regrettably an absolute necessity.

Finally, I would like to comment on the hospital-associated physician reimbursement. Regarding the question of physician reimbursement, this legislation seeks to revise the reimbursement practices.

We feel it is very important for this subcommittee to be provided the opportunity to achieve an accurate understanding of what current employment functions are for laboratory personnel.

Medical technologists perform four major roles in a laboratory. First, the medical technologist performs diagnostic test procedures, routine and specialized.

Second, technologists fulfill the duties and responsibilities of technical supervisors.

Third, the chief administrative technologists assume a variety of managerial responsibilities within a hospital laboratory.

Finally, the medical technologist plays a direct role in the educational process of laboratory personnel.

To expand on each of these roles, first, the role of the medical technologist as a laboratory supervisor. In the majority of hospitals, medical technologists have traditionally served as the technical supervisors of the total laboratory as well as technical supervisors of designated specialty departments or section areas.

Supervisors plan, organize and delineate the responsibilities of personnel working under their direction. They assume the responsibility for instituting new procedures, establishing and maintaining quality control programs. They train personnel, maintain supplies, disseminate information, maintain procedural directions and ascertain reliability of test results.

Medical technologists are unquestionably involved in the supervising, planning, processing and reporting of laboratory tests. These nonphysician functions are commonly established and accepted by hospital administrations.

The role of the chief or administrative technologist in the laboratory management, ASMT recently completed a laboratory management survey. The report illustrates that administrative functions are indeed carried out by medical technologists. A copy of this report has been provided for your committee.

This survey clearly indicates that medical technologists are now playing an essential role in laboratory management. That data points out that the administrative medical technologist carries out the majority of a laboratory's administrative functions.

Thirty-three administrative functions common to laboratories were listed on the survey questionnaire. These functions ranged from who reviews and manages quality control programs to who evaluates electronic data programs and reports.

Senator TALMADGE. I hate to interrupt you, but unfortunately, your time has expired. Your entire statement will be inserted in the record.

I want to thank both of you for your very helpful and constructive suggestions.

I presume my first question would be for Ms. Fiorella. In your experience, can a medical technologist with baccalaureate or master's level training in one of the biological, chemical or physical sciences along with appropriate years of work in clinical laboratory testing, assume responsibility for the direction and supervision of a clinical laboratory?

Ms. FIORELLA. I would say the answer to that is yes, as long as the duties and responsibilities are not of a diagnostic or therapeutic nature do not require diagnostic or therapeutic decisions.

Management, supervisory, technical decisions—definitely yes.

Senator TALMADGE. In clinical laboratory work, what specific activities require a pathologist's skills?

Ms. FIORELLA. Again, those skills would be required in diagnostic and therapeutic decisions as opposed to the clinical significance of tests that are within the educational expertise of the medical technologist.

Senator TALMADGE. My next question would be, I think, for Ms. Preuss. You have asked that S. 3205 be amended to include employee protection,which includes language to protect employees who have testified or are about to testify.

Why are you asking for this protection? Have there been any specific problems in the past?

Ms. PREUSS. Regrettably, there were problems in the early seventies regarding a former president of our organization who provided testimony relative to issues involved in this legislation, and who subsequently lost her employment. Our organization is concerned about this type of activity. I would like to add however that we have recently testified regarding the Clinical Laboratory Improvement Act and there have been no incidents of that nature as a result of those statements.

Senator TALMADGE. Do you have any evidence she was discharged because of her testimony?

Ms. PREUSS. Senator, you can always be discharged because your shoes are not polished or you do not smile appropriately; however, the discharge came immediately following the testimony and the individual had been employed in the institution for 15 years.

Senator TALMADGE. Who fired her?

Ms. PREUSS. In that particular situation, I would assume that both the director of the laboratory and the hospital administration played a role.

Senator TALMADGE. Thank you.

Senator Curtis?

Senator CURTIS. Those of us who have a responsibility of recommending legislation to the Senate may disagree oftentimes on what is the best approach to the problem, but I can assure you that everyone is interested in stamping out fraud and any acts that are unethical and wrong.

I was impressed by your statement concerning the fear of loss of job security by not disclosing fraud.

What types of fraud are we talking about?

I would like to have some examples. Does it have to do with fraudulent records? What type of fraud is occurring that we should strive to give some protection to those who might reveal it?

I am not limiting the testimony before legislative committees. I am talking about the freedom to go to someone right in the local situation, the hospital administrator, hospital trustee, chief of staff, or whomever it is. What type of fraud is occurring and is not being detected because there is that very justifiable fear?

Ms. PREUSS. We are familiar with the fraud that has been described and discussed in the various governmental reports. The reason for that is——

Senator CURTIS. What fraud is that?

Ms. PREUSS. For example——

Senator CURTIS. Performing services that are unnecessary, falsifying records? What is it?

Ms. PREUSS. I would be happy to delineate areas of fraud if I could finish my rationale for qualifying my statement.

It is one thing to learn of these activities from others. It is another to have concrete data from a wide variety of sources to support your feelings and perceptions in this regard.

As president of ASMT last year, I know of members who were aware of fraudulent practices, and felt an obligation to report these. However, there was considerable fear for loss of employment. In one particular case, information was received but it was followed up by a letter which requested that I destroy the information because the individual was afraid they were going to lose their position. Their reason was that they had a family to support.

It has been incredibly difficult to encourage professionals to live up to their obligations in this regard.

As to fraud you asked me to identify—recent disclosures concerning kickback situations—was not news to us.

Senator CURTIS. By whom, to whom?

Ms. PREUSS. Such as in Illinois where laboratories were paying funds back to the physician, who referred his lab work to the laboratory. There are situations where laboratory tests may go from a physician's office to more than one laboratory. That can involve double and triple charging.

There are situations where laboratories are paid for work done yet testing is done in another institution.

There is a great deal of variability in terms of what is charged for a laboratory test. It is possible to effect testing economics which could reduce the cost of the test to the patient. In some cases, the patient is the recipient of reduced charges. In other cases, the charges remain the same. A good question to ask is what happens to these savings.

Senator CURTIS. I realize that my time is up, but I have one more question. Believe me, all I want is information.

When a similar test is referred to more than one laboratory, is that ever for good medical reasons or double-checking, or something of that sort?

Ms. PREUSS. Certainly, there are occasions where that should occur and it would be an abuse of the physician's obligations to his patient not to do so. We are talking about situations where it is a practice. a common practice, which is more than something which is advisable for a particular patient.

Senator CURTIS. How widespread is it?

Ms. PREUSS. I do not know.

Senator CURTIS. Based on your own experience, percentagewise is it happening in 50 percent of the cases, 3 percent?

Ms. PREUSS. I cannot respond to that, Senator. We are unable to get that information.

Senator CURTIS. From your own personal observation?

Ms. PREUSS. My own personal observation.

Senator CURTIS. How big a problem is it?

Does it involve 20 percent, 3 percent of the transactions, 100 percent?

Ms. PREUSS. I have been fortunate to work in laboratory situations where this has not been a problem. If you are asking me to respond from personal experience, I cannot provide the information you request.

Senator CURTIS. How many years have you spent?

Ms. PREUSS. How many years have I been a medical technologist?

Senator CURTIS. Yes.

Ms. PREUSS. Over 15.

Senator CURTIS. That speaks well for all of your associates. It is a helpful bit of information to this committee.

No one knows better than members of Congress what it means to have adverse publicity, guilt by association, or blaming everybody for the abuses that occur in a small number.

Senator TALMADGE. Senator Dole?

Senator DOLE. I will address it to either witness. Does a medical technologist work as an employee of a pathologist or of the hospital?

Ms. FIORELLA. Generally as an employee of the hospital, in most hospital-based laboratories.

Senator DOLE. In that capacity, are you required to make medical judgments? That is, do you for all practical purposes have final responsibility when a diagnosis is made, and are you accountable for that decision or analysis?

Ms. FIORELLA. Accountable as far as having someone over you, yes. I am sorry, is that what you mean?

Senator DOLE. I mean if—as you seem to indicate—you conduct all the tests, make all the diagnoses, and, in effect, supervise the lab as well, what is left for the pathologist to do except collect the fee?

Ms. FIORELLA. There are a number of diagnostic and therapeutic decisions to be made.

Senator DOLE. Who makes them? Does the physician himself actually do it or does he in most cases just leave it up to a technologist?

Ms. FIORELLA. Some of those decisions would be beyond the educational expertise of the medical technologist. We are not saying that there should not be physicians involved in the laboratory.

Senator DOLE. I am not suggesting that either. I am only wondering who is ultimately responsible and whether pathologists review laboratory findings or simply leave the decision up to a technologist who has not had all of the training that they have had.

Do you, in fact, make some of the judgments, and if you do are you in effect practicing medicine some of the time or not?

Ms. PREUSS. Well——

Senator DOLE. Like anything else, maybe these things tend to get routine after awhile. If you make a certain test 500 times or a thousand times, do you just wait for someone to initial the result when everything else is done? Is that how it operates, with the physician getting a big fee for the pathology service?

Ms. PREUSS. It will vary by institution as to what the roles are for medical technologist versus the pathologist. In some of your institutions, you do not even have a pathologist on a permanent basis or a contractual basis. They may be available on a consulting basis.

Obviously, the medical technologist in that situation carries a great deal more responsibility than he may find in an institution that is a specialized institution where you may actually find a pathologist actually involved with the performance of a test.

By and large, the majority of laboratory procedures go directly from the laboratory to the patient's chart. Unless you have a pathol-

ogist who is accepting the responsibility of playing that vital role of reviewing and interpreting laboratory data to assist the physician. In most institutions I have worked for, the laboratory tests go directly from the technologist to the patient's chart.

I am speaking of four or five institutions. That does not mean that the pathologist doesn't, after the result gets on the patient's chart, work with the physician in those cases where it is necessary. The extent to which that occurs is difficult to evaluate. The majority of work in a laboratory is done by medical technologists. They accept a great deal of responsibility, both in terms of assuring that the work is of a quality nature, and providing information when requested.

Senator DOLE. What is the pay differential? Do you have any idea of the comparative incomes of technologists and pathologists?

Ms. PREUSS. The average salary, according to a recent survey of our membership of which 50 percent is involved in management shows that the average monthly salary for an administrative technologist laboratory manager is $1,244 per month. The monthly average for a chief technologist is $996. And, the monthly average for a supervisor is $950. I believe your committee has a full copy of that salary survey. The salaries are low.

Senator DOLE. You appear to be suggesting in your testimony that the differential is far too great between the technologists and pathologists. Do you have any criticism of what pathologists receive? After all, they have had considerably more training.

Ms. PREUSS. ASMT's position is that personnel working in clinical laboratories should be reimbursed on the basis of their personal professional effort and the time spent in the conduct of laboratory procedures and laboratory affairs. We are not asking for an increase in medical technologists' salaries. We are not asking for a decrease in anyone else's reimbursement.

What we are saying is the entire issue of reimbursement, the way it is handled, needs to be assessed. We are committed to the premise that this assessment must be based on what actually occurs in laboratories.

Senator DOLE. What does it take to become a technologist—not a supervisor, but a laboratory technician?

Ms. PREUSS. A baccalaureate degree. Approximately one-third of laboratory administrators responding to a recent survey have master's degrees.

Senator DOLE. Do you have to have a license as well?

Ms. PREUSS. To be a medical technologist, a certified medical technologist, you have to have a baccalaureate degree or the equivalent.

Senator DOLE. Do either one of you have any personal experiences that should be brought to the attention of this committee with reference to Senator Curtis' line of testimony?

Where are you from, first of all?

Ms. FIORELLA. University of Illinois Medical Center.

Senator DOLE. Do you have any personal examples from there of the double and triple charging situations we were discussing earlier?

Ms. FIORELLA. Personal? No.

Senator DOLE. You have never observed any?

Ms. FIORELLA. My situation in the last 8 or 9 years has been strictly academic, involved in teaching, so I have really been out of the clinical setting, so personally, I would have to say no.

Again, as Ms. Preuss has indicated, we do get information from some of our members, but that is not personal.

Senator DOLE. Thank you, Mr. Chairman.

Senator TALMADGE. I guess this question is for Mrs. Preuss.

What percentage of laboratory tests require medical judgment?

Ms. PREUSS. Again, I think that would vary with the institution, depending upon whether it was an institution which handled special medical cases, such as a cancer institute. That would require a different percentage of medical interpretation in terms of diagnosis and therapeutics than would a general hospital that dealt primarily with broken arms and legs. Across the board, institutionwise, it is difficult to establish a percentage. I think that what is done in the future today versus what should be done is a key point to consider.

Physicians need the assistance of pathologists in the diagnosis and treatment of disease. The laboratory industry has exploded technologically to such a degree it is very difficult for the medical community to keep up with it.

It seems that a great deal more activity should occur between the physician in a peer relationship with a pathologist in terms of making certain that diagnoses and therapy is in the best interest of the patient.

What is actually the case now and what should be, and what will be done, are two different things.

Senator TALMADGE. What percentage of the time in laboratory tests is the opinion of a medical technologist final?

Ms. PREUSS. I am sorry?

Senator TALMADGE. What percentage of the time spent by the medical technologist is your decision final, of the test?

Assume you do 50 tests in a given day of all types. What percentage of those tests would your judgment be final, or would they have to be reviewed by pathologists?

Ms. PREUSS. Again, speaking from personal experience, the majority.

Even in blood banks, oftentimes you have very little pathologist or physician involvement in crucial decisions as to whether a unit of blood is compatible or not. Certainly there are exceptions.

The survey I referred to earlier elicited comments suggesting that there was very little supervision as far as their responsibilities were concerned. That should not be interpreted to mean that there are not institutions where pathologists are very much involved.

For the most part, the majority of the laboratory tests go out of the laboratory from the technologist.

Senator TALMADGE. Any further questions?

Senator CURTIS. It goes to a physician?

Ms. PREUSS. That is correct.

Senator CURTIS. Thank you.

Senator TALMADGE. Thank you very much. We appreciate your contribution.

[The prepared statement of the American Society for Medical Technology follows:]

STATEMENT SUBMITTED BY THE AMERICAN SOCIETY FOR MEDICAL TECHNOLOGY

SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS

In response to the proposed "Medicare-Medicaid Administrative and Reimbursement Reform Act," S. 3205, the American Society for Medical Technology:

Endorses the intent of the legislation toward Medicare/Medicaid reform through reorganization within the Department of Health, Education, and Welfare.

Recommends amending S. 3205 to organizationally place the proposed Health Care Financing Administration under the authority of a single Assistant Secretary for Health within HEW.

Endorses the proposed establishment of an Office of Central Fraud and Abuse Control under the direction of an Inspector General.

Recommends amending S. 3205 to specifically include an employee protection provision.

Supports Federal reimbursement mechanisms which fairly compensate personnel based upon their personal professional effort and amount of time spent in the performance of specified functions.

Opposes the abolishment of the Health Insurance Benefits Advisory Council without establishing an alternative advisory mechanism as a conduit for formal and direct input from the private sector.

I. Introduction

The American Society for Medical Technology (ASMT) is most pleased to provide the members of the Senate Finance Health Subcommittee with our views on S. 3205, the Medicare-Medicaid Administrative and Reimbursement Reform Act.

ASMT is a national, professional organization composed of over 27,000 members engaged in the delivery of clinical laboratory services. The Society is composed of 50 constituent state societies, in addition to the District of Columbia, which hold charters granted by the national organization. The country is divided into ten regions with an average of five states per region. An elected House of Delegates forms the governing body of the Society and when not in session, its functions are carried out by an elected Board of Directors. The Society is organized to give each member the opportunity to be an active partner in the development of standards and practices enumerated in ASMT's policies, positions, and publications.

Our membership is made up of a variety of nonphysician categories of clinical laboratory personnel including clinical laboratory administrators, supervisors, educators, technologists, technicians, assistants, and such specialists as microbiologists, clinical chemists, hematologists, immunohematologists, cytotechnologists, histotechnologists, and nuclear medicine technologists. Approximately seventy-five percent of our membership hold degrees at or above the baccalaureate level while another ten percent hold associate degrees. The remainder of the membership is composed of individuals who fall in specified categories such as students.

The Society is actively involved in both the areas of accreditation and certification. ASMT cooperated with the American Society of Clinical Pathologists (ASCP) in establishing the National Accrediting Agency for Clinical Laboratory Sciences (NAACLS) which is an autonomous agency responsible for the accreditation of education programs for clinical laboratory personnel. The Society currently participates with ASCP in the certification of clinical laboratory personnel through a Board of Registry.

In addition to a membership diverse in specialty and generalist functions within the laboratory field, laboratory settings or places of employment range from private or independent laboratories to physician offices, clinics, blood banks, research institutes, to hospital laboratories—both governmental and non-governmental. Thousands, in fact the majority, of our active members work in hospital laboratory settings throughout the country.

On behalf of our membership and in the interest of better health care delivery on a national basis, ASMT is in favor of and has previously gone on record to support the concept of national health insurance. Our Society subscribes to the basic principle that every American should be assured access to quality health care and that no person should be denied health care because of inability to pay.

In testimony on national health insurance presented before the House Ways and Means Committee in May of 1974, ASMT suggested the obvious: that any form of national health insurance adopted by the Congress will undoubtedly have a profound effect on the way health care is now delivered. In fact, close scrutiny and evaluation of our present health care system is critical in order that any form of NHI eventually developed will ensure both efficient and economical health care services to all our citizens.

Although we continue to favor eventual enactment of a well-conceived national health insurance program, ASMT recognizes that the critical problem of controlling the sharp rise in health costs has effectively slowed the drive toward some form of NHI during this session. Moreover, while the current health care system contains acknowledged strengths, an examination of the Medicare program since its enactment clearly demonstrates serious defects which must be eliminated before moving on to a more comprehensive health insurance scheme. It would seem unwise to build upon the current health system until some of the obvious deficiencies within the system can be eliminated. We believe S. 3205 offers a significant opportunity to carefully evaluate certain critical administrative and reimbursement issues related to the Medicare and Medicaid programs and therefore, we commend the initiative of Chairman Talmadge and the bill's various co-sponsors for supporting this important measure.

At this point, ASMT would like to concentrate comments and recommendations on four areas within the legislation of particular interest to the clinical laboratory profession.

II. Establishment of Health Care Financing Administration

Section 2 of S. 3205, as proposed, would establish within the Department of Health, Education, and Welfare, a separate organizational unit to be known as the Health Care Financing Administration. This unit, under the direction of a new Assistant Secretary for Health Care Financing, would include the present functions of the Bureau of Health Insurance (BHI), the Medical Services Administration (MSA), the Bureau of Quality Assurance (BQA), and the Office of Nursing Home Affairs (ONHA). ASMT shares the belief that to effectively reform the existing administrative and reimbursement authority of the Medicare/Medicaid programs, some reorganization within the Department is mandatory. The evidence clearly reveals that the current organization and resultant management of health programs within HEW would not provide a sturdy foundation upon which to build any future structure of national health insurance. Thus, the Society concurs with the Chairman that a major thrust of present program reform must be to rebuild the framework for Medicare/Medicaid responsibility.

Prompted by serious concerns over past efforts at coordinating Federal regulatory activities in the laboratory field, however, ASMT questions the proposal for a separate Health Care Financing Administration (HCFA) to be directed by another Assistant Secretary reportable to the Secretary of HEW. The performance record shows that HEW, which is charged with administering the 1967 Clinical Laboratory Improvement Act and the participation of laboratories under Medicare, has been hampered in regulating the work of clinical laboratories by self-acknowledged jurisdictional disputes between involved agencies. The true source of these problems has been the lack of top management accountability in HEW for coordination of its laboratory-related responsibilities.

As a matter of fact, bureaucratic impasses effectively held up final publication of the Medicare independent laboratory regulations until September 14, 1974, more than two years from the date they were originally proposed. In an effort to rectify the situation, the three agencies responsible for clinical laboratory administration[1] developed and signed an agreement in 1975 intended to delineate and clarify the functions of each agency with respect to the Department's laboratory programs.

But, no sooner than signed, discrepancy erupted between the Public Health Service and the Social Security Administration over divergent interpretations of certain personnel qualifications under the Medicare program. This confusion between these two agencies was finally resolved but not before the Assistant Secretary for Health was drawn into the dispute.

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[1] The Bureau of Health Insurance (BHI) of the Social Security Administration (SSA), the Bureau of Quality Assurance (BQA) of the Health Services Administration (HSA), and the Center for Disease Control (CDC).

The weeks of confusion directly affected a number of laboratory professionals in the field and is but one illustration of the problems involved in separate administration and enforcement of health programs and their financing within HEW. ASMT must question whether the two separate offices—the Public Health Service responsible to the Assistant Secretary for Health and the proposed Health Care Financing Administration (if enacted)—could effectively coordinate the administration and management of the Department's health programs without forcing in many instances final issue resolutions by the Secretary thereby causing unnecessary and unreasonable delays. The Society has not heard sufficient argument that a separate HCFA, as proposed, is the answer to the divergent authorities which have spawned inter-Departmental problems in the past. As a matter of fact, we do not see how the degree of coordination in the Department's health-related activities as they exist in the current organizational framework would be sufficiently enhanced under the proposed reorganization plan called for in the bill.

Nevertheless, ASMT believes that the merger of health care financing and quality assurance is both logical and long overdue. Indeed, the four administrative entities proposed to be consolidated under the new administration are among the most interrelated of the current health program authorities within the Department. Looking to the future, however, the Society views the logical outcome of enacting national health insurance to be the emergence of a separate Department of Health directly accountable to the President of the United States. This nation has been pouring an increasing amount of resources into broadening and bettering its health care services and may be close to reaching the point, perhaps within the next Administration, of recognizing a separate Cabinet-level department responsible for the coordination of our mammoth health industry.

In this regard, AMST feels that the logical progression towards this end is to consolidate the authority for the Department's health care programs and their financing under a single Assistant Secretary for Health. Thus, we would strongly recommend that the Committee consider amending the bill by placing the proposed HCFA under the authority of the Assistant Secretary for Health. In this way, the Assistant Secretary would be the single federal official accountable for the administration and financing of Federal health programs.

III. Office of Central Fraud and Abuse Control

As contained in Section 2. (2)(a) of S. 3205, ASMT strongly endorses the provision establishing an Office of Central Fraud and Abuse Control under the direction of an Inspector General within the Health Care Financing Administrative unit of HEW. In light of recent Medicaid laboratory fraud and abuse disclosures, such an office equipped to deal with fraud and abuse at the various program levels and responsible for initiating and conducting direct investigations within any of the Social Security Administration's health program is essential.

Recognizing the enormous sums of money involved, $38 billion projected for Medicare/Medicaid for FY/77, the Office of Central Fraud and Abuse may provide one method whereby cost savings can be significantly increased through the reduction of flagrant abuses within the Medicare/Medicaid programs. From the standpoint of the clinical laboratory field, ASMT believes that the proposed Office would serve to alleviate acknowledged fraudulent practices within some laboratories and therefore, help contain the costs of laboratory services rendered through Medicare and Medicaid. Towards this end, our Society has vigorously supported anti-fraud provisions which were incorporated in S. 1737, the Clinical Laboratories Improvement Act, passed by the Senate last April. Similar legislation is now pending in the House which also contains specific provisions to eliminate abuses and fraud in clinical laboratories.

According to the recent findings of the Subcommittee on Long Term Care, chaired by Senator Frank Moss (D.-Ut.), rampant fraud and abuse presently exists within some of our nation's clinical laboratories. The hearings conducted by Senator Moss' Subcommittee in February, 1976, culminating a six-month investigation involving 21 medical laboratories and approximately 50 medical clinics, produced conclusive evidence that by conservative estimates, roughly $45 million of the $213 million in annual Medicare/Medicaid business ($1 out of every $5) is either fraudulent or unnecessary in the clinical laboratory field alone.

Among the principal findings contained in the staff's report to the Subcommittee was the disclosure that relatively few laboratories control the bulk of Medicaid business. In Illinois for example, 26 laboratories had 90% of the Medicaid business while in New York, 16 laboratories dominated 70% of the business. As a result, competition for Medicaid accounts is fierce. The staff also learned that kickbacks are so common among certain clinical laboratories that unless a laboratory offers a kickback, it is practically barred from obtaining a Medicaid account.

Moreover, the average kickback by the laboratory was found to be 30 percent of the physicians' total public aid business. These kickbacks took several forms ranging from cash to gifts, supplies, business equipment, and long term credit arrangements. The most common kickback, however, was in the form of supposed rental of a small space within the medical clinic, often far exceeding the rent for the entire building. And, according to the report, these kickbacks are financed any number of ways. For example, certain clinical laboratories have simply been billing Medicaid for tests not authorized by the physician, charging patients rates two and three times as much as a private paying patient would pay.

Another common practice according to Senate investigators has been to bill Medicaid for component parts of tests that should be run and paid for as a panel. Their report indicated that the root of the problem lies within the overgenerous fee schedules which were established in 1967 when Medicaid was initiated and most tests were performed manually. The Senate investigators also charged that with the development of modern technology, costs have been cut dramatically, although the savings are not being passed on to the consumer. Instead, they are being used as inducements for physicians to enter into an arrangement with various laboratories to use their particular service.

With serious concern over abuses as well as other fraudulent practices within the Medicare/Medicaid programs, our Society fully supports the concept of an Inspector General responsible for reviewing, auditing, and inspecting all Federal health care programs with unlimited access to their reports, records, audits, documents, etc., in order to ensure the efficient and honest administration of these programs.

In this regard, while hospital management has increasingly taken a more enlightened approach to the professional responsibilities of their employees, we believe that everyone's interest would be better served if, in carrying out the provisions of the Act or reporting violations therein, practitioners employed in the hospital setting were properly protected from unwarranted job discrimination.

For this reason, ASMT would recommend that the Committee amend the proposed legislation to specifically include an employee protection clause. An employee protection concept was adopted last April by the Senate as an amendment to S. 1737, the Clinical Laboratories Improvement Act. Moreover, the Occupational Safety and Health Act Amendments and the Clean Air and Water Act contain a similar provision.

Specifically, ASMT urges the Committee to amend S. 3205 to include the following language:

(5) (A) "No employer may discharge any employee or otherwise discriminate against any employee with respect to his compensation, terms, conditions, or privileges of employment on the basis that the employee (or any person acting pursuant to a request of the employee) has:

(1) Commenced, causes to be commenced, or is about to commence or cause to be commenced a proceeding under this title or a proceeding for the administration or enforcement of Medicare or Medicaid regulations.

(2) Testified or is about to testify in any such proceeding, or

(3) Assisted or participated or is about to assist or participate in such a proceeding or in any other action to carry out the purposes of this title.

(5) (B) (1) "Any employee who believes that he has been discharged or otherwise discriminated against by any person in violation of paragraph (A) may, within 30 days after such violation occurs, file a complaint (notwithstanding the amount in controversy) in the United States District Court for the district in which the employer or employee resides, alleging such discharge or discrimination. A copy of the complaint shall immediately be served on the employer. The Federal Rules of Civil Procedure shall apply to all action brought under this paragraph."

In summary, it is our belief that inclusion of the employer protection provision within the legislation along with the implementation of the Office of Central Fraud and Abuse under the direction of an Inspector General as pro-

posed could significantly reduce the prospect of fraudulent practice throughout the Medicare/Medicaid Program. In the specific case of the clinical laboratory such implementation could reduce in appropriate laboratory financial arrangements and expenditures, allowing reallocation of resources in such a way as to provide a more reasonable and justifiable cost to the patient as well as to provide for additional quality assurance activities within the laboratory.

IV. Hospital Associated Physicians

Section 22 of S. 3205 would amend the Social Security Act by distinguishing between physicians' services of an educational, executive, or research nature and those personally performed or directed for the benefit of a patient and which are customary and appropriate. Since a special definition would be applicable to pathology services which defines "physician services" to exclude services performed in carrying out responsibilities for supervision, quality control, and for various other aspects of a clinical laboratory's operation customarily performed by nonphysician personnel. ASMT is able to provide the Subcommittee wtih some background information reflecting the scope of duties which are presently performed by nonphysician personnel in the clinical laboratory.

Medical technologists, possessing a broad background in basic and applied clinical sciences perform four major roles within the hospital laboratory setting. Primarily, the medical technologist performs the diagnostic testing procedures essential to the diagnosis of a patient's medical condition. In addition to routine testing across a broad range of laboratory procedures, medical technologists also perform complex testing in a variety of specialized areas such as microbiology, parasitology, serology, hematology, clinical chemistry, urinalysis, and immunohematology. Secondly, technologists fulfill the duties and responsibilities of technical supervisors, in both the generalist and departmental/section areas. Third, the Chief or Administrative Technologist assumes a variety of managerial responsibilities with the hospital laboratory. Finally, the medical technologist also plays a direct role in the educational process of clinical laboratory personnel. At this point it would be useful to more clearly define the supervisory, administrative and educational functions of the medical technologist as an indicator of nonphysician involvement in clinical laboratory operations.

Role of the Medical Technologist in Laboratory Supervision.—In the majority of hospitals, medical technologists have traditionally served as technical supervisors of the total laboratory as well as technical supervisors of designated, specialty departments/section areas. Supervisors usually work under the direction and in cooperation with the administrative technologist or chief technologist.

Supervisors plan, organize and delineate the duties and responsibilities of personnel working under their direction. They assume the responsibility of instigating new procedures and establishing quality control programs. They train personnel, maintain supplies and disseminate information from their department to other members of the laboratory staff. They also maintain procedural directions and ascertain the reliability of test results issued from their departments. Supervisors are also responsible for responding to complaints concerning their departments.

Medical technologists are unquestionably involved in supervising the planning, processing and reporting of laboratory tests. The degree of involvement depends upon the organizational structure of the institution. In the smaller hospitals, the supervisor's duties are all inclusive and even in the largest medical complex the medical technologist maintains supervisory responsibilities of departments within the laboratory. These nonphysician functions are commonly established and accepted by hospital administrations.

Role of the Chief or Administrative Technologist in Laboratory Management.—On December 30, 1975, ASMT issued a Report on a Laboratory Management Survey to document which administrative functions are carried out by the medical technologist holding an administrative level position in the clinical laboratory. The survey was directed and conducted by the Personal and Professional Development Division of ASMT in the fall of 1975. The respondents to the survey totalled 1,292 ASMT members who hold the position of Administrative Technologist or Chief Technologist, with the nationwide distribution of the survey population representing various places of employment, size of institution, geographical regions, and urban and rural settings. A copy of the complete study including statistical analyses has been provided to the Committee for their information.

According to the distribution by place of employment, 61 percent of the respondents were employed in hospitals. Thirteen percent of these were located in 1–99 bed hospitals; 26 percent in 100–299 bed hospitals; and 22 percent in hospitals of 300 or more beds.

Given the expansion of health care services over the past decade, and the associated changes within the medical laboratory, which include increased testing, technological improvements, and changes in roles and functions of certain personnel, the study sought to determine the degree of involvement of medical technologists in the critical areas of management and supervision. The ASMT laboratory management survey clearly indicates that medical technologists are now playing a central role in laboratory management. In fact, according to these data, the administrative medical technologist carries out a majority of the laboratory's administrative functions.

Thirty-three administrative functions common to the medical laboratory were listed on the survey questionnaire. The functions listed ranged from who "interviews prospective employees," to who "evaluates electronic data programs and reports." To aid in reporting the survey results, the functions were separated into three categories of Personnel Management; Clinical Services Management; and General laboratory Management. Table I on Page 25 lists the administrative functions, as categorized.

Five choices of who carries out the functions were available on the questionnaire, consisting of:

(1) Administrative Technologist, Chief Technologist, or Laboratory Manager.

(2) Administrative Technologist *and* Director of Laboratories—joint function.

(3) Director of Laboratories.

(4) Does not apply to my situation.

(5) Other (please specify).

The report summaries functions carried out by four groups in the medical laboratory which may be found in Table II on Page 27.

In sum, the 1,202 medical technologist respondents report that they carry out, on an average, 17.6 or a majority of the 33 listed administrative functions. They report that the Directors of Laboratories on an average, carry out 2.6 of the 33 functions; the medical technologist and director jointly carry out an average of 7.9 functions; and hospital administrators carry out 1.8 functions.

Thus for the 1,292 questionnaires analyzed, Chief and Administrative medical technologists have a significant involvement in a wide range of the administrative functions carried out in the medical laboratory. While the respondents' involvement ranges from an average of 88 percent who "schedule laboratory personnel" to 20 percent who "establish charges for laboratory tests," the responses are remarkably consistent across the major categories of places of employment and the ten geographical regions.

Medical technologists employed in hospitals with less than 300 beds have the highest average direct involvement in the functions of "reviewing and approving new laboratory methodologies"; "selecting the appropriate testing program"; "maintaining laboratory systems"; and "selection of equipment to purchase" for all grouped places of employment. Their average direct involvement for all listed functions in hospitals of 1–99 beds is 61 percent while the average for all places of employment categories is 54 percent.

Role of the Medical Technologist in Medical Technology Education.—While the essentials for Medical Technology Programs prepared by the National Accrediting Agency for Clinical Laboratory Sciences (NAACLS), require sharing of responsibility between the medical director and the medical technologist program director for the organization and administration of the program, the guidelines outline the medical technologist's duties as follows:

"6. Duties of the program director: In consultation with the medical director, education coordinator and senior faculty he should be responsible for overall direction of the program. With the assistance of appropriate committees he should provide leadership in development and implementation of:

(1) program objectives

(2) admission policies

(3) curriculum development

(4) evaluation procedures

(5) promotion of students

(6) recruitment
(7) public relations (including preparation of catalogues and brochures relating to the program).

He should maintain student records and participate in the student services such as counseling and recruitment. He should attend at least one workshop or one course related to education each year."

It can be seen therefore that the medical technologist plays the primary role in the medical technology educational process. Moreover, it should be noted that significant educational activity occurs within the hospital. For example the National Accrediting Agency for Clinical Laboratory Sciences (NAACLS) indicates that as of May 21, 1976, the approved medical technology student capacity stood at 7,736 in over 650 AMA accredited hospital programs. This compares with a student capacity of approximately 1,856 in university-based medical technology programs. The medical technologist, usually entitled an Educational Coordinator in the hospital setting, is in reality if not in title, in most instances, the individual most directly responsible for the education of medical technology personnel within the hospital. As Table III, page 28 demonstrates, the medical technologist is involved in the overwhelming majority of the nineteen roles listed for the medical technology education program. This table is based upon review of the duties and responsibilities of a representative sample of medical technology education coordinators. For certain roles, it will be noted that both the physician and the medical technologist are jointly involved while there are few roles performed exclusively by physician personnel.

As the Committee evaluates current Medicare reimbursement provisions in the hospital setting, the Society believes it is extremely important to carefully examine the actual functions and roles performed by hospital personnel. In this regard, we note that under the provisions of section 22 of S. 3205, personal patient services (physician services requiring direct personal physician involvement) would be allowable on a fee-for-service basis. In accordance with the College of American Pathology's definition of "educational" and "executive" functions performed by the physician, the bill would allow reasonable overall compensation related to the time and effort spent by the physician in the performance of these functions.

Realizing that this is an area of major concern for our physician colleagues, ASMT would like to go on record in stating that we believe that the majority of hospital based physician specialists do not abuse the current reimbursement process. It appears that the very process itself is the crucial issue and we can therefore appreciate the Committee's determination to carefully evaluate this important area. Since functions vary depending on the size of the institution it is difficult to assign exact percentages regarding degrees of responsibility for the many functions performed by both physician and nonphysician personnel in the clinical laboratory.

Regardless of the reimbursement system however, ASMT supports the concept of fairly compensating personnel based upon their personal professional effort and amount of time spent in the performance of specified functions. In this time of escalating health care costs, we do not believe the interests of the American public are best served by any other approach.

V. Termination of Health Insurance Benefits Advisory Council (Sec. 8(a))

Initially conceived by its advocates as an important and influential source of private sector advice and input to the Medicare program, the Health Insurance Benefits Advisory Council (HIBAC) was established under Title XVIII of Public Law 89-97 in July 1965. The chief responsibility of this advisory group has been to advise the Secretary of HEW on matters of general policy in the administration and development of regulations under this Title.

The Council, which is composed of various leaders in the health field and the general public has provided professional input on over 100 policy issues under Title XVIII. These issues have ranged from extended care facilities, home health agencies, independent laboratories, the principles of reimbursement for provider costs and for physician services, as well as policies governing physicians' certification and recertification of the need for medical services.

Our Society firmly believes that while HIBAC has been criticized as being largely ineffective, especially in recent years, the fault does not rest with the concept itself but rather with the inappropriate utilization of the advisory body by HEW. Although neither HIBAC nor most other health advisory groups ac-

tually make final program decisions themselves, such mechanisms should ideally provide valuable input to both the Secretary and the Congress on what actions they believe need to be taken based upon their members' recommendations; members who bring to each group specialized backgrounds and expertise in various areas of the health field including consumer input.

Recognizing that the regulations to implement this Act will be far-reaching and will directly affect the delivery of health services under Medicare/Medicaid programs as well as those professionals who provide these services, ASMT is concerned that abolishing HIBAC without establishing an alternative advisory mechanism would obviate formal and direct private sector input with regard to drafting revised regulations for Titles XVIII and XIX of the Social Security Act. The Society believes that an appropriate advisory council could and should play a useful and important role as a provider of necessary professional and consumer advice and information to the HEW administrative unit responsible for drafting regulations and implementing standards promulgated under the Medicare program.

TABLE I.—CLINICAL LABORATORY ADMINISTRATIVE FUNCTIONS

Personnel management functions	Clinical services management functions	General laboratory management functions
Schedules laboratory personnel	Selects and authorizes expendable supplies.	Prepares statistical reports for laboratory.
Counseling of personnel	Authorizes reagent purchases	Prepares or selects laboratory report forms.
Provides in-service orientation	Maintains a laboratory safety program.	Administers the laboratory budget.
Interviews prospective employees	Selection of equipment for purchases.	Prepares the laboratory budget.
Conducts regular personnel meetings	Maintains preventive maintenance program.	Determines laboratory space allocation.
Determines merit or salary increases	Authorizes equipment purchases	Establishes charges for laboratory testing.
Determines personnel policies in accordance with employer policies.	Selects appropriate proficiency testing program for use.	Represents laboratory in inter- and/or intra-departmental operations.
Determines base salary level for employees when they are hired.	Reviews and approves new methodologies (techniques and/or tests).	Maintains laboratory cost accounting and cost analysis program.
Conducts performance evaluation sessions with employees.		Evaluates electronic data programs and reports.
Determines academic and experience qualifications for each position.		
Selects qualified prospective employees		
Authority to fire employees		
Determines employees' promotions		
Determines academic and experience qualifications for each position.		

TABLE II.—SUMMARY OF THE FUNCTIONS CARRIED OUT BY 4 GROUPS IN THE MEDICAL LABORATORY

[In percent]

	Personnel management	Clinical services management	General laboratory management
Medical technologists (respondent)	57	55	47
Director of laboratories	7	9	8
Joint function of technologist and director	23	26	24
Does not apply	4	2	10
Hospital administrator	5	4	7

TABLE III.—ROLES IN MEDICAL TECHNOLOGY EDUCATION PROGRAM

	Medical technologist only	Physicians only	Medical technologist/physicians
1. Development/review of curriculum	X		X
2. Development of criteria for student selection	X		X
3. Selection of students according to criteria	X		X
4. Development of program philosophy, goals and policies	X		X
5. Provision for medical relevance			X

TABLE III.—ROLES IN MEDICAL TECHNOLOGY EDUCATION PROGRAM—Continued

	Medical technologist only	Physicians only	Medical technologist/ physicians
6. Provides general orientation to multiple facets of the profession such as: medical ethics; legal liabilities; relationship to patient and health professionals, etc.	X	----------	X
7. Development of educational objectives and determination of acceptable levels of competence for all areas.	X	----------	
8. Development and implementation of all necessary schedules and rotation for attainment of educational objectives.	X	----------	
9. Schedules and supervises lectures, lecture content and practicum activities necessary for attainment of educational objectives.	X	----------	
10. Development, review and evaluation of oral, written and practical examinations for use in determining student performance.	X	----------	X
11. Evaluation of student's progress toward attainment of educational objectives.	X	----------	
12. Counsel students in various areas: career choice, performance, attitude, etc.	X	----------	X
13. Teaching (lectures and/or practical): (a) students; (b) peers; (c) faculty; (d) physicians, interns and residents.	X	----------	X
14. Development of cooperative activities between affiliated academic and clinical facilities, including service on designated committees.	X	----------	X
15. Answering written and oral inquiries related to the educational program.	X	----------	
16. Maintaining continuing competence in educational principles and practices and/or in specific technical area(s).	X	----------	X
17. Preparation of budget(s) for educational program	X	----------	X
18. Employment of personnel to be involved in educational program	X	X	X
19. Procurement of external funds for educational programs (writing of grants for Federal, State and private support).	X	X	X

Note: When medical technologist only and medical technologist/physician both are checked, this reflects the variety of approaches which are in practice within existing educational programs. This is due to the variance of educational programs and their administrative structure.

Senator TALMADGE. The next witness is Dennis Dorsey, President, College of American Pathologists.

We are delighted to have you here and your associates. We appreciate your contribution. You may insert your full statement in the record and summarize it in any manner that you see fit.

Senator CURTIS. Mr. Chairman, I would like to have the record show that appearing on this panel is Dr. Jerald Schenken of Omaha. I commend him to this committee as one of our fine, upstanding, civic-minded citizens of Nebraska and a very dedicated physician.

Senator TALMADGE. You come recommended, Doctor. We are very glad to have you, sir.

STATEMENT OF DENNIS B. DORSEY, M.D., PRESIDENT, COLLEGE OF AMERICAN PATHOLOGISTS, ACCOMPANIED BY JERALD R. SCHENKEN, M.D., OF OMAHA, NEBR.; AND VERNIE STEMBRIDGE, M.D., OF DALLAS, TEX.

Dr. DORSEY. Mr. Chairman and members of the subcommittee, I am Dennis B. Dorsey, president of the College of American Pathologists. With me are Jerald R. Schenken, M.D., of Omaha, Nebr.; and Vernie Stembridge, M.D., of Dallas, Tex.

We are grateful for the opportunity to represent the college and its views on S. 3205. We have filed a long statement which we request become part of the record.

S. 3205 is a long and complex bill. Two sections of it—sections 22 and 40—are of particular concern to pathologists.

We share the committee's concern on the subject of containing the costs of medicare and medicaid, and agree that both programs must be

made to function more efficiently and economically. The question is, how best to go about it?

One thing is clear: costs should not be contained in any fashion that would compromise the quality of medical care or disrupt the free exercise of medical judgment.

The College of American Pathologists is convinced that S. 3205, if adopted in its present form, would have those effects.

The pathologist is first and foremost a physician. He functions as one in much the same way as do his "clinical" colleagues.

All physicians may function as physician-managers, physician-administrators, or physician-educators whether they are "hospital associated" or not. All may and most do.

To say that the pathologist is not functioning as a physician when he is practicing medicine in the roles of educator, executive, or researcher and should not therefore be reimbursed as a physician for those services, seems arbitrary and discriminatory.

The effect of section 22 would be to restructure the practice of pathology completely.

To assume that the clinical pathologists operate simply as laboratory overseers is unjustified. The clinical pathologist reviewing tests performed in his laboratory is practicing medicine, just as an internist is practicing medicine when he entrusts a nurse to take a blood pressure.

Compensation arrangements between pathologists and institutions vary widely, depending upon local setting. Each is custom made to meet the varying needs of the pathologist, the institution, and the patient population.

The key factor in any of these arrangements is that they are agreeable to each of the parties involved. And whatever the reimbursement method, their job descriptions and responsibilities are mutually agreed upon by the pathologist, the medical staff, and the hospital administration; and then the entire professional and contractual arrangement is reviewed and approved by the hospital board of trustees.

No single form of contractual arrangement can fit every situation. The CAP believes that any type of contract is acceptable providing it does not interfere with, or impair, the free and complete exercise of medical skill and judgment; or does not tend to deteriorate the quality of medical care.

None of which alters the fact that the rate charged for a particular unit of hospital service, including a pathology service; can vary widely from institution to institution.

Rates for specific laboratory procedures must be evaluated as part of the study of the per diem charge, per illness charge, and patient mix.

In past years, many hospitals have been unable to obtain public and governmental support for establishing the daily service charges at a sufficiently high level to cover the routine costs of operation. These routine, or "room and board" costs, were therefore regularly subsidized by the earnings of such diagnostic departments as the pathology laboratories.

At this point, we should like to bring an extremely important finding to the committee's attention. On the basis of recent analyses made in several States, it appears that neither the size of the institution nor

the pathologists' compensation arrangement has any discernible influence upon the individual fees charged for approximately 20 of the most common laboratory procedures.

This is important because it has been stated or implied in recent years that certain types of contractual relationships between pathologists and institutions are not appropriately cost sensitive and—so the argument runs—in and of themselves cause higher total fees for the clinical pathology services charged to patients.

Recently, therefore, the Nebraska Association of Pathologists undertook a survey of the pathologists in that State. Those surveyed were asked to indicate the size of the hospital covered, the type of contractual relationship existing between the pathologist and the institution, and the fees charged for 25 commonly performed clinical pathology services selected to represent the overwhelming majority of total tests performed within the hospitals of Nebraska.

The survey covered more than 80 percent of the approximately 5,000 acute care hospital beds in the State. These hospitals were ranked from high to low on their total dollar charge for the 25 tests.

Study of these data revealed no relationship between the type of contract and the charge to the patient. The hospital with the highest and the hospital with the lowest combined charges to the patient in the State each had a type of modified percentage contract with their pathologists. The pathologists at the hospital that had the second highest charge to the patient in Nebraska were on salary.

An institution having approximately the mean charge to the patient of all institutions in the State operated under a lease arrangement. So did two of the three lowest.

Similar surveys were performed in Texas, Georgia, New York, Tennessee, and Ohio. They similarly failed to disclose any relationship between contract form and pathologist's charge.

This is why we feel, Mr. Chairman, that the provision in section 22, compensating pathologists for educational or executive services on the basis of a monthly fee reasonably related to what a full-time salaried pathologist would receive for proportionate time and effort, would have little or no effect on the cost of pathology services.

In effect, what would occur would be a process whereby costs were shifted from one account to another. Cut the profitability of the clinical pathology laboratory and the hospital would be faced with the necessity to compensate for the loss of revenues in one fashion or another if it were to subsidize losses in other departments.

A word about the impact of section 22 on the small and rural hospitals.

A great disparity exists between the demand for pathology services by small and rural hospitals, and the supply of pathologists who will serve them. Prior to World War II, pathology, and especially clinical pathology, was virtually unavailable to those hospitals.

These days, pathologists are frequently the only medical specialists to visit rural communities on a regular basis, and their services are invaluable to attending physicians because of their broad specialist training.

Our rural areas are still critically short of doctors, as this committee knows. With supportive help from such hospital-based physicians

as clinical pathologists, some of our primary care doctors are still willing to practice in rural areas. If that support is not available, many more of them will not do so.

The adverse impact of section 22 would be considerable on the teaching hospitals as well. The operation of the university hospital clinical pathology laboratory is additionally complex by reason of its educational thrust. The incomes generated in the laboratories have wide use within and without pathology departments. Any reduction would probably lead to increased drains on already overtaxed State budgets.

Section 22 would have a similar adverse effect on medical schools.

The effect on recruitment of future pathologists would also be damaging—this after years of recruiting emphasis have gradually brought about a reasonable balance between the demand for and the supply of pathologists.

As for section 40, prior approval of the Secretary of HEW of any contract in excess of $10,000 a year made between an institution and consultant, or management and certain contractors, would make the Department of HEW responsible for the establishment of what would have to be the largest purchasing department in the world.

This section would put HEW into virtually any compensation arrangement based upon the percentage. But many valuable management and service contractors traditionally provide services under a percentage arrangement.

In summary, we do not believe this section can be administered effectively, nor do we think it will achieve its desired objective.

A brief word about fraud.

The college shares the concern voiced by Congress about the recent reports of fraudulent conduct in which certain of the health providers have been engaged.

We believe that the transgressors should be punished to the full extent of the law and urge that section 1877(B) of the Social Security Act be vigorously enforced.

Further, we pledge the cooperation and assistance of the College of American Pathologists in any and every way possible.

The CAP would like to make five recommendations to the committee:

One, implement presently existing provisions in the medicare and medicaid laws and regulations relating to fraud.

Two, encourage the use of mechanisms presently available through county medical societies and State boards of medical examiners for dealing with improper or fraudulent activities.

Three, provide for review of pathologists' services and fees in the same fashion as the fees and services of other physicians are reviewed. Appropriate peer review, medical audit, and other utilization review can be made as effective and as appropriate for pathologists as for other physicians.

Four, implement presently existing provisions for disclosure billing.

Five, recognize the differences in the cost of providing clinical pathology laboratory services to ambulatory nonemergency outpatients as opposed to hospitalized inpatients by revising the present rules and regulations to facilitate the implementation of appropriate fee schedules.

Mr. Chairman, this concludes our summary statement.

Senator TALMADGE. Thank you.

Senator Nunn is scheduled to testify and he has arrived, and he must chair a subcommittee hearing at 9:30. Would it be all right if we take Senator Nunn now for his testimony and call you subsequently?

Dr. DORSEY. Yes, sir.

Senator TALMADGE. My distinguished colleague from Georgia has arrived. He has been acting chairman of the Subcommittee on Investigations of the Government Operations Committee looking into this field. I think his contribution will be very helpful.

We will be delighted to have you, Senator Nunn.

STATEMENT OF HON. SAM NUNN, A U.S. SENATOR FROM THE STATE OF GEORGIA

Senator NUNN. Thank you, Mr. Chairman, Senator Dole, Senator Curtis. I want to thank you for inviting me to testify before your subcommittee on what I consider to be one of the most important efforts to reform the medicare and medicaid programs presented thus far to the Congress.

I am a cosponsor of S. 3205 because I believe that we cannot allow these multibillion dollar programs to continue without challenging the waste of taxpayer money and the abuse of patients that has been the result of lax management, fraud and abuse.

Moreover, I am a cosponsor because I believe we must prove to ourselves that we can manage effectively the health care financing programs we already have before we consider seriously any form of national health insurance.

Extensive investigations and hearings into abuses of prepaid health plans were carried on by the Senate Permanent Subcommittee on Investigations in 1974 and 1975 under the direction of Chairman Henry M. Jackson and with the full support of the subcommittee's ranking minority member, Senator Charles H. Percy. The valuable information uncovered as a result of the efforts of Senators Jackson and Percy has been shared with your subcommittee.

As acting chairman of the Investigations Subcommittee, I am presently conducting a preliminary inquiry into welfare industry entrepreneurs and corporations that provide services to Government health programs. We have been looking at management, consulting, and computer service companies, and we expect to begin hearings this fall. I want to express my gratitude to you and the staff of the Senate Finance Health Subcommittee for your cooperation with me and my subcommittee investigators. We have been working closely together, and I am confident that because of this relationship, even further reforms will result.

As I mentioned earlier, in the fall of 1974, Senator Henry M. Jackson, chairman of the Permanent Subcommittee on Investigations, authorized the staff to conduct a preliminary inquiry into the prepaid health plans (PHP's) receiving medicaid funds in California.

Not only was the subcommittee concerned with allegations of fraud and patient abuse, but also, a study of the program afforded us the opportunity to obtain a prospective view of what we might encounter

under a national health insurance program that involves health maintenance organizations (HMO's).

To understand the issue, some background is in order. In 1971, many States began to feel a severe financial strain caused by the unending escalation of medicaid program costs during a period of economic recession. California, in response to this situation, turned to prepaid health plans, which offered the prospect of controlling program costs and providing quality health care at the same time.

Under the fee-for-service reimbursement system there is an incentive to treat patients. The more treatment, the greater the income. Under the HMO and PHP system, administered in good conscience, persons who need treatment get it, but the incentive is to keep patients healthy so they will not need more expensive care. The HMO or PHP receives a fixed monthly amount for each patient enrolled in the plan. This forms an income ceiling under which the plan administrators agree through contract to provide for the health care needs of the people they serve.

In short, the plan is at financial risk. If the cost of providing health care services to enrollees is more than the amount they have agreed under contract to receive, they must still provide the services. Therefore, the incentive is to practice preventive medicine, to keep enrollees in good health, and avoid high cost services.

The California prepaid health plan program won the attention of State officials elsewhere, not only because it offered the hope of reducing costs, but also because it was a step toward maintaining quality in medicaid programs. Moreover, the fee-for-service system had in some cases raised questions about patient treatment, stemming from overutilization of services for patients not actually in need of these services.

The examples cited in advocacy of the PHP program were the Kaiser Foundation Health Plan, the Group Health Association of Washington, D.C., and the Group Health Cooperative of Puget Sound.

California was not the only government interested in HMO's. Congress authorized in 1973 an expenditure of more than $325 million to test health maintenance organizations nationwide. Congress thought at the time that if HMO's could be gradually developed across the country, they would be viable entities by the time a national health insurance program was passed. These HMO's could be easily phased into such a program.

However, it is because of what we found in the California PHP program—and the problems there contained—that I have come to the conclusion that there should be a very slow approach to continued funding of HMO's and PHP's. Although I believe we should encourage the development of health maintenance organizations, we must do so only after we recognize the extraordinary potential for fraud and abuse inherent in this system. Moreover, I believe that there should be no national health insurance program until we have satisfied ourselves that we can control medical profiteering and patient abuse that takes place within government health care programs.

I believe a review of conditions in the California PHP's tells us a great deal about the medical marketplace from which government purchases health care services for program beneficiaries. Though the program in California accounts for only $103 million of the State's

$2.2 billion medicaid budget, though only 224,000 of the State's 2 million medicaid beneficiaries are enrolled in the 28 plans, a look at the PHP program provides an invaluable microcosmic perspective of the health care services industry.

The medical marketplace in Los Angeles is a most competitive industry, mainly because 10,000 of the areas 35,000 hospital beds are judged to be unnecessary by the State health department that licenses them. Moreover, studies of health manpower distribution show that there are more physicians in southern California than are necessary to care for the people there. So with this oversupply of physicians and facilities comes pressure to provide services that generate them.

With more than $20 billion in overall State health care expenditures from public and private sources, there is an obvious reward for the winners in the competition.

The subcommittee investigation of treatment under prepaid health plans found patients who required immediate medical attention left waiting in observation rooms, frequently unattended; a doctor who closed his clinic at night and on weekends and could not be found in many instances for emergency treatment for patients enrolled in his plan; the frequent dispensing of narcotics in lieu of treatment; the use of unqualified doctors, and many other abuses.

Subcommittee investigation showed organized crime figures involved in the enrollment of people in the prepaid plans at high fees. For example, one of the largest PHP's at that time immediately sought, without success, to enroll union local members. So the plan entered into a contract with a consulting company comprised of organized crime figures who promised to deliver union members in exchange for a sizable advance and 10 percent of the union billings.

Subcommittee investigators were also told by welfare recipients that people signed forms that actually enrolled them in a PHP when they thought they were signing impeachment petitions against Gov. Ronald Reagan. People were given free tickets to the Los Angeles Rams football games in exchange for their signatures. They were given free chicken dinners and stereo headsets. One blind lady signed her name to a form after she was told she would have the Bible read to her every week.

These and other instances are contained in the subcommittee hearing record which I would like to submit as an exhibit to my statement.

In short, cutting corners meant increased profits for these prepaid health plans and the people who controlled them.

Indeed, in April 1974, the California auditor general reported he had surveyed 15 prepaid health plans with a view toward determining how much of the medicaid funds they received actually was sent on health care for the poor. He concluded that 48 percent of the aggregate funds received from the State by these plans was spent on health care services. He found that 52 percent was spent on administrative costs or were registered as profits.

But these findings might not tell the whole story. Funds paid to physicians were attributed to direct health care service costs. The subcommittee took testimony that some physicians on salary to plans spent only a small amount of their time with medicaid patients. The lion's share of their time was spent in lucrative suburban practices.

One physician, for example, was paid $70,000 a year by a plan, even though he spent no more than 3 hours a day treating plan enrollees. The balance of his days were spent in the suburbs.

Much of the information obtained by the subcommittee investigators during this investigation was known to the State health department. Indeed, personnel within the department were the sources of a great deal of the data.

State health department staff told investigators that PHP contract managers were transferred to other contracts just as they began to understand the issues in their initial assignment. In short, top level health department officials forced contract managers to play musical chairs, and they were constantly unfamiliar with the plans to which they were assigned.

The health department investigators turned up cases of fraud and program abuse but their reports were ignored in 1972, 1973 and 1974.

There was such a lack of response to the complaints of medicaid beneficiaries over how they were treated in the plans that a group of beneficiaries created the Los Angeles Health Rights Organization. The sole purpose of this group was to assist individuals in disenrolling from plans that refused to release patients once they had been ensnared into enrolling through schemes.

Earlier this month, the California Assembly Health Subcommittee on Investigations held hearings on allegations surrounding the mismanagement of an investigation and audit of a prepaid health plan. In January, the California State Commission on Government Organization and Economy reported that the health department is in a state of disarray. The attorney general of California is conducting an investigation into allegations of criminal improprieties in the prepaid health plan program. The United States Attorney in Los Angeles is likewise looking into related allegations as is the Securities and Exchange Commission.

Mr. Chairman, I catalog the abuses and management problems uncovered in past hearings not to provide a laundry list as to subcommittee accomplishments but to inform you that we are uncovering the same kinds of abuses in our current investigation. Many of these abuses are much more serious. This, in turn, tells me that there are some fundamental questions which must be addressed before there is massive funding of these kinds of programs. Among these are:

One, what kind of audit and monitoring system can be instituted to insure that maximum funds are being used for benefit of patients?

Two, what should the Federal-State relationship be in the many programs involving the delivery of health care services?

Three, are there appropriate criminal penalties for the kinds of abuses we find in these programs?

Four, what kind of system can be set up to assure quality care for the patient?

Five, how can we keep down the costs of processing medical claims which are an important factor in rising medical costs?

Six, what limitations can be placed on management and consulting firm fees which, in many cases, are excessive and again siphon off funds needed to provide quality medical care?

Seven, are prepaid health plans and health maintenance organizations the vehicle upon which to base future programs for delivering health care services?

Mr. Chairman, you and the other members have addressed many of these issues and in a way that will bring about dramatic improvements.

Mr. Chairman, there are a few good prepaid health plans measured by the weak tools that that we have. There are plans with minimal numbers of patient complaints and disenrollment requests from beneficiaries. There are plans which do not divert medicaid funds away from health care. They are run by men and women deeply committed to making the program work.

If somehow, we could legislate the only men and women of good conscience should be involved in receiving and spending government health and welfare funds, then we would have no need for systems to spot the culprits. But we cannot.

We can, however, marshal our resources—both State and Federal—to ferret out corruption and put those who would abuse the public trust on notice of the stiff penalties they face. That is exactly what your bill would do.

We can try to examine our experience in prepaid health plans to see where we can improve upon the concept. In this regard, following our hearings, the California Department of Health sought and received from the Department of Health, Education and Welfare a $5.2 million grant to develop a "Model State Quality Assessment and Cost Control System for Prepaid Health Plans." This grant is intended to develop over a 3-year period computer systems and other tools to spot problems in HMO's. It is our hope that it will.

Mr. Chairman, I have directed the staff of the Permanent Subcommittee on Investigations to share with your staff materials such as contracts, reports, and other documents that may be helpful in writing the final version of S. 3205. I believe we have a good solid record of exactly the kind of abuses we all intend to stop. And I would like to return to you and your subcommittee in the coming months to report to you findings from our current inquiries.

Senator TALMADGE. Thank you very much, Senator Nunn, for your very helpful testimony. Your subcommittee has made available photocopies of the investigation reports that you have developed and have been helpful to us in preparing this bill. I know you will be helpful in the future, and I urge that you continue this effort for the committee.

Senator Curtis?

Senator CURTIS. Senator, we are very grateful to you. This study which you have conducted, and about which you testified this morning, related primarily to HMO's and other prepaid health plans.

Senator NUNN. That is right. We do not pretend that we are going into all the features of the health insurance and medicaid programs. We tried to zero in on those particular programs.

Senator CURTIS. It does not relate to recent testimony we have been hearing about pathologists' arrangements.

Senator NUNN. No, sir.

Senator CURTIS. Did these abuses that you found, particularly in California, did they arise after the Federal Government legislated and appropriated in the field of HMO's?

Senator NUNN. They did, and we find they are still occurring. This is not all dated information. Some of it goes back a year or so.

The disturbing thing is that we are now investigating, in depth, some of the management and computer services involving HMO's, not only in California, but in other places. If anything, the abuses we are encountering now are worse than those that I documented this morning.

Senator CURTIS. They are abuses that came in play after the Federal legislation in that field?

Senator NUNN. That is correct, but I might add that I would think that reasonable people would probably conclude that if we found this much after the Federal Government became involved, there was probably a good deal of abuse prior to Federal participation.

Senator CURTIS. Some of the most successful ones are operating without Federal legislation or Federal help, is that correct?

Senator NUNN. I think that is correct. I have not made a detailed study of that. I would say that we in the Federal Government have created massive incentives for fraud and abuse.

Senator CURTIS. The thing that makes me skeptical about well-intended remedies is that the HMO idea, the Federal Government getting in, taking tax dollars to promote this, it was actually presented by some of the enthusiasts as a cure-all for all the problems that we faced. I do not think that my middle name is Thomas. I did not believe their claims, and I did not vote for them, but I am very disturbed about what was set in motion and what we have to do about it now.

Thank you very much for your contribution.

Senator NUNN. I would like to add one further comment, Senator Curtis. Of course, one of the prime concerns is waste of taxpayers' money. Another important concern, however, is the quality or lack of quality of services the poor people are getting under some of these plans. The incentive, in many cases, is not to give good service.

That is just as disturbing to me as the waste of money. Both of them are tremendous problems for taxpayers in our society.

Senator TALMADGE. Senator Dole?

Senator DOLE. I can appreciate your testimony very much since about a year ago we had an outside labor controlled group come in from the State of Georgia and start up an HMO in one of our most affluent areas of Kansas City. They capitalized on nearly a million dollars of Federal funds. Instead of setting up to help improve health delivery to the low-income, however, they said they were going to take a "rifle shot" approach to enrollment—targeting families with incomes up to $25,000.

Anyway, they took this $850,000 in Federal money and put together an administrative budget of over $500,000. All they were going to have out of that was two physicians at $40,000 each. Of course, they had to have a medical director who got $55,000 a year, but the overall administrative-doctor ratio was almost disgraceful.

I do not think this is the type of thing we intended when we passed this law in 1973, and I communicated my concern to HEW. Predictably, their response was defensive and not very enlightening.

We could not find out how the decision was made to fund this project and, of course, could not get it reviewed either. Since it has been

our experience—and certainly, we have had a great deal of it—that 50 percent of these HMO's fail after Federal funds are withdrawn, it would seem to me maybe the grant award process itself would be appropriate for investigation by your committee.

Senator NUNN. I might say, Senator Dole, I do not know about that particular problem, but we have been very disappointed in HEW's enforcement at the regional level in the areas that we have investigated, very disappointed.

Senator DOLE. We were disappointed, too. As a matter of fact. There were a number of physicians disappointed in me because I could not do anything with HEW. Of course, they have never been here to know what it is like to deal with them.

Perhaps the HMO concept does a great deal for some physicians and is not all bad in theory. In application, however, if it is going to stay around we are going to have to do something, as you suggest, to get a handle on it, and provide some incentive.

Now, with reference to your formal statement, on page 6 you indicate that in California you turned up a lot of cases of fraud and abuse in 1972, 1973, and 1974. Did you go into 1975 and 1976?

Senator NUNN. We are investigating such cases in a very detailed way right now. In fact, the principal investigator is spending most of his time in California now. He is there this morning. I did not go into current cases, because I like to have data documented in hearings and not based on our staff's impression.

I could go into this in considerable detail in private. I know your staff is fully informed. We do have much more updated information. We are going to be documenting it in hearings.

I feel we should make sure we are on solid ground before we put it on the public record.

Senator DOLE. Have your investigators had any problems in their efforts to get at the facts? For example, have they received any threats—been offered any bribes—anything of that kind?

Senator NUNN. I would not want to go into detail at this stage, but there have been problems. There is a potential for massive kinds of corruption, not just in California. We happen to be there because it is a big program and there is big money involved. I do not want to leave the impression that only California has this kind of problem.

Senator DOLE. I was just asking generally because that is where most of your investigation has been.

Senator NUNN. We have had considerable cooperation from many of the officials. There are many dedicated people in health in California doing their best to correct these abuses in other areas. However, we have had many problems.

Senator CURTIS. How much Federal money has gone to the HMO's since this bill has passed?

Senator NUNN. I cannot tell you altogether. I had in my testimony, I believe, that there was $325 million in one year. I do not know what fiscal year that was.

HMO's are not really where the bulk of the money is going now. However, I think it tells us the real story and runs up a red flag as to where we may be going in the future with the National Health Insurance program. That is one of the reasons why we think this investiga-

tion is so relevant. At least it alerts us to dangers and lets us go into any new program with our eyes wide open.

Senator TALMADGE. This information was submitted to HEW and you failed to get adequate response?

Senator NUNN. That is my impression. I was not acting chairman at that time, but that is my impression.

Senator TALMADGE. Thank you very much, Senator Nunn.

Senator DOLE. May I insert in the record this HMO budget I was talking about?

Senator TALMADGE. Without objection, it will be inserted in full at this point.

[The budget referred to follows:]

COMMUNITY GROUP HEALTH PLAN OF KANSAS CITY

Detailed budget for this period (direct costs only)	Annual salary rate	No. Mos. budget	Percent time	Total amount required	Source of funds	
					Applicant and other	Requested from PHS
	(1)	(2)	(3)	(4)	(5)	(6)
1. PERSONAL SERVICES						
Administration:						
Executive director, Robert F. Rasmussen	$35,000	12	100	$35,000	$1,757	$33,243
Marketing director, Michael B. Wood	25,000	12	100	25,000	1,285	23,745
Finance director [1]	20,000	12	100	20,000	1,004	18,996
Enrollment manager [1]	18,000	9	100	13,500	678	12,822
Enrollment representative [1]	15,000	3	100	3,750	188	3,562
Administrative assistant, Sandra L. White	12,000	12	100	12,000	602	11,398
Bookkeeper [1]	10,000	3	50	1,250	63	1,187
Secretary [1]	7,200	12	100	7,200	361	6,839
Do [1]	7,200	12	100	7,200	361	6,839
Secretary, enrollment	7,000	3	100	1,750	88	1,662
Health care:						
Medical director, Michael R. Soper, M.D	55,000	12	100	55,000	2,761	52,239
Primary care physician	40,000	2	100	6,667	335	6,332
Do	40,000	2	100	7,667	335	6,332
Clinic manager	20,000	3	100	5,000	251	4,749
Registered nurse	10,000	1	100	833	42	791
Do	10,000	1	100	833	42	791
Licensed practical nurse	8,000	1	100	667	33	634
Nurses aide	6,000	1	100	500	25	475
Do	6,000	1	100	500	25	475
Do	6,000	1	100	500	25	475
Lab and/or X-ray technician	9,000	1	100	750	38	712
Do	9,000	1	100	750	38	712
Do	9,000	1	100	750	38	712
Do	9,000	1	100	750	38	712
Secretary	7,200	1	100	600	30	570
Do	7,200	1	100	600	30	570
Appointment/telephone clerk	6,000	1	100	500	35	475
Do	6,000	1	100	500	25	475
Clerk	6,000	1	100	500	25	475
Do	6,000	1	100	500	25	475
Fringe benefits (rate 22 percent)—Physicians				15,033	756	14,277
Fringe benefits (rate 18 percent)—nonphysicians				25,503	1,280	24,223
Category total				250,553	12,579	237,974

[1] To be recruited.

COMMUNITY GROUP HEALTH PLAN

Detailed budget for this period	Total amount required	Source of funds: Applicant and other	Source of funds: Requested from PHS
	4	5	6
5. OTHER			
Consultants:			
Medical care organization	$15,000	$2,500	$12,500
Mental health program	1,500	1,500	
Dental hygiene program	2,500	2,500	
Prescription drug program	2,500	2,500	
Home health care program	2,500	2,500	
Accounting and audit	10,000	10,000	
Actuary	2,500	2,500	
Legal services	25,000	2,500	22,500
Architects (for remodeling and renovation of space)	25,000	5,000	20,000
Systems planning	1,850	500	1,350
Advertising	26,710	8,600	18,110
Producting of advertising material	20,850	1,622	19,228
Advertising time/space and production	18,800	944	17,856
Printing, forms, et cetera	12,000	2,977	9,023
Moving and leasehold improvements	1,500	75	1,425
Insurance	10,660	535	10,131
Equipment rental	3,600	181	3,419
Travel	10,500	527	9,973
Office supplies	3,600	181	3,419
Initial supplies for health center	10,450	525	9,925
Recruitment	10,000	502	9,498
Telephone	5,500	276	5,224
Postage	3,600	181	3,419
Data processing	1,000	50	950
Organizational dues	1,500	75	1,425
Temporary office space	5,000	251	4,749
Health center space	31,250	1,569	29,681
Category total	264,876	51,071	213,805

Senator TALMADGE. Dr. Dorsey, would you and your organization come back to the table, please?

Senator NUNN. May I add one thing?

In answer to Senator Dole's question I do not want to leave the impression that there have been direct bribe offers. My answer was more general than that.

We have had interference with our investigation from some quarters, political and otherwise. We have had cooperation in others. I do not know of any particular bribe offer.

Senator TALMADGE. Thank you.

Dr. Dorsey and your associates, we want to thank you for cooperating with the committee.

STATEMENT OF DENNIS DORSEY, M.D.—Resumed

Senator TALMADGE. At the outset, let me say that it is not really the hospital which pays the pathologist, but the public as taxpayers, insurance policy holders and paying patients.

A different perspective from that which you have given today comes from a distinguished pathologist who wrote me the following letter which describes some of the problems with respect to reimbursement of pathologists better than I could myself, and I quote from his letter:

DEAR SENATOR TALMADGE: It is with considerable interest that I read your statements appearing in the Congressional Record dated June 20, 1975, dealing with Medicare-Medicaid administrative and reimbursement reforms. Specifically,

I was interested in the testimony dealing with the reimbursement to certain hospital based physicians such as pathologists, radiologists and anesthesiologists. Since I am a pathologist, these statements were of particular interest to me, and I am sure to the many thousands of other specialists in these categories.

I must certainly admit that these statements are not unfounded. Most senior pathologists do work under some percentage type arrangements with their hospitals, and much of what they contribute to the professional endeavors in no way bear relationship to the financial remuneration. As you look at the work being performed, most pathologists virtually give away their professional expertise in the autopsy and surgical pathology area for the lucrative arrangements coming from the general clinical pathology area which includes Clinical Chemistry, Microbiology, blood banking activities, and hemotology.

In recent months I have traveled to a number of laboratories seeking a new professional location and have been privy to certain financial statements of pathologists and pathologist groups in these new locales. I was somewhat astounded by the size of the financial remunerations of many of these specialists in private practice. It was not uncommon to see annual incomes in the range of over $100,000 per year and in some instances, over $200,000 per year. This, of course, was possible through percentage arrangement contracts in those labs, grossing into the millions of dollars. Particularly obnoxious to me were those senior pathologists who recruited more junior associates placing them on salary, and then using their professional endeavors to further their own income. This latter activity has been negatively commented on by our own professional organization, the College of American Pathologists.

As you are, I am sure, aware, the possibility of astronomical incomes come about with the advent of automation in the clinical laboratories. I really feel that many pathologists, instead of passing along the benefits of automation to patient care were guilty of furthering their own financial gains through this development. Eventually, costs of laboratory tests to patients will have to be more realistically priced, particularly those tests which are readily amenable to automation, which should in effect, markedly reduce the cost of that particular test. Unfortunately, automation has not appeared to any degree in clinical microbiology and blood banking activities, and hence costs in these areas will have to remain relatively high in comparison of the costs in certain areas of clinical chemistry and hematology where automation has appeared to an advanced degree.

I can say that I am basically in agreement with your statement appearing in the Congressional Record demanding that a person's professional activities in some way bear relationship to the specific work he is doing. Many pathologists are on a salary basis, and in many instances this salary is in keeping with their professional training and their professional activities.

Unfortunately, abuse by a few has created problems for many of us in this specialty. Incidentally, many of these high paid pathologists may actually be receiving salaries through certain corporate activities, and this in no way bears a true relationship to their actual income. If these financial arrangements are to be specifically corrected, this is one area that will have to be looked at very carefully.

As you can imagine, some of the statements contained in this letter may be quite unpopular with some of my professional peers. Thus, I would appreciate it if this remains privileged. It is my hope that, as time moves along, members of the profession themselves will recognize certain of these abuses and pressure from internal sources will be brought to bear to correct certain inequities before external pressures become necessary. American medical leaders must themselves do something about markedly escalating costs of medical care before we price ourselves right out of the market.

Would you care to comment on that letter?

Dr. DORSEY. I would say that in any profession, there are differences in methods of reimbursement, amounts of reimbursement. You would need to know much more about the specific local arrangements to pass any kind of judgment on a particular instance.

Senator TALMADGE. Obviously, my concern is not based on one pathologist's letter alone, or on similar communications from other concerned pathologists. There is a clear pattern in data that has come to

the subcommittee's attention over recent years. Several years ago, 1972 in fact, the Washington Post disclosed that a Washington, D.C., physician made $200,000 as a part-time pathologist at the Washington Hospital Center under a percentage contract arrangement. This same physician also had a similar contract with another Washington hospital which refused to disclose the amount of compensation.

The pathologist at Union Hospital in nearby Elkton, Md., negotiated a $433,000 contract in 1975 for the provision of pathology and nuclear medical services. The hospital board was subsequently able to reduce this amount to $293,000. According to the Baltimore Sun, the hospital's attorney contended that the contract was set because, "when your are dealing with a monopoly, you don't have much choice."

These are not isolated instances. St. Mary's Hospital in Cumberland, Md., was paying two pathologists $300,000 per year until the Maryland Rate Review Commission reduced this amount to $180,000.

In rural Nebraska, a circuit-rider pathologist serving six small hospitals was compensated $70,000 from two of the six hospitals. This amount was verified from 1974 accounting information disclosed to us on a confidential basis. If the pattern is the same in all six hospitals that the pathologist served, his compensation would be over $200,000.

Then, there is a 33-bed rural hospital in California where the pathologist was allegedly compensated $198,000, after paying the hospital a mere $750 a month for the use of its facilities.

I am not just singling out pathologists. A similar situation can be found in the compensation of radiologists under percentage arrangement. For example, a 424-bed hospital in Pennsylvania, where the chief radiologist was compensated $200,000; South Amboy Memorial, a 95-bed hospital in New Jersey, compensated its radiologist $201,000 in 1975; Morristown Memorial Hospital, in New Jersey, a 495-bed facility, compensated 4.7 radiologists $571,000 for an average of $121,500 each.

Let use look at some New York payments to pathologists and radiologists in 1975, based on contracts calling for percentage of billings:

Auburn Memorial Hospital, 261 beds, one pathologist, $323,505;
Brunswick Hospital, 255 beds, one pathologist, $327,841;
Chenango Hospital, 159 beds, one pathologist, $159,948;
Faxton Hospital, 139 beds, one radiologist, $139,552;
Good Samaritan, West Islip, 325 beds, one pathologist, $283,540;
Lockport Memorial, 176 beds, one pathologist, $169,152;
Millard Fillmore Hospital, 711 beds, six radiologists, $812,859, or an average of $135,476 each;
Niagara Falls, 448 beds, three radiologists, $452,154, or an average of $150,718 each;
Parkway Hospital, 238 beds, three radiologists, $571,323, or an average of $190,441 each;
St. Francis, Poughkeepsie, 236 beds, one pathologist, $148,120;
St. Joseph's, Syracuse, 352 beds, four radiologists, $606,246, or an average of $151,561 each;
Wyoming Hospital, 176 beds, one pathologist, $169,847.

I could go on, since over 75 examples have been compiled by staff. However, without objection, I would like to have all of these examples entered into the record.

[The study referred to follows:]

ANNUAL AVERAGE PAYMENTS IN EXCESS OF $75,000 TO RADIOLOGISTS AND PATHOLOGISTS

[Based on percentage of billing New York State, 1975]

Name of hospital	Number of beds	Medical doctor [1]	Number in group	Total payment	Average payment to medical doctor
	1	2	3	4	5
Arnold Gregory	50	R	1	$86,427.00	$86,427.00
Arnot Ogden Memorial	270	P	5	509,277.00	101,855.00
Auburn Memorial	261	P	1	323,505.00	323,505.00
Aurelia Fox	130	P	2	150,741.00	75,370.50
Benedictine	252	R	2	235,746.00	117,873.00
Bertrand Chaffee	69	R	1	83,633.00	83,633.00
Brunswick Hospital	255	P	1	327,841.00	327,841.00
Chenango	159	P	1	159,948.00	159,948.00
Champlain, Clinton	376	R	5	379,542.00	75,908,40
Community Hospital, Schoharie	70	R	1	93,480.23	93,480.23
Community General, Glen Cove	261	R	2	190,000.00	95,000.00
Corning Hospital	164	R	2	207,691.00	103,845.50
Cornwall Hospital	120	P	1	81,766.00	81,766.00
Cortland Memorial	169	R	2	177,062.00	88,531.00
Deaconess	428	R	4	437,138.00	109,284.50
DeGraff Memorial	191	P	2	234,618.00	117,309.00
Do	191	R	2	155,871.00	77,935.50
Eastern Long Island	66	R	1	95,146.61	95,146.61
Faxton	139	R	1	139,552.00	139,552.00
General Hospital, Saranac Lake	93	P	1	81,760.00	81,760.00
Do	93	R	1	97,377.00	97,377.00
Good Samaritan, West Islip	325	P	1	283,540.00	283,540.00
Do	325	R	4	366,099.00	91,524.25
Highland Hospital	107	R	1	106,639.00	106,639.00
John T. Mather Memorial	179	R	3	252,312.00	84,104.00
Kenmore Mercy	266	P	3	286,578.00	95,526.00
Do	266	R	3	321,346.00	107,115.00
Kingston Hospital	213	R	2	176,800.00	88,400.00
Lockport Memorial	176	P	1	169,152.00	169,152.00
Lutheran Medical	255	R	1	102,401.38	102,401.38
Memorial Hospital, Jones	102	P	1	85,895.00	85,895.00
Do	102	R	1	100,000.00	100,000.00
Mercy Hospital, Buffalo	383	R	5	492,121.00	98,424.20
Mid-Island Hospital	229	R	3	243,493.71	81,134.57
Millard Fillmore	711	R	6	812,859.00	135,476.50
Newark, Wayne Community	190	R	1	116,565.00	116,565.00
Niagara Falls Medical	448	P	3	238,478.00	79,492.66
Do	448	R	3	454,154.00	150,718.00
Nicholas Noyes Memorial formerly Danville	85	R	1	118,054.00	118,054.00
Nyack Hospital	323	P	2	179,920.00	89,960.00
Our Lady of Lourdes	294	R	5	405,403.00	81,080.60
Our Lady of Victory	280	R	4	350,218.00	87,554.50
Parkway Hospital	238	R	3	571,323.00	190,441.00
Ramapo General	137	R	1	106,525.00	106,525.00
Rochester General	538	R	8	652,330.00	81,541.25
Do	538	RT	2	155,327.00	77,663.50
St. Elizabeth	306	P	2	247,200.00	123,600.00
Do	306	R	2	192,791.00	96,395.50
St. Francis, Buffalo	80	R	1	75,141.00	75,141.00
St. Francis, Port Jervis	108	R	2	172,463.00	86,231.50
St. Francis, Poughkeepsie	236	P	1	148,120.00	148,120.00
Do	236	R	3	301,059.00	100,353.00
St. Joseph's, Elmira	278	R	2	218,890.00	109,445.00
St. Joseph's, Syracuse	352	R	4	606,245.00	151,561.00
St. Luke's, Newburgh	254	P	2	177,331.07	88,665.53
St. Mary's, Rochester	298	R	5	439,694.00	87,938.80
Seneca Falls Hospital	52	R	1	92,092.00	92,092.00
Sisters of Charity	453	R	7	562,329.00	80,332.71
Tioga	73	R	1	103,207.00	103,207.00
Tri-County Memorial	61	R	1	86,166.00	86,166.00
Vassar Brothers	751	R	5	577,435.00	115,487.00
Wyoming	176	P	1	169,847.00	169,847.00
Do	176	R	2	196,430.00	98,215.00
Yonkers Professional	165	R	1	96,825.00	96,825.00

[1] P equals pathologist; R equals radiologist; RT equals radiology-therapeutic.

Source: New York State Health Planning Commission.

AVERAGE COMPENSATION TO RADIOLOGISTS AND PATHOLOGISTS IN SELECTED NEW JERSEY HOSPITALS, 1975

Hospital	Beds	Medical doctor[1]	Total compensation hours	Total compensation	Compensation per FTE[2]
	1	2	3	4	5
North Hudson	147	P	2,088	$111,000	$110,575
Burdette Tomlin	165	P	520	47,000	188,000
Do		R	4,316	302,000	145,542
Valley	321	P	8,320	404,000	101,000
Millville	119	P	1,040	105,000	210,000
Do		R	5,200	292,000	116,800
Riverside	160	P	2,300	115,000	104,000
St. Peter's Medical Center	333	P	8,320	529,000	132,250
Newcomb	235	P	1,950	208,000	221,867
Garden State	204	P	2,080	121,000	121,000
Princeton Medical Center	395	R	9,040	470,000	108,142
Irvington General	149	R	2,080	159,000	159,000
Barnert Memorial	257	R	855	194,000	455,995
Mercer Medical Center	321	R	4,160	308,000	154,000
Zurbrugg Memorial	108	R	4,160	260,000	130,000
Rancocas Valley	292	R	6,853	410,000	124,442
Dover	360	R	6,905	363,000	109,347
St. Mary's (Orange)	228	R	2,080	117,000	117,000
St. Barnabas Medical Center	750	R	11,374	621,000	113,564
Paul Kimball	237	R	3,744	204,000	113,333
J. F. Kennedy Medical Center	367	R	6,180	496,000	166,939
R. W. Johnson Rehabilitation	48	R	60	5,000	173,333
Kessler Institute	48	R	208	11,000	110,000
Carrier Clinic	255	R	690	49,000	147,710

[1] P equals Pathologist, R equals Radiologist.
[2] This calculation based on 2,080 hrs equaling a full time equivalent (FTE).

Source: Based on information provided by the hospitals to the New Jersey Department of Health.

Senator TALMADGE. Senator Curtis?

Senator CURTIS. I do not argue with the chairman. I need some information about the Nebraska case you cited.

The circuit-rider pathologist, the $70,000 referred to, is that gross, or is that net? The reason I ask the question, many of those individuals fly their planes——

Senator TALMADGE. Net, sir.

Senator CURTIS. It is net?

I would like to ask you, Dr. Schenken, how would section 22 of this proposed bill affect the services in the rural hospitals?

Dr. SCHENKEN. Rural hospitals vary in size and for the pathologists onsite services and so a general statement really cannot be made.

However, if the pathologist is unable to bill for many of the services he provides in his main laboratory, he has to bill them at a level that covers every individual and immediate expense he provides. Neither the hospital nor the pathologist will be able to have him there as many times as he is. This will have, in the very small hospitals, this will have an adverse effect on the amount of time that this pathologist would be in the region available to consult with the clinicians where mostly in many of those hospitals he is the only consultant-type that gets into town.

If the hospital is large enough to have a pathologist who is there 2 days a week, 4 days a week, even fulltime, then it will affect him in the way that it affects all other pathologists.

Senator CURTIS. I live in a very small town. I spent a half a day at the hospital, and a great deal of the time was learning about the use of the telephone, the pick-up of specimens by air work. It is a service extended to the rural areas that they have never had before. I am sure it is very advantageous.

Dr. SCHENKEN. We hope so.

Senator CURTIS. Under the proposal before us, arrangements with pathologists will be subject to approval by the Secretary of HEW, would it not?

Dr. DORSEY. That is my understanding.

Senator CURTIS. I have heard from witnesses here and comments by members of the committee how disappointed we are in the performance of HEW and the responsibilities charged to them. This will be an additional burden that would be placed on HEW.

Dr. DORSEY. Yes.

Senator CURTIS. Is it your opinion that local hospital administrators, hospital trustees, and other local involved individuals can meet the problem or can contribute to it materially where abuses exist?

Dr. DORSEY. I think that this is the place where these problems can and should be solved, because this is the place where the quantity and quality of service being provided and the fees being charged to patients and the cost to the patient can best be evaluated.

Senator CURTIS. I would like to ask another question, Mr. Chairman.

On page 46 of the statement, "studies suggest to us that there appears to be no significant relationship between the fees charged to the patient for clinical pathologists' service and the type of contracting relationship that exists between the pathologist and the hospital."

Dr. Schenken, a survey was made in Nebraska on that was it not?

Dr. SCHENKEN. Yes, sir.

Senator CURTIS. In substance, did it bear this out, that the type of arrangement just was not the controlling thing?

Dr. SCHENKEN. Yes; I must grant to you, Senator, that the survey had certain limitations. I would be glad to describe them in detail to you in writing. Basically, the mechanism was described in our testimony, and since we did not have access to actual patient bills, length of stay, all of the other extremely important things when we did this, we just made the assumptions listed in the testimony in regard to the fees charged to the patients and then, assuming that these assumptions might generally reflect the fees charged to the patients in those institutions, we then compared it with the type of arrangement that the pathologist list.

In addition, the size of the sample was small, because, as you know, Nebraska is a relatively small State, population-wise. However, the same general trend was found. We believe it is true and we have been unable to find evidence or have others show us that the charge to the patient is related to the type of contract.

Senator CURTIS. I am very impressed by that. What gives me pause about this proposal is two things. One, I am not at all sure that prohibiting a certain type of arrangement is going to contribute to solving the problem and I am very sure that transferring authority to a huge bureau like HEW which has disappointed people in so many other things, instead of facing the problem at the hospital level with the trustees and so on, is that going to result in a fiasco, like we voted in HMO's.

I want to ask you one more question. How, in your opinion, would this legislation affect the pathology department at our medical schools?

Dr. SCHENKEN. Again, as with all other departments of pathology, there is considerable variation in the makeup, mission, and responsi-

bilities, but it is our general opinion that the effect there will be very similar to the effect in a large community hospital.

I am a professor of pathology at the University of Nebraska. Perhaps Dr. Stembridge, chairman of the department at Southwestern University in Dallas, Tex., would like to respond to your question, if there is time.

Dr. STEMBRIDGE. Senator Curtis, I would agree with what Dr. Schenken said. It will have a rather adverse effect on medical schools, departments of pathology, in the same manner that it has adverse effects on other teaching hospitals and other hospitals around the country.

We feel it is important that the professional individuals in our medical schools be treated in a similar and like fashion as other professionals, such as the physician in a private hospital, and we feel that the adverse effect would be rather significant.

Senator CURTIS. Mr. Chairman, I thank you very much for the extra time.

Senator TALMADGE. Senator Dole?

Senator DOLE. Dr. Dorsey, yesterday I asked a question of the radiologists and they assured me that the pathologists would speak for themselves on why you have a different view of section 22 dealing with hospital-based physicians than they have.

Dr. DORSEY. The way in which radiologists practice differs considerably from the way in which pathologists practice. The pathologist has a much more complex relationship or a series of relationships with the patients and with the medical decisions in relation to patients and to the various types of activities in which he engages.

The great variety of activities and medical responsibilities of the pathologist does not lend itself to simple formulas to the extent that this seems to be applicable for radiology.

I cannot speak for the radiologists' perception.

Senator DOLE. With reference to the figures cited by Senator Talmadge, I believe there is another sheet on New York hospitals where annual payments ranged from some $300,000 a year to a low of $70,000 per year.

This may not be fraud, but it would certainly appear to be indefensible—or at least questionable. How do we get a lid on a handle on unreasonable charges, whether by a pathologist or anyone else?

It seems to me that it is hard to justify these payments in some instances. If the Nebraska case is true, where somebody can net $70,000 in two of six hospitals—I do not care how many airplanes he has or whatever—it is difficult to understand how we can ever expect to contain hospital and medical costs unless the CAP and others are willing to help out.

Dr. DORSEY. In looking at these, certainly some of them would seem to be examples of excessive income. However, we cannot, without extensive knowledge about the specifics in each case, reach any value judgment in regard to that.

We have said that we favor the review of pathologists' services and fees in the same way that other physicians' and pathologists' fees are reviewed. We feel that the mechanisms for insuring that reimbursement is appropriate to services are available at the local level, in the

hands of responsible hospital administrators and boards of trustees that are generally composed of local civic leaders and businessmen.

Senator DOLE. What does a hospital do in a rural area when it does not have any choice because there is only one opportunity to have a pathologist. What if he says, it will cost you so much a year—take it or leave it?

How can an administrator or board of trustees exercise any judgment in these situations, whether in Nebraska or Kansas or any other rural State?

Dr. DORSEY. I am not involved in the provision of services to small and rural hospitals and have no personal knowledge of that field. Perhaps Dr. Schenken will comment.

Dr. SCHENKEN. Senator, I think it is clear that under any system there is the possibility for abuse, and the system itself does not necessarily create the abuse.

We have said that all contractual arrangements have the potential to be held on a high-class honest basis, and we feel that is true in the majority of cases. We also feel that in all systems there is a potential for abuse.

Senator Nunn's testimony is a good case. In answer to your question about rural hospitals, it is possible that that situation existed at one time, at least the potential for that situation existed, where a person could come in and say you have to have my services. That would not be unique in pathology; it would not be unique in medicine.

On the other hand, we feel, with our extensive involvement in training pathology manpower—I refer you to our manpower study that is appended to the report—that that is either a relatively small aspect of it at the present time, or an insignificant one.

We certainly would agree with the testimony 2 days ago that Mr. McMahon said, that most contractual relationships between hospitals and pathologists are held in good faith.

Again, I can only speak in Nebraska, and that is that there are four or five groups of pathologists including my own who have the capacity to serve almost any community in the State, even though the State is almost 400 miles long, and so, at least in Nebraska, it would seem to me that it would be unlikely that an administrator could not go out and seek alternate services.

If it means anything to you, three of ours, for what I hope are other reasons, have chosen to do so in the last 10 years.

Senator DOLE. I understand that anybody can throw out some horrible examples of individual, perhaps even isolated, abuses and these may be just that. It would appear that pathologists on the average are highly paid, however, and maybe deservedly so, but since there is some Federal money involved, it is our responsibility to determine when we reach a point that must, by any standard, be considered unreasonable.

When we start trying to make that judgment, then we are subject to criticism by physicians for attempting to control the practice of medicine. All we are striving to do, however, is control the Federal budget.

I do not think we have to permit somebody to take advantage of a Government program just because we do not want to be attacked for

interfering with the practice of medicine. I certainly agree that pathologists perform a vital service in the health care system whether it is quality control, or autopsy, or whatever. But how can we get a handle on this from a legislative standpoint?

Dr. SCHENKEN. We certainly agree that it is your, and hopefully our, responsibility to look after funds and look after reasonability. We do have a unique responsibility on our part to see within these responsibilities quality of services are maintained.

What we are saying is that the changes reflected specifically in section 22 we do not feel are the appropriate mechanism to go after these changes because of reasons presented in our testimony. We basically feel that redress and approaches are available in other areas that we have outlined, and we do not think that it is basically the system, you know, that causes the abuse. I think that is our point.

When you get to individual numbers, I really would hesitate to pick a number and say, that particular number is a priori, an indication of abuse of a particular dollar value.

Having said that, it sounds on the surface of things that there are problems. We admit that there are problems in our testimony. We have addressed ourselves and addressed our willingness to work with the committee, but the definition of reasonability has been, unfornately, Senator, as difficult for us as it has been for the committee.

We are willing to go as far as we can, but it is tough.

Senator DOLE. Thank you, Mr. Chairman.

Senator TALMADGE. At this point, I would like to clear up a misconception.

Apparently, Dr. Dorsey's colloquy and the colloquy between Senator Curtis and Dr. Schenken—great stress has been put on the surveys showing that there is no difference in charges for laboratory services between hospitals when pathologists are salaried and those where they are on a percentage basis. This seems to clearly imply that doing away with percentage arrangements would not result in any reduction of costs or in charges for medicare and medicaid.

However, that assumption is not correct. Any increased income to a hospital as a result of reductions in payments to the pathologist through more reasonable contracts becomes an offset against the hospital's reimbursable costs. That is, medicare and medicaid and Blue Cross calculate their payments to hospitals only after net income from departments such as laboratory is applied.

So if a hospital got more net income from its laboratory, there would be a reduction in the total cost to the hospital on which medicare, medicaid and Blue Cross is paid.

Do you gentlemen agree with that?

Dr. SCHENKEN. Senator, in general terms, I would agree with that. If you arbitrarily reduce any expenditure at any point, you are going to get a reduced expenditure. What we are saying is that the mechanism for controlling expenditures presented in section 22 does not reflect what the services that we provide——

Senator TALMADGE. You are getting to another question now. Is that not the system that has been existent for years?

Dr. SCHENKEN. Some systems.

Senator TALMADGE. All systems, medicare, medicaid, Blue Cross?

Dr. SCHENKEN. Medicare and medicaid, yes; Blue Cross, I am not sure.

Senator TALMADGE. Dr. Dorsey, in regard to the material that I read prior to my time expiring about these very high figures that some radiologist and pathologist received, I would like to make it clear that these income figures as high as they are, often understate the physician's income from his profession since they represent only the reported income from one hospital.

Many of these physicians receive incomes from tests performed on hospital patients that they do not report to the hospital, and many have incomes from other hospitals, independent laboratories, and other sources that do not show up in these figures.

In addition, averaging the total income equally among the physicians in the hospital department grossly understates the income of some of those physicians since the chief and other senior physicians are remunerated at a much higher rate of pay than the junior members of the group.

Now the data do show that there are a lot of highly-paid hospital-associated physicians on a percentage basis, particularly in New York. You may argue about what a reasonable level of compensation is, but do you believe, Dr. Dorsey, that there is such a thing as an excessive level of compensation? Is it $500,000 a year or $300,000 a year or $100,000 a year, or what? I would appreciate having your view of the matter.

Dr. DORSEY. Certainly there are levels at which the remuneration is inappropriate to the services provided. I do not think it is possible to arrive at a dollar figure that would be fair and applicable in all situations.

Senator TALMADGE. Senator Curtis?

Senator CURTIS. I have no further questions at this time.

I have since learned in reference to the circuit-riding pathologist in Nebraska and the $70,000 that that was not based upon a survey by this committee but based on one letter received from a hospital administrator.

I do not know what the letter disclosed, how he ascertained this, whether it was gross or net. I just thought that the record should show that.

Senator TALMADGE. I understand. Staff says they have the cost reports of two of the six hospitals which substantiate the $70,000 figure. We will make them available to Senator Curtis.

Senator Dole?

Senator DOLE. It has been stated several times this week that overutilization is three times the problem of fraud and abuse. Do you share that observation, Dr. Dorsey?

Dr. DORSEY. That would be my impression, yes.

Senator DOLE. In recent press accounts, there have been all kinds of stories from Chicago and elsewhere about medicaid lab fraud and kickbacks being found. Also, last February—after a six-month investigation of this—a Senate subcommittee concluded that $1 out of every $5 that the taxpayers spend on laboratory services on medicare and medicaid patients is wasted.

Do you think that is a fair and accurate observation or conclusion?

Dr. DORSEY. I do not have the background basis for making that judgment.

Senator DOLE. I assume by "waste," they mean in part, overutilization.

In connection with all these press reports on fraud in clinical laboratories, do you know of any involvement of your members?

Dr. DORSEY. No, I have no information about involvement by our members.

Senator DOLE. Do you have any policing effort, or regulatory effort, in your association to spot fraud, abuse, overutilization, overcharges, or runaway limits on how much a person can receive?

Dr. DORSEY. No, we do not. We do have, we are concerned about the appropriateness of utilization of laboratory procedures, and we have a committee in the college, a committee to develop guidelines for appropriate utilization of laboratory procedures that has been working very hard to try to address the question of how much laboratory testing is enough to answer clinical problems.

This committee is making progress, but it is still far from its goal, but I think that eventually that it can provide the basis for improving the effectiveness and economy of laboratory testing by eliminating excessive testing.

The pathologist does not order tests. The pathologist responds to the order of the clinician. That information developed by this committee will help the pathologist in his consultations to decrease the amount of laboratory studies in many cases.

Senator DOLE. How many pathologists are there, and how many belong to the college?

Dr. DORSEY. There are roughly 10,000 pathologists who practice as such in the country. Our membership is approximately 6,800.

Senator DOLE. There are not very many pathologists, then, are there?

Dr. DORSEY. No, there are not.

Senator DOLE. Maybe that is why there is the potential for some of them to commend unconscionable amounts of money when they are not as professionally discreet as they should be.

Dr. DORSEY. One of the things we are attempting to do is to recruit and train more pathologists.

Senator DOLE. I would hate to see what the headlines would be if Members of Congress ever made that much money. I just wonder if some of those individuals who are exploiting the system are the same ones who have written us about the costs of Government.

Senator TALMADGE. Dr. Dorsey, the College of American Pathologists has published guidelines for pathologists to follow in carrying out their contractual relationship with the hospitals. On page 4 of the 1974 edition of this publication, you state that a pathologist should not even begin negotiations with the hospital unless the former pathologist or a responsible physician on the medical staff states that there is a vacancy. Thus the hospital cannot even begin the negotiations process unless the former pathologist or another physician from the hospital takes this action.

According to another guideline, the pathologist should not proceed with negotiations until he is familiar with local conditions and contractual patterns.

It seems to me, Dr. Dorsey, that these guidelines mean that the hospital is not bargaining with a single pathologist, but he is taking on the entire physician community.

Would you care to comment on these requirements?

Dr. DORSEY. Senator, I would point out that these are not requirements. This is a guideline of professional courtesy, and as much a protection, primarily a protection for the pathologist who may be applying for the position, who may not be aware of some adverse situations locally.

Senator TALMADGE. Now, to follow up our earlier discussions you had with me and our staff in our office concerning payments to pathologists, you stated, "we are very much concerned about the problems that S. 3205 addresses and we plan to make appropriate suggestions in due course."

When do you plan to submit these constructive suggestions about the problems that you are very much concerned with.

Dr. DORSEY. Senator, we still plan to do that as soon as we can identify solutions to the problems that we feel will be effective and which we feel will not seriously jeopardize the provisions and services to patients. We still have a task force very actively working on this problem. It is very complex. The legislation is complex.

Senator TALMADGE. I hope you will continue to do so. It is no pleasure that I have to bring up embarrassing figures to any medical speciality or any profession. The doctors in Georgia have always supported me and many are personal friends.

I do not like the idea of having to negotiate with members of the profession about something like this.

I must tell you, in all candor, the anaesthesiologists and the radiologists, similarly situated to you, have been very forthright and candid and very helpful and have made constructive suggestions.

Thus far, the College of American Pathologists have not. Individual pathologists have, like the letter I read. There are more letters in the files. Also, I have talked to pathologists in Georgia.

I would hope that you and others that represent your specialty, which I greatly admire—it is the basis of science, and that is the basis of medicine—make efforts to bring these astronomical costs under control.

As I pointed out time after time, Medicare and Medicaid costs last year were $31 billion, and will cost over $38 billion in this year. The budget committee on which Senator Dole sits has mandated a $700 million reduction, despite the fact that these costs have been escalating at a rate of about 20 percent a year, so we have to get a handle on it.

I want expert advice from people on the firing line, the physicians, the doctors, lawyers, nurses, everybody else. I am no expert in this field. I am a country lawyer, primarily.

But when I see something going wrong, I know that it has to be corrected, and I hope that you would give us your aid and assistance in correcting it.

One final question. Is it not true, Dr. Dorsey, that for the last 10 years there have been enormous increases in the number of clinical laboratory tests, accompanied by higher and higher levels of automation and increased use of nonphysician laboratory personnel? Given contractual arrangements that tie the pathologists to compensation

to a percentage of gross or net laboratory income, would not such arrangements tend to produce high levels of income, income that is overwhelmingly generated through the efforts of medical technologists, technicians and their sophisticated machines?

Dr. DORSEY. This is a situation that can and should be monitored at the local level and should be adjusted appropriately.

Senator TALMADGE. Let me repeat: I urge and hope that your organization, which I admire very greatly, will work with members of this subcommittee and the staff in trying to get some reasonable handles on the problems we discussed today. Are there any further questions?

Senator Dole?

Senator DOLE. Dr. Dorsey, is there a personal medical service involved in each laboratory test provided by a pathologist?

Dr. DORSEY. Yes.

Senator DOLE. We had testimony this morning, as you know, from the medical technologists. It is understandable that it would be designed to help their own cause, but they do appear to do a great deal of the work for not much pay. They are not employees of the pathologists, are they?

Dr. DORSEY. Generally, no.

Senator DOLE. What about when they do work directly for a pathologist? Are salaries in independent laboratories higher than those paid in hospitals, or are they about the same? What is the comparison?

Dr. DORSEY. We have no information on that.

Senator DOLE. The medical technologists do perform a valuable service, do they not?

Dr. DORSEY. Yes, very much so.

Senator DOLE. Do they make some of the judgments, or is that reserved for the pathologist?

Dr. DORSEY. They work within guidelines and criteria developed by the pathologist, as do many other nurses and other paramedical professions, but the pathologist has the ultimate medical and legal responsibility for the results of the testing.

Senator DOLE. Do pathologists have problems with malpractice suits?

Dr. DORSEY. Yes, they do.

Senator DOLE. In what area?

Dr. DORSEY. In all areas of the laboratory in connection with a diagnosis of surgical specimens and biopsies; in connection with blood transfusion services; with the results of clinical laboratory tests performed on patients and the relation of those tests to the diagnosis and treatment of disease. There is malpractice exposure in all areas of the clinical laboratory.

Senator DOLE. How do malpractice premiums for pathologists compare with those of other specialties?

Dr. DORSEY. Malpractice premiums generally are in the same category with family practitioners who do not do surgery, and they are usually in the lowest category of malpractice.

Senator DOLE. There have been suits filed and judgments obtained though?

Dr. DORSEY. Oh, yes.

Senator DOLE. Sizable judgments?

Dr. DORSEY. Yes.

Senator DOLE. Thank you, Mr. Chairman.

Senator TALMADGE. I think you are correct in your concern over the prior approval of contracts over $10,000. It was not intended, however, that this particular provision apply to contracts between hospitals and hospital associated physicians. An appropriate clarification will be made on this $10,000 figure.

Also, Dr. Dorsey I hope that you can assure this committee that there will be no retribution against any medical technologist or technician who testified before the committee, or who will testify in the future.

Dr. DORSEY. Certainly not.

Senator TALMADGE. Thank you very much.

Dr. SCHENKEN. Senator, may we file later for the record any further observations which we may think are helpful?

Senator TALMADGE. Any further comments or suggestions you may have, we would appreciate it for the record.

One final appeal: Please come in with some helpful, cooperative suggestions so we can get this dilemma resolved. Thank you very much.

[The prepared statement of Dr. Dorsey follows. Oral testimony continues on page 329.]

STATEMENT OF THE COLLEGE OF AMERICAN PATHOLOGISTS

Mr. Chairman and Members of the Committee:

I am Dennis B. Dorsey, M.D., President of the College of American Pathologists, and with me are Jerald R. Schenken, M.D. of Omaha, Nebraska, and Vernie Stembridge, M.D., of Dallas, Texas.

We are most grateful for the opportunity to be here today and to represent the College of American Pathologists and its views on S. 3205, the Medicare-Medicaid Administrative and Reimbursement Reform Act.

Ours is a non-profit, voluntary, specialty organization of physicians with headquarters in Skokie, Illinois. The College of American Pathologists (CAP) was founded in 1947. Our more than 6,800 physician-members practice the medical specialty of pathology. All CAP Fellows are certified by the American Board of Pathology.

Our members practice in hospitals, in independent medical laboratories, in medical schools, in military institutions, and in various facilities of the federal, state and local governments. In addition, our members work in medical laboratory research institutions and in industries producing medical devices and in-vitro diagnostic products.

As you are aware, Senator Talmadge, your bill is a long and complex one. Two sections of it—Sections 22 and 40—are of particular concern to pathologists. We should like to discuss them at considerable length because they are pertinent to the way pathologists practice medicine. We will, however, comment briefly on other sections of S. 3205.

Let us begin by saying that we heartily endorse the bill's objective of containing the costs of Medicare and Medicaid.

Medicare and Medicaid are expensive programs, their costs continue to rise, administrative reforms are very much in order, and there is no question that both programs must be made to function more efficiently and economically.

The question is, how best to go about it.

One thing is clear:

Costs should *not* be contained in any fashion that would compromise the quality of medical care or disrupt the free exercise of medical judgment.

Yet we are convinced that S. 3205, if adopted in its present form, would bring about both of these results.

We are convinced that the effect of this proposal on the practice of pathology would be—there is no other word for it—devastating.

Our concern is therefore with the bill's methods—not its goals.

Non-physicians may not be familiar with what a pathologist does. A brief review may therefore prove helpful.

Pathology is the medical science that deals with the causes, development, and effects of disease. It is the scientific foundation for medical practice and one of medicine's great specialties.

As the basic science most closely related to clinical medicine, and the clinical discipline closest to basic science, pathology is often called the bridge between basic sciences and clinical medicine. It links the basic sciences of anatomy, bio-chemistry, genetics, microbiology, physiology and pharmacology with such clinical disciplines as internal medicine, surgery, obstetrics and gynecology, and pediatrics.

As a pathologist, the physician functions in three major areas:

1. *Patient Care*, by providing laboratory data and clinical pathological consultation essential for the assessment, diagnosis, treatment and management of disease.

2. *Teaching* of new generations of medical students, future pathologists, other physicians, nursing and other allied health personnel.

3. *Research* to expand man's basic knowledge about the nature of illness and the possibilities of applying this knowledge to prevention and cure.

Viewed from the vantage of patient care, these functions are most often inseparable.

For example, the pathologist may be called upon to diagnose Hodgkins Disease, a malignant disease of the lymph nodes. The diagnosis is essential to patient care.

The pathologist then explains to the patient's physician the implication of this diagnosis and many of the newer concepts of classification, etc., educating his colleague at the same time. After all, the pathologist reviews diagnostic material from all patients in his hospital while the individual clinician is limited to those patients in his own practice.

Finally, the pathologist, while providing hematologic support, repeat biopsy evaluation, and when death occurs, the autopsy, provides the foundation on which clinical research in anti-cancer drug therapy is based.

All of these functions are inseparable within the pathologist's patient care function as a physician.

As the physician whose specialty is the identification of disease, the pathologist stands at the center of scientific medicine as it is practiced today.

Other physicians depend upon his knowledge and the laboratory services which he provides for confirmation of their working diagnoses, which is why the pathologist is often termed "the doctor's doctor."

This is not to say that pathologists, like any other physicians, cannot and should never be compensated on a salaried or other reasonable basis for teaching or research not immediately related to the care of patients. This might occur in a medical or dental school, large teaching or research institution. Such arrangements presently are implemented in most areas of the country by contractual arrangements agreeable to the parties concerned.

What we are saying is that the pathologist's daily functions in patient care include research and education and are usually inseparable in clinical practice. Attempts to subsegment them arbitrarily for compensation purposes would be counterproductive, cumbersome, and unfair to patients. They would not meet the stated objectives.

Because pathology is a large and complex field, its practice is classified as follows:

Anatomic pathology, which deals with the gross and microscopic structural changes caused in tissues by disease; and

Clinical pathology, which is concerned with the changes produced by diseases as reflected in blood, urine, other body fluids, and tissue.

The interrelationships between these areas are endless.

Physicians who specialize in pathology are knowledgeable in *both* areas and most are Board certified for the practice of both anatomic pathology and clinical pathology. Some are also certified in one or more of the subspecialties of forensic pathology, hematology, neuropathology, medical microbiology, chemical pathology, blood banking, radioisotopic pathology and dermotopathology.

All tissues removed in a hospital operating room must be independently examined and interpreted by a pathologist.

Thus, surgical pathology implies surgery but actually involves all branches of medicine. Its practice is invaluable, for example, to the internist or the

pediatrician. The surgical pathologist must know not only his own field but he also must have an extensive background in clinical medicine if he is to advise the clinicians expertly about the biopsy or the excised tissue he receives. He is the physician who establishes a histologic diagnosis often determining the presence or absence of cancer.

The pathologist's knowledge bridges the gap between the beginning of disease and its end stages. The surgical pathologist must have a solid foundation of study at the autopsy table, where the ravages of cancer, arteriosclerosis, tuberculosis, ulcerative colitis and other diseases are all too clear.

With this background, he then can correlate even the initial stages of diseases seen in specimens from living patients with their early signs and symptoms and help predict the course of the disease. Only by understanding the mechanisms of disease as a whole can the pathologic process affecting a given organ be understood.

Which brings us to autopsy pathology.

Its goals are these:

1. To determine the morphologic and biochemical expression of disease in the patient.

2. To synthesize a coherent picture of the disease as it existed and to correlate it with the clinical signs, symptoms, physical findings, the hospital course, and previous illness.

3. To serve as a quality control procedure for evaluation of the medical and hospital care received.

4. To provide diagnoses and interpretations for the guidance of the deceased's family and for patients with similar disease.

5. To obtain tissues for various purposes, such as corneal and kidney transplantation, hormone isolation, and research.

6. To provide medicolegal data, as in the investigation of accidental and medicolegal deaths.

In addition, the information developed may or may not be used later in one of the following ways:

1. To provide a data base for epidemiologic and related studies.

2. To investigate undiagnosed diseases—little known ones and new ones. New diseases are constantly being found, and the autopsy constitutes a principal analytic method for investigation, as well as the mode of final understanding of the disease's pathophysiology.

3. To educate students, house staff and senior staff on pathophysiology and pathologic anatomy.

Just as the autopsy is invaluable in making good physicians better physicians, so is it also useful in bringing to light potential changes that are indicated in the management of patients. The autopsy enables the medical staff to determine whether there was an isolated lapse in judgment or a rare slip in surgical technique; or whether the competence of the physician involved should be reviewed.

In short, the autopsy is medically indispensable. It is the ultimate quality assurance in the practice of medicine, especially within the institution. It must not be classified as non-medical, and it must be fairly compensated under any reimbursement program.

The autopsy presents the best mechanism extant for evaluating the reliability, appropriateness and benefit of the many clinical pathology tests which have been performed. Peer review, infection control, death review, utilization review, medical audit—none can be performed effectively without autopsies performed by pathologists. Further, many HEW programs, including NIH and other programs for cancer therapy, heart and lung disease, etc., would be jeopardized without them.

Clinical pathology has several major divisions, such as hematology, chemistry, microbiology, virology, immunology and blood banking, together with subdivisions of these.

Its practice serves as a bridge between the basic sciences and the patient through the patient's physician. The clinical pathologist is the physician who possesses the required combination of broad knowledge in medicine as well as the clinical pathology laboratory sciences to perform this function.

Since the late 1950s, the number of tests and measurements performed in clinical pathology laboratories has increased dramatically. And in the process, patient care has been improved remarkably.

The increase in testing is in part a reflection of the overall increase in the demand for medical care. But in great part, it can be ascribed to the substantially decreased cost per test for the more commonly performed chemistry and hematology tests which lend themselves to procedure automation, the ready availability of test batteries, and the increase in the number of different tests.

These factors coupled with improved accuracy, precision, specificity, and reliability in the performance of tests, have resulted in a mounting reliance on laboratory data for use in assessing the patient's diagnosis and managing his disease.

In addition, the proliferation of malpractice suits and the escalating dollar amounts awarded have predictably motivated physicians to practice "defensive medicine" by ordering more laboratory tests to document their care than conservative patient management might otherwise dictate.

In clinical settings where complex medical cases require high laboratory use—where most of the tests in the battery would be ordered in any event pursuant to evaluation—the early performance of these procedures, by scheduled run on automated equipment, provides substantial per test savings and generally shortens the length of stay in the hospital.

For some diseases or groups of diseases in specific organ systems, tests are now available which simplify diagnosis. Running all of them at the same time in "organ panels" may save patient time and expense, even though this method is generally capable only of semi-automation.

There is a large number of more sophisticated tests and routine bacteriology, urinalysis and immunohematology tests that are not automated and must be ordered individually.

These developments make the practice of clinical pathology ever more complex. Testing must be done quickly, precisely and accurately. The pathologist must be responsible and accountable for quality assurance practices and their documentation to insure good patient care and to provide a defense against litigation.

The pathologist is one of the most active participants in many of the hospital's teaching programs, usually attending the weekly or monthly meetings of every department of the medical staff.

He serves as a resource person to medical staff in its discussions of diagnoses and therapy. These are of immediate and direct benefit to the patients under consideration as well as to many of the other patients in the hospital at the time.

As a member of the hospital's medical staff, he is a key member of the tissue committee which reviews all the reports on tissue removed at surgery and many of the operations performed in the hospital while also conducting seminars that assist his fellow physicians to maintain quality control in the medical treatment of their patients.

As a faculty member of a medical school, or of a school of an allied health science, he lectures, gives seminars and provides instruction to medical students, medical technologists, cytotechnologists and other health science students. These services are usually contributed without direct cost to either the students or the taxpayer.

As a director or supervisor of a hospital laboratory, the clinical pathologist trains interns and residents in clinical and anatomic pathology and frequently consults with the house staff.

To keep pace with an ever enlarging body of scientific and technical knowledge and its application to clinical pathology and medical practice, the clinical pathologist must spend a growing amount of his time learning, teaching and training.

For instance, he is required—in the face of ever more regulation—to assume responsibility for the qualification of laboratory personnel and their continuing competence and to document their ongoing performance.

But the pathologist is first and foremost a physician engaged in the practice of medicine; and he is forever balancing his view of the needs of his patients with the costs of these procedures and practices and the requirements of the many physicians and hospital patients involved.

To assume that this role in the clinical pathology laboratory is simply that of a laboratory overseer is totally without justification.

The pathologist functions as a physician in much the same way as do his "clinical" colleagues. To subclassify his duties by legislative action for purposes

of organization, illustration or evaluation is in no way to separate his duties into medical and non-medical duties.

All physicians may function as physician-managers, physician-educators, or physician-administrators—"hospital-associated" or not.

For example, Mr. Chairman, consider the typical physician in clinical practice and—while you are doing so—compare him with the clinical pathologist.

The non-pathologist physician is involved in establishing and evaluating procedures such as methods of asepsis, skin testing, injection site identification, phlebotomy, surgical preparation, and so on. He also evaluates and chooses equipment and reagents of all kinds.

In his function as a physician-manager, he must be responsible for the fiscal, clerical, technical, and professional operations of his office. He must prepare reports to such organizations as Blue Cross, Blue Shield, state and local health departments, boards of medical examiners, professional associations, and institutions involved in clinical research.

He must ride herd on a continuing program of quality assurance in his office, involving re-usable equipment, sterilization procedures, the taking of blood pressures and temperatures, etc. In addition, his supervisory involvement in quality assurance will steadily increase as the number of physicians employing physician-assistants and nurse practitioners increases year by year.

Besides this, he must educate his employees, his patients, and his colleagues to enhance their abilities to assist him in the practice of medicine.

Finally, he is often a physician-researcher, participating in prospective and/or retrospective clinical trials such as drug protocols in which the benefits accrue simultaneously to the individual patients as well as to all mankind.

In all of these diverse activities, the actions of the physician are intimately involved with his general medical practice and they are inseparable from it.

And we submit, Mr. Chairman, that what is true for any physician in clinical practice holds equally true for the clinical pathologist.

Consider the case of a nurse who assists a physician at a surgical operation, who administers medications and injections, or who takes a blood pressure. She is assisting a physician who is practicing medicine but who is delegating some of the technical aspects of that practice to her. The physician is still practicing medicine because, from his medical knowledge and training, he has determined the need and appropriateness of her activity as it relates to his patients; he has judged carefully the potential for benefit and even for harm of her activity; and he has set the standards for performance, established the methods to be used, and furnished the instruments she requires to carry out her assigned duties.

The physician she assists is practicing medicine.

The clinical pathologist reviewing tests performed in his laboratory by technicians is also practicing medicine. There is not one iota of difference.

The laboratory review of those tests is an integral factor and may be the primary factor, in the diagnosis of the patient's disease. And since the diagnosis of disease is the oldest and most agreed upon definition of the practice of medicine, any attempt to separate the laboratory test from medical practice is inappropriate.

We repeat, Mr. Chairman, most physicians who are not pathologists have little knowledge of the technical limitations of laboratory tests. By the same token, pure technicians have only a limited knowledge of medicine.

What happens, then, when the laboratory results don't seem to fit the patient's clinical condition? Clearly, a correlation must be made between the two. In many instances, it is up to the clinical pathologist to make that correlation, whether by personal examination of the patient, further testing, or other data.

He plays a major role in that critical decision-making. A few examples may help to illustrate this point.

Case 1. A medical technologist brought in a routine urinalysis on an infant. Strip and tablet tests for sugar gave conflicting results. The pathologist confirmed this finding, called the attending physician, and suggested a workup for galactosemia. Further testing confirmed the diagnosis, dietary therapy was begun, and mental retardation was prevented.

Case 2. The pathologist, as part of his routine review of laboratory data, discovered a somewhat reduced white blood cell count which generally would not be considered significant. He tested further and established a diagnosis of acute leukemia. This resulted in a complete change of plans for the patient's care.

Case 3. A hospital underwent a temporary shortage of O-negative blood. (All blood banks undergo temporary shortages of specific blood types from time to time). One surgeon needed six units of O-negative blood for an elective back fusion. Several postoperative patients still had O-negative blood reserved for them. Several others with bleeding ulcers had O-negative blood on reserve. The decision concerning which units of blood should be issued to which patients—literally a life or death decision—was made by the pathologist.

Case 4. An autopsy performed on an elderly woman disclosed glioma. The dead woman's daughter called the pathologist in great agitation, and the possibility of medical liability arose. The pathologist met with the family to discuss the case and in the course of the conversation learned from the daughter that she had heard her mother might have had tuberous sclerosis, and that this was familial. She was worried about the implications of this for herself and her children. The pathologist reviewed the case with her and said that the diagnosis was glioblastoma multiforme, and that there had been no signs of tuberous sclerosis. The patient departed in a relieved state of mind, her mental health greatly improved.

Case 5. A medical technologist brought a serum specimen to the pathologist from an elderly woman. Several specimens had been drawn, each of which was hemolyzed. This finding made the technologist suspicious that subsequent electrolyte and cross-match determinations would be inaccurate. "Why are the red blood cells fragile?" she asked the pathologist. Having examined the specimen, the pathologist took a history from the patient. She had been transfused ten days before. The pathologist ordered a serum bilirubin, plasma hemoglobin and haptoglobin, and direct Coombs test. With the results of these determinations, the clinical history and his own experience, the pathologist was able to diagnose a delayed hemolytic transfusion reaction. The attending physician was notified and, at the pathologist's request, fluids and diuretics were started. The patient experienced no further untoward reaction and no permanent renal damage was done.

Case 6. A medical technologist brought a peripheral blood smear to the pathologist from a young woman with severe renal failure and anemia. Concerned about the marked variation in size and shape of the red cells, the pathologist, who had noted an occasional fragmented red cell, called the attending physician and suggested a workup for disseminated intravascular coagulopathy which was performed—undoubtedly many hours before it would have been performed under ordinary circumstances. The workup was positive and therapy was instituted.

Case 7. A medical technologist brought the results of an emergency analysis for serum pseudocholinesterase to the pathologist which suggested susceptibility to succinyl dicholine. The pathologist called the results to the attending anesthesiologist and inquired if the patient had been notified of her condition. The anesthesiologist said she had not but the patient was still on the respirator. The pathologist asked that she be informed that her condition was known to her physicians, that she would eventually be able to breathe without assistance, and not to worry. Later, when the pathologist interviewed the patient in the course of performing a pharmacogenetic workup, the patient expressed her gratitude at being notified that her physicians were aware of her problem because during the time that she had been unable to breathe, she had also been unable to move or talk, but her mental facilities had been intact and she had been frightened. Unfortunately, her attending physician was certain of his diagnosis, completely confident that she would recover, and unaware of her apprehension because she had been unable to communicate it to him.

The foregoing cases make clear the basis for CAP's position that reimbursable physician services must include that of clinical pathology. For Medicare to assist in providing health care services to those covered by the program, yet exclude clinical pathology services, is nothing more than to fight the battle with one hand tied behind one's back. These cases are typical. This is why clinical pathologists review most abnormal results and, by various techniques, the routine statistical quality control procedures in their day-to-day work (e.g., The College of American Pathologists' Quality Assurance Service).

Because of their medical training and experience, pathologists can frequently see warning flags in subtle abnormalities, which take on meaning not only in a single test but in the context of multiple tests.

To sum up this portion of our testimony, Mr. Chairman, all fifty states of this Union have successfully defined medical practice in their laws. None of those laws require a physician to perform every medical function personally.

But as a physician engaged in the practice of medicine, the pathologist *is* held accountable by law for the assistance he receives from those he employs, supervises or engages to perform services.

One pathologist I know is party to a $3.5 million suit, part of which turns upon the alleged failure of a technologist to carry out his instructions in a hospital laboratory.

Obviously, that pathologist was practicing medicine in the eyes of the court. To hold him legally responsible in such a case, and yet have the government tell him that he is *not* practicing medicine because he is functioning as an executive is neither logical nor just.

Mr. Chairman, who will assume the liability of alleged errors in blood banking and the clinical laboratory if the pathologist is to assume only an administrative role, as proposed in S. 3205? Hospitals are already paying three to four dollars per bed per day in liability premiums. For instance, Michael Reese Hospital in Chicago now spends $3.00 per day and reportedly will go to $16.50 per room per day next year.

We cannot believe that it is the intent of this measure to shift more liability—that previously assumed by pathologists—to the hospital, thus increasing the cost of its operation.

Now, Mr. Chairman, we have gone into considerable detail in our discussion of today's pathologist and how he functions in the complex world of today's medical practice.

We have done so because we believe that some background knowledge of modern pathology is essential to any discussion of a measure that would alter its practice so violently.

In a further effort to clarify the perspective with which S. 3205 should be viewed, permit us to discuss Medicare itself and the subsequent regulations that governed its implementation.

Congress passed the Social Security Amendments of 1965 on July 30th, Section 1801, Title 18 of Public Law 89-97 states—and I quote: "Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency or person."

That seems clear enough. Then, on June 28, 1966, the Social Security Administration published proposed principles of reimbursement for services by hospital-based physicians under the Health Insurance Program for the Aged. Principle 1 reads:

"It is not the function of the Health Insurance Programs established under Title 18 of the Act to determine the arrangement which a hospital and a hospital-based physician may enter into for the compensation of the physician. The Secretary will not specify or influence the provisions of the contract or arrangement between hospitals and hospital-based physicians. . . ."

Again, this seems a clear enough disclaimer and an accurate statement of the law's intent.

But thereafter, things begin to get murky. The law has evolved into a maze of interrelated sections in the United States Code Regulations and Intermediary Manuals. It is further clouded by judicial decisions and by administrative determinations of the Bureau of Health Insurance.

In any event, Medicare's reimbursement principles for hospital-based physicians emerged in a form that totally disregarded the disclaimers I cited earlier. Through a series of regulations numbered Sections 405.480 to 450.488, the physicians and hospitals were advised of the conditions under which the services of hospital-based physicians would henceforth be divided into two separate health insurance programs. Simply expressed, these were (A) hospital insurance and (B) supplementary medical insurance.

Pathology services were stated to involve two separate components for Medicare reimbursement:

1. The charge for technicians, equipment and overhead in support of clinical laboratory services; and

2. The professional fee of pathologists' professional services.

These arbitrarily isolated components were to be treated separately. The first—classified under Title XVIII as the "provider component"—provides reimbursement for those services normally furnished by the "hospital" itself. As such, it is covered by Part A of the Medicare Program. The second—the so-called "professional services" component—is insured and the physician's charge is reimbursed under Part B of Medicare.

The basis for Part A reimbursement is the "reasonable cost" of the services to the provider; the basis for Part B is "reasonable charge." Furthermore, said the Bureau of Health Insurance, "physicians' services" eligible for Part B reimbursement are limited to *anatomical*, as opposed to clinical, pathology: this on the basis that Part A covers "inpatient hospital services" and Part B covers "physicians' services."

While this arbitrary division was not accepted in principle by most pathologists, the College of American Pathologists had gone through three editions of a manual containing guidelines of ethical and contractual relations prior to 1966 without ever adequately preparing pathologists to accommodate to regulatory requirements that their practice was split into professional services to a patient, and "hospital services."

In February of 1967, the College issued a new "Manual of Physician and Hospital Relations." Let me quote from its preamble:

". . . As a concerned citizen the pathologist should contribute his share in the evolution of a changing society. Hopefully, this Manual will assist him to formulate his contribution under the recently altered laws of the land. Public Law 89-97 and its resultant regulations require modification of long standing habits and attitudes to new and sometimes strange concepts. The novelty of an unfamiliar vocabulary, and the necessity to anticipate the vicissitudes of government create understandable anxieties. These changes must be kept in perspective and not be permitted to exercise a disproportionate influence on the patterns of medical practice.

Pathology will not be severed from Medicine even though it has been required to view itself as composed of separate professional and technical components for the purpose of calculating reimbursement. Payments for pathology services may be fractionated, but the service itself is not divisible. (Emphasis added)

The unaltered fundamental position of the American Medical Association and the College of American Pathologists is that the practice of Pathology *is* the practice of medicine . . . *This Manual is designed merely to illustrate the mechanisms by which (pathologists) may provide their services.*

. . . This Manual of necessity must deal with the possible and practical, as well as the desirable."

In the effort to deal with the "possible and practical" the Manual therefore suggested a model by which pathologists and hospitals could develop workable patterns for their relationships. And thus was born the so-called Triad of Pathology Practice, of which the Manual stated:

". . . Although pathology like Gaul may be divided into three parts, the Triad is the totality of activities in three interrelated sectors which together are one."

The Triad was then presented as the following:

1. Activities as a physician providing personal patient services.
2. Activities as a physician providing academic services.
3. Activities as a physician providing laboratory direction.

Let me stress, Mr. Chairman, that each element of the Triad was characterized as "activities of a physician."

It was the next edition of "Contractual Relationships Manual" that omitted the phrase "activities as a physician"; it was editorially omitted in the interests of brevity, perhaps thereby causing a misunderstanding of the College's position.

It was, perhaps, this misinterpretation of the Triad taken out of its full context in the Manual, that apparently served as the rationale for redefining "physicians' services" of hospital-based physicians to exclude those that a physician performs as an educator, an executive, or a researcher.

Let me underscore this point, Mr. Chairman:

All pathologists are physicians.

The Triad of Pathology Practice was developed as a means of conforming with the new and tortuous definitions of physicians' services contained in the 1966 Medicare regulations.

In no way have pathologists, their College, or physicians in general accepted the inference in P.L. 89-93 that the pathologist, in the role of educator, is not

practicing medicine; that the pathologist functioning as a laboratory director is not practicing medicine and bearing a medical responsibility to all patients within the institution; or that the autopsy the pathologist performs is not a physician service.

The CAP Manual simply lists the elements of pathology practice as they may be fitted under Parts A and B of the Medicare reimbursement mechanisms.

Elsewhere it also states that "the College cannot accept the validity of the philosophy reflected in the requirement Reg. 405.483 (a) that a professional component is recognizable as a physician service only when it is performed in person and identified with an individual patient.

"No physician who performs a medical service in his office distinguishes—or is required to distinguish under the Medicare Act—between his own personal service and that of his staff operating under his supervision and control . . ."

Thus, S. 3205 forever sets aside the disclaimer in Public Law 89-97 governing supervision or control over the practice of medicine by federal officers or employees. It similarly sets aside the subsequent disclaimer of the Social Security Administration to the same effect. It accepts, instead, the diametrically opposed regulations promulgated by the Bureau of Health Insurance. And the drafters of S. 3205 also—erroneously—interpret the Triad of Pathology to mean that the College of American Pathologists concurs in their interpretation.

To say that the pathologist is not functioning as a physician when he is practicing medicine in the roles of educator, executive or researcher and should not therefore be reimbursed as a physician for those services, can only be construed as arbitrary and discriminatory.

Section 22 arbitrarily excludes four specific areas of professional pathology services from the definition of Part B reimbursable "physicians' services":

1. "Performance of autopsies."
2. "Services performed in carrying out responsibilities for supervision."
3. "Quality control."
4. "Various other aspects of a clinical laboratory's operations that are customarily performed by non-physician personnel."

The proposed non-physician service classification of a pathologist's clinical supervisory responsibilities squarely contradicts the bill's general description of physician services as including "services personally directed by a physician."

Mr. Chairman, if S. 3205 were passed in its present form, it would completely restructure the practice of pathology, as we hope this testimony will make clear. Indeed, the precedent it would set in fragmenting the pathologist's practice for purposes of reimbursement strongly suggests that all the rest of the nation's physicians—specialists or family practitioners, hospital based or not hospital based—would inexorably be subjected by government action to similar arbitrary constraints.

Perhaps it is appropriate at this point to discuss the pathology manpower supply for the next four or five years, for it could be severely affected by the passage of this proposal.

Ten years ago the nation was faced with a serious shortage of pathologists of all types. In 1965 it was noted that the percentage of medical school graduates entering pathology had remained essentially unchanged over a decade. The problem then—and the problem now—was that a relatively small number of persons are inclined and qualified to become physicians *and* scientists.

Confronted with an increasing patient load, as well as an ever more demanding specialty, recruiting efforts were intensified. Progress was made and soon required quantifying.

Accordingly, the American Society of Clinical Pathologists and the College of American Pathologists together formed a Joint Task Force on Pathology Manpower needs in the United States and surveyed fact and opinion on manpower needs and problems.

The survey was begun in 1973 and completed late last year.

Questionnaires were sent to practicing pathologists; residents in all approved pathology training programs; and program directors of all approved residency training programs in the United States.

The response from pathologists approached 75 percent.

Some of the findings may be of interest to this Committee.

•Of the 8,929 pathologists in solo or group practice in the United States, 93 percent are certified by the American Board of Pathology. Of those responding to the survey, 67 percent are practicing in a single general community hospital ranging from 200 to 700 beds in size.

•Some 22 percent of the respondents are currently and actively seeking to fill at least one funded vacancy.

•The majority of the vacancies (56 percent) are in community general hospitals but 20 percent are in academic institutions. Forty percent of vacancies are in communities with populations ranging from 25,000 to 250,000.

•A total of 2,700 new pathologists will be needed in the period of 1975–1980, according to the respondents.

•Approximately 1,000 of these are needed to meet expanding workloads, some 630 more of them to replace pathologists lost through death or retirement.

•The remaining new positions are anticipated for the following reasons: 442 to relieve present high workload; 322 because of increased subspecialty practice; 234 because of academic expansion; and 81 because of increase demands of training programs.

•About 80 percent of the approved residency positions are occupied, with some 2,153 residents in the graduate medical education or training pipeline.

•The need anticipated by the respondents over the next 10 year period is approximately 5,000 additional pathologists. Since 1,500 at most are expected to replace pathologists now in practice, the growth anticipated is between 3,000 and 4,000 positions.

•It is therefore likely that a deficit of pathologists will continue over the next five years, but there is a relatively good fit between demand and the supply of pathologists in the residency pipeline.

•Finally, of the 6,157 pathologists practicing full time who were accounted for by the survey, 57 percent are practicing in groups of four or more and 33 percent are practicing in groups of six or more.

Mr. Chairman, we are taking the liberty of providing the study to the Committee for its reference.

The relatively good fit between the demand for and the supply of pathologists over the next five years can be viewed as highly encouraging.

But how it would be affected by the passage of S. 3205 is a matter for conjecture. It seems reasonable to assume that medical students would be far less interested in choosing the demanding specialty of pathology if it were to become the most governmentally constrained specialty from a reimbursement standpoint in the practice of medicine.

They would be bound to fear that these arbitrary features would seriously restrict the ability of senior pathologists and institutions to respond to increased professional needs, as they can today under many of our present arrangements.

Earlier in this testimony, Mr. Chairman, I reviewed the evolution of physician reimbursement from the principles clearly laid down in Public Law 89–97 to the diametrically opposite position promulgated by the Bureau of Health Insurance.

Pathologists were particularly affected by the requirements that some services were to be reimbursed through Part A and others through Part B of Medicare's Title XVIII.

As a result, a number of different kinds of compensation arrangements were developed between pathologists and institutions for which they performed services.

These contractual relationships differ widely depending upon the local setting. Each contract is custom-made, in a sense, to meet the varying needs of the pathologist, the institution and the patient population. But most of the more commonly used methods for establishing contracts between hospitals and pathologists were well established prior to the passage of Medicare. With Medicare came a massive increase in the government's obligation and responsibility for participating in the cost of hospital and/or physicians' fees.

Essentially, there are two major patterns for hospital-pathology contracts.

First, those in which the pathologist supplies medical direction only—in which he assumes only the professional responsibility for his work. Such a pattern can take a number of different forms:

1. Billing by the pathologist on an item-by-item basis;
2. Remuneration of the pathologist based on a gross, adjusted gross, or net percentage of laboratory earnings;
3. Salary;
4. Modifications or combinations of these.

Second, there are contracts under which the pathologist supplies medical direction plus assuming proprietorship or franchise. In other words, the pathologist

takes on financial as well as professional responsibilities. Under this pattern, the contract can involve either a lease or a mutual working agreement.

The key factor in any of these arrangements, regardless of their variations, is that they are agreeable to each of the parties involved.

Whatever the reimbursement method, pathologists are chosen by their clinical colleagues for medical staff privileges in the same manner as other physicians. Their job descriptions and responsibilities are mutually agreed upon by the pathologist, the medical staff, and the hospital administration; and then the entire professional and contractual arrangement is reviewed and approved by the hospital board of trustees. In all instances, the performance of the pathologist as a physician is under constant review by the medical staff, just as is the case of his clinical colleagues.

The trustees, of course, as civic-minded local citizens are dedicated to the service of their community and are responsible for the overall operation of the hospital. Therefore, it must be assumed that the various boards of trustees of individual hospitals have good and cogent reasons for entering into any given contractual relationship. If their reasons for entering into the contract were valid, and they are *properly* exercising their fiduciary responsibilities, there can be no abuse.

We recognize that developing a working definition for "reasonable compensation" is very difficult and would not be uniformly applicable in any event. We believe, however, that enough variations do exist with quantity and quality of services provided by pathologists, so that the aim of the bill should be to contain as much as is reasonable and possible, the total cost to the patient, and not to become involved with internal relationships between hospitals and their contracting physicians.

The very multiplicity of options available to the institution and the pathologist in their contractual relationships must be viewed as a strength—not a weakness—of the system.

Hospitals are diverse. They vary from one locality to another. They differ in size, the size of the community they serve, whether they are located in rural suburban or urban setting, whether the hospital is new or old. They are subject to differing local laws and customs, state laws and regulations.

A contractual arrangement between a hospital and a pathologist cannot be designed like a missionary's Mother Hubbard, one model fitting all and covering all essential points at the same time.

For example, small rural hospitals delivering primary care without complicated medical problems are obviously in a different category than urban hospitals handling referral problems. Within urban hospitals, those with massive teaching programs are inevitably more expensive than those without them. A psychiatric hospital is infinitely different from a similar-sized general hospital. And these manifold differences militate against inflexible, general "solutions."

Procrustes, a mythological innkeeper, provided a bed for his overnight guests that fit everyone, regardless of size.

If the guest were too tall, Procrustes lopped off enough leg to make him fit. If the guest were too short, Procrustes simply stretched him on the rack until he fit.

Admittedly, this technique simplified life for Procrustes. But it wreaked havoc on his guests.

It is our position, Mr. Chairman, that no Procrustean solution by government in the matter of pathologist/hospital contractual arrangements can be made to work when it must accommodate so many variables.

The College believes that the very existence of multiple contractual methods for determining a pathologist's compensation establishes beyond all doubt that no one method is best, or even appropriate, in all circumstances.

The College believes that *any* type of contract is acceptable providing it does not interfere with, or impair, the free and complete exercise of medical judgement and skill; or does not tend to deteriorate the quality of medical care.

None of these conditions alters the fact that the rate charged for a particular unit of hospital service, including a pathology service, can vary widely from institution to institution even though certain factors—such as bed size and geographical location—appear to be similar.

This is neither sinister nor difficult to understand.

The primary purpose in establishing laboratory charges is to produce the revenue necessary to cover the *direct* and *indirect* expenses of *equipping* the hospital's clinical pathology laboratory; and *operating* it.

The rates for specific laboratory procedures can be tied far more closely to the hospital's total revenue needs than to the specific cost of the actual procedure for they must take into account the *indirect*, or overhead, costs of the hospital's non-revenue producing "general service cost centers." We must emphasize that a hospital clinical laboratory fee should not be viewed in a vacuum but must be evaluated as part of the study of the per diem charge, per illness charge, and patient mix.

These indirect expenses are a large cost factor and the share allocated to the clinical pathology laboratory can range anywhere from 20 to 70 per cent of the direct cost, depending upon an almost unlimited number of local considerations subject to endless variation.

Under the heading of hospital overhead must fall such costs as those for administrative services; personnel, purchasing, and public relations departments; insurance; taxes; employee's health and welfare; charity; a margin to cover bad debts; and the cross-subsidization of such other non-self-supporting departments as renal dialysis, burn units, cardiovascular surgical units, and maternity.

These areas are often not revenue producers, but they are essential to good patient care and the pathology laboratory must shoulder a share of their expenses in many institutions. It might be considered ideal if all of these costs were included in the daily room rate. But many reasons presently prevent this, including a number of governmental fiscal constraints which prevent the hospitals from making the necessary accounting changes.

Many of the activities necessary to good patient care in a hospital, some part of whose expense is allocated to the pathology laboratory, may seem—and indeed, are—remote from the process of producing and delivering laboratory tests. But the revenue requirements of a particular institution must be met if the doors are to be kept open; and the clinical pathology laboratory is simply one of many departments in the hospital, and one of a relative few that generate revenues in excess of costs.

In addition to indirect costs, *direct* costs also are involved in the laboratory's operation. They include pathologists' compensation, if a separate billing arrangement plan is not in effect; the compensation of technical personnel and related payroll costs; departmental supplies, such as reagents and disposable materials; instrument rental or maintenance; outside services; and so forth.

Let me emphasize this, Mr. Chairman:

The direct costs of the laboratory constitute the only factor in the revenue base of the department over which the pathologists may exercise some degree of control.

After determining the total amount of revenue that must be produced to pay the direct and indirect costs of operating the laboratory, the hospital then must work out a *schedule of charges* and an *estimate of quantities* for each test, in a combination that will produce the total amount required.

In establishing these individual charges, a hospital may use a relative value schedule; or use its own industrial engineering studies; or base its rate schedule on community levels.

In some states—Texas, for example—the rates must be negotiated with third-party payers such as Blue Cross. The criteria used by the third party payers in approving charges for specific tests become a major factor in the relationship of individual charges to each other.

The rates charged by nearby hospitals, or in commercial laboratories, also are taken into account.

Many internal considerations affect the setting of individual charges for tests. Some tests can be automated or manually produced in volume at a low unit cost. Ordered singly, these tests would cost more for drawing the specimens and delivering the report to the nursing unit than for actually doing the test.

On the other hand, there are tests which must be done individually. They require large amounts of time over a period of several days by specialized scientists, including Ph. D.'s and M.D.'s. This is especially true in the highly specialized hospital with separate laboratories for virology, endocrinology, mycology, etc. Such tests are expensive and rarely achieve enough volume to lower their

cost. In fact some of them entail so much personalized attention that an increased volume would add substantially to their cost.

Many of these tests are performed at less than their direct cost because they are needed in small numbers and must be provided as a service to the community. These costs must then be recovered in other areas of the laboratory's operation.

Another factor involved in highly specialized tests is the amount of time the clinical pathologist must devote to their development and refinement. Having done this, he is by no means finished. The process of educating the medical staff on the use of these tests, and the task of assisting physicians in the interpretation of them, continues for months or years after these new, complex procedures are developed and standardized.

Even so simple a thing as changing the supplier for a particular reagent may have dramatic medical significance. For example, many clinical enzyme analyses vary greatly, depending upon the substrate. The clinician would have no way of knowing this unless it is evaluated by the pathologist and a medical judgment made to provide for the best needs of the laboratory and the patient.

It also should be remembered that the clinical pathologist is continually called upon for consultation under circumstances that simply would not provide a satisfactory basis for an equitable system of direct charges to the patient (if this were done by defining a consultation as S. 3205 implies and establishing a fee for it).

Many of these consultations are on an unsolicited, drop-by basis. Neither the clinician nor the pathologist has scheduled the consultation in most cases; but because the pathologist is on the spot, the clinician consults him. This is often to the patient's medical benefit; on occasion reduces his stay in the hospital; and never shows up on his bill.

There are other medical staff factors that may be financed through the charges for laboratory services. For example, autopsies are generally performed without direct charge. They demand large amounts of a pathologist's time; but they are an important contribution to medical knowledge and are essential to the improvement of medical practice within the hospital. Frequently they are of immediate benefit to the patient by providing information essential to the relatives, insurers or government for the settlement of fiscal obligations to the deceased. And although the deceased does not benefit medically from the autopsy, future patients may do so significantly.

Time requirements such as these cannot be compensated equitably by payments for "identifiable personal services" provided by pathologists directly for individual patients.

The regulations of the Social Security Administration dealing with principles of reimbursement for services by hospital-based physicians specifically recognize a reasonable accommodation with the realities of this area of pathology practice:

"(c) *Optional method of recordation and billing on a uniform-percentage basis.* (1) Application of the item-by-item method may present special problems in the case of a particular hospital department. This is illustrated by pathology laboratory services and radiology services, which involve a high volume of individual procedures, variation in the extent of involvement in services on the part of technicians and others and on the part of the physician, and difficulty in distinguishing between professional activities which are of general benefit to all patients and those performed directly for an identifiable patient. Where the physician participates personally in some procedures and not in others by virtue of quality control activities or because his professional concern is directed to the result in a given case, it may be difficult to ascertain the presence or absence of a specific quantum of professional activity in an individual case. Moreover, the assigning of the appropriate amount of 'professional component' to a particular procedure or test for a particular patient receiving the benefit of the physician's service, as defined in paragraph (a) of this section, may not only result in inequality of charges among patients but also may present an undue task of recordation. Administratively costly and impractical requirements could ensue in collecting the data needed for presentation of bills involving minimal charges on an item-by-item basis to individual patients. Under these conditions, it may not be administratively practical for the physician, the hospital and the Part B carrier to keep track of appropriate professional charges on an item-by-item and patient-by-patient basis.

(2) With respect to pathology services, for example, an individual entitled to Part B benefits under Title XVIII of the Social Security Act (in connection

with a hospital stay or in connection with a series of outpatient diagnostic tests) will, on the average, have multiple laboratory procedures which in the aggregate permit the assumption that at some point with respect to at least some of the laboratory services there has been 'an identifiable service requiring performance by a physician in person.'" (20 C.F.R. Sec. 405.483(c)).

In any event, the net income of any individual department of a hospital has little relevance when considered alone. It is misleading to do so because of the interdependency of all parts of an institution.

As an example, in past years many hospitals have been unable to obtain public and governmental support for establishing the daily service charges at a sufficiently high level to cover the routine costs of operation. These routine, or "room and board" costs, were therefore regularly subsidized by the earnings of such diagnostic departments as the clinical laboratories. This practice has declined, fortunately, to the point where most hospitals tend to follow a policy of expecting their various revenue-producing departments to be self-supporting.

The Medicare and Medicaid reimbursement programs do not recognize the community need to support the increasing amount of bad debts being incurred by the institutions. As a result, the institutions are required—by economic necessity—to recover such losses by including an additional increment in the rates established for high service volume departments such as pathology, radiology and pharmacy. These charges must be established on a uniform basis to conform with the requirements of the Medicare and Medicaid programs; however, the charge must be increased sufficiently to cause those patients who pay for services based on established charges to pay the costs of their own care, plus part of the cost of care given to other patients who couldn't pay their own bills.

An evaluation of the total patient mix by financial classification—that is, those patients whose bills are covered on the basis of charges rather than costs—is an integral part of hospital management's planning when determining the amount of revenue that must be produced by the laboratory.

In some areas of the country, Blue Cross, in addition to the Medicare and Medicaid programs, reimburses institutions on the basis of cost. Therefore, losses from bad debts, cross subsidization of other departments, and the capital needs of the institution must be recovered from a smaller base of charge covered patients.

Since Medicare and Medicaid require that the institution maintain uniform rates chargeable to all classes of patients, it may be necessary in some instances to increase those rates by as much as a multiple of five dollars for each one dollar required for subsidies, bad debts, etc. to break even.

At this point, Mr. Chairman, I should like to bring an extremely important finding to the Committee's attention.

On the basis of recent analyses made in several states, *it appears that neither the size of the institution nor the pathologists' compensation arrangement has any discernible influence upon the individual fees charged for approximately 20 of the most common laboratory procedures.*

This is a critical finding because it indicates, we think, that there is *no* overall increase in the cost to the patient because of the individual contractual arrangements that prevail.

Let us comment on in-patient versus out-patient charges, Mr. Chairman.

The College strongly favors lower charges for out-patients than for in-patients, feeling that the out-patient should not be required to pay for service he does not receive.

Moreover, the out-patient does not understand why the rates he pays in a hospital laboratory are so high in view of the fact that he often is required to pay cash in advance and he delivers himself directly to the laboratory for a specimen to be drawn. If that patient does not have insurance coverage, he is very apt to go elsewhere the next time he needs laboratory services. This reduces the potential volume of services which could be provided at an institution-based laboratory and creates an artificial demand for services at outside laboratories. This is complicated even more because the patient's physician must decide if his need for the test results is immediate or may be deferred for days or weeks.

Charges by independent laboratories are generally less expensive. Independent laboratories are not required to support losses in other hospital departments; they may be dedicated to providing sophisticated tests only on a non-emergency basis, or large volume procedures at low unit cost; they are not required to absorb in overhead a portion of hospital costs having little or no relationship to labora-

tory operation; they perform a larger volume of automated tests; they are infrequently faced with the need to staff on a 24-hour, seven-day a week contingency basis, as are the usual hospital clinical pathology laboratories which thereby increase personnel costs; and where hospital laboratories must include the costs of taking test samples, independent laboratories are usually not faced with them as their samples are obtained, separated, labeled and delivered to them by the referring physician.

There is one other factor which significantly affects hospital charges and therefore the charges for clinical pathology laboratory: the cash flow needs of the institution.

In recent years, institutions have encountered a phenomenal growth in the dollar amounts of their accounts receivable. Unparalleled inflation has much to do with it. But other factors also contribute to the problem.

Delays in settlement of claims against the third-party payers and the government; cash outflow for maintaining inventory levels; the payment of a wide variety of insurance premiums, including malpractice: the effect of these has been fiscally disruptive.

Federal minimum wage levels have increased salaries at all levels, not simply at the lower end of the scale. And hospitals, like clinical pathology laboratories, are "labor intensive."

In years past, hospitals and their laboratories paid notably low salaries to their employees. It was common practice to subsidize the hospital by infusing unpaid personnel who were directly related to the church sponsoring the institution. It was also common practice to promulgate the view that personnel working for hospitals and/or physicians should be satisfied with lower incomes than others received.

This is a changing situation, and with that historically overdue change there comes a rising cost.

There are others. Medical liability costs are soaring for hospitals and physicians alike. Increased union activity in the hospital field is noteworthy since the National Labor Relations Board eliminated hospital exemptions. Its impact is felt right now and can be expected to intensify in the years ahead.

All of these factors have intensified the problem of cash flow.

This situation cannot be ignored. It does not require a degree in business administration to see that any reimbursement mechanism based on cost eventually will strip away the working capital of an institution if the amount and frequency of reimbursement payments do not keep pace with the institution's outlays of cash.

Some institutions can generate significant cash flow through profits and the recovery of depreciation. But many must obtain outside capital financing; and debt service cash requirements tend to offset depreciation as a source of cash flow.

All of these financial pressures on the hospitals become, indirectly, pressures on the operation of the clinical pathology laboratory.

But perhaps as important a basic cause as any in the problem of mounting health care costs is the fact that the patient usually does not participate appropriately in the cost of his own medical care under the many full coverage plans.

First dollar coverage in Medicaid and many private carrier's programs discourages patient restraint from over-utilization of medical and hospital services. The discrepancy in reimbursement—present in many government and private medical care plans—between services provided as an inpatient and as an outpatient encourages in-patient utilization. And finally, many third-party contracts are negotiated between employers and others—such as labor unions—without the patient ever being directly involved. The patient therefore has no incentive to develop a positive approach to preventive health care or to show reasonable restraint when considering the use of medical services.

Mr. Chairman, earlier in this testimony we discussed at considerable length the many and complex considerations that must go into the establishing of the fees charged to patients for clinical pathology services.

Regardless of what sort of contractual relationship exists between the clinical pathologist and the hospital, the process of fee setting is complicated.

Nonetheless, studies we shall discuss suggest to us that there appears to be no significant relationship between the fees charged the patient for clinical pathology services and the type of contractual relationship that exists between the pathologist and the hospital.

Valid evidence exists to show that the American patient is getting the best pathology service available in the world today at an appropriate time and setting and at a reasonable fee.

Numerous factors influence the fee charged, as we have explained. Many of them must be taken into account to permit responsiveness to local variations and conditions—among them profiles established by third party payers, welfare, etc.; methods for hospital cost accounting and allocation, including the community bad debt experience; degree of laboratory automation; debt service responsibility for the laboratory and/or the institution; and overhead requirements of Inspection and Accreditation, Quality Control, FDA, Environmental Protection Agency, Occupational Safety and Health Administration, Nuclear Regulatory Commission, and most important, patient mix.

I cannot emphasize the influence of these factors too strongly. Furthermore, all of them may vary with the size and location of the institution and the professional staff size.

Not surprisingly, in the process of working out fees for clinical pathology services, widely varied mechanisms have been developed in different settings around the country.

There is also considerable variation as to who actually establishes the fees, i.e., whether they are set by the pathologist, by the hospital administration, or by some form of joint effort. However, at least one GAO study in the Kansas City-St. Louis area indicates that hospital administrators establish the vast majority of clinical laboratory fees. There is nothing wrong with this unless the view is taken that the pathologist should be responsible for the cost to the patient.

Now, it has been stated or implied in recent years, Mr. Chairman, that certain types of contractual relationships between pathologists and institutions are not appropriately cost sensitive and—so the argument runs—in and of themselves cause higher total fees for the clinical pathology services charged to patients.

Despite these allegations, the College of American Pathologists' Contractual Relationships Manual recommends that "in any percentage agreement, the percentage (should) be related to a specific fee schedule . . . (as) this would prevent excessive increases in a pathologist's income because of rising charges in an inflationary economy."

In our study of the relationship between contract type and patient program cost, the first thing we discovered was how little data exist in this area.

Recently, therefore, the Nebraska Association of Pathologists undertook a survey of the pathologists in that state.

Those surveyed were asked to indicate the size of the hospital covered; the type of contractual relationship existing between the pathologist and the institution; and the fees charged for 25 commonly performed clinical pathology services selected to represent the overwhelming majority of total tests performed within the hospitals of Nebraska.

Responses were received from all the pathologists contacted.

It was difficult to determine the total number of hospital beds covered, however, because of the large number of small institutions in rural Nebraska. We were able to predict with reasonable accuracy, nonetheless, that the survey covered more than 80 percent of the approximately 5,000 acute care hospital beds in the state.

In tabulating the results, those hospital laboratories which did not provide a certain clinical pathology service were allocated the mean charge value for that service. This was determined from all the other hospital laboratories in the state, assuming that they would have to obtain in this service from some other clinical pathology laboratory if it were requested for a hospitalized patient.

It was then determined what the total charge to the patient would be if *one study of each* of the surveyed clinical pathology tests were performed on a single patient—that is, the total dollar charge for one of each of the 25 tests in the survey. The hospitals were then ranked from high to low for this total charge.

Study of these data revealed no relationship between the type of contract and the charge to the patient.

The hospital with the highest and the hospital with the lowest combined charges to the patient in the state each had a type of modified percenage contract with their pathologists. The pathologists at the hospital that had the second highest charge to the patient in Nebraska were on salary.

An institution having approximately the mean charge to the patient for all institutions in the state operated under at least arrangement. So did two of the three lowest in Nebraska.

As with most states, approximately 60 per cent of the Nebraska hospitals had some sort of percentage agreement with their pathologists.

A similar survey was performed by the Texas Society of Pathologists. Laboratories representing 53 major hospitals containing a total of 17,972 beds and more than 200 pathologists responded to the survey. Again, the Texas survey revealed no obvious relationship in that state between the type of contractual arrangement of pathologist and hospital and the amounts charged the patient for laboratory services.

Several other surveys have been taken in Georgia, New York, Tennessee, and Ohio. They similarly failed to disclose any relationship between contract form and pathologist's charge.

Mr. Chairman, we hope these survey findings will lead you to reconsider one of the critical changes that your bill contemplates in Section 22. I refer now to the change in the basis of a physician's compensation.

On the strength of our own data, perhaps the Committee should consider the initiation of other surveys along the same line. It should not be difficult to confirm our findings.

But here we must emphasize that any review of fees for laboratory studies *alone* should be done with the greatest caution and only when length of stay, per diem charges, patient mix, and size of institution are taken into consideration.

Section 22 provides that a physician's charges that are related to the income or receipts of a hospital or any subdivision thereof shall not be considered in determining a physician's Part B customary charges where they exceed an amount equal to the salary which would reasonably have been paid for such services under an employee relationship with the hospital.

When you introduced S. 3205 on March 25th, you stated in your introductory remarks:

". . . The bill would prohibit Medicare and Medicaid from recognizing percentage arrangements in which a pathologist gets a specified percentage of the revenues or income from all laboratory work, regardless of his direct personal service or involvement. This type of arrangement is highly inflationary in that it gears income to hospital charge levels which have been rising more rapidly than other costs . . .

"Under the amendment, for those personal patient services which the pathologists themselves define as 'physicians' services' and for which they have customarily billed on a fee basis in the past and which customarily require direct personal physician involvement, they could, of course, continue to bill on a fee-for-service basis. For those services which the College of American Pathologists defines as 'educational' or of an 'executive' nature, reasonable overall compensation would be paid related to time and effort. *This would consist of a monthly fee reasonably related to what a full-time salaried pathologist would receive for proportionate time and effort in 'educational' and 'executive' work* . . ." (Emphasis ours).

But once again, Mr. Chairman:

Our surveys disclose no obvious relationship between the form of the contractual arrangement and the cost to the patient for laboratory services.

S. 3205 has as its goal the cutting of the costs of services to the patient, thereby reducing the costs of Medicare and Medicaid. Your intention, as we understand it, Mr. Chairman, is not simply to establish a ceiling on the pathologist's income because a handful of pathologists earn large incomes.

Certainly the large incomes of individual pathologists have generated a good deal of press coverage lately—most of it critical, some of it probably deserved. We suppose this coverage reflects the feeling that some reporters and members of government hold on the subject—that there is something inherently wrong with incomes that exceed a certain level.

But all too frequently these stories, and the people who read them, fail to take into account that the incomes under examination often represent the total income of a group practice. Nor does the story always mention that the cited income is gross, not net. The tendency is then to categorize the high income, somewhat casually, as an "abuse."

The College is against fraud and for the vigorous enforcement of the laws which deal with fraud and penalize it. But we do not accept any certain level of income as *a priori* evidence either of fraud, or, indeed, abuse.

Unfortunately, the public is left with the impression that the total laboratory charge is equal to the pathologist's income, which is far from the case. In fact, although the overall relationship of total tests to pathologists' incomes has not been sufficiently studied, there is evidence in at least one recent governmental study that higher charges to patients are *not* directly related to higher pathologists' incomes.

Income comparisons are misleading in any event because of the wide variety of individual situations which exist throughout the country. The duties, responsibilities, abilities, energies, efficiency, training, experience, etc. of pathologists vary widely between pathologists, and between pathologists and other physicians. In addition, comparison of the incomes of medical specialists and non-medical specialists is practically impossible because of the inability to develop constant and equitable guidelines which take such variables into account.

What is far more important is the quality of the work performed; and the charge to the patient.

High quality laboratory services are delivered to millions of Americans every day, at fair prices, under a variety of contractual arrangements developed locally to meet local needs.

Now let us quote once more from the CAP Contractual Relationships Manual.

". . . In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fees should be commensurate with the services rendered and the patient's ability to pay . . .

". . .In any percentage arrangement it is recommended that the percentage be related to a specific fee schedule included as part of the agreement, or to a specific relative value schedule with a fixed conversion factor. This would prevent excessive increases in a pathologist's income because of rising charges in an inflationary economy. . .The use of specific schedules or conversion factors would obviate the necessity for repeated amendments to the agreement between pathologists and hospitals. . ."

And in the next paragraph: ". . .In a stable economy a traditional gross percentage agreement, when realistically derived, had the salutary effect of relating the pathologist's income to the volume of laboratory work.

"In periods of inflation, however, the rising costs of laboratory operation require increases in laboratory charges. It may legitimately be pointed out that in this situation the pathologist has little stimulus for cost control nor does his income necessarily relate to laboratory workload. The availability of sophisticated cost accounting procedures in most hospitals permits ready identification of the cost of laboratory personnel, supplies and equipment amortization. These are the major foci of laboratory expenses and are the areas most susceptible to the exercise of the executive role of the pathologist. If these three expenses are deducted from the gross earnings prior to application of the contractual percentage, the pathologist will share cost sensitivity with the institution."

Thus, to abandon percentage contracts in favor of a rigid monolithic system of imposed ceilings, arrived at arbitrarily and pegged to the level of salaried pathologists, could increase, rather than decrease, health care expenditures in the United States.

The control point for hospital costs rests with each hospital's Board of Trustees, not with the pathologist. Accordingly, no control plan focused on the contracts existing between the hospital and practitioners can assure cost control. Rather, hospital reimbursement and the reimbursement of physicians practicing primarily in hospitals, must be viewed in its entirety.

The hospital Boards of Trustees have the legal authority and responsibility for the conduct of hospital affairs. Unless they have failed to discharge their responsibility, contracts which may seem out of line by national statistical norms may have considerable local relevance and not be abusive in any sense. Alternatively, if abuse exists, the hospital is at fault along with the physician, and along with those various others peripherally involved including third party insurers and the Social Security Administration.

Federal and state laws and regulations presently exist which deal with physician reimbursement and contain the means to deal with abuses by the individual, aberrant physician. Vigorous use of these existing mechanisms by third-party payers, trustees, government and non-governmental agencies would deal effectively with any abuses by the small number of pathologists who have been singled out for press attention.

It is manifestly unfair to penalize the large number of pathologists and other physicians who have been practicing ethically and professionally under equitable contractual relationships with hosptials simply because a few practitioners may have abused the system.

Let us comment now on the effect of establishing an income ceiling on the practice of pathology.

The pathologist constrained by a ceiling might well be forced to concentrate his professional efforts on those services, for those patients, for which he would receive adequate compensation.

This would mean that an individual patient would risk having a fee charged him for a service which would be unpredictable in advance, and which would depend upon whether or not a pathologist were involved.

Consider for example, the patient who arrives at a pathology laboratory requiring a complete blood count. Ordinarily he or she would be charged a set fee, for example, six dollars. The pathologist's contribution would be provided without additional charge.

Under the bill as proposed, the patient would be charged a base fee but then told that this might not be the entire charge and that the charge would ultimately depend on the amount of pathologist involvement.

I submit that this would be an administrative and fiscal nightmare; that its fiscal impact would be adverse; and that a number of the remaining hospital patients would be, of necessity, neglected by the pathologist.

Now prices would begin to rise, for demand would be unaffected by the ceiling while supply would have been reduced. As the value of the pathologist's work hour increased, the ceiling would be reached more quickly, and he would now be required to cut back more on the number of hours he worked. Again the price of services would go up.

Thus, the probable effect of the ceiling would be a continuing increase in the price of pathology services and pathologists' earnings per hour; and a reduction in the volume of hours worked by pathologists and in the volume of their services provided to patients.

As more and more pathologists decided against self-employment, more and more hospitals would have to assume responsibility for their own clinical pathology laboratories. In this climate of medical liability, and under the proposals in S. 3205 which would decrease initiative, the pathologist would have less and less reason to take medical responsibility for any medical services over which he did not maintain complete personal control.

It is arguable whether hospitals would be better at running their own laboratories, using all salaried labor (including pathologists) than pathologists presently are. In fact, the opposite might be the case. By eliminating the incentive to take on such responsibilities, the income ceiling might well lead to less efficient laboratory management. And inefficiency would exact its toll in higher costs, not to mention the serious consequences it would have on patient care.

Finally, the long-run effects of the policy would probably be to reduce the number of newly-trained physicians willing to enter a specialty subject to such constraints—a specialty which would be viewed predictably as threatened with still stronger sanctions in the future.

We are therefore convinced that the effect of the adoption of Section 22 would be to *increase*, rather than to *decrease*, costs. This would become more readily apparent over the long haul than in the near future.

Therefore the result you seek, Mr. Chairman, of cutting costs to the patient and the Medicare-Medicaid programs would not be attained.

The "savings" which it might seem you would generate at the beginning would be, in any case, illusory.

You would not be saving, Mr. Chairman. You would be shifting costs from one account to another.

Consider a typical case of cost shifting.

In 1965, Methodist Hospital in Memphis, Tenn., a non-profit institution of 1,180 beds, was operating in the last year before the Medicare program got under way. The private patients who exclusively underwrite certain community service loss departments and furnish the total operating margin requirements represented some 93 per cent of the total patient population.

By 1975—a decade later—the private segment had dropped to 59 per cent.

The problem became how to compensate for the loss of a large segment of full-charge paying patients without cutting back on either the quality of care or the quantity of it provided by the hospital.

The solution was to increase charges substantially across the board for *all* patients.

Similarly, suppose S. 3205 succeeded in cutting the so-called profitability of the clinical pathology laboratory. How would the hospital compensate for the loss of revenues that are helping to subsidize losses in other departments, such as burn units? Should the hospital raise its charges for emergency room services? Or those for the intensive care unit?

The illusory "savings" made in the clinical pathology laboratory, having been translated into revenue loss for the institution, simply must be recovered somewhere else.

When Congress passed the original Medicare law, it recognized that it would be unfair to burden private patients with the cost of providing care to Medicare beneficiaries. The legislation states clearly that "the cost in respect to individuals covered by the Medicare insurance program will not be borne by individuals not so covered."

The fact remains that this intent of the law has been virtually invalidated by the regulations and interpretations of regulations that have subsequently been promulgated by government agencies.

Programs of the Medicare-Medicaid type cover a growing percentage of the nation's population. The utilization of such programs is stimulated by insurance contracts, governmental promises, and medical liability problems brought about by changing social attitudes toward compensation for injury regardless of the lack of negligence.

The continued failure of the government to recognize the operating margin requirements of not-for-profit hospitals in a day when these forces are impinging on our entire health care system can only result in either subsidization by the Federal government or reduction of the quality and/or quantity of patient care.

A word about the impact of Section 22 on the small and rural hospitals of this country. . .

Some 67.6 per cent of the nation's hospitals have 200 beds or fewer; 47.5 per cent of the nation's hospitals have 100 beds or fewer.

For the most part, these are rural hospitals.

According to the "Manpower Need Survey", completed by the College in 1975, only 7.4 per cent of pathologists engage in full-time practice in communities of 25,000 population or less; and only 5.8 per cent of full-time practicing pathologists derive their incomes solely from the provision of services to multiple small hospitals.

It is therefore clear that a great disparity exists between the demand for pathology services by small and rural hospitals and the supply of pathologists who will serve them either as full-time pathologists practicing in a single small hospital or as full-time pathologists serving several small hospitals. This difference between demand and supply is made up by pathologists who are primarily hospital based, or based in independent laboratories located in the larger population centers. These people provide services on a regular part-time, scheduled basis to the smaller institutions.

The medical staffs of the 100 bed or less hospitals are composed largely of general practitioners.

Prior to World War II, these hospitals had access only to those laboratory services which could be provided by a few, often inadequately trained, technical personnel. Sometimes a physician, usually a general practitioner, assumed nominal responsibility for the operation of the laboratory. There was no other choice. Pathology, and especially clinical pathology, was virtually unknown in these institutions.

Since World War II, pathologists have responded to this challenge. In doing so, they have brought about dramatic improvements in the quality of care, and the scope of services, that rural hospitals can provide.

In adapting to these demands, the pathologist often sacrificed time at home and in his parent institution to spend many apparently unproductive hours in a car, bus or airplane. For this, he has been dubbed as a "circuit rider" by many in government.

These "circuit riders" are frequently the only medical specialists to visit rural communities on a regular basis. Their services are invaluable to attending physicians because of the clinical pathologist's broad specialist training. In a very real sense, the pathologist provides some of the diagnostic expertise. He

is available for consultation with the attending physician either in person or by telephone.

It is important to patients to be as near to home as possible when they are hospitalized. It is also important to them financially, in that the per diem cost of services is usually considerably lower in small rural hospitals. Many illnesses are such that the family practitioner, working in the small institutions, can care for his patient with confidence only if he is supported by a high quality, clinical pathology laboratory and a radiologist.

The value of being close to home is enormously important to the patient, who can be visited by relatives and friends and receive care from the practitioner whom he has known and trusted over the years.

Mr. Chairman, let me urge you and the other members of this Committee to meet with the trustees, physicians and patients in the rural hospitals of your states the next time you are home. Among other things, I think you will quickly learn from them the value of the "circuit riders" and their contribution to rural health care.

The rural hospitals of the United States do not aspire to become medical centers, Mr. Chairman. But rural America deserves decent hospital and medical care; and the rural hospitals help provide that care.

The effect of Section 22 would be to lose rural America much of the ground it has gained during the past 25 years insofar as clinical pathologists' services are concerned, for the physician who wants to become a "circuit rider" for several small rural hospitals is of a rare breed.

Our rural areas are still critically short of doctors, as this Committee knows. With supportive help from such hospital-based physicians as clinical pathologists, some of our primary care doctors are still willing to practice in rural areas. If that support is not available, many more of them will not do so because their education has taught them to depend upon the clinical pathologist and his services, and to utilize them well.

The adverse impact of Section 22 would be considerable on the teaching hospitals, as well. The operation of the university hospital clinical pathology laboratory is additionally complex by reason of the educational thrust of medical students, residents, graduate students and medical technologists. Research and development are added responsibilities. The incomes generated in the laboratories have wide use within and without pathology departments. Any reduction would probably lead to increased drains on already overtaxed state budgets.

House staffs are larger, as are full-time attending and teaching staffs. Clinics and emergency rooms are also larger, and patients tend to be more seriously ill than those in private hospitals of comparable size. Under the circumstances, the clinical pathology laboratory is even more important.

Section 22 would fragment laboratory services in medical schools.

In general, this legislation would completely restructure the practice of pathology and might well eliminate the clinical pathologists.

Historically, pathologists only performed surgical and autopsy services. But as the technology of clinical pathology developed and expanded, the entire practice of pathology was revolutionized.

To exclude clinical pathology from the practice of medicine within the medical school—as S. 3205 would effectively do—would be a giant step backwards into the past, and confine pathologists once again to surgical and autopsy services, which do not afford broad exposure to, or participation in, overall patient care.

A major problem would be that of attracting additional faculty for clinical pathology departments and laboratories and being able to meet the payroll requirements. Certainly there would be the fear that such positions eventually would be phased out as it became increasingly obvious that an active professional role in patient care could not be supported for lack of sufficient revenues.

In short, passage of this legislation would be similar in its effect on medical school departments to its effects on pathology practice in other settings, except that it would be greater by reason of its sharp impact on the educational and training programs.

We alluded earlier to the bill's probable effect on the recruitment of pathologists in the year ahead. The damage would be severe, Mr. Chairman—make no mistake about it. If S. 3205 were to become law as it is now written, years of recruiting effort would have gone down the drain at the very moment when we are close to achieving a supply of new pathologists consonant with medicine's demand for their services.

In addition to this measure's crippling effect on recruitment, it would have a secondary impact by decreasing the medical student's motivation for subspecialization within laboratory medicine. Few would henceforth be greatly attracted to the medical specialty singled out by the government for discriminatory regimentation.

In view of the various comments we have made, we should briefly mention that in the Committee's effort to reach a fair and reasonable solution to the problems it perceives, consideration should be given to the requirements of law that any classifications established by statute must be based upon a legitimate and proper governmental purpose. Of course, as we indicated earlier, everyone concurs in the goal of cost-containment. But, we emphasize, the law requires that the specific means to achieve the objective must be proper. Further views on this subject are contained in Appendix A.

We should like to comment on Section 40 of this bill.

We appreciate the concern of Congress about instances of conflict of interest which involve some institutions, providers and contracting parties. Indeed, our comments later on in this testimony will address themselves specifically to the problems of fraud and abuse.

But although we share your concerns on this score, we do not believe that the benefits to be realized under section bear any relation to the potential cost of implementation, the possible disruption of our health care system, or the risk this sort of legislation poses to the future of quality health care delivery in the United States.

Prior approval of the Secretary of HEW is required for all contracts in excess of $10,000 per year made between the institution and consultants, or management and certain contractors.

Based on our interpretation of this proposal, Section 40 would make the Department of HEW responsible for establishing the largest purchasing department in the world.

It would be required to assemble a staff of attorneys, contract administrators, auditors and what have you, in unimaginable numbers, to administer this one section of the bill. We say "unimaginable numbers" because if such a staff were not huge, and presumably possessed of selfless dedication to its work, all management decision-making and administration in the health care system would be brought to a grinding halt.

This section would inject HEW into virtually every hospital board and executive management decision made in an American institution. In addition, it would directly affect many business enterprises which are compensated for their services or their effectiveness through arrangements based on percentages of savings or volumes of income.

Section 40 is certain to have an adverse effect upon the confidential and cooperative working relationships which exist between institutions and their attorneys, certified public accountants, management consultants, and providers of such purchased management services as data processing, housekeeping, food service, maintenance, etc.

The requirement to obtain prior approval could have adverse effects upon achieving efficiencies in the operation of institutions. For example, management may call upon its attorney to handle an incident potentially capable of developing into a major malpractice suit. Any delay could have severe financial consequences. Or, management may detect certain financial trends in operations and call upon a management consultant to review the situation and make recommendations.

The prior approval process can only cause expensive delays, and if competitive bidding is a requirement, the cost savings from a competitive bid may be more than offset by continuing losses.

This section appears to eliminate virtually any compensation arrangement based upon the percentage. But many valuable management and service contractors traditionally provide services under a percentage arrangement. Fund raisers, food service managers, housekeeping and maintenance service contractors, etc. are compensated on the bases of funds raised, expenses saved, or additional patient services provided. These enterprises perform valuable services, and neither the services nor their style of business can be ignored.

Another feature of this section is that it purports to control the amount and relationship of overhead costs to direct costs in any determination of total cost. This concept may be very desirable in its achievement. But as we pointed out earlier, in that section of our testimony covering the methods for establishing

the charge for a pathology test, overhead costs allocated to the cost of a service are extremely difficult to determine within an institution and virtually impossible to compare between institutions or organizations. The variable factors such as size, age of facilities, location, profit versus non-profit, and patient mix, prevent useful or meaningful comparisons.

In summary, we do not believe this section can be administered effectively, nor do we think it will achieve its desired objective. It represents an unreasonable intrusion into the affairs of the voluntary private health care system and the many enterprises which provide services and supplies for that system.

In those institutions where the combined Medicare and Medicaid utilization is less than 30 percent, measured against the total patient load, Section 40 will be considered more of an annoyance than a restraining factor. In those institutions which have a high utilization rate from Medicare and Medicaid covered patients, Section 40 adds a bureaucratic burden which assuredly will increase costs in such non-patient care cost centers as administration.

Mr. Chairman, we have testified at great length on Section 22 of S. 3205; and in some detail on Section 40. We would now like to comment very briefly on other section of the bill.

1. The CAP is strongly on record that fraud should be eliminated from all federal health care programs. However, we do *oppose* the establishment of an Inspector General for health care administration because it is not necessary, would introduce a new function within HEW in conflict with the Justice Department, and could result in a double standard for prosecution with prejudice against providers in health programs (Section 3).

2. The CAP *supports* the provision that rules should not become effective less than 60 days after publication in the Federal Register. We also *support* a provision which would provide a reasonable opportunity for comment by interested parties before guidelines become final (Section 7).

3. The College is greatly concerned about the effects that the proposals for changes in the reasonable cost reimbursement, uniform systems of accounts, and cost reporting for determining operational and capital costs, would have on hospitals (Section 10).

4. The College is *opposed* to changes in the criteria for determining reasonable charges for physician services as being contrary to the basic policy of usual, customary, and reasonable payment (Sections 20, 22).

5. The College is *opposed* to the proposal for facilitating the acceptance of assignments in general and specifically *opposed* to the special prejudicial treatment afforded pathologists providing laboratory services. This would, in effect, deny pathologists the right to engage in direct billing of patients for services under such arrangements as a lease or mutual working agreement which have been successful in reducing costs and in helping in rural areas (Section 21).

6. The College *supports* the proposal to arrange for payment under Medicare of certain physician fees provided to deceased individuals (Section 25).

Mr. Chairman, the College shares the concern voiced by Congress about the recent reports of fraudulent conduct in which certain of the health providers have been engaged.

We are alluding particularly to illegal acts involving kick-backs, rebates and other violations of the law by a relatively few clinical laboratories. These were made public earlier this year by the Senate Special Aging Subcommittee on Long Term Care.

We deplore these illegal practices and share your determination that they must be stopped.

We have said just that in our communications with two Congressional committees and a number of Members of both Houses.

We reiterate it here today, Mr. Chairman.

The College believes that the law-breakers should be punished to the full extent of the law. The public, which includes all ethical providers of health services participating in federal health programs, deserves the protections afforded to its tax dollars.

Additionally, the fiscal integrity of the funds allocated to Medicare and Medicaid requires strong and effective enforcement.

There is no need for new law to accomplish this. Section 1877 (b) of the Social Security Act provides all the law required. What is needed is its vigorous enforcement against offenders, and the College urges that enforcement.

At its annual meeting in Dallas last month, the American Medical Association adopted the following statement:

"The American Medical Association condemns and deplores all acts of fraud and wrongdoing, including in particular any wrongful acts as recently reported in the Medicaid and Medicare programs. We urge that responsible government agencies proceed with all due speed in the prosecution of all who are guilty of fraudulent misconduct. We will continue to offer our cooperation and assistance in bringing to an end such activities."

The College of American Pathologists endorses that statement wholeheartedly and adds its own pledge to cooperate and assist in any way possible in order that acts of fraud committed in violation of federal law and the Medicare-Medicaid regulations can be stopped and the violators punished.

Mr. Chairman, early in this testimony we stated that we were in full agreement with the objectives of S. 3205 but disagreed with the methods it proposed.

The College of American Pathologists therefore recommends to the Committee the following actions:

1. Implement presently existing provisions in the Medicare and Medicaid laws and regulations relating to fraud.

2. Encourage the use of mechanisms presently available through County Medical Societies and State Boards of Medical Examiners for dealing with improper or fraudulent activities.

3. Provide for review of pathologists' services and fees in the same fashion as the fees and services of other physicians are reviewed. Appropriate peer review, medical audit, and other utilization review can be made as effective and as appropriate for pathologists as for other physicians.

4. Implement presently existing provisions for disclosure billing.

5. Recognize the differences in the cost of providing clinical pathology laboratory services to ambulatory non-emergency out-patients as opposed to hospitalized in-patients by revising the present rules and regulations to facilitate the implementation of appropriate fee schedules.

Mr. Chairman, on behalf of our members, we appreciate, very much, having the opportunity to present the views and the position of the College of American Pathologist on this very significant legislation.

APPENDIX A

Legal Considerations

From a legal perspective, Sections 22 and 40 of S. 3205 raise questions as to the proposed classifications of physicians and physician services in light of controlling principles of constitutional law. Briefly stated, a classification established by legislation must have a rational basis in relation to the purposes of the Act. *U.S. Department of Agriculture v. Moreno*, 413 U.S. 528 (1973).

Section 40 of S 3205, which excises from the definition of "reasonable" charge or cost any amount determined by a percentage or lease agreement, has the clear effect of creating two classes of physicians—those who are compensated by such agreements, and those who are not. These two classes are indistinguishable in that they both perform identifiable physician services; however, on the sole basis of their compensation arrangement, the former is denied and the latter granted Medicare reimbursement for their services.

The Fifth Amendment to the Constitution forbids discrimination "so unjustifiable as to be violative of due process." *Shapiro v. Thompson*, 394 U.S. 618 (1969). While the Fifth Amendment governing federal legislation does not have an equal protection clause, it is well settled that its due process clause contains equal protection principles or what the Supreme Court has called its "equal protection component." *U.S Department of Agriculture v. Moreno*, 413 U.S. 528, 533 (1973); *Frontiero v. Richardson*, 411 U.S. 677, 680 n. 5 (1973); *Bolling v. Sharpe*, 374 U.S. 497, 499, 500 (1954).

Section 40 of the proposal defines a class of physicians who will not receive Medicare reimbursement for their services. According to the Supreme Court, such a classification "must always rest upon some difference which bears a reasonable and just relation to the Act in respect to which the classification is proposed, and can never be made arbitrarily and without any such basis." *Gulf C. & S. F. R. Co. v. Ellis*, 165 U.S. 150, 155 (1897); *U.S. Department of Agriculture v. Moreno, supra.*

In *Hartford Steam Boiler Inspection and Ins. Co. v. Harrison*, 301 U.S. 459 (1937), the Supreme Court struck down a state licensing statute which discriminated on the basis of compensation arrangements. The Court held that the statute incorporated a discrimination of "unusual character" which was unconstitutional as a denial of equal protection, concluding "it is plain that

requirement that the resident agent of stock companies should not work on a salary has no relation to economy or efficiency in management." This conclusion was based largely upon the fact that similarly situated employees of mutual insurance companies, allowed to be licensed under the statute, were paid by a salary arrangement found by the parties to be mutually desirable. Section 40 of the bill conversely discriminating against percentage or commission contracts while permitting salary arrangements, posits the same legal issues.

In proposed Section 1861(q)(3) of the Social Security Act, Section 22 of the proposal also creates two classes of physicians, this time singling out pathologists for special and unequal treatment. That section excises from the definition of physician services, and therefore denies Medicare reimbursement for certain services personally performed by pathologists; those services include autopsies, supervisory activities, quality control, and laboratory operations.

This exclusion is squarely at odds with the bill's general definition of physician services as including service "personally *directed* by a physician," found in the proposed Section 1861(q)(1). The clear effect of this section is to deny pathologists Medicare reimbursement for their directory services while at the same time granting other physicians such reimbursement, all of which services are performed ultimately for the benefit of the patient.

As applied to an analysis of S. 3205, there is no shred of evidence to suggest that the classifications that would be established by S. 3205 are rationally related to a legitimate governmental interest. Indeed, our evidence discussed earlier suggests exactly the opposite.

The final comment on the proposed legislation in this context is a technical one. First, there appears to be a fundamental inconsistency between Sections 22 and 40 concerning the permissibility of percentage compensation arrangements utilized by physicians and hospitals. Secondly, certain portions of the Bill are simply difficult to understand. See, for example, proposed Section 1133(a)(1). Basic technical improvements will have to be made.

Senator TALMADGE. The committee will stand in recess until 8 a.m.

[Whereupon, at 12:20 p.m. the subcommittee recessed, to reconvene Friday, July 30, at 8 a.m.]

MEDICARE-MEDICAID ADMINISTRATIVE AND REIMBURSEMENT REFORM

FRIDAY, JULY 30, 1976

U.S. SENATE,
SUBCOMMITTEE ON HEALTH OF THE
SENATE FINANCE COMMITTEE,
Washington, D.C.

The subcommittee met, pursuant to recess, at 8 a.m. in room 2221, Dirksen Senate Office Building, Hon. Herman E. Talmadge presiding.

Present: Senator Talmadge.

Senator TALMADGE. The subcommittee will please come to order. Our first witness this morning is Mr. Bernard Tresnowski, senior vice president, Blue Cross Association.

The witnesses are reminded that oral testimony will be limited to 10 minutes.

STATEMENT OF BERNARD TRESNOWSKI, VICE PRESIDENT, BLUE CROSS ASSOCIATION

Mr. TRESNOWSKI. Mr. Chairman, and members of the committee, I am Bernard R. Tresnowski, senior vice president of the Blue Cross Association, the national coordinating agency of the 70-member Blue Cross plans in the United States and Puerto Rico.

Even more pertinent to this hearing, the association is a prime contractor to the Social Security Administration for the medicare program nationwide. Individual Blue Cross plans are subcontractors to the association for this program. Many of our plans also administer the medicaid program in their territories.

I am here to give the views of our association on S. 3205, the Talmadge bill proposing amendments to the "Medicare-Medicaid Administrative and Reimbursement Reform Act."

If acceptable, I would ask my entire statement be introduced into the record as having been read and I will summarize briefly allowing time for questions.

Senator TALMADGE. The entire statement will be inserted in the record.

Mr. TRESNOWSKI. Thank you very much. Included in my statement are a great many details and also technical recommendations which we believe will make the bill more practical, more workable, and more affective, in helping to improve the total performance of the medicare and medicaid programs.

Many of the ideas presented in the bill, indeed most of them, are sound. Our organization recognizes in them the desire of the bill's

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authors—and the desire of the Congress as a whole—to review and revise various aspects of the medicare and medicaid programs to achieve four goals:

One, efficient administration of the programs.

Two, reduction in the rate of health care cost inflation.

Three, reasonable and prudent control over the use of beneficiary and taxpayer funds.

Four, more effective and accessible delivery of health care services.

Those are worthy goals, and they are the same goals we are striving for—both in our administration of Federal programs and in our handling of private business.

But there are two other broader goals that I think all of us should try to attain. You will find that both of them are closely woven into the specific comments we will offer on the proposed amendments.

One of the goals should be flexibility. Which means that legislation should not be so detailed and restrictive that it prevents changes from being made when they should be made. Instead of through legislation, we strongly believe that details of form and structure and function should be left to regulations—to rulemaking.

For example, there is considerable detail in this bill that makes it too prescriptive for legislation. An example is defining the specific hospital bed size categories in the reimbursement reform section. Considering the state of the art of classifying hospitals, that would better be left for rulemaking. Another example is defining the specific State medicaid administrative performance criteria in the State medicaid reform section. To make a change in such performance criteria, for instance to move forward with medical science or management innovation, would require a new act of Congress if the standards and criteria are solidified into legislation.

Our second goal is that reform, whether in administration or reimbursement, should be designed so as to promote results, and not dwell on form and function. Our association is not alone in seeking both of these goals—maintaining flexibility and being judged by results. In my statement I have referred to the June 1973 medicare program panel of the National Academy of Public Administration which after studying medicare for 3 years made the same findings.

A year later, in 1974, results of a 15-month study were released by an HEW advisory committee on medicare administration chaired by former HEW Assistant Secretary Roswell Perkins. The Perkins committee report said that with the development of better evaluation criteria and performance incentives,

SSA should reduce its role in carrier decisionmaking and rely on its capacity to test carrier performance by results.

Most important to all of these deliberations is that the medicare program has worked. It has done what it was created to do. It has made quality medical and health care available to the elderly citizens of this Nation. Furthermore, it has done that job while maintaining efficiency for the Government and the intermediaries, and preserving the integrity of the beneficiaries.

Our specific comments on the individual sections of the bill are all intended to be supportive of the need to improve on the performance of all participants in medicare and medicaid.

I would comment now only on section 10, determining reasonable cost for hospital services; section 11, the hospital transitional allowance board and section 22, hospital associated physicians.

Concerning section 10, the intent of this provision is sound in that it focuses on a measurement of result in determination of provider reasonable costs. However, we believe that the method of arriving at the payment limitation is so complex that it may give the provider no realistic way to relate that limitation to its operations.

Because that is so, the elements of predictability, control, and incentive are greatly diminished. The proposal may also be inflationary. The hospital is allowed reimbursement up to 120 percent of an adjusted group rate, which already includes factors for wage and nonwage inflation. There is no way to predict whether hospitals will tend to move toward the group rate or toward the 120 percent.

The complexity of the control placed on the identified part of the hospital costs, plus the realization that the issues of capital costs, et cetera, are not included, make the proposal appear administratively cumbersome and costly.

It would be hazardous to try to identify and universally apply one payment approach and to mandate it in the legislation. Instead, we suggest that the legislation should require the Secretary to develop one or more performance-based payment systems which would be made available to hospitals. Hospitals would then have the choice of selecting one of the Secretary's methods or another system which meets the basic criteria of the bill.

In our written comments on section 10, we have identified 10 basic design principles which we strongly believe should be incorporated into any performance-based payment system.

We have also indicated that the legislation should require the Secretary to have prospective reimbursement systems in place within 3 steps. Steps toward final installation would include—

One, establishment of a uniform accounting system as mandated under Public Law 93-641, including issuance of the system; tests of it in various State programs under the reimbursement experiments allowed through Public Law 93-602 section 222 waiver; and evaluation of the tests.

Two, evaluation of experimental prospective reimbursement systems already in place.

Three, development, deployment, and evaluation of any additional experimental systems deemed necessary over the next 3 years.

Four, the ideas embodied in the proposed classification scheme and the adjustment for the several cost variables might be used to develop target rates which could be used to monitor the effectiveness of payment under the various prospective payment systems.

As to the hospital transitional allowance board we support this provision. If duplicate and unneeded services and facilities are going to be closed or converted, protection against severe loss has to be available. The capital structure of the industry is the key element in any long-range cost containment strategy. This proposal and recently enacted planning legislation are important steps in developing appropriate cost containment measures.

Since this is a real innovation, we recognize the need for study before full use of it. Nevertheless, we urge that the board be given latitude in making its determinations. That way, a fair test of the approach can be established. But we believe that limiting the test to 50 hospitals for 2 years may be too restrictive. One area that will need careful consideration is the relationship between actions taken under section 1523 of Public Law 93–641 and actions of this board. Support through the transitional allowance can provide a significant base from which HSAs and/or other agencies administering certificate-of-need programs can take action.

We have offered specific recommendations for changes in this amendment in the body of our full statement.

As to the hospital associated physicians, we agree with this provision because it is appropriate that physicians bill patients only when there has been direct physician service rendered. However, we are concerned about the specific provisions as to how many patients an anesthesiologist can serve at one time and what charges can be billed. These matters should be part of the regulations where necessary changes can be made much more easily.

We believe the provision for physician "volume" arrangements might not be effective for two reasons:

One, it is concerned with the form of transaction—volume-related contract—rather than with the result. There are many arrangements on a volume basis which will produce a reasonable level of compensation for a physician. But on the other hand, salary or other nonvolume arrangements could result in unreasonable levels.

Two, it could cause physicians to move toward a direct billing arrangement for direct medical services to avoid this provision, with a separate contract for administrative functions. We believe that would increase medicare's total cost.

Senator TALMADGE. He called time on you. We have a number of other witnesses. The Senate goes in session, as you know, at 9 a.m.

Mr. TRESNOWSKI. May I conclude?

Senator TALMADGE. Sure.

Mr. TRESNOWSKI. I have detailed a specific recommendation on how we feel that hospital associated physicians change should be made and then I could conclude my comments by saying that if it is helpful to the committee on any of those points or any of the detailed points in our statement we will be glad to provide either in writing or to the members of your staff, and we thank you for your time and attention.

Senator TALMADGE. We appreciate very much your helpful and constructive statement, Mr. Tresnowski, and I am sure you will be of invaluable assistance to the staff and subcommittee in further perfecting the bill.

I understand your concerns with the hospital reimbursement approach in S. 3205. I believe, however, with the help of organizations such as yours we can improve that provision.

Given the enormous pressure on Federal and State budgets for hospital care as well as those same pressures which are creating serious difficulties for Blue Cross plans, do you have any recommendations as to ways of moderating hospital costs which can go into effect quickly on a nationwide basis?

Mr. TRESNOWSKI. We will be offering some detailed comments and recommendations on this matter to the Committee on Ways and Means next week and we will supply that, of course, to the committee.

Let me tell you right now that we are saying to the Committee on Ways and Means essentially what I have said in this statement. We would propose that the program allow for a diversity of reimbursement systems, either those directed by the Secretary or those that have been locally developed.

For example, in the State of Michigan, because of the financial pressures in that State, the Blue Cross plan there has placed a 10-percent limitation on its costs over the next year.

In the State of Rhode Island, there is a similar cost limitation based on how much money the medicaid program has as well as the Blue Cross plan.

What we are urging is that the program take advantage of these locally developed arrangements.

We will be telling the House Ways and Means Committee, that in order to motivate the providers to accept these locally developed prospective payment systems, you should take the medicare retrospective cost system and place limitations on it. What those limitations are, of course, will be dependent upon how much money the Congress has. But the limitations would be designed in such a fashion as to move providers away from retrospective cost reimbursement to prospective. That could be implemented immediately and over time you would move them as we say in the statement over 3 years.

Senator TALMADGE. Now we have penalties and no incentive. Do you think an incentive approach would help?

Mr. TRESNOWSKI. It depends on whether you want to call it a penalty or an incentive. We think the provider is better served if its administrator is given the latitude to operate his institution. He can do that best under a specific payment system. He has got to be motivated to move to specific payment and we think a limitation on the cost reimbursement system would help motivate him in that direction.

Senator TALMADGE. I appreciate your support of the provision in the bill which would establish a more equitable payment mechanism for Hospital Associated Physicians.

As the largest hospital insurer in the country is your support for this provision out of concern for excessive payments to such physicians?

Mr. TRESNOWSKI. Yes, we have testified before the Senate Finance Committee and various committees of Congress since the advent of the medicare program that the essentially artificial separation between the professional components and the administrative component has, in fact, increased the cost not only to the medicare program, but to us as private insurers.

Senator TALMADGE. What had been your experience in this regard?

Mr. TRESNOWSKI. Well, our experience is that the costs are higher because of this artificial separation. What we are arguing in our statement is that they be brought back together again, that there be a single payment.

Senator TALMADGE. What about the percentage arrangement that they have with so many hospitals?

Mr. TRESNOWSKI. The difficulty we have with the percentage arrangement lies in reconciling the amount paid out of the trust funds with an amount determined to be reasonable reimbursement.

We know these differences are there, but how large they are we don't know. It is apparent from analysis of the cost report that we really have very serious difficulties knowing how much was paid out of the part B trust fund.

Senator TALMADGE. Thank you very much. We will be relying on your future suggestions as we proceed with work on the legislation.

[The prepared statement of Mr. Tresnowski follows:]

STATEMENT OF THE BLUE CROSS ASSOCIATION BY BERNARD R. TRESNOWSKI, SENIOR VICE PRESIDENT

Mr. Chairman, and Members of the Committee. I am Bernard R. Tresnowski, Senior Vice President of the Blue Cross Association, the national coordinating agency of the 70 member Blue Cross Plans in the United States and Puerto Rico.

Even more pertinent to this hearing, the Association is a prime contractor to the Social Security Administration for the Medicare program nationwide. Individual Blue Cross Plans are subcontractors to the Association for this program.

Many of our Plans also administer the Medicaid program in their territories.

I am here to give the views of our Association on S. 3205, the Talmadge bill proposing amendments to the "Medicare-Medicaid Administrative Reimbursement Reform Act". (1)

A large number of experienced and knowledgeable people within the Blue Cross Organization have analyzed the Talmadge bill, line by line, and all of their comments have been consolidated into this rather lengthy statement.

I will present to you a great many detailed and often technical recommendations which we believe will make the bill more practical, more workable and more effective in helping to improve the total performance of the Medicare and Medicaid programs.

Before getting into the details, however, I would like to offer some background information that is both pertinent and important to your consideration of our individual comments.

Many of the ideas presented in the bill . . . indeed, most of them . . . are sound. Our organization recognizes in them the desire of the bill's authors—and the desire of the Congress as a whole—to review and revise various aspects of the Medicare and Medicaid programs to achieve four goals:

1. Efficient administration of the programs.
2. Reduction in the rate of health care cost inflation.
3. Reasonable and prudent control over the use of beneficiary and taxpayer funds.
4. More effective and accessible delivery of health care services.

Those are worthy goals, and they are the same goals we are striving for—both in our administration of federal programs and in our handling of private business.

But there are two other, broader goals that I think all of us should try to attain. You will find that both of them are closely woven into the specific comments we will offer on the proposed amendments.

One of the goals should be flexibility. Which means that legislation should not be so detailed and restrictive that it prevents changes from being made when they should be made. Instead of through legislation, we strongly believe that details of form and structure and function should be left to regulations . . . to rulemaking.

For example, there is considerable detail in this bill that makes it too prescriptive for legislation. An example is defining the specific hospital bed-size categories in the reimbursement reform section. Considering the state of the art of classifying hospitals, that would better be left for rulemaking. Another example is defining the specific state Medicaid administrative performance criteria in the state Medicaid reform section. To make a change in such performance criteria, for instance to move forward with medical science or management innovation, would require a new act of Congress if the standards and criteria are solidified into legislation.

Our second goal is that reform, whether in administration or reimbursement should be designed so as to promote results . . . and not dwell on form and function.

Our Association is not alone in seeking both of these goals—maintaining flexibility and being judged by results. (2)

In June of 1973, the Medicare Project Panel of the National Academy of Public Administration issued a report after studying Medicare for three years. The panel found that the present contractual partnership in Medicare is—"less a shared responsibility and more a dependency relationship." It recommended a new relationship that would—in the panel's words—"enable the private sector to add its full capability to the administration of the Medicare program.

To do that, the panel recommended that SSA make several changes, including reliance on established standards of performance for carriers—"with an emphasis on results rather than detailed regulations" and reorganization of the policy processes to give contractors" an earlier and more significant role in establishing policy and in formulating administrative procedures."

A year later, in 1974, results of a 15-month study were released by an HEW advisory committee on Medicare administration chaired by former HEW assistant secretary Roswell Perkins.

The Perkins committee report said that with the development of better evaluation criteria and performance incentives "SSA should reduce its role in carrier decision-making and rely on its capacity to test carrier performance by results".

It also urged that carriers be given a larger consultative role in the program, pointing out that private carriers are better equipped, in its words, "to adapt to the needs of circumstances of the localities in which they operate."

Finally, the committee said, that "carriers have well-established facilities and procedures of direct contact and communication with beneficiaries. It would take a great deal of time and the addition of larger numbers of personnel for government to be able to create similar relationships."

In speaking for the Blue Cross organization today, I represent nearly 50 years of experience in private health care protection . . . and 10 years of administering federal programs. On both counts, we are glad to be judged on the basis of our results and out contributions to the flexibility, efficiency and effectiveness of the services we have provided. Our contributions to Medicare and Medicaid, we feel, are significant.

Most important to all of these deliberations is that the Medicare program has worked. It has done what it was created to do. It has made quality medical and health care available to the elderly citizens of this nation. Furthermore, it has done that job while maintaining efficiency for the government and the intermediaries, and preserving the integrity of the beneficiaries.

Our specific comments on the individual sections of the Bill—all of them intended to be supportive of the need to improve on the performance of all participants in Medicare and Medicaid. (3)

SPECIFIC PROVISIONS

Section 2—Health Care Financing Administration. Central Fraud and Abuse Unit Prosecution by the DHEW General Counsel

We agree with the need to centralize policy formulation for the Medicare programs into one agency, thereby reducing the existing fragmentation among various offices. However, we do have a concern with the suggested approach. The proposal would result in having two Assistant Secretaries responsible for HEW health matters.

Although the change could produce some improved coordination, it could also possibly create another form of fragmentation by separating financing from other health matters such as quality.

We believe one official as Undersecretary should have primary internal responsibility for coordinating all health concerns within HEW. That person could then be assisted through the establishment of inter-agency committees to better coordinate policy and regulations. There is already some movement toward that end in carrying out PL 92-641.

Regarding the Central Fraud and Abuse Unit, we believe an intensive effort is needed to evaluate the extent of the problem and to take corrective measures, including sanctions where warranted. We do, however, believe that most providers are honest; that fraud is probably of much less magnitude than abuse,

which largely stems from provider misinterpretations of law and regulations, lack of appropriate incentive or regulatory gaps.

Establishing the Office of Central Fraud and Abuse Control would be good provided other departments in HEW did not continue to pursue their separate inspections of fraud and abuse. Some degree of duplication in this regard might be necessary and valuable, but the potential of this section is to add another inspection level rather than producing the needed coordination.

That raises the question as to whether this new unit is necessary at all, in light of existing HEW and congressional units such as HEW Audit, the Office of Investigations and GAO, which could—and do—perform all or part of the proposed functions.

Overall, we wonder whether the same objective could not be accomplished through expansion of existing investigatory bodies, by realigning priorities and by giving existing agencies more authority and accountability.

Authorization of the Office of the General Counsel to prosecute civil fraud cases is a good suggestion and will help speed up prosecution of cases. We would further suggest that the General Counsel be given authority to handle all Medicare litigation.

The Medicare program involves a vast amount of regulatory material and some novel features, such as the use of intermediary. It cannot realistically be expected that the typical U.S. Attorney will be able to devote the time and effort necessary to learn as much about the program as he needs to represent effectively the government's interests. And if he doesn't know enough about the program, he cannot do a competent job of educating the judge. The results, in some cases, have been uninformed decisions.

By consolidating responsibility for Medicare litigation of all kinds in the Office of the General Counsel, the government would be able to develop a corps of lawyers experienced in Medicare litigation. We believe that would improve the quality of representation for the government and would result in a more efficient use of the government's manpower.

Section 3—Inspector General for Health Administration

The Inspector General would have a separate audit responsibility. He would report directly to the Secretary, but would have specific accountability to the Congress. The arrangement raises a question in our minds of internal departmental coordination of fraud and abuse, as well as the separation of congressional and executive branch powers. These are fundamental questions which should be considered.

Section 4—State Medicaid Administration

Naturally, we support measures to encourage more consistent and efficient administration of all federal programs. Developing performance standards and criteria is one way to help do that.

However, the bill sets forth in detail specific performance criteria which would better be left for rulemaking. And more important, the bill does not go far enough to assure Medicaid credibility.

For example, the bill does not identify over-all program components, such as payment of claims, financial management, audit, reimbursement, and so forth; nor the data needed to measure performance in each of those areas. The data reporting requirements in the amendments are not necessarily linked to performance measurement and do not identify exactly what will be measured once the data are received. There is a similar situation in Medicare, where volumes of data are requested that have little or no impact on the actual management of the program.

Furthermore, the standards have not been based upon historical data and have been imposed upon the state without thorough statistical analysis.

Here are a few specific deficiencies:

Standards of quality proposed by the legislation deal only to a limited extent with judgment. Most deal with the rates of clerical errors.

Quality standards are not part of the penalty provisions. For example, a state's error rate could be deficient in terms of eligibility determinations but federal matching funds would never be reduced or terminated.

There are no standards for the audit process or audit quality, such as desk reviews, field audits, accurate settlements and others.

There are no standards in the legislation for administrative accounting or financial management.

And there are no utilization guidelines or cost containment standards.

Regarding the standards, here are some technical considerations:

The definition of a claim in Medicaid varies from state to state. In one state, a hospital claim is all services provided to one patient during a stay in the hospital. The only cutoffs that could divide the stay are the hospital's fiscal year or the state's fiscal year.

The definition assures a larger number of line items on a claim and therefore increases the likelihood that a claim can fail to pass all of the edits and audits in a system.

With respect to the definition of "paid", does it mean that the check is in the mail; or that the claim has been processed and is now on the payment register? If the latter is true, then meeting the standard is easier.

If "check in the mail" is the definition, another problem arises: Fiscal agent contracts usually show how often bills are to be paid—monthly, biweekly, weekly or daily. If a fiscal agent is required to run his payment tape monthly, there is no way he can meet the requirement.

In addition to things already listed, fiscal agents must process the claims, write the checks and provide the state with the total dollar value of the checks written. The state forwards the money to cover the checks. This exchange can cover one to two weeks. Consequently, at this point, "check in the mail" is less realistic as a definition of "claim paid."

The question posed by those difficulties is not whether standards can and should be applied to the Medicaid program, but whether they can and should be legislated. The Medicaid program is complex, and enforceable standards will have to take that complexity into account.

Section 5—Economical Processing of Claims by Carriers

We favor contracting on the basis of a fixed price per claim. However, there is no definition of the "claims processing functions" in the proposed amendment or the "claims processing services" in the summary following the legislative language. The lack of those key definitions leaves much to interpretation.

At the present time, neither regulations nor BHI instructions define the terms, either, but such definitions are vital for contractors bidding on a fixed-price basis.

Without the definition, both contractors and BHI staff frequently refer to certain line items on the Part A and B cost reports as "claims processing function" cost. Using that commonly assumed definition makes it clear why the proposed amendments focus on claims processing cost, which includes approximately 80 percent of the carriers' reported costs. Within the accepted line item groupings, however, there is substantial variation among carriers in the cost reported and in the elements each includes in reported costs.

Also, if the proposed amendment means a fixed price, rather than a fixed cost, the cost should not necessarily be a consideration in awarding contracts. But the amendment provides "access to the claims processing operation and the cost thereof," presumably for the purpose of quality inspection. But the wording is vague enough to imply a continuing audit of costs. If an audit or some test-of-reasonableness of the cost (as opposed to the price) is to be made by the government, it is absolutely necessary that the elements of cost be defined because those cost elements will affect the price paid to the contractor under a fixed-price agreement.

The proposed amendment does not say how the prospective price per claim will be established other than "on the basis of the economical and efficient performance of such functions and . . . (considering) the reasonable cost . . . incurred . . . by the various entities which are available to perform such function. This language appears to relate fixed-price contracting back to cost. That may be an attempt to assure that the fixed price covers carrier costs; however, the language is not clear. The summary following the legislative language indicates that a carrier could earn profits (called "productivity incentives") but does not clearly place the carrier at risk of loss.

There are other concerns with this section.

The amendment requires the Secretary to establish procedures for contracting that are consistent with federal procurement requirements. However, those requirements include competitive bids and the amendment does not appear to change the present stipulation in Section 1842(b)(1) that competition is not required for carrier contracts. The summary may indicate that present carriers will be required to convert to a fixed-price basis rather than instituting open competition for all carrier contracts but that point is not clear.

Quality standards are necessary to review carrier operations, but such standards are not yet available; nor are they addressed in the legislation other than a reference to allowing the Secretary access to the claims processing operation. The law and regulations should clearly say what quality is expected.

Finally, the approach for fixed-price contracting seems to be accepted as a panacea to reduce administrative costs without any statement or estimate of the effect on service to beneficiaries, improvements in administration or the potential cost savings from consolidation of carrier functions and locations where claims are processed. Given the history of the Medicare program, it is important that legislation setting up fixed-price contracting clearly allow for either price escalation clauses or suitable change orders as a result of program changes and continuing BHI manual changes. If that is not clearly stated, a contractor will likely lose money.

An alternative to fixed-price contracting for all carriers would be an experiment with a limited number of carriers—ten, perhaps—within a certain time. That would require HEW to use a fixed-price approach rather than relying on the current authority in the 1972 amendments which say the Secretary "may" enter into reimbursement experiments.

Section 6—Claims Processing and Information Retrieval

This provision would authorize states to send explanations of benefits on a sample basis rather than to all recipients. The decrease in workload would reduce costs and would be a helpful change in program administration. However, we believe the provision should specify that private contractors should have the opportunity to develop the desirable compatibility between Medicare and Medicaid systems.

Section 7—Regulations of the Secretary

We would recommend excluding any provisions to reform the rulemaking process. The regulatory process is already under study by the government and HEW has established an Office of Regulatory Review. Those efforts are responding to expressed concerns from providers and others that the period allowed for public comment on HEW proposed rules has not been sufficient in many cases.

We question whether the language in the bill will satisfy what appears to be the intent, which is to allow at least 60 days for public comment on non-urgent regulations. The bill says that a non-urgent regulation "shall become effective no less than 60 days after publication" of the rule. Given the likelihood that 60 days will become the guideline, and the need for HEW staff time to review and modify the proposed rule after getting comments, the public comments, the public comment period could often be less than 60 days. The bill should specifically stipulate a 60-day period for public comment.

In addition, the bill fails to provide any criteria to guide the Secretary in deciding which are urgent and which are non-urgent regulations. It also fails to address any process or time period for urgent regulations.

Section 8—Termination of HIBAC

Because Titles 18 and 19 are major public programs which affect so many aspects of society, we feel there is need for a strong and effective external advisory body to the Secretary, to provide external points of view at critical stages in program development.

Section 10—Determining Reasonable Cost for Hospital Services

The intent of this provision is sound in that it focuses on a measurement of result in determination of provider reasonable costs. However, we believe that the method of arriving at the payment limitation is so complex that it may give the provider no realistic way to relate that limitation to its operations. Because that is so, the elements of predictability, control and incentive are greatly diminished.

The proposal may also be inflationary. The hospital is allowed reimbursement up to 120 per cent of an adjusted group rate, which already includes factors for wage and non-wage inflation. There is no way to predict whether hospitals will tend to move toward the group rate or toward the 120 per cent. The complexity of the control placed on the identified part of the hospital costs, plus the realization that the issues of capital costs, etc., are not included, make the proposal appear administratively cumbersome and costly.

Constant surveying and adjustment to rates (both prospective and retroactive) will reduce measurable results and performance. The complexity of the program also lends itself to too much tampering.

In general, the proposal is a piecemeal approach to hospital costs. In current cost-finding methods for hospitals, routine costs divided between personnel and non-personnel—excluding capital, energy, educational and medical service costs—is not a recognized unit.

The proposal also omits all ancillary service costs, the costs of special care services and energy, capital, educational and medical service costs. Those have to be dealt with; they represent a large portion of a hospital's costs. While the aim of this section was to develop the largest grouping of comparable costs possible among providers, it has underestimated the ability of the uniform accounting system proposed later in Section 10 to provide a more realistic and comparable base.

The proposal establishes eight bed-size categories. The science of hospital classification is still under investigation and debate, and it is unwise to mandate such a classification system. Section 1533(d) of PL 93-641 requires the Secretary to establish a hospital classification system, and we think that mandate should be left in place.

There is general agreement among observers of present payment systems that:

They must actively promote efficient management.

They must include rewards that provide incentives large enough to motivate managers to make and uphold the difficult decisions that characterize efficiency.

No one best kind of performance-based payment has yet emerged.

Regarding the last point, experience with performance-based payment is relatively limited in terms of time, number of systems being used and the nature of those systems. For the most part, experimentation has taken place only in the last five to eight years and part of that period was restricted by the Economic Stabilization Program. Moreover, approaches that have been tested have been mostly technocratic in nature, focusing on operations rather than management policy issues; and they allow for only small, institutional rewards.

It would be hazardous to try to identify and universally apply one payment approach and to mandate it in the legislation. Instead, we suggest that the legislation should require the Secretary to develop one or more performance-based payment systems which would be made available to hospitals. Hospitals would then have the choice of selecting one of the Secretary's methods or another system which meets the basic criteria of the bill. (3)

Criteria defined in the act, we believe, should reflect these design principles:

1. *Results orientation.*—The payment mechanism should rest on results, not process; allowing for both technical and policy matters; with operating decisions left to the hospital.

2. *Equal risk.*—Both payer and provider should be subject to similar levels of risk; subject to both rewards and penalties.

3. *Employee participation.*—Any incentive rewards should be available for distribution to all or part of the employees and medical staff.

4. *Significance.*—The size of potential rewards and penalties should be sufficient to motivate management and staff to improve performance.

5. *Uncontrollable events.*—The payment mechanism should allow negotiated adjustment for mutually agreed uncontrolled events, such as substantial changes in volume or mix of patients, legislative changes and natural catastrophies.

6. *Tie to health planning.*—The payment mechanism should reflect the reasonable costs of only existing and new services and facilities determined to be needed and appropriate by designated health planning agencies.

7. *Tie to effective utilization review.*—The payment mechanism should provide internal and, where necessary, external utilization review systems that assure the provision of only medically necessary and appropriate services.

8. *Quality maintenance or improvement.*—The mechanism should not be so restrictive that the quality of patient care is jeopardized.

9. *Equitable incentive system.*—The reward and penalty systems should be designed so that the efficient hospital is not penalized and the inefficient one rewarded. Since efficiency has no absolutes, the rewards and penalties should focus on the relative performance among "like" types of institutions.

10. *Financial equity.*—The mechanism must reflect the provider's total cost of operations, including (1) unrecovered costs because of patients' inability to pay; (2) beneficiary credit losses; (3) the costs associated with necessary working capital and financing approved capital facility and services projects; (4) reasonable rate of return and risk factors to attract needed capital and to recognize the risk assumed in performance-based payment systems; and (5) any other costs of doing business as identified by the Secretary.

The legislation should require the Secretary to have prospective reimbursement systems in place within three years. Steps toward final installation would include:

1. Establishment of a uniform accounting system as mandated under PL 93-641, including issuance of the system; tests of it in various state programs under the reimbursement experiments allowed through PL 93-002 Section 222 waiver; and evaluation of the tests.

2. Evaluation of experimental prospective reimbursement systems already in place.

3. Development, deployment and evaluation of any additional experimental systems deemed necessary over the next three years.

4. The ideas embodied in the proposed classification scheme and the adjustment for the several cost variables might be used to develop target rates which could be used to monitor the effectiveness of payment under the various prospective payment systems. (4)

Section 11—Hospital Transitional Allowance Board

We support this provision. If duplicate and unneeded services and facilities are going to be closed or converted, protection against severe loss has to be available.

The capital structure of the industry is the key element in any long-range cost containment strategy. This proposal and recently enacted planning legislation are important steps in developing appropriate cost containment measures.

Since this is a real innovation, we recognize the need for study before full use of it. Nevertheless, we urge that the board be given latitude in making its determinations. That way, a fair test of the approach can be established. But we believe that limiting the test to 50 hospitals for two years may be too restrictive.

One area that will need careful consideration is the relationship between actions taken under Section 1523 of PL 93-641 and actions of this board. Support through the transitional allowance can provide a significant base from which HSAs and/or other agencies administering certificate-of-need programs can take action. (5)

Section 1132(b)(2)B provides for determining efficient and economical delivery of health care services by "an appropriate health care facility planning agency." While consultation with local planning agencies is essential, the board must be free to make independent decisions. This action may be too restrictive.

Section 1132(b)(3) relative to specific reimbursement is confusing since it deals with providers that continue in operation and those that close. Since the reimbursement provisions are different in the different cases, the organization of the section would be improved if they were given separate paragraphs.

These are our suggested modifications throughout the section:

1. Section 1132(a)(2): Add after "application by hospitals . . . XIX" the phrase "HSAs and other planning agencies designated by the Secretary with respect to such hospitals." The addition provides the opportunity for HSAs and other planning agencies to take the initiative to get appropriate financial relief in implementing their decisions. Such a provision should give support to the agencies in some difficult situations.

2. Section 1132(b)(2)B: Delete two parenthetical phrases: "(as determined by an appropriate health care facility planning agency)" and "(as determined by such agency)". Add, at the end of the paragraph, the following: "Such determinations will be made by the board only after consultation with and advice from appropriate health care facility planning agency." This language would clearly establish the board as the decision-making authority. It also would protect against decisions by local groups which may be clearly political.

3. Section 1132(b)(3): Delete "or (C). . . . salvage value" from this section. Establish new Section 1132(b)(4) which includes reimbursement treatment for hospitals that cease operations. Included would be provisions (B) and (C) from Section 1132(b)(3). This clarifies the differences in reimbursement for hopsitals that close and those that remain open.

4. Section 1132(c)(1) and (2) should be modified to allow for prospective application to the board.

5. Section 1132(c)(4)(C) should be modified to indicate that the transitional allowance is not considered when determining cost limitations. This protects the transitional allowance from dilution by any reasonable cost limitation. Since this is a special circumstance, the remaining provider operations should not be penalized because of payments from the board. However, the lower of cost or charges would apply since it is appropriate that hospitals "charge" other payers for the part of reimbursement not covered by the Medicare program.

6. Section 1132(e): We recommend that this section be modified to provide for more hospitals during the test. The minimum should be 100. Adding hospitals would expand the test and provide a broader base for analysis of its impact.

Section 12—return on equity included in "reasonable cost" in proprietary hospitals

Any changes in the rate of return on equity capital should be made cautiously. In considering any change, careful cognizance should be given to the need of expansion of facilities and whether new capital needs to be encouraged at this time. Of relevance is (Section 11) which is concerned with ways to discourage expansion by closing or converting unneeded or excess capacity.

Also, because return on equity capital is subject to income tax, and presuming to corporate tax rate of 50 percent, payment of any return on equity capital transfers 50 percent of the return from the Medicare Trust Fund to the General Revenue Fund. Considering the current crisis in funds available for health care, such a transfer may not be appropriate.

Section 20—criteria for determining reasonable charge

This provision would stop the prevailing fee for a service in a given locale from being increased in a given year where it is more than 50 percent higher than a computed statewide prevailing fee (set at the 50th percentile of prevailing fees within the state). We are not sure such a measure will produce more "rational" pricing of physician services across locales—either to recognize real geographic differences in the economics of practice or to promote a redistribution of physicians to medically underserved areas. One of the causes of current disparities may relate to inappropriate designations of locales for fee determination.

The proposal to encourage new physicians to begin practice in medically underserved areas by paying them at the 75th percentile of prevailing fees rather than the 50th percentile has merit, but we doubt that this reform by itself will produce any significant redistribution of physicians to shortage areas. It might work better to add some type of reform measure favorable to physicians who already practice in medically underserved areas.

It might be preferable for HEW to accelerate its efforts to try new physician reimbursement approaches aimed at designing effective charge and payment methods that (1) promote full assignment/participation by physicians for care to beneficiaries; and (2) promote better distribution of physicians both by geography and specialty.

Section 21—agreement of physicians to accept Part B assignment

A better incentive program to get physicians to accept full assignment (participating status) for covered services for Medicare beneficiaries is highly desirable.

We doubt seriously, however, whether the batch-billing, $1 per patient administrative expense "rebate" and cash flow features will achieve the desired result.

The primary obstacle to physician participating status may well be the problems they perceive in the complexities of paperwork, cash flow and perhaps more important, inadequacies of the programs' fee structure. That last point is not mentioned in this provision.

On the matter of the $1 per patient "rebate," we question whether that is much of a financial incentive either for physicians who have comparatively small Medicare case loads or who have already built increments into their prices to cover Medicare paperwork costs.

We would recommend that the bill require HEW to study and experiment in this area to find a better approach.

Section 22—Hospital Associated Physicians

We agree with this provision because it is appropriate that physicians bill patients only when there has been direct physician service rendered. However, we are concerned about the specific provisions as to how many patients an anesthesiologist can serve at one time and what charges can be billed. These

matters should be part of the regulations where necessary changes can be made much more easily.

We believe the provision for physician "volume" arrangements might not be effective for two reasons:

1. It is concerned with the form of transaction—volume related contract—rather than with the result. There are many arrangements on a volume basis which will produce a reasonable level of compensation for a physician. But on the other hand, salary or other non-volume arrangements could result in unreasonable levels.

2. It could cause physicians to move toward a direct billing arrangement for direct medical services to avoid this provision, with a separate contract for administrative functions. We believe that would increase Medicare's total cost. (6)

We have consistently advocated that any contract limitation on cost should not be related to form or process, but rather should relate to the output or result. Results orientation preserves the management rights of the provider as well as the contractual rights of physicians.

We propose substantial changes in the basis for reimbursement of hospital associated physicians. Our suggestions are designed to make administration of the program easier; to assure that payments to physicians are appropriate; and to reduce the fragmentation of payment choices that now exist for hospital/medical services.

Our proposals are these:

1. Require that Medical program payments to all hospital associated physicians be made through the provider. This would require that all physicians bill for their services on a "combined billing basis" if they do not directly relate to the patient and do not have a "private patient relationship:" We believe that would reduce cost because it would eliminate direct billing. It also returns to the more traditional form of billing prevalent before Medicare. The provision would apply most frequently to radiologists, pathologists, cardiologists and emergency room physicians. Splits between Part A and B trust funds could be made at the end of the year based on the provider cost report.

2. Add provisions to assure that payments and increases in payments by providers to physicians are appropriate. The provisions should focus on the total amount paid to the physicians rather than on the type of arrangement; and should establish an acceptable level and rate of increase of payment, published in advance for various categories of hospital associated specialists. They would be based on current experience in comparable settings.

Major components would be these:

Provider classification system—based on the system currently used for routine cost limits or the one promulgated by this legislation for the "target rate proposal."

Specialty subclassification—a limited number included in the classification system to measure the complexity and intensity of services. The design of the subclassifications should be made in consultation with professional associations representing the specialities.

Unit of measure—amounts paid by the provider for all services of each physician specialty would convert to an amount per adjusted patient day, the statistic used by the American Hospital Association to equate both in patient and outpatient services.

Annual limit—the Secretary would promulgate annually for each specialty and each classification the level of adjusted per diem payment to physicians beyond which Medicare would not reimburse unless an exception is allowed.

Annual increase—where the limit is not exceeded, the Secretary would establish a level of increase from the prior period in the amount per adjusted patient day. This provision would tend to retard unreasonable movement toward the limit amount.

Exceptions—procedures would be developed to provide appeal for an exception to the limit on a prospective or retrospective basis. Existing appeal mechanisms could be used.

Contracted services—where services are contracted from an outside laboratory or another provider, the supplier of service would certify to the amount of physician compensation included in the contracted amount. This amount plus any physician compensation paid directly by the provider for that specialty would become the amount subject to the limitation.

Section 23—Payment for Physician Services under Medicaid

The provision that Medicaid pay physicians at least 80 percent of Medicare reasonable charges for similar covered services in physician offices should help equalize reimbursement levels between the two programs. That may be desirable from an equity standpoint.

However, it may well increase the cost of the program and not meet the intended goal of shifting services to physicians' offices from hospital emergency rooms and outpatient departments. That is because; (1) physician office capacity in many "Medicaid areas" (often medically underserved areas) may already be strained so that the shift cannot realistically occur, or (2) even if additional physician office capacity exists, the Medicaid reimbursement may not be sufficient financial incentive for physicians to treat more Medicaid patients in their offices.

Consequently, it is entirely possible that this provision will do nothing but increase the level of reimbursement to physicians already treating Medicaid patients in their offices.

Section 24—Payment for Certain Antigens under Part B of Medicare

Currently, many patients in rural areas are not reimbursed for antigens. They travel to larger towns where allergists are located, buy a supply of antigens and give the supply to their physician for him to administer.

This provision is good in that it will help to avoid any allegations of fee-splitting between the two physicians. Allergists would be paid directly by the program for preparing supplies of antigens which would then be administered by the patient's physician.

In addition, where patients are not now reimbursed for antigens, the attending physician does not pay the allergist. Under the proposed changes, more patients who are entitled to those services will receive reimbursement for them. Payment would be handled by carriers.

Section 25—Payment of Services for a Deceased Patient

This section of the bill is good in that it would permit payment by Medicare, on the basis of a non-receipted bill, directly to the spouse or legal representative of a deceased beneficiary. Now, Medicare can only pay where the physician accepts assignment or where the family has actually paid the bill. Where a physician refuses assignment, families have had difficulty raising funds to pay the bill in order to be eligible for payment by Medicare. This change would be handled primarily by carriers.

Section 26—Prohibition Against Assignment of Fees by Physicians

This provision is good in that it should substantially reduce the fraud and abuse situations that have occurred through the use of power of attorney agreements concerning assignment.

Section 31—Medicaid Certification and Approval of SNFs

This is a good provision that would provide more uniform application under Medicaid, to coincide with Medicare, of the health and safety standards and timely termination of skilled nursing care facilities with previous deficiencies. The Secretary would be the final certifying officer for the facilities under Medicaid. He now has this authority for SNFs participating under Medicare only or both Medicare and Medicaid; but not Medicaid only.

If the Secretary becomes the certifying officer for SNFs now certified for Medicaid only, we expect that many of them would seek a new dual certification (Titles 18 and 19) in order to retain Title 19 reimbursement. Consequently, there could be a fairly substantial increase in new Title 18 SNF providers.

Section 33—Visits Away From Institutions by Patients

This section is good in that it would prohibit the Secretary from limiting the number of home visits by Medicaid patients in skilled nursing homes or intermediate care facilities. Now a Medicaid patient cannot leave more than six times a year because it would mean he is not sick enough to require confinement. The bill indicates that the answer to the problem is to have effective admissions and follow-up review to provide proper patient placement.

Under the proposed change, more patients would become eligible for Medicaid benefits; but it would eliminate the need for checking admissions to verify whether the patient had more than six leaves during the year.

Section 10—Reasonable Cost and Reasonable Charge; Disclosure of Ownership and Financial Information (Section 1133(a)(1))

This provision appears to focus on form rather than results. Flat fee or rental arrangements can be as unreasonable as a percentage arrangement. The focus of the law should be on over-all containment of costs through the reimbursement mechanism, rather than on individual elements of cost.

Section 1133(a)(2)—Direct and Indirect Overhead Costs

This provision is another example of a piecemeal approach to cost control through the reimbursement mechanism. The best approach is one that addresses the total costs of the facility, as we suggested in our comments on Section 10 of the bill.

There is no basis for comparing the cost of certain services provided through a hospital (with related overhead) and through a free-standing facility (with limited overhead). Any savings perceived by such comparisons are largely illusory because the hospital will continue to incur the same general levels of overhead. The addition of these services in a hospital should be measured on an incremental basis for a more valid comparison of total cost to the community.

While services such as home health care, renal dialysis, etc., can be provided by a free-standing limited facility at a unit cost less than a hospital's, the hospital is a key focal point of community health and should not be disadvantaged in the provision of services because of a legislative provision such as this. Often the hospital is required to provide back-up and emergency services to free-standing units.

Section 1133 (b)(1) and (b)(2)—Management Consulting Services

This section focuses on form rather than results and is a direct interference with the management prerogatives of the provider. Existing program provisions can address unreasonable payments made under contractual arrangements; for example, routine cost limitation, contracted therapy services and prudent buyer. We believe that the administration of this provision would not be cost-effective.

Section 1133(c)(1)—Answering Requests For Any Information

This is a very difficult section to assess. If applied on a broad scale, the reporting detail would be enormous.

Regarding "consolidated" and "certified" cost reports, the provision would cause confusion without definition of "consolidated." A report consolidating two or more organizations could result in a great deal of information unrelated to provision of health care services by the provider. That could greatly increase the cost of auditing.

The term "certified" is also undefined. If it means certification by certified or independent public accountants, this provision would greatly increase provider costs.

We agree that the government should have access to records and information which describe financial interests, transactions, etc., which affect government payments for services. But our concern is with the non-specific nature of the provision.

The section also applies to any request made for the information, although it appears the information would be useful only in three circumstances: (1) Suspected fraud or abuse, (2) prudent buyer misapplication (excessive cost or conflict of interest), and (3) related organization application.

To protect related organizations against unwarranted and excessive requests for disclosure of such information, it would appear appropriate to limit the circumstances under which the requests could be made.

Reporting 1 percent of ownership and total reporting of security interest—particularly when both direct and indirect relationships are considered—appears to be excessive. It is not likely that such minor levels of interest would be pertinent to any of the three situations noted before.

The following is suggested as qualifying language intended to limit requests to those where a showing of cause can be made and to establish a more reasonable level of reporting:

1. In Section 1133(c)(1)(B) add after the phrase "promptly comply with any request," the phrase "accompanied by a showing of good cause."
2. In Section 1133(c)(1)(C) substitute in (i) "10" percentum for "1" percentum.
3. In Section 1133(c)(1)(C) add in (i) after the phrase "who is the owner (in whole or in part) of" the phrase "10 percentum or more."

Substitute for the proposed Section 1133(c)(1)(E) as follows:

"(E)(i) a statement with respect to the costs and charges of related organizations (as that term is employed for purposes of Title 18) included in its cost report (ii) a statement, from any related organization identified in (i) above, with respect to the relationship of such costs and charges to the total costs and charges of the related organization."

The change would give legislative authority to the reporting of information currently required for proper payment under the existing principles of reimbursement.

Section 1133(d)—Pharmacies and Laboratories

We support this provision as a necessary tool in detecting fraud and abuse. However, we urge that the administration of such a provision be reasonable and focus on high volume operations.

An additional category of supplier not covered under this or any other similar provision is free-standing renal dialysis treatment centers. Since Medicare and Medicaid pay for almost 100 percent of renal services, and the free-standing facilities are a significant part of the volume, such a provision would be an appropriate safeguard.

Section 41—Standards for Payment Under Medicaid to HMOs

We recommend against this section. In our judgement, it would seriously impede if not actually block availability of the HMO option to Medicaid eligibles.

First, cost reimbursement with retroactive adjustment is contrary to HMOs' established method of operating and is expensive. It violates the principles of prospective rate setting, which is the fiscal basis for HMOs' success and economy as a health services delivery system.

Second, the risk-sharing option is particularly unattractive in that the HMO assumes the risk of providing benefits for the estimated per capita cost of non-HMO beneficiaries in the community. If the HMO's cost is less, the government retains a share of the savings; if it is more, the government does not share in the loss.

Furthermore, if the Secretary's estimate of the non-HMO beneficiary per capita turns out to be high after all the bills are in, a year or more later, the HMO's share of any savings is reduced and must be recovered by the government. In other words, the HMO contracting under Section 1876 is a risk for after-the-fact determination of reduced reimbursement cost, and in risk-sharing contracts for over-estimates of the non-HMO costs by the Secretary. It may have to pay back money already spent for equipment, improving operations and salaries. Consequently, HMOs generally and prototype HMOs (these in existence before 1971) particularly are showing little enthusiasm for Section 1876 Medicare contracts, in spite of active solicitation by SSA. They will have even less interest in dealing with one or more of 50 state Medicaid agencies on cost reimbursement and risk-sharing contracts.

Section 42—Ambulance Services

This provision is good in that it would cover ambulance services under Medicare to a more distant hospital where the closer hospitals do not have the medical staff qualified to provide the required treatment. Currently the physician who practices in a hospital is not a consideration in determining whether ambulance services to a more distant hospital would be covered. That means a patient, for example, who needs the services of an orthopedic specialist could not receive ambulance service to a more appropriate hospital. This change would increase costs to a small extent, and manual instructions would have to be revised.

Section 43—Grants to Regional Pediatric Pulmonary Centers

We believe that support by federal grant of this type of center is a good use of federal grant money.

Section 44—Resources of Medicaid Applicant

This provision sounds reasonable because it would help prevent individuals from giving away property to their heirs for purposes of becoming eligible for Medicaid.

Section 45—Penalty for Defrauding Medicare and Medicaid

The proposal to make Medicare fraud a felony is desirable, although it is not necessary. There is a general provision in the U.S. Criminal Code (18 U.S.C. Section 1001) which makes it a felony to knowingly conceal or cover up a material

fact or make a false statement in connection with any matter within the jurisdiction of a department or agency of the United States.

In the decision of the U.S. Court of Appeals of the Fifth Circuit, involving United States versus Oakley G. Smith, there is precedent for felony prosecutions of Medicare fraud.

CONCLUSION

Mr. Chairman, that ends our comments on the individual sections of the bill. If it would be helpful to the committee to have any further information on any of the items, or a fuller explanation of our point of view, we would be glad to provide it—either in further testimony or by letter to the committee or its staff.

I hope that our comments bore out the points I made at the beginning of this testimony—that legislation should provide directions and established concepts, but should not lack in operational details. And further, that legislation and the regulations that are based upon it should preserve the kind of flexibility that any large program needs.

We believe that the changes we have proposed for various sections of the bill support that objective, and help make both the Medicare and medicaid programs more effective for the people they are meant to serve . . . and more efficient and effective from the standpoint of the carriers and the government who are accountable for their performance.

Thank you for your time and attention.

Senator TALMADGE. Our next witness is Mr. William C. White, Jr., vice president, Prudential Insurance Co., on behalf of the Health Insurance Association of America, accompanied by Fred J. Malley, Jr., vice president, Equitable Life Assurance Society.

Delighted to have you, gentlemen. You may insert your full statement in the record and summarize it, sir.

STATEMENT OF WILLIAM C. WHITE, VICE PRESIDENT, PRUDENTIAL INSURANCE CO., ON BEHALF OF HEALTH INSURANCE ASSOCIATION OF AMERICA; ACCOMPANIED BY FRED J. MALLEY, JR., VICE PRESIDENT, EQUITABLE LIFE ASSURANCE SOCIETY

Mr. WHITE. With your permission, I would like to insert the full statement in the record. I will touch on only a few points in my oral testimony.

We appear to present the comments of the Health Insurance Association of America and, in particular, the views of the 13 member companies of the association involved in the administration of Medicare.

We have reviewed S. 3205, Medicare-Medicaid Administrative and Reimbursement Reform Act, from the standpoint of its effect on the medicare-medicaid programs and its effect on the private health care sector. We share your concern for the ever-increasing cost of the governmental programs and applaud your efforts to contain costs.

Our comments today are aimed at improvement of the bill to achieve the desired goal without further impairment of the ability of these programs to provide appropriate health care financing for medicare and medicaid recipients.

SECTION 5—PROCEDURES DESIGNED TO INSURE ECONOMICAL PROCESSING OF CLAIMS BY CARRIERS

It is not clear from the language of this section as to the intent of the proposal to contract with carriers on the basis of a fixed price per

claim for claims processing functions. This could be interpreted to mean all functions performed by the carrier. On the other hand, the language in the summary of the bill appears to limit the definition of "claims processing functions" to data processing.

In either case, we do have grave concerns about this approach to contracting with carriers. Unlike manufactured products, claims service is not a well-defined product since it is subject during the contract term to many variable factors including changes in the law, regulations, and general instructions.

It is, therefore, extremely difficult to bid on a fixed-price basis at the most economical cost to the government because of the margin that would be needed in the bid to cover the contingencies related to the variable factors. Periodic rebidding would also require margins for tooling-up costs and termination costs since there would be no guarantee of continuity of contract.

Frequent changes in the assignment of carriers could be counterproductive since a new carrier may not initially have the expertise for effective administration of this complex program. During the past several years, the carrier unit claim cost nationally has been relatively stable despite the severe inflation in the cost of labor, equipment, and supplies, and the many additional duties required by changes in the law and regulations.

We, therefore, believe that the carriers have performed their medicare duties in an economical manner. We would suggest a revision of this section to provide for a continuation of the reasonable cost reimbursement now utilized under existing contracts with an added feature for the payment of financial incentives on a merit rating approach to those carriers performing on an above average basis as to cost, quality, and service.

For those carriers performing well below an acceptable level—and this undoubtedly would be a very limited number—contracts should be terminated upon failure to improve after a designated probationary period. An impartial review panel could be established to evaluate performance and establish the appropriate awards.

We will be happy to work with the committee in the development of language to accomplish this recommended approach.

SECTION 10—IMPROVED METHODS FOR DETERMINING REASONABLE COST OF SERVICES PROVIDED BY HOSPITALS

Unless the hospital rates determined under this section apply to all payers, once again excess costs will be passed on to nongovernment payers and this section will fail to achieve its intended cost containment. Consideration should be given to State health-care cost commissions operating under guidelines established by the Secretary of HEW as the vehicle to achieve the desired goal of this section. Such commissions could be required as a condition for the payment of Federal matching funds to the States for medicaid. Also, it should be required that these commissions determine prospectively the appropriate rate of reimbursement to each health-care institution and that the rate so determined must apply to all patients. Although we would prefer this approach to cost containment, we do have further comments about the provisions of this section.

This section classified hospitals by size and type only. We recommend that consideration should be given to the geographic location of the hospital. We do not disagree with the concept of establishing a prospective method of reimbursement based upon an "average per diem routine operating cost." It should be observed, however, that with such an approach there may be a tendency to have quality of care rank below the cost considerations.

Accordingly, it is suggested that some provision be made for a system of reviewing quality of services.

SECTION 11—INCLUSION IN REASONABLE COST OF HOSPITAL SERVICES AN ALLOWANCE FOR RETIREMENT OR CONVERSION OF UNDERUTILIZED FACILITIES

There will continue to be problems, however, in the financing of the retirement of conversion of underutilized facilities since the Government's share of such allowance will be limited to a proportion based on the usage of such facilities by patients covered under titles XVIII and XIX of the Social Security Act.

This will leave a substantial amount of financing necessary from other sources and problems in finding such sources may defeat the purpose of this provision. We, therefore, suggest consideration of an amendment to Public Law 93–641 to provide funds to health systems agencies to assist in filling this gap in financing for the retirement or conversion of underutilized health facilities.

SECTION 20—CRITERIA FOR DETERMINING REASONABLE CHARGE FOR PHYSICIAN'S SERVICE

We agree with the provision in this section for the improvement of the reimbursement to physicians in physician shortage areas, but we do have some concern about other provisions of this section.

The application of a new limit on locality prevailing charges in addition to the limit established by the economic index factor may further discourage the acceptance of assignments by physicians.

While it is understandable that the Federal Government wishes to control increases in benefit payments, the impact on beneficiaries should be considered. If the proposed approach does, in fact, further limit annual increases in prevailing charges, with further decreases in the assignment rates, the elderly beneficiary will be hit even harder than he now is for out-of-pocket expenses.

Because of the unknown degree of impact, perhaps this proposal should be deferred. Alternative methods of determining benefit payments under medicare should be investigated to arrive at the best possible solution from the beneficiary's standpoint.

SECTION 21—AGREEMENTS OF PHYSICIANS TO ACCEPT ASSIGNMENT OF CLAIMS

The concept of "participating" and "nonparticipating" physicians seems logical on the surface. However, the implementation of this concept as provided in the bill could be counterproductive. The "all or nothing" aproach to assignments may drive the assignment rate down because the "incentives" in this section are not sufficient to achieve a high rate of participation.

If fact, the billing and payment procedures may be a disincentive which will not be overcome by the $1 per patient "incentive." The proposed simplified billing form could be an administrative monstrosity if all other requirements under existing rules and regulations must be met. Also, the partial payment to the physician within 5 days followed later with the many individual patient adjustments with respect to the deductible, reasonable charge, utilization, and eligibility determinations will create more recordkeeping problems for the physician's office assistant. We recommend deletion of this provision.

We recognize the problems of the Federal Government in financing the medicare program. On the other hand, we also recognize the financial problems in the medicare beneficiary and we hope that appropriate incentives can be found to increase the rate of assignments.

SECTION 22—HOSPITAL ASSOCIATED PHYSICIANS

This section established better controls on the reimbursement for hospital based radiologists, pathologists, and anesthesiologists. From a conceptual viewpoint, the provisions address themselves to real problems and we are in agreement with the need for further control.

We hope that consideration will be given to providing that reimbursement to all hospital associated physicians be made on the basis of reasonable cost to the hospital with payments to the hospital under Part A of Medicare.

We believe the provisions of this section also should apply to Medicaid.

We would like to suggest an additional provision for S. 3205. Reform of the durable medical equipment benefit under medicare is needed. Presently, the claimant has the option to rent equipment indefinitely—presuming medical necessity—even though rental installments in total may far exceed the purchase price.

This should be modified to permit flexibility on the part of the carrier to make the determination, including the right to arrange for a lease-purchase agreement.

In closing, Mr. Chairman, we want to again commend you and your colleagues for your constructive efforts to meet some of the very difficult problems affecting the cost of the Medicare-Medicaid Programs. Also, we offer the subcommittee and its staff the continued cooperation of the Health Insurance Association of America in working out solutions to these problems.

Senator TALMADGE. Thank you very much, Mr. White. We appreciate the very constructive suggestions and hope you and others will continue to work with our staff in improving the bill as we go along.

I appreciate the support of the Health Insurance Association of America for Section 22 of my bill, which is designed to avoid excessive payments to hospital association specialists. You indicate that some clarification is needed in connection with the word reasonable, and in connection with limiting provisions for services of anesthesiologists.

Could you elaborate on your concerns about these matters and Section 22 generally?

Mr. WHITE. As the previous witness, we also have some concern about the specifics—as to the number of patients that are to be

covered under certain situations. We think that it might not be appropriate to do it exactly the way it is in the bill.

It is not a major point of contention. But on the word "reasonable," we feel that we should have spelled out what determinations will need to be made to arrive at what the word reasonable means.

For example, in part B there is a definition of what reasonable means with regard to a prevailing charge or customary charge. Perhaps consideration could be given to language of that nature so we would know what is meant by reasonable.

Senator TALMADGE. If you can develop such language I would appreciate it if you would give it to the staff.

I understand your concerns with the hospital reimbursement approach in S. 3025. I believe, however, that with help of organizations such as yours we can improve that provision. But given the enormous pressure on Federal and state budgets for hospital care, do you have any recommendations as to ways of moderating hospital costs which can go into effect quickly on a nationwide basis?

Mr. WHITE. Frankly I don't know of any ways we can put in quickly. It is very difficult. I think there are many efforts being made in the various states with hospital associations, with state governments, to develop prospective rate review, as you have indicated. I think every effort should be made to strengthen those efforts. Again it can't be done quickly.

This bill could be a vehicle to help strengthen State operations like we suggest, by establishing State health cost commissions with some financing from the Federal Government and under Federal guidelines. Perhaps consideration should be given to providing that, in the case of failure of a State to act within those guidelines, the Federal Government would move in and operate in that area.

Senator TALMADGE. I understand that you have done some work comparing the processing time between medicare assigned claims and unassigned claims.

Mr. WHITE. Yes, sir.

Senator TALMADGE. What did you find as to the difference in relative time and effort between the two types of claims?

Mr. WHITE. There is a significant difference. The difference in time of processing, Senator, obviously means money in the administration of the program. An assigned claim, which is prepared in a doctor's office is more complete and easier processed.

The average processing time in our organization was 4½ minutes. The average time for processing of nonassigned claims was 27 minutes, and that is a significant difference when you consider the volume of claims that are handled in the U.S.

Senator TALMADGE. A very significant difference.

I understand your concern about the limits on reasonable charge determinations for physicians under part B of medicare. The Congress is faced with excessive drains on the part B, trust fund. Would you recommend the use of fee schedules under part B, of medicare as a means of controlling the cost of the program?

Mr. WHITE. First of all, there are lots of problems in the use of fee schedules. Initially, if you try to establish a fee schedule to bring the level of assignment to a very high percentage you have an immediate increase in the cost to the government, which is a problem itself I

do think that long range there might certainly be value in fee schedules as a means to have reimbursement, however. For one thing, it would indicate to both patient and physician what the benefit is. Today neither the patient nor physician are sure in advance what is going to be paid.

Therefore, I would recommend that experimentation be engaged in soon in certain areas to see what the difficulties are in arriving at an appropriate fee schedule and how they can be resolved.

I think in this way we can make the decision whether we should go with them long range.

Senator TALMADGE. Our study of medicare prevailing charges in various States indicates great variance and irrationality among prevailing charges for the same services from one area to another even within the same State. For example, the medicare prevailing charge for a hemorrhoidectomy is $450 in Los Angeles and $280 in San Francisco.

Does this make sense to you, and if it doesn't, how do you propose that we deal with these variations?

Mr. WHITE. Well, Senator, the rationale, if there is one, for variations in Medicare fees applies to all physician fees because, basically, what is paid under medicare prevailing charge levels is determined mathematically and is based on what doctors are charging all their patients. In our study we have found that doctors are not charging differently to medicare patients than they are to other patients, except in a few cases which they are lowering their charge to other patients who are in poor financial condition.

What is being reflected in the medicare charges is the actual practice of the medical community from area to area. Perhaps it is hard to rationalize wide differences, but they do exist for the rest of the population, not only for Medicare.

Senator TALMADGE. Is there any way we can control it?

Mr. WHITE. Well, I really don't have the answer to that. Obviously you can't really control it by what you pay in medicare because that is only about 10 percent of the population. You are still going to have to deal with the other 90 percent of the population. Wide variation does exist throughout the country, not just in California.

Senator TALMADGE. Thank you very much for your very helpful testimony.

[The prepared statement of Mr. White follows:]

STATEMENT OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA

(Presented by William C. White, Jr.)

Mr. Chairman, I am William C. White, Jr., Vice President, The Prudential Insurance Company of America. With me are Frederick J. Malley, Vice President, Health Programs Department, The Equitable Life Assurance Society of the United States, and Paul M. Hawkins, Vice President and Washington Counsel, Health Insurance Association of America. We appear today on behalf of the Health Insurance Association of America. The member companies of the Association are responsible for some 85% of the private health insurance written by insurance companies in the United States.

Our statement today also represents the views of the member companies of the Association involved in the administration of Medicare. These companies are: Aetna Life & Casualty, Mutual of Omaha Insurance Company, Nationwide Mutual Insurance Company, The Prudential Insurance Company of America, The Travelers Insurance Company, Connecticut General Life Insurance Company,

Continental Casualty Company, Equitable Life Assurance Society of the United States, General American Life Insurance Company, Metropolitan Life Insurance Company, Occidental Life Insurance Company of California, Pan-American Life Insurance Company and Union Mutual Life Insurance Company. All of these companies serve as carriers under Part B. (Supplementary Medical Insurance). In addition, the first five companies named also serve as fiscal intermediaries for hospitals, home health agencies, and skilled nursing facilities under Medicare Part A (Hospital Insurance Benefits).

We have reviewed S. 3205, "Medicare-Medicaid Administrative and Reimbursement Reform Act" from the standpoint of its effect on the Medicare-Medicaid programs and its effect on the private health care sector. We share your concern for the ever increasing cost of the governmental programs and applaud your efforts to contain costs. Our comments today are aimed at improvement of the bill to achieve the desired goal without further impairment of the ability of these programs to provide appropriate health care financing for Medicare and Medicaid recipients.

This statement presents our comments in section number sequence.

The sections omitted are those for which we have no comments.

Section 2—Establishment of Health Care Financing Administration

There are problems today in policy development and coordination among the several agencies within HEW involved in health care financing and related programs. The bill proposes consolidation of the Bureau of Health Insurance, the Medical Services Administration, the Bureau of Quality Assurance, and the Office of Nursing Home Affairs under a new organization, within HEW, to be known as the Health Care Financing Administration headed by an Assistant Secretary for Health Care Financing. Since, today, the Secretary of HEW has responsibility for all of the above-named programs, it is not clear that the reorganization proposed will solve the existing problems of coordination.

We do have concerns about the operation of the proposed Office of Central Fraud and Abuse Control which would be directed by the Inspector General for Health Administration as proposed under Section 3 of the bill. While we agree that the investigation of potential fraud, in the sense of developing a case for prosecution is not a proper function for intermediaries and carriers, we do believe that such contractors should continue to investigate suspected program abuses for referral to HEW for further development. It is recommended, therefore, that this section be modified as follows:

Page 3, line 23, strike "and Abuse".

Page 3, lines 24–25, strike "Inspector General for Health Administration established under section 1124;" substitute "Assistant Secretary for Health Care Financing.".

Page 4, line 2, strike "and abuse".

Page 4, line 7, strike "or abuse".

Page 4, line 7, strike period and add following the word programs, "except that under Title XVIII the initiation and conduct of a direct investigation of a beneficiary or provider suspected of program abuse shall be done by the intermediary or carrier servicing that beneficiary or provider."

We believe that the subsection appearing on page 4, lines 12 through 18, should be deleted. The prosecution of fraud cases more properly should be handled by the Department of Justice rather than by the General Counsel of HEW. The Department of Justice may need additional staff dedicated to the prosecution of fraud cases arising under the governmental health care programs, but this could be handled through the congressional appropriation process or through separate legislation.

Section 3—Inspector General for Health Administration

We believe that the creation of an Inspector General for health administration could be counterproductive with respect to efficient administration of the Health Care Financing Administration unit in HEW. The bill provides that the Inspector General shall report directly to the Secretary of HEW as does the Assistant Secretary for Health Care Financing. These parallel organizations could produce unnecessary competition and result in inefficiencies. Also, with the broad authority granted to the Inspector General, conflicting rules and regulations could be issued by the two administrative bodies. Generally, the duties of Inspector General could be carried out more efficiently under the direction of the Assistant Secretary for Health Care Financing.

Section 4 (a), (b), and (c)—State Medicaid Administration

While we agree with the intent of this provision, we are concerned about the possible adverse impact of the penalties proposed. If a State fails to meet any one of four criteria for administration, as set forth in the bill, and does not correct such deficiency within six months, 50% of the Federal matching funds for administration would be terminated. Failure to meet any two criteria, without corrective action within six months, calls for complete termination of Federal matching funds.

If there are serious deficiencies, a six-month period for corrective action would appear to be too short. Also, reduction or termination of Federal matching funds for administration may cause further deterioration in the State's administrative procedures resulting in massive overpayments of Medicaid benefits, including Federal matching funds, which could far exceed the administrative expenses.

Rather than to impose penalties which could be counterproductive, the Federal Government should provide technical assistance to the States, as proposed in the bill, with increased Federal matching funds for administrative expenses for those States meeting or exceeding established criteria. The resulting improvement in administrative procedures could provide substantial savings in benefit payments far exceeding the additional cost to the Federal Government for the increased amount of matching funds for administration.

Section 4(d)—Quality Control

Do not disagree with the intent of this provision but we suggest consideration of a range for a normative error rate rather than the 50th percentile of error rates of all States.

Section 5—Procedures Designed To Insure Economical Processing of Claims by Carriers

It is not clear from the language of this section as to the intent of the proposal to contract with carriers on the basis of a fixed price per claim for claims processing functions. This could be interpreted to mean all functions performed by the carrier. On the other hand, the language in the summary of the bill appears to limit the definition of "claims processing functions" to data processing, which, while important, represents only a portion of the carrier's total cost per claim processed.

In either case, we do have grave concerns about this approach to contracting with carriers. Unlike manufactured products, claims service is not a well-defined product since it is subject during the contract term to many variable factors including changes in the law, regulations, and general instructions. It is, therefore, extremely difficult to bid on a fixed-price basis at the most economical cost to the government because of the margin that would be needed in the bid to cover the contingencies related to the variable factors. Periodic rebidding would also require margins for tooling up costs and termination costs since there would be no guarantee of continuity of contract. Frequent changes in the assignment of carriers could be counterproductive since a new carrier may not initially have the expertise for effective administration of this complex program.

During the past several years, the carrier unit claim cost nationally has been relatively stable despite the severe inflation in the cost of labor, equipment and supplies, and the many additional duties required by changes in the law and regulations. We, therefore, believe that the carriers have performed their Medicare duties in an economical manner.

We would suggest a revision of this section to provide for a continuation of the reasonable cost reimbursement now utilized under existing contracts with an added feature for the payment of financial incentives on a merit rating approach to those carriers performing on an above average basis as to cost, quality and service. For those carriers performing well below an acceptable level (and this undoubtedly would be a very limited number), contracts should be terminated upon failure to improve after a designated probationary period. An impartial review panel could be established to evaluate performance and establish the appropriate awards.

We will be happy to work with the committee in the development of language to accomplish this recommended approach.

Section 6—Claims Processing and Information Retrieval Systems for Medicaid Program

While this provision seems appropriate from a systems point of view, it may present some very practical problems to the States in its implementation.

Section 7—Regulations of the Secretary

We favor this proposal.

Section 8—Termination of HIBAC

While we do not have strong feelings about this section, perhaps consideration should be given to a restructuring of this council in order to provide input to the Secretary of Health, Education and Welfare with respect to the problems of Medicare and Medicaid and other governmental health programs from interested and knowledgeable public representatives.

Section 10—Improved Methods for Determining Reasonable Cost of Services Provided by Hospitals

Unless the hospital rates determined under this section apply to *all* payers, once again excess costs will be passed on to nongovernment payers and this section will fail to achieve its intended cost containment. Consideration should be given to State health care cost commissions operating under guidelines established by the Secretary of H.E.W. as the vehicle to achieve the desired goal of this section. Such commissions could be required as a condition for the payment of Federal matching funds to the States for Medicaid. Also, it should be required that these commissions determine prospectively the appropriate rate of reimbursement to each health care institution and that the rate so determined must apply to *all* patients. Although we would prefer this approach to cost containment, we do have further comments about the provisions of this section.

This section classifies hospitals by size and type only. We recommend that consideration should be given to the geographic location of the hospital.

We do not disagree with the concept of establishing a prospective method of reimbursement based upon an "average per diem routine operating cost." It should be observed, however, that with such an approach there may be a tendency to have quality of care rank below the cost considerations. Accordingly, it is suggested that some provision be made for a system of reviewing quality of services.

Routine operating costs should be defined more clearly. Wages should be included in routine operating costs and should not be subject to a wage index factor as provided in Section (3)(e). Routine operating costs should then be limited, for reimbursement purposes, by category of hospital (including geographic area) to some appropriate figure such as the mean (for each category) plus one standard deviation.

Section 11—Inclusion in Reasonable Cost of Hospital Services an Allowance for Retirement or Conversion of Underutilized Facilities

We take exception to the provision that one of the five members of the Hospital Transitional Allowance Board be "a representative of the largest private nonprofit third party payer for hospital services in the Nation." Other third party payers should be represented on the Board. With this exception, we agree with the intent of this section.

There will continue to be problems, however, in the financing of the retirement or conversion of underutilized facilities since the government's share of such allowance will be limited to a proportion based on the usage of such f. cilities by patients covered under Titles XVIII and XIX of the Social Security Act. This will leave a substantial amount of financing necessary from other sources and problems in finding such sources may defeat the purpose of this provision. We, therefore, suggest consideration of an amendment to P.L. 93–641 to provide funds to Health Systems Agencies to assist in filling this gap in financing for the retirement or conversion of underutilized health facilities.

Section 12—Return on Equity To Be Included in Determining "Reasonable Costs" of Services Furnished by Proprietary Hospitals

The current return on equity seems adequate, providing 11 to 12% return.

Section 20—Criteria for Determining Reasonable Charge for Physician's Service

We agree with the provision in this section for the improvement of the reimbursement to physicians in physician shortage areas, but we do have some concern about other provisions of this section.

The application of a new limit on locality prevailing charges in addition to the limit established by the economic index factor may further discourage the acceptance of assignments by physicians. We do not have a statistical evaluation of the impact of this proposal as set forth in this section of the bill. While it is understandable that the Federal Government wishes to control increases in benefit payments, the impact on beneficiaries should be considered. If the proposed approach does, in fact, further limit annual increases in prevailing charges, with further decreases in the assignment rates, the elderly beneficiary will be hit even harder than he now is for out-of-pocket expenses. Because of the unknown degree of impact, perhaps this proposal should be deferred. Alternative methods of determining benefit payments under Medicare should be investigated to arrive at the best possible solution from the beneficiary's standpoint.

We recommend that existing law be changed to provide for the updating of physician profiles and prevailing charges on a semi-annual basis. The current system of annual updating on July 1 of each year based on charges rendered during the prior calendar year produces an excessive time lag. This is a disincentive to the physician in his consideration of whether to accept assignment of benefits.

Section 21—Agreements of Physicians To Accept Assignment of Claims

The concept of "participating" and "nonparticipating" physicians seems logical on the surface. However, the implementation of this concept as provided in the bill could be counterproductive. The "all or nothing" approach to assignments may drive the assignment rate down because the "incentives" in this section are not sufficient to achieve a high rate of participation. In fact, the billing and payment procedure may be a disincentive which will not be overcome by the $1 per patient "incentive."

The proposed simplified billing form could be an administrative monstrosity if all other requirements under existing rules and regulations must be met. Also, the partial payment to the physician within five days followed later with the many individual patient adjustments with respect to the deductible, reasonable charge, utilization, and eligibility determinations will create more record-keeping problems for the physician's office assistant. We recommend deletion of this provision.

An alternative approach which might have more appeal to the physicians would be to provide that reasonable charge determinations for participating physicians be based on the 90th percentile rather than the 75th percentile. To improve administrative procedures, it might be required that participating physicians code all claims. Physicians should be required to declare in writing to the carrier that they will either take assignments for all of their Medicare patients or none of them. A physician could change his decision on sixty days' notice to the carrier.

We recognize the problems of the Federal Government in financing the Medicare Program. On the other hand, we also recognize the financial problems of the Medicare beneficiary and we hope that appropriate incentives can be found to increase the rate of assignments.

Section 22—Hospital Associated Physicians

This section establishes better controls on the reimbursement for hospital-based radiologists, pathologists, and anesthesiologists. From a conceptual viewpoint, the provisions address themselves to real problems and we are in agreement with the need for further control.

Some clarification is needed in this section with respect to the word "reasonable" and the limiting provisions for anesthesiologists.

We hope that consideration will be given to providing that reimbursement to all hospital associated physicians be made on the basis of reasonable cost to the hospital with payments to the hospital under Part A of Medicare.

We believe the provisions of this section also should apply to Medicaid.

Section 23—Payment for Physicians' Services Under Medicaid

This provision would increase the level of reimbursement to physicians participating in the Medicaid Program in many states, but, at the same time, creates new problems. Many states are in financial difficulty under the present methods of reimbursement and this provision would aggravate those problems. Furthermore, this provision legislates two levels of reimbursement; namely, one for the poor and another for self-supporting individuals.

Section 24—Payment for Certain Antigens Under Part B of Medicare

We support this provision.

Section 25—Payment Under Medicare of Certain Physician's Fees on Account of Services Furnished to Deceased Individuals

This provision would permit payment by Medicare on the basis of a nonreceipted bill directly to the spouse or other legal representative of a deceased beneficiary. We completely endorse this proposed change.

Section 26—Prohibition Against Assignment of Fees for Physicians and Others

This provision contains new language that would close a loophole in the law under which factors have been operating as discounters of Medicare and Medicaid claim receivables. We agree with the provision.

Section 41—Standards for Payments Under Medicaid to Health Maintenance Organizations

These provisions are designed to assure appropriate operation and prevention of abuse by HMOs under Medicaid and essentially apply the same rules that relate to Medicare to Medicaid. Under the Medicare law, however, there is a provision for phasing in the requirement with respect to the composition of the HMO membership over a period not to exceed three years. It might be appropriate to consider applying this same rule for Medicaid.

Section 42—Ambulance Service

This is a relatively minor provision which would cover ambulance service to more distant hospitals where the nearest hospital does not have staff qualified to undertake the care required. We agree with the provision.

Section 45—Penalty for Defrauding Medicare and Medicaid Programs

This provision changes Medicare or Medicaid fraud from a misdemeanor to a felony with penalties of up to two years imprisonment and a $10,000 fine. We agree with the provision.

We would like to suggest an additional provision for S. 3205. Reform of the Durable Medical Equipment benefit under Medicare is needed. Presently, the claimant has the option to rent equipment indefinitely (presuming medical necessity even though rental installments in total may far exceed the purchase price. This should be modified to permit flexibility on the part of the carrier to make the determination, including the right to arrange for a lease-purchase agreement.

In closing, Mr. Chairman, we want to again commend you and your colleagues for your constructive efforts to meet some of the very difficult problems affecting the cost of the Medicare-Medicaid Programs. Also, we offer the Subcommittee and its staff the continued cooperation of the Health Insurance Association of America in working out solutions to these problems.

Senator TALMADGE. The next witness is Mr. William Ryan, president of the National Association of Blue Shield Plans.

You may insert your full statement in the record and summarize it.

STATEMENT OF WILLIAM E. RYAN, PRESIDENT, NATIONAL ASSOCIATION OF BLUE SHIELD PLANS

Mr. RYAN. Thank you, Mr. Chairman, I am William E. Ryan, president of the National Association of Blue Shield Plans. It is a privilege to discuss with the subcommittee pending improvements in the medicare and medicaid programs as introduced in S. 3205. Because of time constraints we ask that our entire statement be inserted into the record.

I will review the key points in the time allotted. This association consists of 70 locally-based, not-for-profit medical care prepayment plans, covering 72 million private subscribers, and serving 12 million medicare beneficiaries. In 1975 our 32 part B carrier plans processed

51 million part B claims which amounts to 63 percent of the total medicare part B claims processed.

Blue Shield has been active in, and concerned with, the medicare program since its enactment 10 years ago. Our performance is vastly superior today as compared to the early days when carriers were faced with only a 4-month lead time for the onrush of claims.

The record of positive progress made by carriers in the administration of medicare part B is traced in our more lengthy statement filed with this committee; therefore, I will not elaborate on it now due to time restraints. However, I feel that our record is impressive and would urge you to look —carefully at that portion of our statement.

Mr. Chairman, we have some concerns about the medicare part B program. Claims reimbursement is unquestionably the major problem the program still faces. It is the foremost cause of dissatisfaction among beneficiaries and physicians alike. The absence of a true reasonable charge determination discourages physicians from taking assignment and, therefore, shifts program costs to the elderly.

This imposes a serious burden on older Americans. We believe that Congress should place limits on beneficiary cost-sharing which, once fulfilled, would entitle the patient to catastrophic protection under medicare. At the same time, however, we have urged the Congress to recognize its obligation to choose intelligently between a program based upon payment-in-full, or limitation of the Government's liability.

Mr. Chairman, I would now like to speak briefly to some specific provisions in S. 3205, as many of these appear to be unduly restrictive and burdensome, thus lessening the opportunity to truly institute reforms in the medicare and medicaid programs.

Section 2 would combine medicaid, medicare, Office of Nursing Home Affairs and the Bureau of Quality Assurance into one administrative unit—the Health Care Financing Administration, headed by an Assistant Secretary for Health Financing.

NABSP supports any move that will bring more effective and efficient administration to these programs. However, if true managerial reforms are to be instituted, they must be accomplished at the operational or carrier level. This is where the day-to-day work of these programs is done.

For example, changing the criteria and method for carrier selection in the medicaid program, to assure that the carrier is the one most capable of effectively performing its role, would significantly improve the quality of medicaid administration. If Congress would focus on reforms that would upgrade program administration at the carrier level, the administrative superstructure would be less of a concern.

Another section would establish the Office of Inspector General for Health Administration. This appears to be duplicative of both the new HEW Office of Investigations and certain activities of the Justice Department. We would urge that any Inspector General's authority be exclusive and not run concurrent with nor duplicate that of other agencies.

S. 3205 also addresses State medicaid administration. The detailed performance standards for medicaid appear to be attainable for any State contractor participating in title XIX. However, we feel strongly

such standards should be created as a regulatory function of program administration, rather than fixed by law. Once standards have been established, it should be the carrier's responsibility to achieve these standards, utilizing methods of their own choice. In the final analysis, it's the end results that really count—effective and economical claims administration.

Mr. Chairman, we have some serious concerns with section 5. The present language of this section seems vague, and susceptible to differing interpretations. It appears that if passed, section 5 would change the basis of part B carrier contracting with the Federal Government, and would require that carriers be reimbursed for the cost of their claims processing functions on a prospective fixed cost per claim basis.

We have repeatedly urged the Congress to give carriers more latitude to use their expertise in support of medicare. To provide for fixed price reimbursement on an experimental basis would be consonant with this approach. However, we suggest that there is not yet enough experience to warrant universal application of fixed price reimbursement.

Therefore, we recommend and support amending S. 3205 to provide legislative direction for such experimentation. Regardless of the type of contract negotiated, we wish to emphasize that it is still the carrier's prerogative as to how it will manage its operations to meet its contractual obligations.

There is language in section 5 which suggests that in negotiating the contract, estimates from other entities capable of performing claims processing functions would be considered. Whether this would require that carriers subcontract certain claims processing functions to the lowest bidder or estimate and whether such subcontracts be open to competitive bidding is unclear. However, in any event, NABSP cannot support this approach. Mr. Chairman, we wish to remind the committee that the basis upon which carriers participate in the program is as carriers and not merely as claims processors. The carrier function as defined in title XVIII goes well beyond claims processing.

The management decision to subcontract any functions or to do them in-house should be solely a carrier prerogative. In the event a carrier decides to subcontract a claims processing function under a cost reimbursement contract, the subcontract may be let by competitive bid.

NABSP would reognize this as a legitimate interest of Government since any resultant subcontract price entered into would directly impact on the Government's total cost. However, with respect to a fixed price per claim contract, if a carrier makes a decision to subcontract, then it is inappropriate for carriers to be required to use a competitive bidding basis for the subcontract.

The decisions regarding subcontracting must be that of the carrier, not the Federal Government's. The Government's interest should be only in the "bottom line" as reflected in satisfactory performance at the price agreed upon.

Section 6 would modify the existing criteria imposed upon the States in order for a State to qualify for a higher level of Federal moneys in the development and operation of its medicaid system. Simply stated, this section would require that States securing these funds develop and implement a system which would be capable of being "integrated into" the medicare system in addition to the present requirement that the systems be compatible.

Presently, under the medicaid program, States receive substantial Federal funds to assist them in administering the medicaid program. Each State is given the option to either administer the program itself or contract with a carrier. A large number of States have opted to develop their own capabilities and administer the program.

As a consequence, many States have a large investment both financially and politically in their medicaid programs. Under these circumstances, it might be difficult for a State to objectively evaluate its performance and make an objective decision as to whether or not it is the best entity to administer the medicaid program.

Consequently, a major contribution to improving medicaid administration could be made by changing the agency which selects the carrier so that there is assurance that the designated carrier is selected on an objective basis. This section also would reduce, for States wanting the higher level of Federal funding, the explanation of benefits requirement from 100 percent to a sampling basis. While Blue Shield has found from its own experience that the EOB is an effective cost control device, it recognizes that its impact is limited. NABSP supports this amendment.

We support the proposal in section 7 to extend from 30 to 60 days the time for comments on proposals. We would suggest that there should be other opportunities for organizations to give input to Federal agencies before final rules are adopted and implemented, preferably during the drafting stages.

Section 8 would terminate the Health Insurance Benefits Advisory Council. This would create a void in an area which appears doubly important if the health portions of HEW are to be recognized and expanded. Sections 20 and 21 deal with charges for physicians services and physician acceptance of assignment of claims.

Claims reimbursement is unquestionably the major problem the program still faces. It's the greatest cause of dissatisfaction among beneficiaries and physicians alike. Blue Shield recognizes the importance of containing medicare expenditures within reasonable bounds. The medicare carrier plans have worked with SSA to accomplish this objective.

Unfortunately, Mr. Chairman, the inflationary trend in the economy has caused the original objectives of the program based upon reasonable charges to conflict with the pressure to limit the Government's financial liability. Medicare part B cannot continue to be regarded as a paid-in-full program and at the same time, attempt to control program costs at a level which does not recognize the economic realities of our time. Therefore, we urge the Congress, as we have in previous testimony, to choose between a true paid-in-full program or a limited liability program so that all parties, beneficiaries, providers, and carriers will be able to understand better what the program will actually cover.

To encourage physician assignment, S. 3205 proposes to reduce paperwork in their billing process through use of multiple billing forms instead of the traditional separate claim form for each patient. This concept has merit. However, the recommendation to pay 50 percent of all claims within 5 working days would not appear to encourage physicians to accept assignment.

Carriers presently process approximately 75 percent of physician claims in less than 14 days with an average of 14 days for all claims. If part of the claim is paid immediately and then reviewed again, it would just serve to increase administrative costs.

Finally, the section equalizing payment for physician's services under medicaid with the medicare reasonable charge is not an equitable basis for reimbursement. What is actually needed here is the recognition of a reasonable and equitable charge under each program, bearing in mind the different characteristics of these two distinct population groups. In addition, this section develops the concept of physicians to accept assignment of claims. For any full payment program to work with consistent predictability, there must be a commitment in advance by the physicians to the full payment concept. There is absolutely no equivalent substitute to deliver predictable results to both the patient and the physician. Participation is a two-way street. If any program is to succeed, the people involved must be confident of the basic equity of the arrangement. In order for Government programs to succeed, they must satisfy this need.

Mr. Chairman, we would like to make one additional point. There are various methods available to improve administration. However, by specifying a single method through legislation, there is no leeway for these other methods to be tried. We, therefore, would suggest that legislative language be very general to keep the program flexible.

Finally, overall we feel that any action on the part of Government to fix or otherwise adjust reimbursement at its sole discretion which can be interpreted as capricious and arbitrary, will discourage physician participation. The health care economy has its own features. We recently testified regarding this particular subject before the Council on Wage and Price Stability. A copy of that statement is attached to the statement which was submitted to this committee. We would recommend it to you for additional insights into this area.

To summarize, we urge that before this bill is reported to the entire committee, further consideration will be given concerning the net effect of this legislation. We realize that reforms are necessary in certain areas so that the populations who were originally intended to benefit by them, the elderly and the poor, will receive good health care at minimal out-of-pocket cost.

Mr. Chairman, we feel that the public and the private sectors can work together to find flexible solutions.

Mr. Chairman, thank you for the opportunity to appear and submit our views on S. 3205.

Senator TALMADGE. Thank you very much for your testimony, Mr. Ryan.

In the testimony on Monday, the Secretary of HEW and the Director of the Bureau of Health Insurance indicated that appropriately established fee schedules might significantly help to simplify the administration of part B of medicare.

What is your view as to using properly established fee schedules in place of the present cumbersome costly and uncertain method of paying physicians under medicare?

Mr. RYAN. There is no doubt, Mr. Chairman, fee schedules are a simple way to operate this kind of program. I think we have to have some cautions, however, Blue Shield had fee schedules long before

usual and customary payments were initiated. Some place in the early or midsixties we had subscriber income ceilings, below which participating physicians would agree to the fee schedules. There were legitimate reasons for changing those.

The question of inflation was coming about and we consistently increased those schedules, gaining physician acceptance of them when you had a vast difference between the procedures that were performed by specialists and those that were performed by general practitioners. I see problems in being able to decide on the level of fee schedules by States and gaining physician acceptance without perhaps providing an inflationary increase rather than leveling the cost of the program.

I think there is one other point we attempted to make in our testimony. I think the Congress has to decide if the reimbursement under medicare is going to be related to payment in full or are we going to simply limit the liability of the U.S. Government.

Because when we initiated this law, it did have a direct relationship to payment in full. This is the way we talked to our older patients, beneficiaries.

It seems that through regulation, we now have a program that neither the beneficiaries or providers have been able to understand completely.

Senator TALMADGE. You can appreciate that we are concerned not only with medicare and medicaid but with the effects of rapidly rising health care costs on major private health insurers such as Blue Shield.

Are any Blue Shield plans experiencing financial difficulties as a result of increasing costs of physicians' services and, if so, what are these plans doing about the situation?

Mr. RYAN. Obviously, in the last several years, with the spiraling increase in aggregate cost of health care, we do have Blue Shield plans whose reserves have been reduced below what we think would be a sufficient level. There are a number of reasons. Some plans have individual State regulatory bodies which have expressed their reservations and therefore have not given the opportunity for increases. But I think we have to look at the problem in two ways. It is not just a question of fees, Mr. Chairman, it is also a question of increasing use. As a matter of fact, I have seen a statistic that if we were to reduce physicians individual charges by 20 percent, we would only have a 3-percent impact on the aggregate cost of health care and, therefore, we are working on both bases. We are attempting to find an equitable way of dealing——

Senator TALMADGE. How much would the 3-percent reduction be in dollars?

Mr. RYAN. Well, as far as Blue Shield is concerned, we have something over $6 billion. It is not a small amount, but when you are talking about an increase of 7 and 8 and 10 percent a year in the overall, it is not as much as we might like to be able to do in other ways; that is why we are working most assiduously in terms of the demand and the use of the services.

We are attempting to initiate a public education program. We have spent millions of dollars—I think the Government has, too—in informing people how they can better use the programs they have. I think it is time, and Blue Shield believes we have to go to our

subscribers and say it is not just us, it is not just the physicians, you have to learn to use your program efficiently. Perhaps it is in the doctor's office and not the hospital where you can receive——

Senator TALMADGE. What percentage of overutilization would you estimate?

Mr. RYAN. It is difficult to put a percentage on, Mr. Chairman, but we have seen unique escalations. Some of the diagnostic claims are up 15, 20 percent, a year. There are so many factors it becomes difficult to grasp them. I am sure this committee and the chairman are aware of the malpractice situation where you do have defensive medicine and it is a concern of physicians. We think this is one of the things that has to be addressed in order to have an effective impact as far as use is concerned and use is a significant part of this increase.

Senator TALMADGE. Mr. Ryan, how desirable is it to have a single claim form for all health insurers, including the Government? I understand such a form has been developed for physicians. Should it be mandatory for medicare and medicaid?

Mr. RYAN. Well, a good deal of work has been done on a uniform claim form with the commercial corporations, with Blue Shield, and with the providers. I am not sure I can stand here and say that this particular form should be mandated but the idea of a uniform claim form that would be easily recognized by both the physician assistants and by the carriers would increase our efficiency and ability to process claims. So certainly, the concept is good.

Senator TALMADGE. Thank you very much. Mr. Ryan, we appreciate your testimony.

[The prepared statement of Mr. Ryan follows:]

STATEMENT OF THE NATIONAL ASSOCIATION OF BLUE SHIELD PLANS, PRESENTED BY WILLIAM E. RYAN, PRESIDENT

Mr. Chairman, I am William E. Ryan, President of the National Association of Blue Shield Plans. It is a privilege to discuss with the Subcommittee pending improvements in the Medicare and Medicaid programs as introduced in S. 3205. Because of time constraints we ask that our entire statement be inserted into the record. I will review the key points in the time allotted. This Association consists of 70 locally-based, not-for-profit, medical care prepayment plans, covering 72 million private subscribers, and serving 12 million Medicare beneficiaries. In 1975 our 32 Part B carrier Plans processed 51 million Part B claims which amounts to 63 percent of the total Medicare Part B claims processed.

The Medicare program was enacted 10 years ago to protect the elderly from the high cost of health care. Although the aged make-up only 10 percent of the population, they account for 25 percent of medical costs. Medicare beneficiaries are poorer than the rest of the population—60 percent of the elderly had family incomes of less than $5,000 in 1970.

BLUE SHIELD'S ROLE IN PART B

Carrier performance is vastly superior to the early days when the carriers were ill prepared—with only four months lead time—for the onrush of claims. In 1970 the Senate Finance Committee summed up Congressional concern by noting that, "Carrier performance under Medicare has in the majority of instances been erratic, inefficient, costly, and inconsistent with Congressional intent."

Last year, in testimony to the House Ways and Means Subcommittee on Social Security, SSA Commissioner James Cardwell described an array of serious administrative problems besetting SSA in implementing black lung legislation, the kidney dialysis program and—most notably—the Supplemental

Security Income program. However, he went on to praise Medicare as the one Social Security program working without major difficulties. With respect to the positive aspects of Medicare, Mr. Cardwell told the Subcommittee:

"Under Part B . . . it is estimated that claims will have increased from just over 58 million in 1973 to 79.4 million in fiscal year 1975—an increase of over 36 percent. Despite this increase in workload, the contractors' processing time for Part B claims dropped from 19.4 days in 1973 to 17.1 days in (the latest quarter) which ended December 1974."

This record of improved performance has continued. In March of 1976 the Bureau of Health Insurance reported that in the fourth quarter of 1975, the average Part B carrier claim processing time improved over the 1974 corresponding quarter "for the fourth consecutive quarter." BHI stated that "the latest average of 14.8 days per claim represents a decrease of 10.4 percent from October-December 1974 and 6.5 percent from July-September 1975. Over 73 percent of the claims cleared during October-December 1975, took 15 days or less to process compared to 64 percent for the same quarter last year."

Further, a February 11, 1976 GAO study (Report to the Human Resources Task Force, House Committee on the Budget, "History of the Rising Costs of the Medicare and Medicaid Programs and Attempts to Control These Costs: 1966–1975") reported that "the administrative costs per claim for SSA Part B carriers remained relatively stable between fiscal year 1968 through fiscal year 1975." To illustrate, it cost $3.16 to process a Part B claim in 1970 and $3.21 in 1975.

Mr. Chairman, as we trace the positive progress made by carriers in the administration of Medicare Part B we must also call to your attention the report of the HEW Advisory Committee on Medicare Administration, Contracting and Subcontracting. This Committee, after some 16 months of indepth review and analysis, has provided the most comprehensive, objective and thoughful analysis of this subject yet available. We will refer to the Report's recommendations throughout our statement but let me initially quote the Committee's central conclusion:

"We have reviewed the advantages perceived by Congress in relying on a contractual relationship with private health insurance organizations, and they appear to us to be valid today. Moreover, the evidence before the Committee leads us to conclude that the job of administering Medicare is being carried out with considerable success—although there is room for much improvement. A monumental task was undertaken, and the basic challenge has been met by Government and the private sector."

CONCERNS IN THE MEDICARE PART B PROGRAM

Claims reimbursement is unquestionably the major problem the program still faces. It is the foremost cause of dissatisfaction among beneficiaries and physicians alike. The absence of a true reasonable charge determination discourages physicians from taking assignment and therefore shifts program costs to the elderly. The current assignment rate is 51 percent. In 1969, the assignment rate was 61 percent. Physicians in greater numbers each year are refusing to accept assignment chiefly because Medicare reimbursement levels have been held artificially low.

Millions of older Americans find these out-of-pocket expenses a serious burden. It is for this reason that we believe rather emphatically that Congress should place limits on beneficiary cost-sharing which, once fulfilled, would entitle the patient to catastrophic protection under Medicare. At the same time, however, we have urged the Congress to recognize its obligation to choose intelligently between a program based upon payment-in-full, or limitation of the government's liability. We do not advocate one objective over the other, and will refrain from doing so now as we comment on the specifics of S. 3205.

Many of the provisions of S. 3205 appear to be unduly restrictive and burdensome, thus lessening the opportunity to truly institute reforms in the Medicare and Medicaid programs.

Section 2: Consolidating the administration of federally supported health programs

This section would combine Medicaid, Medicare, Office of Nursing Home Affairs and the Bureau of Quality Assurance into one administrative unit—the Health Care Financing Administration, headed by an Assistant Secretary for Health Financing.

NABSP suports any move that will bring more effective and efficient administration to these programs. However, Blue Shield must point out that if true managerial reforms are to be instituted in these programs, they must be accomplished at the operational or carrier level where the day-to-day work of these programs is done.

For example, changing the criteria and method for carrier selection in the Medicaid program, to assure that the carrier is the one most capable of effectively performing its role, would significantly improve the quality of Medicaid administration. In the same vein, eliminating some of the burdensome Social Security Administration carrier regulations as suggested by the HEW Advisory Committee on Medicare Administration, Contracting and Subcontracting (the Perkins Committee) and allowing carriers that were selected for their expertise and capability to manage their Medicare operations would lead to a more efficient administration of Title XVIII.

If Congress would focus on reforms that would upgrade program administration at the carrier level, the administrative superstructure would be less of a concern.

Section 3: Inspector General for Health Administration

The proposed Office of Inspector General for Health Administration appears to be duplicative of both the new HEW Office of Investigations and certain activities of the Justice Department. Any Inspector General's authority should be exclusive and not run concurrent with nor duplicate that of other agencies.

Section 4: State medicaid administration

While the detailed performance standards for Medicaid appear to be attainable for any state contractor participating in Title XIX, we feel strongly such standards should be created as a regulatory function of program administration, rather than fixed by law. However, once standards have been established, it should be the carrier's responsibility to achieve these standards, utilizing methods of their own choice. This will allow for innovation and experimentation with those methods which promise to be most effective. In the final analysis, it's the end results that really count—effective and economical claims administration.

Section 5: Procedures designed to assure economical processing of claims by carriers

The present language of this Section seems vague, and susceptible to differing interpretations. It appears that, if passed, Section 5 would change the basis of Part B carrier contracting with the Federal Government, and would require that carriers be reimbursed for the cost of their claims processing function on a "prospective fixed cost per claim" basis.

We have repeatedly urged the Congress to give carriers more latitude to use their expertise in support of Medicare. To provide for fixed price reimbursement on an experimental basis would be consonant with this approach. However, we suggest that there is not yet enough experience to warrant universal application of fixed price reimbursement. Therefore, we recommend and support amending Section 5 to provide legislative direction for such experimentation. Regardless of the type of contract negotiated, we wish to emphasize that it is still the carrier's prerogative as to how it will manage its operations to meet its contractual obligations.

There is language in Section 5 that suggsets that in negotiating the contract estimates from other entities capable of performing claims processing functions would be considered. Whether this would require that carriers subcontract certain claims processing functions to the lowest bidder or estimate, and whether such subcontracts be open to competitive bidding, is unclear. However, in any event, NABSP cannot support this approach. Mr. Chairman, we wish to remind the Committee that the basis upon which carriers participate in the program is as carriers and not merely as claims processors. The carrier function as defined in Title XVIII goes well beyond claims processing. The management decision to subcontract any function or do them in-house should be solely a carrier prerogative.

In the event a carrier does decide to subcontract a claims processing function under a cost reimbursement contract, the subcontract may be let by competitive bid. NABSP would recognize this as being a legitimate interest of government since any resultant subcontract price entered into would directly impact on the government's total cost. However, with respect to a fixed price per claim con-

tract, if a carrier makes a decision to subcontract, then it is inappropriate for carriers to be required to use a competitive bidding basis for procuring the subcontract. The decisions regarding subcontracting must be that of the carrier, not the Federal Government's. The government's interest should be only in the "bottom line" as reflected in satisfactory performance at the price agreed upon.

Section 6: Claims processing for medicaid programs

This section would modify the existing criteria imposed upon the states in order for a state to qualify for a higher level of federal monies in the development and operation of its Medicaid system. Simply stated, this section would require that states securing these funds develop and implement a system which would be capable of being "integrated into" the Medicare system in addition to the present requirement that the systems be compatible.

We have noted earlier in this statement the problems which the Medicaid program is experiencing and the need to focus reform efforts at the carrier operational level. Blue Shield suggests that Congress assess this section in that same context.

Presently, under the Medicaid program, states receive substantial federal funds to assist them in administering the Medicaid program. Each state is given the option to either administer the program itself or contract with a carrier. A large number of states have opted to develop their own capabilities and administer the program. As a consequence, many states have a large investment both financially and politically in their Medicaid programs.

Under these circumstances, it might be difficult for a state to objectively evaluate its performance and make an objective decision as to whether or not it is the best entity to administer the Medicaid program. Consequently, a major contribution to improving Medicaid administration could be made by changing the agency which selects the carrier so that there is assurance that the designated carrier is selected on an objective basis.

This section also would reduce for states wanting the higher level of federal funding the explanation of benefits requirement from 100% to a sampling basis. While Blue Shield has found from its own experience that the EOB is an effective cost control device, it recognizes that its impact is limited. NABSP supports this amendment.

Section 7: Regulations of the Secretary

We support the proposal to extend from 30 to 60 days the time for comments on proposals. We would suggest that there should be other opportunities for organizations to give input to federal agencies before final rules are adopted and implemented, preferably during the drafting stages.

Section 8: Termination of Health Insurance Benefits Advisory Council

The termination of the Health Insurance Benefits Advisory Council (HIBAC) would create a void in an area which appears doubly important if the health portions of HEW are to be reorganized and expanded.

Section 20: Criteria for determining reasonable charge for physician's service

Claims reimbursement is unquestionably the major problem the program still faces. It's the greatest cause of dissatisfaction among beneficiaries and physicians alike.

In areas with high proportions of older citizens, the Medicare allowance determinations discourage physicians from taking assignment and, therefore, shift program costs to the elderly. The current assignment rate is 51 percent. In 1969, the assignment rate was 61 percent. Consequently, millions of older Americans are forced to dig deeper into their pockets to pay for health services.

Blue Shield recognizes the importance of containing Medicare expenditures within reasonable bounds. The Medicare carrier Plans have worked with SSA to accomplish this objective. Unfortunately, Mr. Chairman, the inflationary trend in the economy has caused the original objectives of a program based upon reasonable charges to conflict with the pressure to limit the government's financial liability. Medicare Part B cannot continue to be regarded as a paid-in-full program and at the same time, attempt to control program costs at a level which does not recognize the economic realities of our time.

Therefore, we urge the Congress, as we have in previous testimony, to choose between a true paid-in-full program or a limited liability program so that all parties, beneficiaries, providers, and carriers will be able to understand better what the program will actually cover.

Section 21: Agreements of physicians to accept assignment of claims

This section develops the concept of participating physicians and provides mechanisms for agreements of physicians to accept assignment of claims. For any full payment program to work with consistent predictability, there must be a commitment in advance by the physician to the full payment concept. There is absolutely no equivalent substitute to deliver predictable results to both the patient and the physician.

Participation is a two-way street. If any program is to succeed, the people involved must be confident of the basic equity of the arrangement. In order for government programs to succeed, they must satisfy this need.

To encourage physician assignment, S. 3205 proposes to reduce paperwork in their billing process through use of multiple billing forms instead of the traditional separate claim form for each patient. This concept has merit. However, the recommendation to pay 50 percent of all claims within five working days would not appear to encourage physicians to accept assignment. Carrier presently process approximately 75 percent of physician claims in less than 14 days with an average of 14 days for all claims. If part of the claim is paid immediately and then reviewed again, it would just serve to increase administrative costs.

Finally, the section equalizing payment for physician's services under Medicaid with the Medicare reasonable charge is not an equitable basis for reimbursement. What is actually needed here is the recognition of a reasonable and equitable charge under each program, bearing in mind the different characteristics of these two distinct population groups.

ADDITIONAL COMMENTS

Additional comments and concepts which are currently being tried on an experimental basis in the Medicare program and further suggestions follow.

Improved administrative procedures to encourage physician assignment in Medicare are evolving as carriers work with the SSA's Bureau of Health Insurance through the Carrier Representative Group and the carriers' associations. To legislate administrative procedures appears unwise as it tends to stifle long-range innovation by health insurers. Instead, the Congress might well consider substituting legislative intent language in the report accompanying S. 3205 which urges SSA and BHI to administratively encourage and fund cost-saving innovations by carriers to effectuate administrative reforms of the nature described below.

The requirement by SSA for the beneficiary to sign the claim form certifying that the services were actually rendered could be waived. However, the physician would have to continue to itemize his services and charges for each patient listed on the multiple billing form. The actual pieces of paper would be reduced, but not the technical description of services provided. This description of services provided accounts for almost all delays in payment and if not properly recorded results in inaccurate payments by the carrier. This lack of correct information and/or paying a minimal amount which is later adjusted when the additional information is received, are the two factors which have contributed to physician dissatisfaction with the program. As a result, they tend to bill the patient directly, asking the patient to bear he brunt of obtaining this information. Meanwhile the physician's bookkeeping procedures are reduced to one entry and his office assistant is freed from spending hours on the telephone both with the carrier and/or the hospital (to obtain operative reports, etc.). Even though the physician's office staff is much more experienced and sophisticated in obtaining this required information, they don't want to go through the continuous time-consuming hassle.

One approach to easing the paper workload has been offered by Blue Shield Plans in the form of their various education seminars for doctors' office assistants offered in the community. Blue Shield in its experience has found if the office assistant is shown how to itemize the doctor's bill, especially those specifications related to this type of specialty, the claims come in clean and are processed accurately and on a timely basis and the physician's office is more likely to accept assignment.

Some carriers have already implemented summary payments. The physician submits individual claims for each patient, the carrier processes them but retains and consolidates a week's billing into one check. The physician receives one check and an EOMB for each patient along with a listing of the amount paid.

This has been most helpful, in that the doctor's office receives one check, once a week. His office staff can set aside one day a week to do bookkeeping, rather than receive several checks every day. Again, some physicians prefer this method, some do not for various reasons.

The point we are trying to make and emphasize, Mr. Chairman, is that there are various methods available but by specifying a single method through legislation, there is no leeway for these other methods to be tried. We therefore, would suggest that legislative language be very general to keep the program flexible.

Finally, overall we feel that any action on the part of government to fix or otherwise adjust reimbursement at its sole discretion which can be interpreted as capricious and arbitarary, will discourage physician participation. The health care economy has its own features. We recently testified regarding this particular subject before the Council on Wage and Price Stability. A copy of that statement is attached. We would recommend it to you for additional insights into this area.

Recently, the General Accounting Office released a report on the rising costs of Medicare and Medicaid. One recommendation concerns the payment for durable medical equipment.

Often a beneficiary needs a device which is rented even though the period of time suggests that purchasing would be justified. The GAO recommended that in such instances purchasing the equipment should be covered or renting should be limited to a percentage after the purchase price has been met.

CONCLUSION

To summarize, we urge that before the bill is reported to the entire committee, further consideration will be given concerning the net effect of this legislation. We realize that reforms are necessary in certain areas so that the populations who were originally intended to benefit by them, the elderly and the poor, will receive good health care at minimal out-of-pocket cost. Mr. Chairman, we feel that the public and the private sectors can work together to find *flexible* solutions.

Mr. Chairman, thank you for the opportunity to appear and submit our views on S. 3205.

STATEMENT OF THE NATIONAL ASSOCIATION OF BLUE SHIELD PLANS ON HEALTH CARE COSTS SUBMITTED TO THE COUNCIL ON WAGE AND PRICE STABILITY PRESENTED BY LAWRENCE C. MORRIS, SENIOR VICE PRESIDENT, JULY 21, 1976

Mr. Chairman, my name is Lawrence C. Morris. I am Senior Vice President of the National Association of Blue Shield Plans. The Association represents 70 local Blue Shield Plans, covering 73 million Americans in privately underwritten coverage, and servicing an additional 13 million in government programs. About 40 percent of the nation's population looks to Blue Shield for coverage of professional health care services.

We are pleased to have this opportunity to appear before you and discuss the questions you have posed: why are health care costs rising, and what can the private sector do about the increase?

We have reviewed the Council's paper of April, 1976, entitled "The Problem of Rising Health Care Costs." We respect it as an attempt to understand and promote discussion of some of the issues in the rise of health care costs and expenditures of the past decade. We must underscore, however, the limitation acknowledged in the paper: its examination of the health care problem is an economic one, with little reference to social, demographic, and clinical factors. We respectfully suggest that this is too narrow a view for a real understanding of either why health care costs have risen, or what can be done about it.

Fundamental to an understanding of the current situation is the recognition that health care has been a vehicle for social change. Much of the increased health cost has been dictated by changing social priorities, some emerging from the relatively free processes of consumer choice and collective bargaining, and some from the federal government.

The health care system does not set its own course; rather it responds to demands, some of which conflict. This does not imply that the system does not have some significant faults. There are a number of things that can and should be done to increase its cost-consciousness, and to influence unit price, utilization, and intensity of service, which are the basic elements of cost. We will discuss some of them.

To a large degree health care costs got where they are because of insistent demand for increased supply, access and quality of care. The economic rationing processes have been destroyed, both by private choice and by public policy. This is probably good, to the extent that it results in improved access and quality of service for those who bore the brunt of economic rationing. The decision is not to be condemned, but to be understood, so that a rational response can be developed.

Most expenditures to expand the system have been made without effective planning and with little real consideration for the future. Many of the social and political decisions affecting health costs were made not only without reference to economics, but frequently for the specific purpose of reversing the normal outcome of economic processes. An economic view which fails to consider social and political factors fully is likely to be too narrow.

There are major influences on health care costs which cannot be controlled by the health care system or government. Had there been no private insurance, and had there been no Medicare nor Medicaid, there would still have been major increases in health costs. Most major countries are experiencing comparable health cost increases. We are dealing with a worldwide phenomenon which operates quite independently of type of financing system.

The United States experienced a 124 percent general rate of inflation from 1950 to 1975. No industry as basic or large as health care could have been insulated from that.

Less obvious, perhaps, is the significant change in the composition of the United States population. The proportion of elderly, those 65 and over, has risen more than 50 percent from 6.8 percent of the population in 1940 to 10.3 percent in 1974. Their health patterns differ from younger people's. They experience more chronic and degenerative diseases that require extended care over long periods of time, at substantially increased cost. Senior citizens account for 22 percent of all hospital stays, and occupy 32 percent (or three times their relative share) of all hospital beds. They consume other health services comparably.

Concurrently, there has been a shift from non-market to market production of health care services. Victor Fuchs has pointed out that part of the increase in medical care costs results from an increase in the proportion of medical care produced and sold in the market, that is, delivered by professionals and institutions, and a decline in the proportion of care provided outside the market by family, friends and neighbors. Some of the reasons are urbanization, the fragmentation of the family, and the increased participation of women in the labor force.

There are obviously other factors, but these begin to show that much health cost escalation is not controllable by the health system.

A second factor to consider is the deliberate policy of government to expand the supply and capability of and access to health care services. This probably has been the single greatest force in increasing health care costs. Again, it is not necessarily to be condemned. Most of us would endorse the objectives. Few, however, fully appreciate the extent to which government policy has increased health care cost by stimulating both the supply and the demand.

That Medicare and Medicaid substantially expanded the financial access of the elderly and the poor to health services is obvious. Less widely understood is that the federal government, through the Hill-Burton program, played a role in constructing 40 percent of the beds in the non-federal short term hospitals that existed in 1974. It cost more than $15 billion in 1974 to operate Hill-Burton supported beds. Unfortunately, the bulk of this activity took place without effective planning. Many factors having little to do with real need governed decisions to build.

In 1966, Congress attempted to remedy this difficulty by passing legislation to provide some coherent health planning. However, planning agencies were given no real authority regarding allocation of Hill-Burton funds or hospital construction. Local planning agencies objected to many facilities that were built. By 1974, when Congress passed the National Health Planning and Resources Development Act, 365,250 Hill-Burton beds were in place.

We have had similar experience in training health manpower. The number of graduates of schools of medicine and osteopathy more than doubled from 7,516 in 1955 to 15,274 in 1975. The number of accredited educational programs for allied health personnel grew from 1,774 in 1963 to 2,741 in 1975, and the number of graduates has grown to more than 200,000 annually.

Much of this rapid growth resulted from the federal government's increasing involvement in financing medical education. Its share of the medical schools'

total annual income grew from 0.4 percent in 1945 to 53 percent in 1968 and to 41 percent in 1974. Between 1949 and 1969, the average medical school increased its full-time faculty from 70 to over 250, nearly half of whom received some or all of their salaries from federal research funds.

The research orientation produced by these funds has had its own unique impact. Not only has it tended to lower the percentage of new physicians in the primary care specialties, but it has also tended to increase the use of sophisticated medical technology. One study has shown that physicians in university hospitals order an average of 11 percent more laboratory tests than physicians in non-university hospitals for comparable patients. This tendency, presumably, is passed on to their students.

Federal expenditures for health research grew from $27 million in 1947 to $2.4 billion in 1974. The majority of these funds have been allocated by the National Institutes of Health, which have consistently been funded beyond their budget requests by Congress. Advances in diagnosis and treatment realized from these expenditures have contributed significantly to the costs of medical care.

The point, again, is not that government has necessarily been unwise in its objectives, but that it has pursued a national policy of substantially increased health care capacity, and therefore cost, with no discernible coherent national health strategy.

There have been significant changes in the health care product, many of which are not reflected in health care cost data.

The increasing share of the Gross National Product allocated to health services does not indicate simply that we are purchasing increasing amounts of the same kind of health care. The Bureau of Labor Statistics, which produces the Consumer Price Index, has developed effective measures for accommodating the effect on price of changes in the quality of commodities. However, it has not successfully accommodated changes in services. The Consumer Price Index, therefore, relies on a group of simple, reasonably standard services and implicitly assumes that changes in quality will be small. Dramatic new procedures aside, it is clear that a patient undergoing a routine operation within an institution which incorporates intensive care units, surgical recovery rooms, and extensive cardiac care facilities is not receiving the same product as a patient undergoing the same operation without similar facilities. The quality of his care and his probability of survival have improved.

Discussions of health care cost tend to present data simply in terms of increased expenditures for services. This is an over-simplification. There are a number of areas in which increased expenditures yield net economic savings by reducing morbidity and mortality.

Examples of this effect are in the "Study of Surgical Services in the United States," sponsored by the American College of Surgeons and the American Surgical Association. For a specific list of research contributions, the study indicates that direct costs of treatment increased $121.1 million in 1970 over what could have been expected in 1960, without the technological advances which occurred during the decade. Concurrently, however, the additional expenditure resulted in economic savings of $2,184.5 million in mortality, and of $192 million in morbidity. The ratio of indirect cost savings to direct expenditures was thus approximately 20 to one.

Similarly, the National Institutes of Health indicate that the direct costs of treatment for kidney transplants and hemodialysis, recently developed modalities, were $13,991,000 in 1970. Savings attributed to decreased mortality were $1,003,129,000, and to decreased morbidity $53,860,000. Net savings, then, were on the order of $935 million. In the same year, and by similar method, NIH estimated savings for use of the cardiac pacemaker at $123 million.

It is probably possible to extrapolate these fundamentally imprecise data to ridiculous lengths. However, the basic point—that there are significant economic returns on health care services—is valid, and should be noted.

The Council's paper has cited the widespread existence of health insurance, typically with employer contribution to its cost, as obscuring the consumer's perception of the cost of care, his spending decisions, and the treatment decisions of the physician. It focused on "first dollar" coverage (i.e., coverage without copayment or deductibles) as leading patients to demand more services than they otherwise would.

It is true that insurance frequently lessens the individual's knowledge of and concern for health care costs. It is also true, as the Council notes in a different

context on page 6 of its paper, that the individual does not purchase health care with the same attitudes as those with which he buys other goods and services.

The purchase of health care services does not follow the normal interaction of supply and demand. Under the classical assumptions of utility and profit maximization resources, including expenditures, are allocated optimally if the market operates perfectly. But price is not usually the major mechanism for allocating medical resources, and we have just shown that there has been massive intervention through public policy to assure that it is not. Effective coverage essentially equalizes income for health purposes, and thus does tend to minimize income differences as a form of economic rationing. In our view, this is desirable.

The consumer lacks information about his medical needs, the cost of medical care, and what lies in the future. Frequently, he has no real choice as to whether or what services to purchase. He attempts to avert risk by purchasing health insurance. This is a rational decision in economic terms, and in first dollar coverage, it has an immediate dual impact: it affords the consumer financial protection; and it assures that an agency other than the subscriber will deal with the physician on price. This demand for security in the form of first dollar coverage can only exist in the present environment in which, concurrently, money has been freed from other needs and there are, in fact, effective health care services to be purchased.

The Canadian national health insurance system originally imposed cost-sharing on all patients. The practical effect was to reduce utilization six to seven percent among the general population, but 18 percent among the poor. This is clearly not in accord with the social priorities of our country.

It is probable that high-level indemnity coverage is more inflationary than full coverage, provided that the full coverage applies reasonable controls to allowances. An excellent example is afforded by the Medicare program. An HEW-sponsored study conducted by Nathan Associates attempted to determine the relative effects of general inflation and the Medicare program on increases in physician fees. It concluded that the introduction of the Medicare program in 1966 caused an additional rise in physicians' fees of about three percent annually from 1966 through 1969. The study attributed 1.75 of this three percent to the specific method of reimbursement which is open at the top. The remaining 1.25 percent was attributed to the Medicare program considered only as insurance.

Further confirmation of this is in a study of expenditures for physicians' services in the pre-Medicare period, 1956–1966. The National Bureau of Economic Research concluded that the main factors contributing to increases were technical changes in the health care product and the increased supply of physicians. Insurance was found to have comparatively little influence on expenditures for physicians' services.

First dollar coverage probably does cause some expenditures to be identified which are otherwise "lost"—absorbed by the patient or the physician. An HEW study of the Medicare B program from July, 1966 to December, 1971 shows that of the beneficiaries eligible for the program, 33.7 percent had never met the $50 deductible. This impresses us as a high figure for this age group. It is entirely possible that many of these patients incurred enough expense to be eligible for reimbursement, but simply failed to file because of lost bills, confusion, or inability or unwillingness to cope with the process. If this is true, utilization and expense differences between forms of coverage are misleading.

First dollar coverage tends to reduce the provider's costs of doing business by eliminating bad debt and dual billings. In return for this, he is frequently willing to contract with the carrier for an agreed level of payment which frequently provides the subscriber both his most efficient possible purchase and his optimal level of risk aversion.

The Council has asked what the private sector can do about health care costs. Blue Shield specializes in professional services, and devotes most of its income to reimbursement for physician services. Some simple arithmetic is critical to the answer. Physicians receive about 20 percent of the health care dollar. Typically, 40 percent of their income pays for overhead which is relatively inflexible, while 60 percent is considered net income. If the physician's net income portion of the health care dollar were reduced 20 percent—without regard to the feasibility or desirability of such action—total health care costs would be reduced by about two and one-half percent. Clearly, then, major reductions in the overall cost of health care are not available to Blue Shield from claims

processes. There are, however, a number of things that Blue Shield Plans do to help hold down benefit costs. They include:

1. Physician participation. This concept, essentially unique to Blue Shield, provides an agreement in advance of service that the physician will accept the Plan's price determinations. The subscriber, who is usually uninformed and in poor bargaining position to establish price, substitutes the Blue Shield Plan's experience and knowledge for his own. This is probably the most effective of all cost containment devices.

2. Charge determinations. The data base provided by decentralization and intensive commitment to the geographic area of the Plan permits Blue Shield Plans to administer coverage with comparative precision, and yields charge reductions in the tens of millions of dollars annually, with comparatively little sacrifice of the full payment commitment to the subscriber. Exception mechanisms for determining reasonable charges in unusual medical circumstances extend the commitment further.

3. Utilization review. All Blue Shield Plans review utilization to assure that covered services are reasonable in relation to the medical circumstances of the case.

4. Coordination of benefits and subrogation. Most Plans apply these devices to eliminate collateral payments, which increase the costs of a given episode of care.

The National Association attempts to support individual Plans in administering their benefits, by such efforts as:

1. Central systems development for utilization review, accounting, and other common purposes.

2. Development of a program by which out-of-area subscribers incurring medical care costs have their charges adjudicated by the local Plan in order to maintain the most precise possible determination of allowances.

3. In conjunction with the Blue Cross Association, a program of Total Plan Review has been developed to assist the management of the local Plan in achieving the most cost effective administration. This program has, over the years, achieved millions of dollars in savings for Plans.

4. Also with the Blue Cross Association, a multi-million dollar program of Long Range Systems Planning, for the purpose of placing advanced software technology in the hands of Blue Cross and Blue Shield Plans for the more efficient and economical administration of future programs.

The combined efforts of the Plans and the Associations have permitted Blue Cross and Blue Shield to return 94 cents of each premium dollar to the subscriber in benefits—a highly efficient return on a complex operation.

In the long term, these programs can be expected to have less impact upon total cost than other activities in which Blue Shield is involved which are aimed at either changing fundamental incentives within the system or making it possible to reimburse for services on a different basis. Examples of such programs include:

1. Development of alternate delivery systems. With Blue Cross, Blue Shield is the most active developer of such systems in the country. Blue Shield has supported and will continue to support development of prepaid group practice systems. It recently has, however, placed increasing emphasis on the individual practice type of HMO. We feel that involving whole medical communities in alternate forms of delivery offers greater promise, in the long run, for widespread changes in the cost-efficiency of medical practice.

2. Experimental programs to determine the feasibility of paying for medical care in a single "payment by diagnosis," rather than in a succession of charges by visit.

3. Second opinion surgical programs, to make confirmation of the need for surgery a subscriber benefit, and to test the efficacy of this approach.

4. Active participation in the Professional Standards Review Organization program, including the development, with Blue Cross, of specialized systems to permit the integration of hospital and medical records for professional review in government programs or in private business.

5. Active programs to teach physicians about the costs of the services they order. Some of these programs are directed at hospital staffs. Others are being developed for inclusion in medical school curricula in an attempt to reach the physician in the earliest stages of his career.

6. A program to work with medical specialty groups to determine more clearly which procedures through outmoding, redundancy, lack of established efficacy, or other evolutionary processes have become medically unnecessary, in most cases.

This review of carrier activity tends to illustrate the point that there is no single solution to the problem of health cost, but rather a need for a series of coordinated activities designed to influence the system within a framework of defined objectives. While the carriers' role is limited, the same principle applies to a broader public-private effort which is necessary if we are to achieve overall results.

We are concerned that the nation is looking for a single, dramatic stroke of policy that will change the direction of health care costs, and we do not believe that such a stroke is possible. If our informal consensus regarding the use of resources for health care has not been very satisfying, perhaps it is because it has not been very realistic. We have put enormous resources into developing a health care system and assuring its availability to anyone who wishes to use it, and we are now concerned about the inevitable result—significantly increased costs. If these costs are to be constrained, the major requisite is a consistent national health policy.

Such a policy has not been pursued in the past, and it is not being pursued now. Increasing the supply of health care may ultimately have an effect, but in the short term it is inflationary. Reducing demand could help but comparatively little public or private money has gone to educate patients in better health habits or more intelligent use of the system. A lower quality of care could be effective in many cases, but little has been done about the malpractice environment in which a physician who works from a reasonable hypothesis rather than all available laboratory and X-ray evidence is risking serious personal consequences. The efficiency of health service might improve, but we are confronted with a federal HMO Act which has been a positive barrier to free experimentation, and state regulatory authorities which have depressed carriers' reserves, in some cases to the point that their willingness and ability to try new approaches to reimbursement has been severely inhibited.

It would be a terrible error to try to manage the health system as a single enterprise. It is too complex, and the consequences of inflexibility, a politicized economic base, and stifled innovation are too great. At the other extreme, a series of unrelated, uncoordinated regulatory efforts might very well be counterproductive as some of these examples show.

But genuine easing of costs through behavior modification is probably possible, for example, through a concerted effort to decrease demand. Some of the areas on which such an effort might concentrate are:

Improved health habits for the general population.

Education in better use of the health system. For example, when is it appropriate to use the hospital emergency room, or the physician's office at half the price, or self care at little or no cost?

Proper use of preventive medicine, based not on a shotgun approach but on a realistic consideration of age, health status and risk factors.

Physician education in the costs of care, and the use of effective but less expensive procedures.

Easing of the malpractice situation, to provide less incentive to defensive medicine.

Use of more non-physician health personnel to teach patients maintenance procedures and the prevention of complications.

Employer based programs to promote safety and heath consciousness.

Similarly, a concerted effort could increase the efficiency of the system. Examples of useful projects would include:

More effective planning to reduce the unnecessary proliferation of beds and equipment, and retire excess capacity.

Federal mandate of a minimum scope of health coverage, to minimize bias in the selection of treatment. Such a mandate should be phased in over a reasonable period of time to minimize its inflationary and cost impacts.

Restructure of HMO legislation to permit genuine experimentation and competition based upon innovation and provider cooperation rather than compliance with preconceived models.

Federal guidelines for efficient, effective carrier performance, implemented through state regulatory authorities.

Encouraging the use of health personnel other than physicians for many types of services.

These examples are not intended to be comprehensive, but to illustrate the point that there are things which can be done through a joint effort of the public and private sectors to influence health costs through improved efficiency and lowered demand without trauma to the social goals we have set. To the extent that health care has served as a vehicle for major social change, the social forces which have brought change must participate in the revision of priorities.

Senator TALMADGE. Our next witnesses are Frank Hughes, President-elect, National Retired Teachers Association-American Association of Retired Persons, accompanied by Laurence F. Lane, legislative representative. Mr. Hughes is not only a constituent of mine but a very valued long-time friend. He served as president of the Georgia Education Association when I was Governor of Georgia. We worked very closely with him.

STATEMENT OF FRANK HUGHES, PRESIDENT-ELECT, NATIONAL RETIRED TEACHERS ASSOCIATION-AMERICAN ASSOCIATION OF RETIRED PERSONS, ACCOMPANIED BY LAURENCE F. LANE, LEGISLATIVE REPRESENTATIVE

I am Frank Hughes. I appear this morning not only representing half a million members of the National Retired Teachers Association, but also over 9 million members of our sister organization, the American Association of Retired Persons.

Now, we have prepared a statement which I would ask that it be submitted for the record.

Senator TALMADGE. It will be inserted in the record.

Mr. HUGHES. I shall summarize the testimony to meet time restrictions.

At the outset, allow me to emphasize our associations are pleased that this committee has initiated legislation and legislative reforms to improve the performance of medicare and medicaid programs. We believe the chairman of this subcommittee is to be commended for his leadership in sponsoring S. 3205 as a working document to improve our health reimbursement programs.

NRTA and AARP generally support the administrative and reimbursement procedures set forth in the legislation as a first step toward necessary improvements.

However, we solicit additional action by the committee to strengthen further the administrative and reimbursement procedures to improve the responsiveness of the medicare benefit package to the needs of the elderly and federalize the Medicaid program.

Recognizing the members of this committee continue to seek assistance and direction that they should be pursuing to improve the responsiveness of health programs, our association reiterates the message which we brought to the Congress during the discussion of national health insurance.

That is, action must be taken by the Congress to augment medicare and to provide for a complete continuum of health services for the aged and the disabled to incorporate a new system of payment procedures designed to restrain health care costs.

Our testimony sets forth a plan which could be implemented in spite of budgetary procedures. Additionally, our testimony provides a section-by-section analysis of S. 3205 with our association's view toward the legislation.

Mindful of our concerns that point out the need for an immediate committee action to expand the medicare benefit package and to federalize the title 19 medicaid program, we offer the following comments concerning the specific provisions of S. 3205.

Our associations see merit in the proposed revision to combine the title XVIII (medicare), title XIX (medicaid) programs with the functions of the Bureau of Quality Assurance and the Office of Long-Term Care under the direction of an assistant secretary for health care under the direction of an assistant secretary for health care financing.

The present patchquilt of HEW offices with responsibility for health management has often compounded the development of a rational health care delivery system.

Likewise, our associations are supportive of the establishment within the Department of Health, Education, and Welfare of an Office of Central Fraud and Abuse Control under the direction of an Inspector General for Health Administration as proposed in section 3 of S. 3205.

The consumer is placed in a real dilemma in responding to the need for tighter administrative controls in the reimbursement programs. On the one hand, we are wary of advocating reimbursement controls inasmuch as they often translate out in the long run to reductions in benefits while on the other we are shocked by the continued inefficiencies tolerated.

Congressional oversight will be necessary as we walk the line between providing necessary services to eligible recipients while constraining unwarranted costs.

We emphasize the above thoughts to point out a major deficiency of S. 3205, that is, its failure to address the need to improve the administrative responsiveness of the fiscal intermediary. While section 5 expands the functions of the intermediary, no mention is given to improving performance.

Our associations commend the sponsors of S. 3205 for attempting to construct an improved reimbursement procedure for medicare and medicaid. While we question whether the components of the plan of action add up to effective containment of spiraling health care costs, the legislation does take the first steps toward control.

With respect to the physician reimbursement provisions of S. 3205, our associations question whether they will achieve their intended goals. As with our stance on institutional reimbursement, we believe more decisive action is required. As with several other sections of the legislation, our associations are generally supportive of the efforts initiated by the sponsors, however, we would encourage additional steps by the committee. For instance, medicare skilled nursing coverage is an extremely limited benefit whereas the needs of the beneficiary population for both skilled nursing and intermediate nursing services is growing.

The net result is that the recipient ends up paying for the care out of his own pocket, and, or, the cost of such care are transferred from medicare to medicaid. Attention should be given to the comprehensive long-term care reforms set forth in S. 2702, the Medicare-Long Term Care Improvement Act. Our associations strongly endorse the provi-

sions for an expanded Federal responsibility for certification and approval of medicaid skilled nursing facilities.

In conclusion, Senator Talmadge, I wish to thank you for giving me this opportunity to present the views of my associations before this committee. My members are the beneficiaries of these programs and we appreciate the efforts which you have initiated to improve the responsiveness of the Federal health programs to our needs. We stand ready to assist you in this effort.

Senator TALMADGE. Thank you very much, Mr. Hughes, we appreciate your testimony.

While I personally support many of the suggestions that you have made to improve medical services in the Nation, we are confronted with very acute budgetary restraints not only on the Federal level but the State level also. The cost of medicare and medicaid has increased from about $30 billion last year to about $38 billion this year.

It is escalating at a rate of 25 percent a year. It is absolutely necessary for us to get some sort of handle on this cost before we can make further improvements, in my judgment, in the health programs.

Thank you very much, we appreciate your contribution.

[The prepared statement of Mr. Hughes follows:]

TESTIMONY OF THE NATIONAL RETIRED TEACHERS ASSOCIATION AND THE AMERICAN ASSOCIATION OF RETIRED PERSONS

Mr. Chairman, I am Frank Hughes, President-Elect of the National Retired Teachers Association. I appear this morning not only representing the half million members of the National Retired Teachers Association but also the over nine million members of our sister organization, the American Association of Retired Persons. These two affiliated membership organizations are the largest service and advocacy groups promoting the interests of the elderly. Accompanying me this morning is Laurence F. Lane, who is a Legislative Representative on the staff of the Associations.

At the outset, allow me to emphasize that our Associations are pleased that this committee has initiated legislative reforms to improve the performance of the Medicare and Medical programs. We believe the Chairman of this Subcommittee is to be commended for his leadership in sponsoring S. 3205 as a working document to improve our health reimbursement programs. NRTA-AARP generally support the administrative and reimbursement procedures set forth in the legislation as a first step toward necessary improvements. However, we solicit additional action by the committee to strengthen further the administrative and reimbursement procedures, improve the responsiveness of the Medicare benefit package to the needs of the elderly, and federalize the Medicaid program.

NEED TO IMPROVE MEDICARE

Recognizing that the members of this committee continue to seek assistance in directions they should be pursuing to improve the responsiveness of health programs, our Associations reiterate the message which we brought to The Congress during the discussion of national health insurance i.e. action must be taken by this Congress to augment Medicare to provide for a complete continuum of health services for the aged and disabled and to incorporate a new system of payment procedures designed to restrain health care costs.

We continue to hold out the provisions of the Comprehensive Medicare Reform Act as a model for committee action. This bill in addition to preserving present Medicare benefits would add additionally needed ones such as intermediate care facility services, dental services and out-patient hospital skilled nursing and home health care would be abolished. The legislation would eliminate deductibles and coinsurance under present law and would substitute a system of minimal copayments with respect to the more expensive items of health care. However these copayments and remaining limitations on benefits would be subject to a

catastrophic protection feature under which low income persons would pay nothing and others pay out-of-pocket amounts related to their income.

Knowing that there are those who contend that such a sweeping overhaul of the Medicare program while needed might be beyond imposed fiscal limitations let us emphasize that there are steps that can be taken by the Congress that would enhance Medicare without straining resources.

1. There is immediate need for congressional action to control health care inflation. The reaction of the health sector to the cost restraints imposed under S. 224 of the 1972 amendments clearly indicated that without increased governmental controls over that sector the market mechanism will be abused to excess. It is absurd to think that controls on reasonable cost reimbursement will provide sufficient leverage to force cost consciousness on the health sector.

While we are pleased with the thrust of S. 3205 as a first step toward containing Medicare inflation, we commend the provisions of the Comprehensive Medicare Reform Act of 1975 to the committee as a model for a more responsive reimbursement system. In this legislation, we endorse cost restraints which require participating institutional providers to submit annually for approval a budget and schedule or proposed charges based on the reasonable cost of efficient delivery of services. Reimbursement would be based on predetermined, approved rates with built-in incentives to reward efficiency and economy. With respect to licensed professional practitioners, payment would be provided in accordance with annually predetermined fee schedules for local areas under which fair and adequate compensation would be provided. A provider would be required to accept the Medicare payment plus any copayment as payment in full for services.

These proposals for cost restraint put older Americans on the front line of the struggle to contain health care inflation, but, our members have emphasized the seriousness of the issue. They are being priced out of the health market in spite of Medicare and other public health assistance. They face the options of becoming wards of the state under medical assistance vendor programs or face lack of attention to their medical needs.

2. It is imperative that the benefit package under Medicare be broadened to provide reimbursement for additional ambulatory and preventive services. It is important to note that one of the prime weaknesses of existing public programs is that they are skewed among the different medical services causing an uneven distribution in benefit coverage and an unbalanced and generally expensive pattern of utilization. The failure of S. 3205 to deal with this issue is perhaps the most serious deficiency of the measure's attempts to improve program efficiency. Essentially, we have no preventive strategy built into our health care system for the aged. We fail to address the possibility of preventing premature aging and incapacitation disabilities. Furthermore, preliminary evidence from the Current Medicare Survey Reports indicates that those areas showing a high rate of multiple hospitalization are those with low rates of use of ambulatory physician services, thus reinforcing the potential economic tradeoffs between an expanded benefit package and the present restricted coverage.

3. There is a major need to refocus our health strategies to improve efficiency and ensure optimum utilization of all medical resources. We urge the committee to concentrate on following through on the recommendations of the July 9, 1974 GAO Report to Congress on "Home Health Care Benefits under Medicare and Medicaid" to ensure that necessary legislative reforms and/or administrative regulations are made. We solicit continued committee activity to report legislation broadening the definition of eligibility for and reimbursement of home health services.

4. Restrictive durational limitations under the Hospital Insurance program should be adjusted to alleviate the threat of losing benefits. Under present law, after 90 days of hospitalization during a benefit period, the recipient is forced to use lifetime reserve days. While few individuals deplete their benefits, there is a fear held by the recipients that prolonged institutionalization would be catastrophic. With the oldest segment of the aging population being the fastest growing, we are witnessing a slight increase in the number of individuals who are using up their hospital insurance lifetime reserve. Immediate action should be taken to extend the durational limit for hospital insurance coverage per spell-of-illness with the elimination of the provision for lifetime reserve days. Likewise, there should be a revision of the Medicare spell-of-illness definition to provide greater flexibility in safeguarding the beneficiary's coverage, so that in those special cases where an individual has remained institutionalized in a

skilled nursing facility, but not receiving skilled care, there would be Part A coverage if hospitalization is required.

5. Medicare eligibility should be extended to individuals aged 60 through 64, and to the spouses of individuals entitled to Medicare. The Senate has passed this provision on several occations, only to have the amendment thrown out in conference committee. Many older persons find great difficulty in securing adequate insurance coverage, especially if the spouse is over 65. While the at-risk population are not particularly high users of health care services, we find continual demands among our members for the extension of Medicare on a buy-in basis.

6. Pharmaceuticals remain one of the largest out-of-pocket medical expenses for older Americans. A stronger federal effort is required to regulate properly the cost, quality, and dispensing of these vital substances to older persons. Medicare should be extended to reimburse out-of-institution prescriptions.

7. Congress must take action to contain rising out-of-pocket costs to the Medicare recipient. At a minimum, steps should be taken to update the base year used in the calculation of the cost sharing features. The optimum would be the structure suggested in the Comprehensive Medicare Reform Act which calls for the consolidation of Parts A and B of Medicare and the elimination of premium payments.

8. There is an obvious need to tighten administration of the Medicare program to protect against fraud and abuse. We applaud the strong provisions of S. 3205 to deal with the errosive affect of fraudulent practices upon the Medicare program. We want this committee to be cognizant that the public, and especially the recipients of Medicare, demand a better accounting of program funds. While it has been our experience that many newspaper dramatizations of fraudulent practices stretch the truth, both the widespread acceptance of Medicare and the financial integrity of the program are jeopardized by the underpinnings of fact.

FEDERALIZING THE MEDICAID PROGRAM

If our Associations were asked to point out where our legislative objectives differ the most from the provisions of S. 3205, it would be with respect to the Medicaid program. S. 3205 assumes a broadened, more responsible role by the States in the management of Title XIX, while, we view the present program design as perhaps one of the most complex and singularly unmanageable programs which the Federal government has initiated.

There is no escaping the fact that we have fostered the development of 53 differing health systems which are not meeting the health needs of the intended beneficiaries, while at the same time, the services which are being provided are financially draining the states of their limited resources. Welfare costs typically constitute one of the largest items in a state's budget, and vendor payments for medical care have represented an increasing share of welfare costs. Looking at State and local funds only, medical vendor payments have risen from $764 million for medical vendor payments in fiscal year 1966 to an estimated $4,445 million in fiscal year 1974, a 583 percent increase in under ten years.

Insufficient income has forced millions of older Americans to rely upon Medicaid as a primary vehicle for health care protection. Medicaid is the primary source of funding for long-term care to the older population. However, program cut-backs mandated by fiscal restraints in the stages have seriously jeopardized the availability of such assistance to those in need.

Congress must address the policy issue of whether Medicaid would be improved if placed under federal administration. Title II of the national health legislation introduced by Senators Long and Ribicoff clearly offers a workable plan for such federalization.

SECTION-BY-SECTION ANALYSIS

Mindful of the above stated concerns that point out the need for immediate committee action to expand the Medicare benefit package and to federalize the Title XIX (Medicaid) program, we offer the following comments concerning the specific provisions of S. 3205.

. . . Administrative Reforms:

Our Associations see merit in the proposed revision to combine the Title XVIII (Medicare), Title XIX (Medicaid) programs with the functions of the Bureau

of Quality Assurance and the Office of Long-Term Care under the direction of an Assistant Secretary for Health Care Financing. The present patchquilt of HEW offices with responsibility for health management has often compounded the development of a rational health care delivery system. It has been our experience that much of the delay in the implementation of key provisions of Public Law 92-603 was directly attributable to timelags in the decision-making process among the several entities responsible for writing regulations. At the same time that we support the combining of these administrative components under one umbrella agency, we believe that without additional steps to bring the complete Medicaid program under the primary direction of the Federal government these reforms will fall short. As long as there is a difference of management in the two health reimbursement programs and differing funding sources, there will be continued conflicts and irreconcilable disputes.

Likewise, our Associations are supportive of the establishment within the Department of Health, Education and Welfare of an Office of Central Fraud and Abuse Control under the direction of an Inspector General for Health Administration as proposed in Section 3 of S. 3205. Consideration should be given to clarifying the relationship of the Inspector General's role to that of the Assistant Secretary for Health Financing established by Section 2. One of the primary difficulties in the present administration of regulations appears to be the diffused responsibility between promulgating regulation and enforcing them. We would view the primary enforcement mechanism as a responsibility of the Health Care Financing Administration with the Inspector General for Health Administration serving an ombudsman function. We would emphasize that initiatives to improve our capacity to monitor against fradulent practices should also direct themselves to improving our capacity to ensure the delivery of quality care to the patient. Improving the efficiency of the government to account for dollars it spends on health services does not assure that the government can account for the type of care it reimbursed.

One provision which we strongly support in S. 3205 is the authority for the General Counsel of the Department of Health, Education and Welfare to prosecute any civil fraud case should the Department of Justice not act within a reasonable amount of time. We would strengthen that authority to give the General Counsel the power to initiate and or to enter as a party in actions where patient care has not met the quality of prescribed standards. It is our understanding that one of the primary reasons why the abuses in New York nursing facilities became so common was that the workload of the prosecutors was such that the threat of court action was negligible.

With respect to the reporting procedures set forth in Section 1124(e)(1) we would ask consideration be given that such reports be also forwarded to the Senate Special Committee on Aging and the House Select Committee on Aging. While neither of these committees have legislative authority, both have served as advocates and overseers of government policies with respect to older Americans.

Actions to improving the State Medicaid program proposed in Section 4 are generally supportable with the exception of the provision for Medicaid redeterminations within a six month period. For the one out of every five elderly who must rely on Medicaid for a portion of their health care coverage, an every six month redetermination appears administratively cumbersome and openly demeaning. Additionally, as we have mentioned, improving the capacity of the states to administer the Medicaid program does not cope with the basic issue of whether the states can continue to underwrite a growing health reimbursement system while ensuring the availability of quality services. Improving the administration of the program does little to standardize the eligibility and benefit package of Medicaid. Our Associations urge an immediate federalization of Medicaid. Pending the enactment of such legislation, federal standards for state plans should be strengthened to include provisions for mandatory eligibility for the medically needy, improved uniformity of benefit packages, and greater conformity of eligibility. Furthermore, we urge federal requirements that the state plan contain provisions for a fraud and abuse unit, adequately staffed and subject to prescribed federal guidelines including provisions for auditing and inspection of providers.

To the extent that S. 3205 addresses the necessity for greater Federal supervision and technical assistance, our Associations applaud the legislation. Likewise, we see merit in expanding the role of the Comptroller General to review the procedures of the Department to assure sufficient attention to Congression-

ally mandated standards. The recommended efforts to improve the reporting to Congress on the Medicaid program are equally commendable. We would hope the systematic information flow would assist in building the case for federalizing the program.

The consumer is placed in a real dilemma in responding to the need for tighter administrative controls in the reimbursement programs. On the one hand, we are wary of advocating reimbursement controls inasmuch as they often translate out in the long run to reductions in benefits while on the other we are shocked by the continued inefficiencies tolerated. Congressional oversight will be necessary as we walk the line between providing necessary services to eligible recipients while constraining unwarranted costs. We can point to several General Accounting Office studies that clearly indicate that when the Bureau of Health Insurance attempted to contain costs there has been a general over-reaction that generated a series of retroactive denials and reductions in benefits to recipients. It appears that attempts to improve efficiency often provoke difficulties in the translation of program goals.

We emphasize the above thoughts to point out a major deficiency of S. 3205, i.e., its failure to address the need to improve the administrative responsiveness of the fiscal intermediary. While Section 5 expands the functions of the intermediary, no mention is given to improving performance. While our experience in monitoring the performance of the intermediaries is limited, in the area of home health where we have reviewed such activities, we have been appalled by the latitude which private intermediaries have to define public programs. It has been our experience nationwide that the availability of in home services under Medicare are often tightly intrepretated by the intermediaries and, therefore, the recipient often must elect institutionalization to secure necessary care. Certainly, if the performance of the intermediary in providing home health care is indicative of the general performance in managing the reimbursement programs, there is serious grounds to question the integrity of such a system. The committee must address the responsiveness of the private intermediary to public program and insure that adequate safeguards are in place to prevent the thwarting of the public policy goals by those contracted out to manage the program.

The recent General Accounting Office report on the "History of the Rising Costs of the Medicare and Medicaid Program and Attempts To Cut These Costs: 1966–75" underscores the provisions of Section 7 requiring the prompt promulgation of regulations and greater attention to secure public comment. Our Associations feel the intent of this provision is commendable.

With respect to the termination of the Health Insurance Benefits Advisory Council, we would prefer a restructuring of this committee to ensure its input within the policy process rather than its demise. HIBAC served a primary function during the formative years of Title XVIII, and, we think it should be restored to its policy activities rather than terminated.

REIMBURSEMENT REFORMS

Our Associations commend the sponsors of S. 3205 for attempting to construct an improved reimbursement procedure for Medicare and Medicaid. While we question whether the components of the plan of action add up to effective containment of spiralling health care costs, the legislation does take the first steps toward control.

One need only review the findings of the General Accounting Office to document the seriousness of inflation upon our health reimbursement programs. Their recent report points out that the cost of the Medicare program has more than tripled since its first year of operation. But the finding clearly show that the blame for such cost increases cannot be placed upon the beneficiaries:

> During fiscal year 1967, part A benefits cost about $2.9 billion for its 19 million eligibles and Part B benefits approximately $1.2 billion for the 18 million people enrolled. By fiscal year 1975, Medicare costs had increased to $10.5 billion for the 23.7 million Part A enrollees and $4 billion for the 23.2 million Part B enrollees. Thus, while the number of part A eligibles increased only 25 percent, Part A costs increased 263 percent, (an average annual rate of 17.5 percent). Also, part B costs increased 243 percent (an average of 16.7 percent) while part B enrollees increased only 30 percent.

With specific reference to hospital cost inflation, the report further dispelled the myth of patient overutilization as a major cause of increased costs:

> In summary our analysis of the Medicare hospital data indicates that, of the $7.4 billion increase in the cost of providing hospital benefits, $6.2 bil-

lion was due to inflation (and possibly the provision of more extensive services in the hospital), $870 million was due to more people being eligible for Medicare hospital benefits, and $315 million was due to an increase in the use of the hospital benefit by eligibles.

While the report was less specific in its statements concerning the Medicaid program, it concluded that inflation was one of several direct causes of cost increases within that reimbursement program.

What that report did not mention, but we hope is of priority concern to the members of this committee, is the fact that spirally health care costs has forced the beneficiary of the program to assume an ever increasing cost of his own care regardless of the Title XVIII and Title XIX benefit package. This continuing trend is pricing the older American out of the health marketplace inspite of Medicare and Medicaid. Ever increasing premiums, coinsurances and deductibles are forcing older persons to defer seeking medical assistance until a condition is so acute to require the most expensive health treatment. Likewise, for those older persons who seek medical aid, they are confronted with continuing erosion of their Medicare benefits as the medical sector ignores reasonableness as a criteria for billing.

We solicit this committee's leadership in total controls over the health sector, not just token efforts to contain Medicare and Medicaid dollars. The continued debate concerning restructuring our health sector has given liberty to the providers within that sector to seek all they can before the controls are imposed. The time for such a lid is now! Attempting to contain the rise in health care costs just through the Medicare and Medicaid reimbursement mechanisms may be thwarted unless there are steps taken to contain the complete sector.

The beneficiary fears that reimbursement controls in the institutional sector may lead to second-class treatment, while in the non-institutional structure such controls normally translate out to increased out-of-pocket costs to the individual while constraining program costs.

With the above as an introduction to the position which our Associations have adopted on cost containment, let us look at the specific provisions of S. 3205.

We question whether the elaborate mechanism set forth in the legislation for containing institutional cost will achieve intended results. While we strongly support prospective budgeting as the mechanism for reimbursement to facilities, and, in general note that the committee is considering codifying certain practices that appear to assist in identifying the roots of cost increases, the legislation is deficient in two aspects. First, while the measure spells out a system of prospective budgeting, it does not fully address the need for rate setting as an intregal component of that budget process. We commend for your consideration the provisions of the Comprehensive Medicare Reform Act, S. 1456, which provides that the amount of reimbursement to a participating institutional provider is to be made on the basis of a predetermined schedule of patient care charges approved, for an accounting year with the fiscal intermediary making the initial determinations, but with the final rate setting authority vested in the Secretary or, in a state that has a State rate review and approval agency operating under equivalent standards, approved by the State gency.

The second deficiency in S. 3205 is that it provides too many opportunities for the institution to be exempted from the process. Our experiences in Medicare administration show that if there is an opportunity for a waiver from a given provision, there will always be a number of providers that will take advantage of the loophole.

Tightening the standards and providing for a rate review mechanism would improve upon the provisions of S. 3205. The fact that the committee has provided for a phase-in of the reimbursement plan should negate those arguments which contend the committee is acting prematurely. This plan of action allows for the additional controls that are under review by the Department under the authority of Section 222. In fact, the committee action might heighten the priority to those research projects which appear of limited interest to those administering the Department.

While there is merit to separate skilled nursing facility care and home health services from under the prospective budgeting requirements written for hospitals, we question whether three more years of study will improve upon suggested reimbursement controls on those services.

While our Associations do not have the expertise to evaluate Section 11 providing for the retirement or conversion of underutilized facilities, it would appear

that such a program would be within the public interest. We have often received inquiries from members requesting assistance in finding skilled nursing and intermediate nursing facilities. To the extent that this proposal would expand the supply of certified facilities, it deserves consideration.

The recent successful court challenge of HEW's regulations establishing a specific formula for determining the appropriate rate of return on equity capital may force the committee to seriously review Section 12. We would hope the committee gives careful attention to the future of for-profit involvement in the health sector before encouraging too great of an investment from that sector in hospital services.

With respect to the physician reimbursement provisions of S. 3205, our Associations question whether they will achieve their intended goals. As with our stance on institutional reimbursement, we believe more decisive action is required. In the Comprehensive Medicare Reform Act, S. 1456, which was drafted with the assistance of our staff, provision is made for the reimbursement of non-institutional services in accordance with annually predetermined fee schedules for local areas. The fee schedules, to the extent possible, would be established on the basis of negotiations with representatives of professional societies, beneficiaries, and government. The final schedule could not be imposed until after public hearings. The schedule would be based on a forecast of what would be fair and equitable compensation, not exceeding reasonable charges, in each area during the applicable fiscal year. Participating practitioners must agree to accept the Medicare payment (plus any copayment) as the full charge for the service, and, the physician would be prohibited from charging fees in excess of the Medicare reimbursement. The Secretary would be required to make public, for each local area, the established fee schedule for the area and the names, professional fields and professional addresses of participating practitioners in the area. While this approach to physician reimbursement places the Medicare beneficiary in the vanguard of efforts to contain health costs, there are limited alternatives unless Congress moves to constrain the whole health care sector.

The inducements provided in S. 3205, while certainly in the right direction, may not resolve the problem. Assignment rates continue to fall inspite of efforts to encourage physicians to accept the reimbursement rates. Certainly, if the committee is unwilling to move toward rate setting, the alternative is to provide sufficient incentives for assignment. Provision should be made in Section 21 for the notification to the public of those physicians who are willing to accept the assignment inducements.

Likewise, the provision set forth in Section 23 may be one of several appropriate actions that must be taken to encourage physicians involvement in the Medicaid program.

Our Associations heartily concur with the technical improvements in the program provided in Section 24 and Section 25. While we would prefer to see the committee adopt it's previous stance on coverage of pharmaceuticals, i.e., comprehensive coverage under Medicare, any benefit improvements have our support. With respect to the payment of certain physicians' fees on behalf of the deceased, our members have reported numerous instances when hardships have been suffered because of the provision of present law.

We applaud the intent of Section 26 to prohibit certain fee collection practices that have been a drain upon the program integrity. However, we would agree with those who contend that a speedy response in the claim process will have a greater affect than the prohibition set in statute.

LONG-TERM CARE REFORM

As with several other sections of the legislation, our Associations are generally supportive of the efforts initiated by the sponsors, however, we would encourage additional steps by the committee. For instance, Medicare skilled nursing coverage is an extremely limited benefit where as the needs of the beneficiary population for both skilled nursing and intermediate nursing services is growing. The net result is that the recipient ends up paying for the care out of his own pocket, and, or, the costs of such care are transferred from Medicare to Medicaid. Attention should be given to the comprehensive long-term care reforms set forth in S. 2702, the Medicare-Long Term Care Improvement Act.

Our Associations strongly endorse the provisions for an expanded Federal responsibility for certification and approval of Medicaid skilled nursing facilities. We have supported this committee in its past efforts to upgrade the enforce-

ment mechanism, and you can be assured of our continued support. While Public Law 92-603 unified the standards for skilled nursing facilities under Medicare and Medicaid and the agency in the State responsible for applying such standards, the underlying differences in characteristics, authorities and responsibilities in Medicare and Medicaid remain. It is not sufficient to focus on the common aspects of both programs while ignoring the differing statutory, legal and administrative bases of Medicare and Medicaid.

It cannot be over emphasized that any Congressional effort to unify long-term care policies and procedures under Medicare and Medicaid must address the differing locus of primary responsibilities in the two programs. Equally important, the committee must strengthen the functional responsibilities and authorities within the Federal government so that those who write the regulations will have the authority to enforce their standards. It has been apparent during the past several years that differing elements within the Department have not always reflected a unified approach in policies, procedures and guidelines.

Our Associations are supportive of Section 32 which addresses the issue of determining the reasonable value of certain transferred facilities. The findings of Volume 2 of the Moreland Act Commission in New York State has underscored the necessity for such standards.

Additionally, we concur with Section 33 of S. 3205. This issue of home visits has generated a great deal of concern by some of our members and their families. It seems that the implementation of the Medicaid policy with respect to home visits has generated much misunderstanding. While we welcomed the Department's attempt to clarify home visitation policies through regulations, it appears as if a number of states had instituted a more liberal leave policy than that of the Federal standard. Removing the barriers to such visits through statute might aid in clarifying the Department's policy.

MISCELLANEOUS REFORMS

As with the other sections of S. 3205, our Associations are generally supportive of the efforts which the sponsors have spelled out in this working document, however, we believe the final product of this committee should tighten the statutory language. For instance, we have fully supported efforts to surface through disclosure of ownership and financial information potential conflicts of interest. Section 40 will add to present disclosure requirements, and, therefore we support this provision. At the same time, experience has shown that unless we move toward prohibiting certain types of conflicts of interest such as physician investment in nursing facilities, pharmaceutical involvement in service delivery, ownership of clinical laboratories in physician practices, durable medical equipment corporations in facilities etc., there will be a certain few who will exploit the weakness of the law.

The committee should favorably report the provisions of S. 3205 to control franchising and marketing assistance based on utilization. Obviously, these marketing aids are predicate on over-utilization, adding to the costs of the program. Attention should also be given to the issue of non-profit entrepreneurs.

We call your attention to a recently published paper prepared by the Center for Policy Research concerning *Profits in Not-For-Profit Institutions*. Its discussion, and, that of the Chapter 16 of the 1970 Senate Finance Committee Staff Report on *Medicare and Medicaid; Problems, Issues and Alternatives*, appear relevant to the issues raised by your committee. Both studies raised the same central thesis: "existing laws and regulations governing not-for-profit corporations are insufficient to safeguard the underlying legitimate purpose of these corporations."

The Center's report identified four avenues for profit making in not-for-profit corporations: (1) staff income tied to entrepreneurship rather than to work; (2) self-dealing: (3) real estate transactions; and (4) unreasonable and uncustomary fees, salaries and fringe benefits. Note, with the exception of real estate transactions, your committee has discovered each of these patterns occurring in home health. Disclosure, improved reimbursement guidelines, strict enforcement, tighter tax laws, and competitive bidding are among the recommendations set forth to check abuses. We believe the committee should review the Center's report in preparing its own recommendations.

The Senate Staff committee report which we mentioned discussed the possibility of the Department of the Treasury exploring the issue of potential abuse in the securing of tax-exempt status.

We are not familiar with such a study having been undertaken, however, inasmuch as several major corporations have expressed an interest in franchising operations and in their literature promote assistance in securing a tax-exemption, maybe the time is ripe for the establishment of a realistic yardstick for measuring whether a health delivery agency is truely non-profit.

With respect to Section 41, our Associations would ask the committee to review the complete reimbursement process for Health Maintenance Organizations rather than to accept the Title XVIII procedures as adequate. Our Associations support the development of HMO's, and, we believe that if sufficient attention was given to constructing an equitable capitation payment system with sufficient incentives for HMO's to accept the higher-risk Medicare and Medicaid patients, that older persons would benefit from the move toward prepaid health care. Certainly, the California experience with so-called Health Maintenance Organizations cannot be used as the model for punitive legislation to contain experimentation with the delivery of health services.

While we have received only limited membership complaints concerning ambulance services, we support the provisions of Section 42 which would slightly liberalize the current benefit. Consideration should be given to expanding the ambulance service coverage to include certain types of secondary health vehicles which are needed for the handicapped and others with limited mobility to reach medical services.

Section 44 of S. 3205 appears to be a red-herring, predicated upon myth rather than fact. There is limited justification for further complicating the Medicaid eligibility process by requiring attention to the disposal of property. This provision directly points a finger at older persons who are forced into poverty by the excesses of the health sector. The incidence of property transfer simply do not justify this committee's over-attention to such miniscule resource testing while massive abuses go unchecked in the reimbursement process.

The increased penalties of Section 45 are not sufficient to deter abuse. One need only point to the recent prosecution of certain New York nursing home operators to evidence the weakness of the law. Provision should require mandatory prison sentences, authority for recovery of all overpayments plus a penalty factor, and, authority for recipient suits—either self-initiated or through class-action for up to three times damages. Only through the threat of actual penalties will the situation improve.

In conclusion, Senator Talmadge, I wish to thank you for giving me this opportunity to present the views of my Associations before this committee. My members are the beneficiaries of these programs and we appreciate the efforts which you have initiated to improve the responsiveness of the federal health programs to our needs. We stand ready to assist you in this effort.

Appendix to the Testimony of the National Retired Teachers Association and the American Association of Retired Persons Before the Subcommittee on Health of the Committee on Finance, U.S. Senate

Medicare Performance—Present Law

Hospital insurance (part A)

Eligibility for Title XVIII Hospital Insurance Benefits is predicated on meeting one of several requirements. If a person is 65 or over and entitled to monthly social security or railroad retirement benefits, he is also eligible for hospital insurance benefits. If a person is not entitled to social security or railroad retirement benefits, he will nevertheless be eligible for hospital insurance at age 65 if a resident citizen (certain aliens can also qualify) and (1) was born before 1903, or (2) earned 3 quarters of social security coverage for each full year occuring after 1966 and before he reached 65. A social security or railroad retirement beneficiary who has been entitled to disability benefits for not less than 24 months in a row is also entitled to hospital insurance, even though under age 65. Also, almost all persons age 65 or over who are ineligible for benefits can voluntarily enroll for hospital insurance coverage, provided they pay a premium that has been set at $40 a month from July 1975 to June 1976 (to be raised to in July 1976). Volunteer enrollees must also enroll for supplementary medical insurance and pay that premium too. Additionally, certain individuals

who need hemodialysis or kidney transplantation are eligible for hospital insurance.[1]

Hospital insurance (Part "A" Medicare) covers the following benefits:

Hospital: for each day, up to a maximum of 90, in any benefit period, hospital insurance covers almost all hospital costs except the first $104 and a charge of $26 a day for the 61st through the 90th days of hospitalization. In addition, one has a lifetime reserve of 60 days of hospital care after he exhausts the 90 days to which he is entitled during a benefit period, but he pays a charge of $52 a day for each of these 60 days used.

Covered costs include those for bed and room in 2- to 4 bed room (or private rooms if medically required), nursing services (except private duty nursing), the usual drugs and supplies furnished hospital patients and other diagnostic services or kinds of treatment furnished in-patients by the hospital. Doctor services within the facility are generally not covered under the hospital insurance part of Medicare.

Post hospital extend-care: After at least 3 consecutive days in a hospital, hospital insurance also covers post hospital care in a qualified skilled nursing facility for up to 100 days in any benefit period. The patient, however, pays a charge of $13 a day for each day of care over 20 in a benefit period. A person must be in need of skilled nursing care and/or skilled rehabilitation services on a daily basis to qualify for this benefit.

Hospital insurance will also cover the costs of up to 100 home health visits if they occur within one year after discharge from the hospital (required 3 day hospitalization) or from a skilled nursing facility following hospitalization, and, if skilled home health services are provided by a qualified home health agency.

Benefit period: The law provides for limitations of hospital and post hospital extended care within each benefit period (technically—spell-of-illness). The benefit period begins with the first day on which an individual is eligible for Medicare and is furnished services, provided that the day was not in a previous benefit period. A benefit period concludes when the recipient has been out of the hospital or skilled nursing facility for 60 consecutive days. A person pays the deductible only one in each benefit period.[2]

Medical insurance (part B medicare)

Medical Insurance benefits are available to all resident citizens 65 or over. Enrollment is automatic for hospital insurance eligibles unless declined premised upon the payment of monthly premium of $6.70 (to be raised to $7.20 per month in July 1976).

In general, the Medical Insurance Plan is designed to supplement the coverage provided by the hospital insurance plan. Under Part B, the Federal Government pays 80% of the reasonable costs of charges for covered services except for the first $60 each year which is a program deductible. One hundred percent of reasonable charges of a radiologist or pathologist for services to hospital in-patients are covered. Likewise, special program coverage is provided in certain instances for home health services, clinical laboratory testing, and physical therapy services.

Medical insurance (Part B Medicare) covers the following benefits:

Doctor services: Most physician services are covered, including surgery, consultation, home, office and institutional calls reimbursed on reasonable charge determinations.

Medical and other health services: A range of medical services to include diagnostic X-ray and laboratory testing, X-ray and radiation therapy, many services and supplies, durable medical equipment are included within the benefit package.[3]

Performance of medicare

In fiscal year 1966, just before the advent of Medicare, the elderly of the United States accounted for approximately 21 percent of the $38.6 billion paid for the health care costs in that year. A total of $7.8 billion was spent on the aged in fiscal year 1966, 66 percent from private sources and 31 percent from public funds. Of the share of public funds, better than half were state and local funds.[4]

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[1] Based on description contained in: Commerce Clearing House, "1976 Social Security Benefits," pp. 25–28.

[2] *Ibid.*

[3] *Ibid.*, pp. 28–31.

[4] *Social Security Bulletin*, "Age Differences in Medical Care Spending FY 1972," May 1973.

With the implementation of Medicare and Medicaid, the federal government has assumed a significant portion of the expenditures formerly made by the private sector in the financing of health care for the aged. The fact that by itself, Medicare spent more in each year since 1972 than the total amount of the health care bill of the aged in 1966, is a measure of its impact.

Unfortunately, despite Medicare's large outlays, its portion of the health care bill of the aged continues to shrink—from 46 percent in 1969 to less than 39 percent in 1974. And, while Medicaid provides assistance supplementing Medicare for one-out-of-every-five elderly, private, per-capita out-of-pocket payments for health expenditures in 1974 were in excess of $480.[6]

Chart I summarizes the estimated per capita personal health care expenditures for the aged in 1974 and the percentage distribution of public financing of each expenditure. Be mindful, that these dollar amounts and percentage distributions do not take into account individual's premium payments under Parts A and B for non-title II eligibles ($40 per month) or the Part B premium ($6.70 per month). If the supplementary medical insurance premiums were regarded as private payments, the public share would be reduced from 60 percent to 56 percent, or an increase in excess of $80 per capita private out-of-pocket costs.[6]

CHART 1

ESTIMATED PER CAPITA PERSONAL HEALTH CARE EXPENDITURES, BY TYPE AND SOURCE OF FUNDS FOR INDIVIDUALS AGE 65 AND OVER, FISCAL YEAR 1974, AND DISTRIBUTION OF PERSONAL HEALTH CARE EXPENDITURES FOR THE AGED BY TYPE AND SOURCE OF FUNDS, FISCAL YEAR 1974

Type of expenditure	Per capita			Percentage distribution			
					Public		
	Total	Private	Public	Private	Total	Medicare	Other
Total	$1,217.84	$483.75	$734.14	39.7	60.3	38.1	22.2
Hospital care	573.18	115.58	457.59	20.2	79.8	62.0	17.9
Physicians' services	182.14	79.43	102.71	43.6	56.4	51.9	4.5
Dentists' services	19.58	18.17	1.42	92.8	7.2	----------	7.2
Other professional services	19.08	12.64	6.44	66.3	33.7	23.7	10.1
Drugs and drug sundries	103.17	89.29	13.92	86.6	13.5	----------	13.5
Eyeglasses and appliances	21.40	20.72	.32	98.5	1.5	----------	1.5
Nursing home care	289.10	146.99	142.11	50.8	49.2	3.3	45.8
Other health services	10.55	.91	9.63	8.7	91.3	----------	91.3

Source: Social Security Bulletin, "Age Differences in Medical Spending fiscal year 1974", June 1975, adapted from table 2 and table 5.

Three important conclusions can be reached in looking at Chart 1. First, note that older persons are still shouldering a sizable portion of their health care bills. In fact, the per capita private expenditures of the elderly is nearly twice the expenditure for all ages ($483.75 as contrasted with $260.88 for all ages).[7] Second, Medicare's reimbursement is heavily skewed toward hospital and physician coverage, but fails to address many important health expenditures of the aged. Third, other public programs, especially Medicaid, interface with Medicare to provide additional relief to older persons from health care costs (approximately 15 percent of the health care costs were met by Medicaid and another 7 percent came from general hospital and medical care programs primarily at the state and local level and from the Veterans' Administration's programs).

The decline in Medicare's share of the health care expenditures of the elderly is the result of a variety of factors. The most significant drop in Medicare payments has been for extended care facilities (skilled nursing facilities) due to massive reclassification of patients from skilled to intermediate care facility status. In 1969, Medicare spent $367 million for extended care—nearly 16 percent of the nursing home bill for those aged 65 and over—but, by 1974 the Medicare outlay was $210 million and its share of the bill had dropped to 3 percent.[8]

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[5] *Social Security Bulletin*, "Age Differences in Medical Care Spending FY 1974," June 1975.
[6] *Ibid.*
[7] *Ibid.*
[8] *Ibid.*
[9] *Ibid.*

Medicare's share of expenditures for physician services for the aged has also declined. In 1969, Medicare's contribution was 60 percent; in 1974 it was 52 percent. One factor in the decline is the increase in the Part B deductible from $50 to $60 in 1973; another is the decrease in the proportion of claims for which physicians have accepted assignment.

Physicians who take assignment accept Medicare's determinations of a reasonable charge and bill the patient only for unmet part of the annual $60 deductible, plus 20 percent of the remaining part. Physicians who do not accept assignment may bill the patient for fees in excess of the reasonable charge determination.

While a number of factors appear to influence physician assignment, to include attitude toward program, size of the bill for specific service, relationship with patients, assurance of payment, there has been a steady erosion of doctors who accept Medicare's determination of reasonable costs. In fiscal year 1969, the net assignment rate was 61 percent; in 1973 it had declined to 53 percent; in fiscal year 1974, the projected rate is down to 52 percent.[10]

These charges have been accompanied by significant increases in the reasonable charge reduction rates, i.e. the proportion of claims where the allowed charge is less than that billed by the physician or supplier. In essence, the recipient is forced to shoulder more than the 20 percent co-insurance rate because Medicare's portion of the expenditures for physician services is decreasing.

Another contributing factor in Medicare's decreasing share of the total health care bill for the aged relates to hospital care. In fiscal year 1969, Medicare paid two thirds of the hospital bill for those aged 65 and over. In 1974, this proportion dropped to 62 percent. Interestingly, this decrease is related to the fact that in 1969, the average length of stay for the aged in community hospitals was 13.2 days but had dropped to 11.4 days in 1974.[11] Since the aged individual is responsible for a hospital deductible roughly equivalent to one day of care, his proportion of the bill goes up as the average length of stay goes down. One can assume that with the recent increase in the Part A deductible to $104 couple with the continued decline of coverage lengths of stay to less than 11 days, that Medicare's present share of hospital costs has been further reduced.[12]

Medicare does not pay for dental care, out-of-pocket hospital prescribed drugs and eyeglasses. Medicaid and other public programs picked up the bill for only about 7 percent of dental costs, 14 percent of prescribed drug expenditures, and less than 2 percent of the costs of eyeglasses, leaving the majority of these costs to be met by the elderly by direct out-of-pocket payments.[13]

Senator TALMADGE. Mr. Bruce D. Thevenot, director, Government Services Division, American Health Care Association and Jack A. MacDonald, executive vice president, National Council of Health Care Services.

We are delighted to have you. You may insert your full statement in the record and summarize it.

STATEMENT OF BRUCE D. THEVENOT, DIRECTOR, GOVERNMENT SERVICES DIVISION, AMERICAN HEALTH CARE ASSOCIATION

Mr. THEVENOT. Thank you, Mr. Chairman. As you indicated, my name is Bruce Thevenot, I represent the American Health Care Association. By way of identification, since I don't believe we have submitted testimony to this committee since our name change, we were formerly the American Nursing Home Association, and some may recall us more appropriately that way. By any name, we are delighted to be here.

I should like to begin by commending the chairman on the conduct of these hearings, and on the purposes embodied in the legislation which is the subject of these hearings. The vast majority of AHCA

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[10] Health Insurance Statistics, "Assignment Rates for Supplementary Medical Insurance Claims, Calendar Year 1973," (DHEW-SSA). December 5, 1974.
[11] See note 7.
[12] Social Security Bulletin, "Table M-19," January 1976.
[13] See note 7.

members participate as providers of services in the medicare and medicaid programs. We agree with you that fundamental changes in the administrative and reimbursement features of these programs must be effected before implementation of a national health insurance plan can be seriously contemplated.

It is in this spirit, Mr. Chairman, that we extend our pledge of cooperation with this committee in finding equitable and workable solutions to these problems. I will confine my remarks today to a summary of those provisions of S. 3205 which relate either directly or indirectly to nursing homes. AHCA supports the proposal in section 2 to consolidate BHI, MSA, BQA, and the Office of Long-Term Care under a single administration. I believe that an attempt must be made to achieve a compatible realinement of Federal agencies with whom health care providers are required to deal. Therefore, AHCA welcomes this effort at consolidation.

With regard to section 4, which seeks to make improvements in the quality of State medicaid administration, AHCA supports this provision because we support the retention of a major role for State governments in the administration of these programs now and in the future.

For this reason we welcome the adoption of performance standards by which to measure the effectiveness of State medicaid agencies.

AHCA supports the continuation of the Health Insurance Benefits Advisory Council. We think that HIBAC has been an important forum for providers and consumers and Government officials to explore in some depth a myriad of issues affecting medicare and more recently medicaid.

We believe its vitality and role should be reaffirmed and should not be terminated as proposed in section 8.

With regard to section 10, dealing with hospital reimbursement reforms, AHCA generally supports the proposal to develop per diem hospital rates for routine operating costs under a classification system. We indicate in our comments what we regard as the proper relationship of nursing home reimbursement to this section, and point out that nursing homes are undergoing a similar procedure by virtue of section 249 of the 1972 amendments. We suggest that any later consideration of reimbursement for nursing homes be made in consideration of the outcome over the next several years of section 249.

Section 11 relates to making allowances to hospitals for the cost of conversion or retirement of underutilized facilities. We support this provision and are pleased to see that a specific link is created in section 11 to prior approval by health planning agencies in defining such qualified facility conversions.

Section 12 would increase the rate of return on equity capital for proprietary facilities in medicare. We support this increase, in view of the fact that it would make the rate more nearly comparable to other investments having similar risks.

However, we have a more fundamental concern about the use of equity-based returns to nursing homes as a sole opportunity for profit and we elaborate on these concerns in our statement.

Section 30 relates to a provision which I alluded to earlier, section 249 of the 1972 amendments, concerning cost-related payments to nursing homes in the medicaid program.

This section 30 as presently drafted would make clear that the States may include a reasonable profit as part of payments to skilled and intermediate care facilities. Regulations implementing section 249 were recently published by HEW. We feel that because of some confusion that has been created by these regulations, that a further amendment to the law is necessary to clarify congressional intent regarding methods by which a State may pay amounts which are designated as profit.

Section 31 proposes, as I understand it, to extend the authority for certification of approval of skilled nursing facilities under the medicaid program in much the same way as the Secretary exercises the authority presently with respect to facilities which participate in medicare or which participate in both programs.

We understand that the purpose of this provision, Mr. Chairman, is to try to bring about a more uniform application of health and safety standards and timely termination of facilities.

At the request of the committee earlier, ACHA has developed in conjunction with this section a background paper reviewing decertification procedures and suggesting how we feel the objectives of this section could best be achieved.

We include a legal analysis and a review of the existing case law in this area for the committee's use.

Essentially, our suggestion in this area is to provide a timely due process hearing in the title 19 program by which a decision would be made fairly rapidly regarding the certification status of the facilities which have deficiencies. The aim is to avoid unnecessary delays in the courts seeking to resolve these matters.

We have given a good deal of thought to this, Mr. Chairman. I think we have come up with some suggestions which are fair and will help to meet the objectives which you have raised in earlier statements on the floor concerning this legislation.

You will find this background paper and suggested amendments attached to our statement.

In section 32, we would support the proposed restriction on setting values of transferred facilities in the medicaid program by adopting the title 18 criteria for establishing asset valuation. We would suggest a clarifying amendment to make it clear that this test will apply only where the reimbursement system provides for a change in the cost basis and adjustment of allowances for capital items.

Some States which pay on a class basis prospectively set rates which are not affected by the change in ownership of facilities. We think that it would be largely irrelevant to apply this restriction where reimbursement is not based on sales price.

AHCA supports section 33, elimination of numerical limits on number of days during which a bed can be reserved by while patients or residents of nursing homes are away on visits.

I will skip over comments on section 40 for the moment, Mr. Chairman. AHCA supports the restriction in section 44 which we believe is necessary to close a loophole in the eligibility procedures which allow individuals to establish medicaid eligibility by disposing of assets to relatives.

And, finally, we also support the change of statutory penalties for fraud from misdemeanor to felony.

In addition to these direct comments, Mr. Chairman, we have three recommendations for additional provisions which we feel should be included in the bill when appropriate.

One relates to the implementation of section 1122 of the act, which was included as part of Public Law 92603. Section 1122 links reimbursement of capital expenditures to prior approval by health planning agencies. HEW regulations which implement section 1122 have subjected hospitals and nursing homes to this approval process solely on the basis of a change in ownership of an existing institution, even though no new beds, equipment or services are involved in the transaction.

We believe this regulation misreads congressional intent on section 1122.

Senator TALMADGE. That amendment was not intended, it originated in this committee.

Mr. THEVENOT. Thank you. We are requesting that some clarification be made in view of the regulation which apparently contravenes that.

We have several other suggestions, Mr. Chairman. However, I will suspend my remarks at this time and ask that the full statement be inserted in the record.

Senator TALMADGE. The full statement will be inserted in the record, and we appreciate your helpful and constructive testimony.

We want you to continue to work with our staff and the members of the subcommittee in developing this legislation. I agree with you completely that the 18 month delay in the implementation of reasonable cost related reimbursement regulations is too long.

I think 6 months should be significant and sufficient in view of the fact that the department has had 4 years to implement these regulations. I have made my views known on this matter to the Secretary.

Senator Nelson has expressed concern to me over the lack of medicare skilled nursing facilities in the State of Wisconsin, where such facilities have dropped from 125 in 1972 to 64 today. These facilities, however, participate in the medicaid program.

Can you enlighten us as to why such a reduction has taken place, especially since Public Law 92–630 requires medicare and medicaid skilled nursing facilities to meet identical standards.

Mr. THEVENOT. Mr. Chairman, did I understand you to say that the facilities in question continue to participate in medicaid as skilled nursing facilities, or have they dropped their status to ICF's?

Senator TALMADGE. Yes.

Mr. THEVENOT. Quite candidly I am not familiar with all the facts in that particular situation. I would certainly be glad to provide——

Senator TALMADGE. Will you look into it and advise our staff to the best of your ability. Specifically, the Wisconsin situation. I understand several States are considering a requirement whereby skilled nursing facilities participating in Medicaid must also participate in Medicare.

What are your views on such a requirement.

Mr. THEVENOT. Our views, Mr. Chairman, are that this is an unwise restriction to be placed at this time.

It is my understanding the State of New York has created such a requirement by virtue of amendments to its licensing law. The legal status of other proposed State laws I am aware of, which do not relate to licensure, we think is questionable. Whether there can be in fact a requirement legislated by the State to participate in a Federal contract program as a prerequisite of participating in Medicaid, is and will be a subject of litigation.

I realize this is a legalistic answer to your question. My own personal opinion is that we will support any rational method by which to increase participation in title 18 by skilled nursing facilities. I think there are some complex reasons why the participation is inadequate at the present time. I do not believe a shortcut to solving this problem can be found by simply requiring this participation as a prerequisite. We would hope the outcome of existing provisions of law which conform the standards, and eventually conform the payment system under which nursing homes would operate in both programs, would lead us to a point where we can begin to realize a good deal more participation in title 18.

Of course, I think the most significant problem, however, is the very restrictive definition of covered care presently embodied in the medicare law respecting long-term care.

I am not commenting about the appropriateness of that at the moment one way or another, but I think it certainly helps to explain why nursing home participation is low in the program when only 5 to 6 percent of the patients in skilled nursing facilities at any particular time are likely to be covered by the medicare program. That is the economic reality of the situation which we face.

Senator TALMADGE. Thank you very much, we appreciate your contribution to the committees deliberations.

[The prepared statement and attachment of Mr. Thevenot follows:]

STATEMENT OF BRUCE D. THEVENOT ON BEHALF OF THE AMERICAN HEALTH CARE ASSOCIATION

Mr. Chairman and members of the subcommittee: I am Bruce Thevenot, Director of the Government Services Division of the American Health Care Association. The AHCA, formerly the American Nursing Home Association, is the nation's largest organization representing licensed long-term care facilities, with a membership composed of more than 7500 facilities under both proprietary and non-profit sponsorship.

I should like to begin by commending the Chairman on the conduct of these hearings, and on the purposes embodied in the legislation which is the subject of these hearings. The vast majority of AHCA members participate as providers of services in the Medicare and Medicaid programs. We agree with you that fundamental changes in the administrative and reimbursement features of these programs must be effected before implementation of a national health insurance plan can be seriously contemplated. In the past, this Association has advocated—and we shall continue to advocate—expansion of health benefits for the elderly beyond the scope of coverages presently available. I do not believe our commitment to these goals is diminished in any way by the fact that we recognize the very present need to put our house in order insofar as these programs are concerned. It is in this spirit, Mr. Chairman, that we extend our pledge of cooperation with this Committee in finding equitable and workable solutions to these problems.

I will confine my remarks today to a summary of those provisions of S. 3205 which relate either directly or indirectly to nursing homes. The following sec-

tion-by-section commentary concludes with several suggestions for additional changes in law not currently in the bill.

Section-by-section comments on S. 3205

SECTION 2—ESTABLISHMENT OF HEALTH CARE FINANCING ADMINISTRATION

AHCA supports the proposal in Section 2 to consolidate BHI, MSA, BAA, and the Office of Long-Term Care under a single Administration headed by an Assistant Secretary. Although statutory distinctions between the Medicare and Medicaid programs will limit in some ways the degree of program uniformity that can be attained, we feel there is room for considerable progress in creating greater consistency in policy and standards, reimbursement, and data collection activities, and a reduction in unnecessary paperwork burdens now faced by providers. Most important in our view is the need to fix responsibility in fewer places—reducing the number of niches in which agency personnel can find haven from accountability.

Despite previous attempts by the Congress to require uniformity in the areas of nursing home standards, reimbursement, and utilization policies, there continues to be an unacceptable level of confusion and fragmentation within DHEW's various officers which are concerned with long-term care. In particular, delegation of authority to the regional offices has often taken the form of "abdication" of authority because of the lack of clear direction from Washington. Regionalization, properly directed, has great potential for making government more responsive and effective. At present, the regional long-term care offices often only mirror the confusion that exists at the national level.

I believe that an attempt must be made to achieve a compatible realignment of Federal agencies with whom health care providers are required to deal. Therefore AHCA welcomes this effort at consolidation.

SECTION 4—STATE MEDICAID ADMINISTRATION

AHCA supports the retention of a major role for state governments in the administration of health services programs now and in the future. The efficiency of state administrative agencies varies widely, however. For this reason we welcome the adoption of performance standards by which to measure the effectiveness of state Medicaid agencies. Likewise, we believe the concept of gearing Federal administrative matching funds to good or poor performance is a sound incentive approach. Our only caution on the latter point is that certain problems experienced by States can be laid to underfinancing of various administrative functions. In such a situation, it might not be prudent to further reduce funds available to correct the deficiency.

SECTION 7—REGULATIONS OF THE SECRETARY

We understand the intent of this section as requiring substantive rules carrying out provisions of the Social Security Act to be issued with reasonable promptness while insuring adequate public notice and opportunity for comment.

In this regard, AHCA applauds the action earlier this week by Secretary Mathews formalizing much needed reforms in the Department's rulemaking procedures.

Nevertheless we continue to support the adoption of this section of S. 3205, particularly subsection (b) which would require publication of regulations within one year following enactment of changes in the law, unless otherwise specified in the enabling legislation. No clearer example of unreasonable delay in rulemaking can be found than the recent publication of final regulations for Section 249 of P.L. 92-603 on July 1—the date on which the provision was to be fully effective—more than 3½ years after enactment.

SECTION 8—TERMINATION OF HEALTH INSURANCE BENEFITS ADVISORY COUNCIL

AHCA is of the opinion that HIBAC should be continued with a devitalized role as a consultative body to the Secretary on a wide variety of policy and regulatory questions. It would be unfortunate if the Council were to fall victim to disagreements between Congress and the Executive Branch regarding its proper

function. We believe that HIBAC has been an important forum for providers, consumers, and government officials to explore in some depth a myriad of issues affecting Medicare and more recently Medicaid. Its vitality and role should be reaffirmed.

SECTION 10—HOSPITAL REIMBURSEMENT REFORMS

[AHCA generally supports the proposal to develop per diem hospital rates for routine operating costs under a classification system.](3) The approach offers the possibility of introducing incentives for efficiency and economy which are absent in the present retrospective cost reimbursement formula applied to hospitals and skilled nursing facilities in Medicare. SNF's and ICF's will be subject to the recently-effective cost-related Medicaid payment provision of the 1972 amendments (Sec. 249). States are now in the process of modifying their payment systems for SNF's and ICF's. The Sec. 249 regulations strongly encourage the establishment by the States of simplified, prospective rate-setting, including payment on a class basis with incentives for restraining costs. It is our expectation that this process will offer an opportunity to gain experience with innovative payment methods which may be evaluated at a later date. For this reason, we believe that any later decision to apply methods of the type described in Section 10 of S. 3205 to nursing homes should be made in consideration of the results of Sec. 249.

SECTION 11—ALLOWANCE TO HOSPITALS FOR COSTS OF RETIREMENT OR CONVERSION OF UNDERUTILIZED FACILITIES

AHCA believes that clear and precise criteria should be laid down regarding conversion of excess hospital bed capacity to other uses, such as conversion to SNF or ICF services. We are pleased that a specific link is created in Section 11 to prior approval by health planning agencies in defining "qualified facility conversion". It would be entirely self-defeating to foster excess SNF or ICF services in an area in the guise of eliminating excess hospital capacity.

SECTION 12—INCREASE IN RATE OF RETURN ON EQUITY CAPITAL FOR PROPRIETARY FACILITIES IN MEDICARE

An increase in the return on net equity paid to proprietary institutions is certainly welcomed inasmuch as any increase would make the rate more nearly comparable to other investments having similar risk characteristics.

We have a more fundamental concern that payment of equity-based returns to nursing homes as the sole opportunity for profit is inequitable and imprudent. Briefly, the equity approach is unacceptable for three essential reasons:

(1) It discriminates among providers on the basis of the wholly irrelevant issue of capital structure. Providers with lease agreements or depleted equity are penalized. Those with inflated equity are rewarded. The quality or costs of services rendered do not figure in the outcome.

(2) It requires the administratively burdensome step of frequently determining the equity status of all affected providers, fostering delays, controversy, and even occasional manipulations.

(3) No incentive is provided by which providers can earn profit by operating efficiently.

I would suggest that the more significant arena for dealing with these issues as they relate to nursing homes is Medicaid's cost-related payment feature which can, under Section 249(b) of P.L. 92-603 be adopted by the Secretary for use by Medicare on a state-by-state basis when fully implemented.

SECTION 30—REIMBURSEMENT RATES UNDER MEDICAID FOR SKILLED NURSING AND INTERMEDIATE CARE FACILITIES

As presently drafted, Section 30 would amend Section 1902(a)(13)(E) of the Act to make it clear that States may include a reasonable profit factor as part of payments on a cost-related basis to SNF's and ICF's.

Since S. 3205 was introduced on March 25, DHEW has published final regulations carrying out Section 1902(a)(13)(E). As a result of the final regulations, considerable confusion has been spawned on the profit question. The Department decided not to include any mention of profit in the regulation on the grounds that the issue was beyond the scope of the "cost-related" mandate of

the law. On the face of this decision, it could be assumed that profit is purely a State matter.

However, the Department's regulation writers proceeded to include very specific elaboration on profit in the preamble to the regulation, stating specifically that "(t)his return on net equity of proprietary providers is the only item of profit that may be included as an item of allowable cost". An exception is made for payments made on a class basis.

We are unsure of either the motives or rationale of the Department's action in this case, nor are we certain at this time of the extent to which this statement I just quoted from the preamble of the regulation is binding on the States. The only thing that is certain is that both the States and the providers are as completely confused. If a net equity limitation is enforced, other simpler and wiser methods of paying profit now being used by many states will have to be discontinued. For example, the payment of flat per diem allowances would be prohibited. Also it is possible that incentive allowances would be unacceptable in prospective rates paid on a facility-by-facility basis. Finally, payments of any kind above costs to non-proprietary institutions would be discontinued.

For these reasons AHCA strongly requests that Section 30 of S. 3205 be amended to allow for the payment of a reasonable profit factor (or investment allowance in the case of non-profit facilities) to SNF's and ICF's which may be paid in the form of flat per diem amounts or incentives related to efficiency. We believe that such a clarification would put an end to the present confusion, and allow for more administrable approaches to be taken by the States.

SECTION 31—MEDICAID CERTIFICATION AND APPROVAL OF SKILLED NURSING FACILITIES

This provision would grant to the Secretary authority to terminate participation of an SNF in the Medicaid program. (It is assumed that the provision is intended to apply to ICF's as well). As we understand the language of Section 31, the authority which the Secretary presently exercises with respect to facilities which participate in Medicare, or both Medicare and Medicaid, would be extended with respect to facilities which participate only in Medicaid.

Further, we understand that purpose of the provision is to assure more uniform application of health and safety standards and timely termination of facilities with serious deficiencies. In the Chairman's remarks on the Senate floor on June 20 of last year, he coupled the need for timely termination of deficient facilities with the rights of providers to be accorded fair hearings:

> The courts have hampered effective and timely suspension of facilities which do not comply with health and safety requirements. Appropriate statutory provision would be made authorizing timely termination with, of course, provision for hearing and appeal. (Congressional Record, June 20, 1975, p. S. 11124.)

At the request of the Committee staff, AHCA has developed some specific suggestions for accomplishing these objectives. Appended to this statement is a background paper on the decertification issue together with a memorandum which provides an extensive analysis of the existing case law in this area. Included are two proposed amendments which would amend Titles XVIII and XIX to provide, in substance, for timely due process hearings on a pre-termination or pre-non-renewal basis for providers. An exception to this fair hearing procedure would be granted where there is a written determination that the continuation of provider status constitutes an immediate and serious threat to the health and safety of patients. The right to judicial review is provided following an adverse hearing decision, although payments would not be required to continue during the course of such litigation.

I invite the Subcommittee to consider carefully our suggestions on this matter. I believe you will find that the proposed amendments offer a solution which is fair to both government and providers and includes a mechanism for timely action to protect patients.

SECTION 32—CRITERIA UNDER MEDICAID PROGRAM FOR DETERMINING REASONABLE VALUE OF CERTAIN TRANSFERRED FACILITIES

This provision would apply to Title XIX and Title XVIII criteria for valuation of facilities in order to establish a cost basis for computing allowable capital expenses to the new owner following a sale, lease or other transfer.

AHCA supports this provision subject to an amendment which would make clear the applicability of this provision only where the reimbursement method employed makes payments for capital costs on a facility-by-facility basis requiring the establishment of a new cost basis upon sale or lease. Where payment is made on a class basis, sales prices or lease agreements have no direct relation to the payments received by an individual provider; rather, allowances for capital items are imputed by reference to average costs and other external criteria.

Section 32(b) should begin with the following clause: "Where payment is made on a reasonable cost or reasonable cost-related basis which permits revaluation of property when ownership is transferred at a gain, . . ."

SECTION 33—VISITS AWAY FROM INSTITUTION BY PATIENTS OF SKILLED NURSING OR INTERMEDIATE CARE FACILITIES

AHCA supports the elimination of numerical limits on the number of days during which a bed can be reserved while patients or residents of nursing homes are away on visits.

SECTION 40—PROCEDURES FOR DETERMINING REASONABLE COST AND REASONABLE CHARGES; DISCLOSURE OF OWNERSHIP AND FINANCIAL INFORMATION

In the context of direct cost reimbursement, AHCA recognizes the need for some restrictions on percentage arrangements and other similar practices between and among providers. We also have no specific objection to prior approval of service, consulting, or management contracts where abuses have been found to exist in non-arms-length situations. However, we are quite concerned about the vagueness of this section in several areas. The provisions should be clarified so as to avoid the unintended effect of crippling routine services which are legitimately and efficiently provided on a contract basis. For example, the proposed $10,000 threshold for prior approval of contracts is much too low. We are pleased to note the Chairman's pledge earlier in these hearings to make modifications to this section in order to more clearly focus on the areas where reforms are needed.

Also, we do not know the precise intent of the proposed requirement of "consolidated cost reports" from entities encompassing related organizations. We would ask that a clearer reference to accounting standards and principles be included in this section.

More fundamentally, we believe that the problems which Section 40 seeks to correct could be largely obviated through prospective payment rates based on approved budgets.

SECTION 44—RESOURCES OF APPLICANT TO INCLUDE CERTAIN PROPERTY PREVIOUSLY DISPOSED OF TO APPLICANT'S RELATIVE FOR LESS THAN MARKET VALUE

AHCA supports this restriction as necessary to prevent individuals from establishing eligibility for Medicaid through the subterfuge of giving assets away to relatives.

SECTION 45—PENALTY FOR DEFRAUDING MEDICARE AND MEDICAID PROGRAMS

AHCA does not object to changing the statutory penalty from a misdemeanor to a felony.

SUGGESTIONS FOR ADDITIONAL PROVISIONS

Clarification of section 1122 of the act

Section 1122 of the Act, which was enacted as part of P.L. 92-603, links reimbursement of capital expenditures to approval by health planning agencies. HEW regulations implementing Section 1122 subject hospitals and nursing homes to this approval process solely on the basis of a change of ownership of an existing facility, even though no new beds, equipment, or services are involved in the transaction.

We believe this regulation misreads Congressional intent on Section 1122 and amounts to granting planning agencies a back-door recertification power which Congress explicitly rejected during its deliberations on the National Health Planning and Resources Development Act of 1974 (P.L. 93-641).

AHCA requests that clarifying language be included in S. 3205 to resolve this problem.

Utilization review amendments

We urge the Subcommittee to seriously consider the adoption of the Utilization Control Amendments of 1976 which have been submitted by the Administration.

Furnishing of consultant services to SNF's

Section 277 of P.L. 92-603 granted to States the option of providing certain consultative services required by Medicare standards directly to SNF's through salaried employees of the State. One aim of this provision was to alleviate problems experienced by SNF's in retaining consultants in areas where such personnel are in short supply. Also the necessity for allocating the cost of these services between Medicare and non-Medicare patients presented difficulties.

Since the enactment of Section 277, Medicare and Medicaid standards for SNF's have been conformed. In addition, new requirements for consultative services have been added which further complicate matters, particularly for rural facilities. In view of these developments, we believe there is a need to revise and expand Section 277 (Sec. 1864 of the Act) to make it mandatory and extend the concept to Medicaid, including ICF services.

CONCLUSION

On behalf of the AHCA, I urge the careful consideration by the Subcommittee of the foregoing comments and recommendations. Our objective has been to take a cooperative and responsible approach to the issues raised by S. 3205. We trust that our views will prove helpful, and offer the assistance of our staff and membership if we may provide further information to the Subcommittee on any of these matters.

APPENDIX A

(Submitted to the Sub-Committee on Health, Senate Finance Committee, on July 30, 1976)

DUE PROCESS HEARING FOR PROVIDERS IN THE CASE OF TERMINATION OR NON-RENEWAL OF CERTIFICATION UNDER MEDICARE AND MEDICAID

The American Health Care Association has been asked to explore the question of provider certification status and make suggestions with respect to procedures for the timely resolution of disputes concerning the fitness of nursing homes with alleged deficiencies to maintain participation as providers in the Medicare and Medicaid programs.

Senator Talmadge and others have expressed concern that, in the absence of clear guidelines for resolving these disputes, providers have found it necessary to initiate court action seeking to maintain provider status. Some have alleged that providers have been able to use the court system to hamper and delay enforcement efforts. Providers, on the other hand, frequently argue that the existence of a fair due process hearing prior to termination of a provider agreement would obviate the necessity for litigation in most instances.

AHCA believes that the interests of all concerned can best be served by setting forth in Federal law a clear guideline around which timely and fair procedures for the resolution of certification controversies can be established.

The following comments and suggested amendments have been developed with this objection in mind.

COMMENTS AND PROPOSED AMENDMENTS

The attention of the Sub-Committee is directed to an area in which existing Medicare and Medicaid legislation has proved inadequate. This relates to procedures concerning both the termination of existing Medicare or Medicaid provider agreements and the failure to renew such agreements upon expiration.

Specifically, there appears to be some uncertainty whether providers, whose agreements are not renewed or are terminated, are entitled to a due process hearing on that decision *prior* to non-renewal or termination.

A substantial amount of litigation on these questions has produced conflicting results. By and large, however, federal and state courts have tended to reject providers' arguments that, in the absence of specific statutory directives, constitutional due process requires a pre-non-renewal hearing. See e.g., *Paramount Convalescent Center v. Dept. of Health Care Services*, 15 Cal. 3d 489 (Cal.

Supreme Ct. 1975) cert. denied, — U.S. —, 96, S. Ct. 2204 (1976); *Nicobatz v. Weinberger*, Medicare & Medicaid Guide (Transfer Binder) Para. 27.427 (C.D. Cal. 1974). AHCA believes that such a result is unfair and economically devastating to affected providers, undercuts the purposes and efficacy of the Medicare and Medicaid programs, and has a detrimental impact on the welfare of the patients in whose interests the nonrenewals are allegedly effected. On the other hand, courts have generally ruled that some form of hearing, though not necessarily a full due process hearing, must be held prior to termination of a provider agreement (i.e., where the provider agreement has not expired). See e.g., *Case v. Weinberger*, 523 F. 2d 602 (2d Cir. 1975) (some form of hearing sufficient); *Shady Acres Nursing Home v. Canary*, 316 N.E. 2d 481 (Ohio Ct. of Appeals 1973) (due process hearing required). However, the lack of statutory directives in this area subjects such holdings to the potential of change. Accordingly, AHCA would suggest that Titles XVIII and XIX of the Social Security Act be amended to provide for due process hearings prior to terminations or non-renewals of Medicare or Medicaid provider agreements.

The Medicare statute does provide for hearings and judicial review of terminations or non-renewals under Section 1866(c) of the Social Security Act. 42 U.S.C. § 1395ff(c). This section specifies that any institution or agency—dissatisfied with the Secretary's determination that it is not a provider of services *or* with the Secretary's termination of an existing agreement—is entitled to a hearing by the Secretary and judicial review of that final administrative decision. However, the statute and the regulations (20 C.F.R. § 405.1501 *et seq.*) do *not* indicate when those proceedings are to be accorded the provider and, as previously explained, courts have tended to validate post-non-renewal proceedings.

The Medicaid statute is totally silent as to whether hearings and judicial review of termination or non-renewal decisions are required and, if so, when they must be held. Generally, court decisions have, in this instance, applied Medicare principles to Medicaid program. See *Case v. Weinberger*, *supra*, 523 F.2d at 609–11. That is, in non-renewal cases, they hold that the provider is entitled to a hearing and judicial review but only after its agreement has expired. In termination cases, pre-termination hearings have been favored.

AHCA believes that postponement of hearing procedures often means that the provider is never given an opportunity to vindicate itself. Instead, a lower level administrative decision—which may be arbitrary, shrouded in secrecy, and erroneous—is insulated from any review whatever. This results because, as a practical matter, the termination or expiration of a provider's agreement, and the removal of its patients puts the provider out of business. Obviously, a post-termination or non-renewal hearing is of little or no benefit under such circumstances.

Yet there are adverse consequences to such administrative actions. Terminations and non-renewals of provider agreements limit the availability of program facilities. In many instances, this limitation restricts a potential Medicare or Medicaid beneficiary's opportunity to receive prompt treatment. It may also require a potential beneficiary to seek treatment at a facility which is far from his home and remote from his relatives. Hence, the efficiency of the program and its accessibility to beneficiaries is diminished in such circumstances. And, while terminations or non-renewals are often necessary to increase the quality or economy of care, it is difficult to believe that these laudable objectives are necessarily achieved by denying the provider an immediate opportunity to rebut the charges against it. If providers are ostracized from the program *before* a hearing is held, the benefits to the program are speculative at best. The program is benefited only if the termination or non-renewal proves to have been correct. In the interim, the availability of program resources is diminished, beneficiaries may be inconvenienced or, worse, deprived of their right to immediate treatment, and the provider may be forced out of business. Yet the administrative determination leading to these results may never be reviewed. In effect, an initial decision, having drastic consequences for the program, its beneficiaries, and the providers becomes a final determination insulated from review of any sort. Except in emergency circumstances, this result is unwarranted.

Other undesirable consequences may flow from terminations and non-renewals. Transfer of patients may have deleterious effects on their welfare. Older patients, accustomed to their surroundings, may suffer from the trauma and disorientation of patient transfer syndrome. Their regime of care and treatment may be disrupted. They may be transferred to under-utilized facilities far from

home and relatives. Such risks are warranted only if transfer will demonstrably improve the caliber of patient care or prevent program abuses. It is doubtful that they are justifiable on the basis of initial findings which have not been subjected to serious scrutiny.

For these reasons, AHCA deems it imperative to amend the Medicare and Medicaid statutes to require, *except in limited circumstances*, pre-termination or pre-nonrenewal hearings for providers. AHCA recommends that the Medicare statute, specifically, Section 1869(c) of the Social Security Act, 42 U.S.C. § 1395ff(c), be amended by adding the following material at the end thereof: "If the Secretary's determination terminates a provider with an existing agreement pursuant to section 1866(b)(2), or if that determination consists of a refusal to renew an existing provider agreement, the provider's agreement shall remain in effect until the provider has been afforded the hearing provided by this section. An exception to this requirement shall be granted if the Secretary makes a written determination, specifying the reasons therefor, that the continuation of provider status constitutes an immediate and serious threat to the health and safety of patients and if the Secretary certifies that the provider has been notified of such deficiencies and has failed to correct them."

AHCA also suggests that the Medicaid statute, particularly, Section 1902 of the Social Security Act, 42 U.S.C. § 1396a, be amended by adding at the end thereof the following new subsection: "( ) Notwithstanding any other provision of this title, each State plan for medical assistance approved under this subchapter must provide procedures whereby any institution, agency, or person, dissatisfied with any determination by the State or local agency administering such plan that it is not a provider of services, shall be entitled to a hearing thereon by such State or local agency (after reasonable notice and opportunity for hearing) and to judicial review in a court of competent jurisdiction of the final decision of such State or local agency. If State or local agency's determination terminates a provider with an existing agreement, or if that determination consists of a refusal to renew an existing provider agreement, the provider's agreement shall remain in effect until the provider has been afforded the hearing provided by such plan. An exception to this requirement shall be granted if the State or local agency administering such plan makes a written determination, specifying the reasons therefor, that the continuation of provider status constitutes an immediate and serious threat to the health and safety of patients and if such State or local agency certifies that the provider has been notified of such deficiencies and has failed to correct them."

These amendments would ensure that in ordinary cases a provider's status could not be altered without an administrative hearing. As such, the amendments would recognize that the stability of these programs and the continued welfare of their beneficiaries are related to these proceedings. They would also demonstrate that provider agreements are essential to the provider's continued business viability. Finally, the amendments would take cognizance of the fact that—absent the provider's demonstrated failure to continue to adhere to the requirements of participation—the provider ordinarily has a reasonable expectation of and a legitimate claim of entitlement to the fulfillment of its existing agreement and the subsequent renewal of that agreement. Although this claim of entitlement is particularly compelling in situations where the provider's agreement is terminated prior to expiration, it also exists in renewal situations where, despite the lapse of the term of the agreement, the provider's business is contingent upon renewal and the provider has reason to believe that this agreement will be renewed.

The hearing and judicial review provisions minimize the potential for administrative arbitrariness by requiring the agency to compile evidence justifying its actions. Likewise, the requirement that a hearing be accorded the provider before it is stripped or provider status assures that a provider will be granted a meaningful opportunity to correct misunderstandings or to rebut adverse determinations. The Medicare and Medicaid programs will be strengthened by elimination of this potential for bureaucratic caprice.

AHCA is ware that ceratin provider deficiencies mal constitute any immediate hazard to the welfare and safety of the provider's patients. In such circumstances, the delay necessary for a hearing cannot be justified. Therefore, the amendments provide for an exception to the hearing requirement if the relevant administrative body finds that an immediate and serious threat to patient safety exists and if it enumerates in writing the reasons for this finding. Additionally, the administrative body must certify that the provider has been notified of the deficiencies and has not corrected them. The certifica-

tion process makes imperative notification of the provider and some opportunity, however, abbreviated, to rectify the deficiencies.

In sum, the proposed amendments alter the present presumption, which often cannot later be rebutted because the provider has gone out of business, that the provider has failed to abide by its conditions of participation. In effect, these amendments shift the burden of proving the need (or lack of need) for immediate action to the pertinent governmental entity. The burden properly lies with the government because its fact-finding is the supposed basis for administrative action.

In drafting these provisions, we considered whether a provider's status should be changed only after judicial review of the administrative decision. We felt, however, that the lengthy delays necessary for judicial review could undesirably elongate the terms of a provider's agreement and make it virtually impossible to terminate a provider. Therefore, such a provision might preclude effective and expeditious administrative action, however fair. It would seem that the provider's interests, as well as those of the program, are given sufficient weight by requiring a hearing prior to the effectiveness of a termination or non-renewal decision.

APPENDIX B

REVIEW OF EXISTING CASE LAW RE: DUE PROCESS HEARINGS FOR TERMINATED OR NON-RENEWED MEDICARE AND MEDICAID PROVIDERS

In discussing the legal aspects of hearings for Medicare-Medicaid providers whose agreements are terminated or not renewed, the important points to emphasize are, of course, the timing and nature of any hearing which is accorded the affected provider. As a practical matter, a *post*-termination or *post*-non-renewal hearing, though providing all due process requisites, may come too late to afford the provider any adequate or effective relief. By that time, the provider's business may have been so severely and adversely affected that a hearing is rendered meaningless. On the other hand, a *pre*-termination or *pre*-non-renewal hearing, which may be less formal than a full due process evidentiary hearing, may obviate any problems or misunderstandings *before* the termination or non-renewal becomes effective and causes deleterious business consequences. Ideally, provider interests would best be protected by full due process hearings before the effective date of termination or non-renewal. Present statutory and case law, however, does not achieve this ideal. Instead, a state of confusion exists concerning provider rights under these circumstances. It will probably require Congressional amendments to Medicare and Medicaid to dispel this confusion.

The resolution of questions relating to termination or non-renewal hearings will inevitably lie either in statutory or constitutional law as each is interpreted by the judiciary. A brief examination of existing statutory and case law will suffice to demonstrate this confusion.

Under Section 1866(b)(2) of the Social Security Act,[1] the Secretary may terminate the Medicare provider agreement of any skilled nursing facility prior to its date of expiration. The Secretary may terminate such an agreement if he determines that the provider has not complied with the agreement; that the provider no longer meets the basic qualifications for provider status (this includes compliance with the Life Safety Code); that the provider has been uncooperative regarding information relating to payments; that the provider has made false statements or representations in payment applications; that the provider has submitted requested for payment of amounts substantially in excess of the costs of those services; *or* that the provider has furnished services of grossly inferior quality, in excess of patients' needs, or harmful to individuals.

The Medicare statute does provide that any institution, dissatisfied with the Secretary's determination that it is not a provider of services *or* with the Secretary's termination of an existing agreement, is entitled to a hearing by the Secretary and judicial review of that final decision. Section 1869(c) of the Social Security Act, 42 U.S.C. § 1395ff(c).[2] This provision seems to assure that Medicare providers are entitled to hearings on and judicial review of termination or non-

[1] 42 U.S.C. § 1395cc(b)(2).

[2] The hearing and judicial review are specifically tracked to Sections 405(b) and 405(g) of Title 42.

renewal decisions. However, the Medicare statute leaves unclear when that hearing and review are to be furnished.[3] The Medicaid statute is even more reticent. It leaves unclear whether Medicaid providers have similar rights to hearings and judicial review of such decisions and, if so, whether those rights must be granted before the provider is severed from the program.

Because of this statutory silence, providers faced with terminations and non-renewals have raised constitutional due process objections to proceedings which have not provided hearings and judicial review *before* terminations or non-renewals. Litigation of these issues has been lively, particularly in the Medicaid field where, because of state regulation of the programs under federal guidelines, state law becomes important. But the results have been varying; the courts have *not* uniformly recognized a constitutional right to a hearing and judicial review prior to terminations or non-renewals. Indeed, some courts have held that due process requires no such procedure.

In *Maxwell v. Wyman*, 458 F. 2d 1146 (2d Cir. 1972) (hereinafter "*Maxwell I*"),[4] a number of skilled nursing facilities participating in New York's Medicaid program were threatened with terminations for failure to meet the provisions of the Life Safety Code. New York officials had determined that no Life Safety Code waivers would be granted and that terminations were to be effective without a *prior* hearing.

The facilities sued, seeking a preliminary injunction. They argued that New York officials could not uniformly refuse to grant any Life Safety Code waivers. They contended that prior hearings were required because: (1) ineligibility for a provider agreement would effectively revoke their outstanding state operating certificates which could not be annulled without a prior hearing, and (2) constitutional due process mandated such hearings. 458 F.2d at 1151 and n. 7.

The Second Circuit granted injunctive relief on the first ground, but it avoided the constitutional question. See also *Case v. Weinberger*, *supra*, 523 F. 2d 602 at 607 n. 10 (reiterating that this was the basis for the *Maxwell I* decision). Thus, the importance of *Maxwell I* lies, in large part, with its emphasis on state law as providing Medicaid providers with the right to a hearing and judicial review prior to termination.

The exact nature of that hearing was clarified by the Second Circuit in a recent opinion, *Case v. Weinberger*, *supra*, 523 F.2d 602. There, a New York Medicaid provider was terminated following informal hearing procedures which fell short of full due process. The provider argued that a due process hearing must *precede* termination. The Court rejected this contention, holding that, although the provider had a property interest in its expectation of continued participation in the Medicaid program, due process did not require a full evidentiary hearing prior to termination. Rather, it was sufficient that the provider had been given informal administrative consideration which provided notice of the alleged deficiencies and accorded some opportunity, albeit abbreviated, to rebut those allegations. 523 F. 2d at 605–07.

The *Case* opinion is significant in several respects. First, it recognized that Medicaid providers have a property interest in their expectation of continued participation in the Medicaid program (523 F. 2d at 606). There would seem to be no reason why this property interest should not apply to both Medicare and Medicaid providers in both termination and non-renewal situations.[7] Second, it expressed the view that, although a full due process hearing need not be given Medicaid providers prior to termination, some process—in the form of notice

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[3] In a termination situation, affording the provider a right to a hearing *and* judicial review prior to the effective date of termination would mean, as a practical matter, that the provider would be insulated from termination during the term of its agreement. This is due to the fact that the agreement itself would probably expire before administrative and judicial review are complete. For this reason and because of the fact that terminations may be sought in circumstances that are truly emergency in nature (that is, immediate hazards to the lives and safety of patients), the provider's right to a full hearing and judicial review under medicare may be post-termination in time. At least one court appears to have drawn that conclusion, albeit in *dicta*. *Case* v. *Weinberger*, 523 F.2d 602, 609–611 (2d Cir. 1975). *Cf.* Coral Gables Convalescent Home, Inc. v. Richardson, 340 F. Supp. 646, 650 (S.D. Fla. 1972).

[4] Maxwell v. Wyman, 475 F.2d 1326 (2d Cir. 1973) (otherwise known as "*Maxwell II*") requires no discussion except insofar as it linked judicial review with the administrative process.

[7] This interest is particularly great in termination cases but it also appears to have sufficient weight in non-renewal situations, even though in the latter circumstance contractual rights, as opposed to expectations, have expired. *See* Board of Regents v. Roth, 408 U.S. 564, 577 (1972).

and hearing—is due (523 F. 2d at 606–07).[8] Obviously, this limits the potential for administrative arbitrariness. Third, the court determined that, *following* termination, Medicaid providers—like Medicare providers—are entitled to a full evidentiary hearing (523 F. 2d at 609–11). As previously noted, the federal Medicaid statute is silent in this respect.

A slightly different decision, even more favorable to providers, was reached in *Ross* v. *State of Wisconsin Dept. of Health & Social Services*, *supra*, 369 F. Supp. 570. In that case, a three-judge court invalidated, on constitutional grounds, a Wisconsin statute which permitted the state health deparment *immediately* to withdraw patients, receiving county or state support, from nursing homes. The withdrawal could be performed if the department found that the homes' failure to comply with departmental regulations created an emergency jeopardizing the health, safety, or welfare of patients.

The court reasoned that the nursing home's property interest in and claim of entitlement to the retention of publicly supported patients required that the home be given a hearing prior to withdrawal of patients, except in "true emergency situations posing serious threats to . . . [patients'] health and safety." 369 F. Supp. at 572 (bracketed material added). The court further held that such a hearing *must* comply with minimum due process standards. These standards include: timely written notice of alleged violations, disclosure to the home of evidence against it, right to counsel, opportunity for a hearing at which witnesses and evidence could be presented on behalf of the home, opportunity to confront and cross-examine opposition witnesses, a neutral hearing body, and a written statement by that body of the reasons for its action and the evidence upon which that action was based. *Id.*

Providers have fared less well in cases involving non-renewal of provider agreements. In *Shady Acres Nursing Home* v. *Canary*, 316 N.E. 2d 481, 39 Ohio App. 2d 47, Medicare & Medicaid Guide (Transfer Binder) ¶ 27,051 (Ohio Ct. of Appeals 1973), the court—confronted with a suit for injunctive relief—held that skilled nursing facilities cannot be summarily decertified as Medicaid providers and must be granted a due process hearing prior to termination. It also held, however, that Medicaid providers whose agreements have expired have no right to a due process hearing.[9] Later, the same court in *Convalescent Care, Inc.* v. *Bates*, 3 CCH Medicare & Medicaid Guide ¶ 27,795 (1975), held, with one judge dissenting, that a Medicaid provider was not entitled to a full due process hearing prior to non-renewal of its agreement. The United States Supreme Court denied certiorari. — U.S. —, 96 S. Ct. 1727 (1976).

Non-renewals of both Medicaid and Medicare provider agreements were at issue in *Nicobatz* v. *Weinberger*, Medicare & Medicaid Guide (Transfer Binder) ¶ 27,427 (C.D. Cal. 1974). The court held that due process did not require that either Medicare or Medicaid non-renewals be preceded by a hearing. It reasoned that post-non-renewal hearings were sufficient in such cases.

Recently, the California Supreme Court held, with one judge dissenting, that Medicaid providers were not entitled to a hearing prior to the state's non-renewal of the provider agreement, *Paramount Convalescent Center, Inc.* v. *Dept. of Health Care Services*, 15 Cal. 3d 489 (1975) [also reported at Medicare & Medicaid Guide (Transfer Binder) ¶ 27,575]. The majority explicitly distinguished the termination cases according pre-termination hearings to providers and held that the provider's expectation of renewal did not rise to the level of an entitlement. Additionally, the court noted that it must consider the interests of the patients as the primary concern. This would seem to imply, perhaps erroneously, that the interests of patients and providers are necessarily antagonistic and cannot be harmonized. Again, the United States Supreme Court denied certiorari. — U.S. —, 96 S. Ct. 2204 (1976).

In sum, the case law indicates that Medicare or Medicaid providers which are terminated may have a strong constitutional claim to some form of prior hearing, if not a full due process hearing. Providers which are not renewed, however, are less likely to be afforded a hearing prior to non-renewal. The distinction, as drawn by the courts, appears to be that a terminated provider has a legitimate expectation of operating under the terms and during the course of

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[8] The court refused to decide whether, where conditions are particularly hazardous, the Secretary can take summary action. 523 F.2d at 607. Most likely, such power exists. *See* Ross v. State of Wisconsin Department of Health and Social Services, 369 F.2d 570 (E.D. Wis. 1973) (three-judge court), discussed, *infra*.

[9] The court's opinion, singularly lacking in constitutional analysis, would appear to mean not only that a pre-non-renewal hearing is unnecessary but also that a post-non-renewal hearing is not required.

the provider agreement. On the oher hand, a non-renewed provider has been deemed to have no valid entitlement to automatic renewal of its provider agreement. It can be argued that this distinction ignores the realities of the certification process. Renewals of provider agreements are often routine. Providers expect renewals of their agreements, and their businesses are dependent upon these renewals. Indeed, without Medicare or Medicaid certification, the provider's license may mean little. In this sense, certification is an extension of the licensing process.

However, based on existing case law, it is unlikely that courts will alter this distinction. This may reflect, among other factors, an increasing tendency by the courts to informalize the requirements of due process. In light of these developments, the best way to assure a provider's entitlement to pre-termination or pre-non-renewal hearings is to seek Congressional amendment of the Medicare and Medicaid statutes.

Senator TALMADGE. Next we will hear from Mr. Jack A. MacDonald.

STATEMENT OF JACK A. MACDONALD, NATIONAL COUNCIL OF HEALTH CARE SERVICES

Mr. MACDONALD. I am Jack MacDonald, of the National Council on Health Care Services. I will just briefly summarize our statement.

The National Council of Health Care Services strongly supports the intent of S. 3205 as reflected in the title of the bill Medicare—Medicaid Administrative and Reimbursement Reform Act. That title effectively delineates the two areas which are the cause of the major problems of the medicare and medicaid programs.

Senator TALMADGE. If you will yield at this point. I would appreciate it very much if you would summarize your statement as briefly as you can and highlight any differences that you may have with Mr. Thevenot's testimony because we anticipate a vote in the Senate at any time.

Mr. MACDONALD. Very well, Mr. Chairman. Generally, we strongly support most of the items that Mr. Thevenot has related in his statement and are also in our statement. I would like to specifically address the point that you discussed in your letter to Secretary Matthews concerning section 249 and those regulations. We strongly support any type of initiative that might be developed by the subcommittee in terms of a timetable for the department to implement or publish regulations.

As you are well aware, we do not even see the proposed regulations published in the Federal Register until April of this year concerning section 249.

The other point is with regard to his recommendation concerning section 1122. It is becoming a problem and a number of facilities are faced with that.

With that I will defer to Mr. Crowley.

[The prepared statement of Mr. MacDonald follows:]

STATEMENT OF JACK A. MACDONALD ON BEHALF OF THE NATIONAL COUNCIL OF HEALTH CARE SERVICES

SUMMARY

The National Council of Health Care Services strongly supports the intent of S. 3205 as reflected in the title of the bill "Medicare—Medicaid Administrative and Reimbursement Reform Act". That title effectively delineates the two areas which are the cause of the major problems of the Medicare and Medicaid programs. Solutions to the problems in the Medicare and Medicaid programs must be found before the adoption of any national health insurance program. If we do not solve those problems now, they will be magnified tenfold under a national health insurance program.

The present diffusion and confusion in the administration of the Medicare and Medicaid programs has created a regulatory quagmire which has prevented the effective operation of the two programs. It has also created problems in the enforcement of standards which in many instances have led to the abuses noted by various critics of the health industry. These problems involve eligibility criteria for beneficiaries, the delivery of services, certification of providers, and payment for services rendered under the programs.

A more effective administration is required if this situation is to be corrected. This can only result, however, if a single authority has the overall responsibility and accountability for (1) determining the acceptable scope and levels of services, and (2) monitoring and assuring that the budgetary constraints are met for services rendered to beneficiaries.

In so far as reforming the payment system for nursing homes is concerned, we are of the opinion that the authority is already available under amendments to the Social Security Act developed by the Senate Finance Committee in 1972. Specific authority exists under both Sections 222 and 249 of P.L. 92-603 for developing new methods and reforming the payment systems for nursing homes participating in the Medicaire and Medicaid programs. The problem, however, has been in securing the implementation of the provisions by the Department of Health, Education, and Welfare.

It is paramount that an effective prospective payment system be developed and tested before a national health insurance program is established. That system must balance incentives with disincentives in order to encourage the provider to meet the general goal of providing quality care at a reasonable cost. In order to accomplish that objective, experimentation and implementation needs to start now on various systems and concepts under Sections 222 and 249 of P.L. 92-603.

We recommend that any further legislative initiatives involving nursing home payment systems other than those of a clarifying nature as suggested in our statement, be held in abeyance at this time. On that basis, we concur with the scope of the reform proposed in Section 10 of S. 3205 of limiting itself initially to hospitals.

While there is a strong need to restructure the administration and the payment systems of the two programs, there is also a counter-balancing need to stabilize the Medicare and Medicaid standards for beneficiaries and providers. In this area, the changes made as a result of the Social Security Amendments of 1972, P.L. 92-603, need to be examined and evaluated as to their impact before any new major revisions are made involving the skilled nursing and intermediate care facilities and services under the two programs.

Based on that philosophy, the National Council of Health Care Services briefly offers specific recommendations concerning the following sections of S. 3205.

Section 2. Establishment of Health Care Financing Administration.

Section 10. Improved methods for determining reasonable cost of services provided by hospitals.

Section 11. Inclusion in reasonable cost of hospital services an allowance for retirement or conversion of underutilized facilities.

Section 12. Return on equity to be included in determining "reasonable cost" of services furnished by proprietary hospitals.

Section 30. Reimbursement rates under Medicaid for skilled nursing and intermediate care facilities.

Section 31. Medicaid certification and approval of skilled nursing facilities.

Section 32. Criteria under Medicaid program for determining reasonable value of certain transferred facilities.

Section 40. Procedures for determining reasonable cost and reasonable charge: disclosure of ownership and financial information.

STATEMENT

Mr. Chairman, members of the Subcommittee, my name is Jack A. MacDonald. I am the Executive Vice President of the National Council of Health Care Services, which represents a select group of proprietary multi-facility

nursing home firms. Members of the National Council own and/or administer more than 75,000 beds in long term care facilities throughout the country. Members of the Council also are involved in other health related services such as hospitals, psychiatric, rehabilitation and day care centers.

We appreciate this opportunity to appear before you today, and submit a brief statement concerning S. 3205.

First, we would like to commend the Chairman for taking the initiative reflected in his bill to correct, and hopefully, reform the Medicare and Medicaid programs. We strongly support the intent of S. 3205 as reflected in the title of the bill "Medicare-Medicaid Administrative and Reimbursement Reform Act." That title effectively delineates the two areas which are the cause of the major problems of the Medicare and Medicaid programs. Solutions to the problems in those two areas must be found before the adoption of any national health insurance program. If we do not solve those problems now, they will be magnified tenfold under a national health insurance program.

Mr. Chairman, your efforts and those of your colleagues are vitally important in the meeting of that need.

I. INTRODUCTION

The present diffusion and confusion in the administration of the Medicare and Medicaid programs has created a regulatory quagmire which has prevented the effective operation of the two programs. It has also created problems in the enforcement of standards which in many instances have led to the abuses noted by various critics of the health industry. These problems involve eligibility criteria for beneficiaries, the delivery of services, certification of providers, and payment for services rendered under the programs.

A more effective administration is required if this situation is to be corrected. This can only result, however, if a single authority has the overall responsibility and accountability for (1) determining the acceptable scope and levels of services and (2) monitoring and assuring that the budgetary constraints are met for services rendered to beneficiaries. The present administrative formats of the Medicaid program and the Medicare program have been costly and ultimately detrimental to the provision of quality health care at a reasonable cost.

Though one might argue that Medicaid is significantly different from Medicare because it is administered by the States, nevertheless, the States are administering the Medicaid program under federally mandated regulations. These regulations presently leave the States with little flexibility once they have determined the beneficiary's eligibility and need for services under the Medicaid program. For these reasons, the proposed consolidation and restructuring of the responsible Federal agencies under a single authority, the Assistant Secretary for Health Care Financing, as set forth in S. 3205, would greatly assist in resolving the confusion in the administration of the Medicare and Medicaid programs.

While there is a strong need to restructure the administration and the payment systems of the two programs, there is also a counter-balancing need to stabilize the Medicare and Medicaid standards for beneficiaries and providers In this area, the changes made as a result of the Social Security Amendments of 1972, P. L. 92-603, need to be examined and evaluated as to their impact before any new major revisions are made involving the skilled nursing and intermediate care facilities under the two programs. An exception might be made for the amendments clarifying or correcting unintended or undesirable results. Maintaining stability in standards is as important as consolidating and restructuring the administration and payment systems of the two programs. Mr. Chairman, this may be achieved under the format proposed by S. 3205.

Based on that philosophy, we offer the following comments and recommendations concerning the specific sections of S. 3205.

II. SPECIFIC COMMENTS

A. Section 2

We support the proposed consolidation of agencies, as well as the administrative and policy responsibilities set forth by this section. As noted earlier, an effective administration of the Federal Government's participation in the Medicare and Medicaid programs can only evolve if a single agency has the overall responsibility and authority to administer the programs. Anything less is both duplicative and cumbersome.

B. Section 10

It is our understanding that this section, as proposed in S. 3205, only pertains to hospitals. It would require, however, the Secretary of HEW to "develop" and report to Congress within three years, recommendations for "comparable reimbursement methods" for any or all other providers, including "skilled nursing and intermediate care facilities".

We are concerned that this might preclude the use of Medicaid payment systems developed by States pursuant to Section 249 of P. L. 92-603. The regulations implementing Section 249 were just published July 1, 1976, and will not be effective until January 1, 1978, even though the statutory provision clearly states an effective date of July 1, 1976. Regardless, we would anticipate a number of new payment systems will be developed under this provision, which should not be encumbered by the system outlined in Section 10 of S. 3205.

It is our suggestion that the Secretary should be strongly encouraged to utilize Section 249 as a means to develop "improved methods" for establishing prospective payment systems for nursing home services for both the Medicaid and Medicare programs.

C. Section 11

Mr. Chairman, we would acknowledge the fact that there may be, at the present time, an excess of hospital beds in some parts of the country. However, we are concerned with the possible results of this section of S. 3205.

It should be noted that the shifting of excess hospital beds to another purpose could easily result in an excess of beds in the latter area. At the same time, it might be necessary at a later date to switch the hospital beds back to their original purpose, which could result in a shortage of the alternative service area.

We would also point out that there is a difference in physical plant standards between hospitals and nursing homes. Nursing facilities are now being required to have more available floor space than for hospital patients outside, as well as inside, their rooms, for what the regulations define as general "activities of daily living."

We would suggest that any facilities being converted from hospital usage to that of a nursing home should have to meet the same standards as are required of facilities originally constructed and developed as nursing homes. To do otherwise would be to discriminate against those facilities built for the purpose of nursing facilities.

It is, therefore, our recommendation that the Sub-Committee should carefully weigh and consider the possible ramifications of the conversion of excess hospital beds on other segments of the industry. To put it simply, we are concerned that the medicine might be worse than the disease.

D. Section 12

This section would increase a proprietary facility's rate of return, which it is allowed under the Medicare program, on its net capital equity. In the context of the present Medicare payment system, we would, of course, favor this change since we do not feel Medicare's current rate of return, after taxes, is competitive with that of other service industries.

In general, however, we oppose the use of equity as the only basis for a profit or a growth factor under Medicare. Equity based returns in the health industry, we feel, tend to provide few positive incentives for efficiency or the delivery of high quality services. In fact, the reliance on the equity standard has encouraged a number of abuses in the area of real estate transactions and their invested capital. This industry, as a whole, tends to be labor intensive as opposed to most other industries which utilize an equity based return are usually capital intensive.

We, therefore, would recommend that the Sub-Committee give consideration to allowing experimentation with a factor for profit or growth under the Medicare program, on a basis other than solely on an owner's net equity. The opportunity for this, we feel, exists at the current time under the Medicaid program, as provided for under Sub-Section E of Section 249 in P.L. 92-603.

E. Section 30

This section would insert a parenthetical phrase clarifying the intent to allow State Medicaid agencies the discretionary authority to include a "reasonable profit" in cost related payment systems and rates, developed pursuant to Section 249 of P.L. 92-603. The original statutory language of Section 249, along with

the Senate Finance Committee's Report on P.L. 92-603, as well as the items which you raised recently, Mr. Chairman, with the Secretary of HEW, F. David Mathews, regarding the proposed regulations, leaves little doubt that States were intended to already have that type of discretionary authority in the development of their State Medicaid payment systems.

This viewpoint was reflected in the final regulations, issued by the Department of Health, Education and Welfare implementing Section 249. The regulatory language neither prohibits nor requires that a State include in its rate a profit or a growth factor.

The Preamble to the final regulations, however, has confused the issue somewhat. On the one hand, it specifically recognized the need for a profit for proprietary facilities, while at the same time tending to limit the flexibility of States to have a return other than one based on net capital equity. The Preamble to the regulations, however, also speaks favorably of a payment system developed by a State which provides for a return based on items other than solely the owner's net equity.

We would suggest that the Sub-Committee might wish to consider availing itself of the opportunity to clarify this issue in this section of S. 3205. This could be accomplished by allowing a State the specific option to design and determine for itself not only the amount of profit or growth opportunity, but also the method of determining that factor under its payment system.

This would also provide the opportunity to develop and ultimately reform the payment system for services under both the Medicare and Medicaid programs. This, we feel, would provide a method for correcting the apparent failure of the Social Security Administration to develop new and innovative payment systems from nursing homes under Section 222 of P.L. 92-603. Hopefully, it would also facilitate the development of a solution to the problems outlined in our comments on Section 12.

F. Section 31

This section would establish the Secretary as the certifying authority for skilled nursing facilities. Presently, skilled nursing facilities participating in the Medicare and Medicaid programs are certified by a State survey team on the basis of Federal regulations. However, present regulations require that the survey findings be reviewed by the various responsible Federal agencies in the HEW regional offices.

It is our opinion that the problem in the area of certification and enforcement of standards is not one of who should be certifying, inspecting, and enforcing, but rather one of unifying the standards and surveys under a single authority. There is presently no authority empowered to say yes or no on a timely basis in response to a certification finding.

It should be noted that skilled nursing facilities participating under the Medicare and Medicaid programs are at the present, subject to more than 520 detailed Federal requirements. These standards are surveyed and reviewed by different authorities, including, in some instances, duplicate Federal and State survey teams reviewing a facility's compliance with the same standard. As we have stated, there is a clear need to unify the certification process under a single authority, and we strongly support any attempt to accomplish this task.

Another related issue is the need to distinguish between those facilities which, as a result of the certification surveys, are found to present an immediate and serious threat to the safety and health of the patients and those facilities with lesser violations of health care. In the former situation, there might appropriately be a basis for the temporary take-over of the facility, pending a hearing by a Federal court, by a trustee.

In the latter instance, there ought to be an immediate hearing with a specified maximum period set during which time payment continues to the facility, subject to the results of the hearing.

In the latter instance, there ought to be an immediate hearing with a specified maximum period set during which time payment continues to the facility, subject to the results of the hearing.

If the Federal Government assumes the role of the final certifying authority for both programs, then the hearing procedure would also become a Federal function, and should be delineated as a part of Section 31. If the States continue to retain the certification authority for the Medicaid only provider, then we would also suggest that the States be required to provide a fair hearing on the basis that they are applying and administering Federal standards.

We would also recommend that the certification procedure and authority for the intermediate care facilities be the same as that used for skilled nursing facilities. This is necessary, we feel, since many skilled nursing facilities are also intermediate care facilities under the Medicaid program. Any other arrangements would not be administratively sound or in concert with the expressed intent to consolidate the policies and administrative authority for the two programs.

G. Section 32

This section would require the use of Medicare's tests in determining the reasonable value of facilities bought, sold, or leased for purposes of payment under the Medicaid program. We would readily acknowledge the problems which have been brought to light as a result of the manipulation of property costs in certain situations, however, we are concerned that these problems will not be resolved by the simple application of Medicare standards.

We would point out that the emphasis on real property, capital, and equity, in the calculation of payment rates under the Medicare program is an inherent weakness of that payment system. We would urge that the Sub-Committee give thought to allowing and encouraging the States to develop payment systems which de-emphasize an individual owner's equity standing in the calculation of a fair and reasonable profit or growth factor.

The sale of assets should not be a key determinant of a facility's profit or growth factor. There are several methods which could be used under Medicare and Medicaid, which would de-emphasize the need to recalculate the value of a property after a sale.

H. Section 40

Generally, we are somewhat concerned with some of the provisions in this section which would retrospectively restrict individual operational cost items. We would hope to have more emphasis on the competitiveness of aggregate rates in relation to a given quality level of service as a result of prospective payment systems.

This section specifically concerns us in regard to the following four provisions:

1. *Overhead costs*

HEW would be directed to limit payment for overhead costs by taking "appropriate account" of the relationship between overhead and direct service costs. This is a burdensome involvement in a provider's day to day operational management, under a standard so vague as to give HEW almost total discretion. If better services can be provided by spending more on management and less on direct labor, for example, the facility's administrator should be free to make the choice.

The concern should be with the competitiveness of the aggregate rate, not with the manner in which a provider allocates his operational costs.

2. *Leases*

Leases based on a percentage of service costs would be prohibited. While there has been abuse in this area, it too has been primarily between related parties. Where the lessor and lessee are at arm's length, percentage leases, if determined in the aggregate to be competitive, should be allowed as a proper method to apportion risk and reward effective management. Leases of this type are standard in other business settings and we question whether they should be prohibited here.

3. *Consolidated cost reports*

Consolidated cost reports would be required from provider firms. The language as now drafted appears to be extremely broad and vague as to what will constitute a "consolidated cost report". The term "consolidated cost report" from the standpoint of an entire corporation, could include those substantial dealings of the corporation which have no involvement in health care or government programs. The preparation of a cost report on that basis might be an accounting nightmare going far beyond the data needs of either the Medicare or the Medicaid agencies.

We would recommend a clarification in S. 3205 or the Sub-Committee's Report to take into account this potential problem by referencing the appropriate specific criteria from generally accepted accounting principles or the Cost of Financial Accounting Standards Boards.

4. Advance approval of contracts

We would respectfully submit that advance approval of all contracts in excess of $10,000 as proposed in this section, presents numerous administrative problems. First, the dollar amount is so low as to be almost totally inclusive of all operational contracts. This wuold entail greatly increased involvement by the Government in the day to day administrative decisions of a provider. It would severely tax the ability of either States or fiscal intermediaries to process approvals on a timely basis.

Second, the standards for approval of contracts are in our opinion too vague; i.e., that the service be "appropriate", that the contractor be "qualified", and that the price be "reasonable". This leaves too much discretion to the administering agencies, and would necessitate the development of extensively detailed regulations. Even with detailed regulations, however, their uniform application among intermediaries and State agencies would be extremely difficult.

The inevitable effect would be to discourage the use of all contract services and require increased capitalization of providers. This will in turn result in fewer providers and less competition in the industry, not to mention possibly increasing the cost of services. This would be unfortunate for the beneficiary, taxpayer, and provider, in that many operation services can be provided more efficiently and at a lower cost on a contractual basis, than by the individual provider.

The abuses in the area of contracted services have again involved related party transactions. This has ultimately been a problem of disclosure and enforcement. The Senate Finance Committee's amendments to the Social Security Act of 1972 provided the means to resolve this situation, but they have not been implemented and enforced in a timely manner.

Where a genuine arm's length relationship does exist, we see no need for the amount of constraint proposed by this section, especially for services of a general operational nature. Where there is an absence of a genuine arm's length relationship, we suggest the application of a standard based on a comparison to market price, rather than a "reasonableness" standard. In addition, the final regulations implementing Section 249 of P.L. 92-603 already require disclosure of related party transactions and cost determination on the basis of the lower of actual cost of market price.

III. ADDITIONAL RECOMMENDATIONS

A. Jurisdiction over the sale or purchase of an existing facility

We would like to take this opportunity to call to the attention of the Sub-Committee the problems created by the interpretation and resulting regulations implementing Section 221 of P.L. 92-603. The Department of Health, Education and Welfare issued regulations (42 CFR 100.103(a)(1)) on November 9, 1973, which require that the purchaser of an existing facility must obtain approval for that purchase from the appropriate comprehensive health planning agency.

This is beginning to present a severe problem and hardship for both the sellor and purchaser of health facilities.

In the case of Herbert L. Rogers vs. F. David Mathews, Secretary of HEW, the Department has acknowledged in its brief that they inserted the word "or" in the regulation between the statutory phrase "(i) exceeds $100,000" and "(ii) changes the bed capacity of a facility with respect to which such expenditure is made". On the basis of that insertion, the Department of Health, Education and Welfare is attempting to exercise jurisdiction over the sale of existing facilities. This has resulted in some instances, in the purchaser having a hardship in obtaining financing for the facility because of the fact that it is unknown whether or not the facility will be allowed to continue to be used as a nursing home.

This situation is further exacerbated by the fact that the Medicare program has published regulations which reflect the Department's apparent attempt to exercise jurisdiction over the sale of an existing facility, while the Medicaid program has not. As a result, while the effective date of the statutory provision was originally October 1972, the implementation through the regulatory process is still incomplete. We would urge the Sub-Committee to give consideration to clarifying this particular problem in S. 3205.

B. Effective dates

We would strongly encourage the Sub-Committee to review the time frame of the effective dates of the provisions of S. 3205. There seem to be continuous problems with effective dates once legislation is enacted involving the Medicaid

and Medicare programs. The regulations implementing Section 249 of P.L. 92-603 are a prime example. While the provision was passed in 1972, the final regulations were not issued until July 1, 1976, which was the effective date of the provision. In acknowledging that the State would not be able to meet the requirements of the regulations, the Department of Health, Education and Welfare has attempted by regulation, to delay the effective date to January 1, 1978.

In other cases, the effective date has occurred shortly after the legislation is enacted or has actually passed. This has resulted in compliance problems for providers which could have added implications as a result of the provisions set forth under Sections 31, 40, and 45.

We would, therefore, recommend, Mr. Chairman, that the Sub-Committee consider:

1. Establishing effective dates for financial or cost related provisions on an accounting year basis.
2. Requiring that the Department of Health, Education and Welfare submit progress or status reports to the Sub-Committee when extended effective dates are used for a provision.

IV. CONCLUSION

Mr. Chairman, again we appreciate the initiative which you have taken with S. 3205, and in holding these hearings. The need for reforming the administrative structure of the Medicaid and Medicare programs is clear. S. 3205 represents a large step in that direction.

In so far as reforming the payment system for nursing homes is concerned, we are of the opinion that the authority is already available under amendments to the Social Security Act developed by the Senate Finance Committee in 1972. Specific authority exists under both Sections 222 and 249 of P.L. 92-603 for developing new mothods and reforming the payment systems for nursing homes participating in the Medicare and Medicaid programs. The problem, however, has been in securing the implementation of the provisions by the Department of Health, Education and Welfare.

It is paramount that an effective prospective payment system be developed and tested before a national health insurance program is established. That system must balance incentives with disincentives in order to encourage the provider to meet the general goal of providing quality care at a reasonable cost. In order to accomplish that objective, experimentation and implementation needs to start now on various systems and concepts under Sections 222 and 249 of P.L. 92-603.

We would recommend that any further legislative initiatives involving nursing home payment systems other than those of a clarifying nature as suggested in our statement, be held in abeyance at this time. On that basis, we concur with the scope of the reform proposed in Section 10 of S. 3205 of limiting itself initially to hospitals.

Mr. Chairman, again let me say that I sincerely appreciate this opportunity to present our comments to you and the members of the Sub-Committee on S. 3205. If you have any questions concerning our statement, I will be happy to attempt to answer them.

Thank you.

Senator TALMADGE. You may proceed.

STATEMENT OF DAVID C. CROWLEY, EXECUTIVE VICE PRESIDENT, AMERICAN ASSOCIATION OF HOMES FOR THE AGING

Mr. CROWLEY. Senator Talmadge, thank you. My name is David Crowley; I am the executive vice president of the American Association of Homes for the Aging. By way of identification, AAHA is a national association of nonprofit, primarily church-sponsored, homes for the aging throughout the country. I would just make two comments, one or the question of using a class-based method for determining reimbursement payments under the section 249 regulations, and one on the delayed implementation of section 249 "Cost-related reimbursement." I believe our position is different, or at least our concern is different from that of Mr. Thevenot as to the use of

the class-based method for determining reimbursement to homes for aging and to nursing homes.

We are aware that this method is allowed for in the legislation, but we are concerned as we begin to see States devise and implement their systems that the class-based method of reimbursement to homes will turn out to be a subterfuge for nothing more than a return to the fixed rate or flat rate system for determining payments.

We, too, are very concerned about the long delay in the implementation of the section 249 reimbursement system. We think a year and a half is far too long and that such a delay defies congressional intent. We support the provisions of the Senate bill S. 3205 which calls for an administrative reorganization of the medicare and medicaid programs. We would merely add, Senator, that it should be considered that the kinds of services necessary for older people are significantly and identifiably different from those needed by the general population. Long-term care is quite different from acute hospital care, and its problems must be considered differently. We hope that whatever reorganization takes place, this committee will pursue the idea of holding further hearings to examine the particular problems under medicare and medicaid for the long-term care field. We would be happy to cooperate.

Senator TALMADGE. We appreciate that very much. Thank you, gentlemen, we appreciate your contribution.

[The prepared statement of Mr. Crowley follows:]

STATEMENT BY DAVID C. CROWLEY, EXECUTIVE VICE PRESIDENT OF THE AMERICAN ASSOCIATION OF HOMES FOR THE AGING

Mr. Chairman and Members of the Committee, my name is David C. Crowley. As executive vice president for the American Association of Homes for the Aging, I am here representing 1,300 community nonprofit elderly housing projects, homes for the aging, and health-related facilities for the aging.

I welcome the opportunity to appear before you today and to comment on legislation (S. 3205) proposed by Senator Talmadge to make administrative and reimbursement reforms in Medicare and Medicaid. In my testimony I shall concentrate on the implications of S. 3205 for those aspects of our Federal health programs affecting the elderly, specifically those suffering from multiple, chronic diseases and in need of care and services over an extensive time.

Establishment of health care financing administration

S. 3205 recognizes the very serious administrative problems which now exist in Medicare and Medicaid by proposing the consolidation into one administrative unit of the various agencies administering pieces of these programs. We concur in the viewpoint implicit in this proposal that there is a need for better coordination and consistency in interpretation of policy.

While supporting the intent of the administrative reorganization provisions of S. 3205, however, *we urge caution that the distinction be made between the need for uniformity and consistency in policy interpretation and the need for recognition of diversity and heterogeneity the characteristics of the population and living arrangements of those served by Medicare and Medicaid.*

In our opinion, no reorganization of the current bureaucracy will straighten out the contradictions and anomalies now plaguing long term care unless and until it is accompanied by a better and more thorough understanding of the physical and social characteristics of the elderly receiving or needing long term care services.

Shuffling agencies around will not, for example, cure the type of problem created when health policies appropriate for the young or middle-aged population, whose single diagnosis is amenable to short-term treatment in an acute care setting, are glibly applied to persons suffering from three or four diseases on the average, and for whom deficiencies in family, social, economic, and/or environmental circumstances often complicate recovery.

We see this problem now occurring in the PSRO law and policies as they apply to long term care. The Department of Health, Education, and Welfare is supposed to develop norms and criteria for lengths of stay in hospitals and other health care institutions.

Although such norms can be developed with relative ease and precision for middle-aged persons with single diagnoses and no other complicating factors, attempts to pinpoint the "appropriate" length of stay in a long term care institution become much more difficult when the patients involved suffer from multiple diagnoses and lack the social and environmental supports which would ordinarily aid recovery.

Delayed implementation date of section 249 regulations

Section 30 of S. 3205 relates to methods for determining payment rates under Section 249 of P.L. 92-603, reasonable cost-related reimbursement under Medicaid.

In our opinion, the enactment in 1972 of reasonable cost-related reimbursement for skilled nursing and intermediate care facilities participating in Medicaid was one of the most important and significant steps ever taken to improve the quality of long term care services provided to the elderly. The passage of this law represented a major step forward in eliminating the inequities of flat rate systems.

The original Section 249, which emanated from the Senate Committee on Finance, called for an implementation date of July 1, 1974, for reasonable cost-related reimbursement. This date was moved back in the conference on H.R. 1 to July 1, 1976, to make sure that the Administration had ample time to develop and write the regulations for Section 249.

Now, after four years of delay in publishing implementing regulations for Section 249, HEW has issued rules that allow another year and a half's delay. The regulations published in the *Federal Register* on July 1, say in effect that states now have until January 1, 1978 before they must make payments on a cost-related basis. It is noteworthy that no warning of this year-and-a-half delay appeared in the April 13 proposed regulations for Section 249, but rather was inserted at the last minute in the final rulemaking as if it were a minor matter. Persons interested in the proper implementation of the section were thereby shut out from commenting on the delayed implementation date. Such actions on the part of the bureaucracy merely add to the already widespread feelings of cynicism held by the public about government.

Mr. Chairman, we believe that this delay is plainly illegal and that retroactive adjustments in payments should be made as soon as the individual states have cost-based reimbursement systems in place.

We are also concerned that the 249 regulations allow payments to be made on a "class" basis totally unrelated to costs. We are aware that payments could be determined according to a class-based method. The final regulations on Section 249 give the states such wide latitude in determining classes, however, that the likely end result will in no way be related to reasonable costs.

In the State of Pennsylvania's proposed plan for cost reimbursement, for example, facilities are lumped into classes simply on the basis of "level of care" (skilled or intermediate) and county. Averages are then struck for these crude groupings and the rates are thereby determined. We submit that such "class-based" rates are in no way "cost-related." Indeed, they strike us as being fundamentally antithetical to the concept of cost-based reimbursement.

The pitfalls and inequities of class-based rates are illustrated in a rather astonishing statement made by HEW in the preamble to the July 1 249 regulations: "While return on proprietary owners' net equity is the only item of profit that may be included as an allowable cost, these regulations also provide another opportunity for profit, in permitting states to set payment rates on a class basis. An efficiently operated facility that provides services under the plan at a cost less than the class rate will in effect make a profit equal to the difference . . . It is intended that States have great flexibility in determining classes in setting class rates, as long as their criteria for classes and rates are reasonable."

Later, the regulations say "Where rates . . . are determined . . . for classes of facilities on the basis of the quality of services *or level or care* provided. . . ." thereby adding to the likelihood that "levels of care" will become the basis for rates in many states without assurance that the rates are in any way reasonably related to cost.

If such crudely drawn classification systems are allowed to go into effect and if states are allowed to use averages or medians within these groupings as the method for determining payments, then we will not have moved forward to a system of cost related reimbursement at all. The original problem that this Committee set out to solve—that of overpayments as well as underpayments to facilities—will remain as serious as it has ever been.

We recommend that legislation be enacted to prohibit class-based payment rates which are not reasonably related to cost.

State medicaid administration

S. 3205 contains several provisions aimed at improving state administration of Medicaid.

One provision would require states to complete eligibility determinations for Medicaid applicants in a timely fashion; another would require faster and more efficient processing of approved Medicaid claims.

We strongly support both of these provisions.

We are opposed, however, to the provision calling for re-determinations of Medicaid eligibility on a six-month basis rather than on an annual basis as now allowed. We believe that the financial resources of the elderly do not change so frequently or drastically as to warrant re-determinations on a six-month basis.

HEW regulations, saving provisions

S. 3205 would require HEW to give the public 60 days instead of just 30 days to comment on regulations of a non-urgent nature. We support this and other provisions in the bill aimed at opening up the regulation-development process. Current rules and regulations, particularly in the field of long term care, have evolved largely without the involvement of people most directly concerned with the day-to-day operation of the programs, whether providers, professionals, or consumers.

Among the most confusing sets of regulations pertaining to long term care now in force are the utilization review standards. There are rife with internal contradictions and inconsistencies. They are so poorly written and hard to understand that we believe a complete rewrite job is in order. Following a re-write, efforts should be made by HEW, in the form of special meetings and workshops in every region of the country, to explain and interpret the utilization review regulations to professionals in the field, many of whom now feel utterly perplexed by utilization review procedures currently in effect.

Termination of HIBAC

S. 3205 proposes the abolition of the Health Insurance Benefits Advisory Council, which advises Congress and the Administration on Medicare and Medicaid matters, on the ground that it has outlived its usefulness.

We do not oppose the abolition of this Council, but in its stead call for the creation of a new, broadly-based council to advise on matters relating to long term care.

Earlier in our testimony we pointed out that Federal policies in long term care are not likely to improve unless and until Administration officials responsible for developing the policies are better informed as to the characteristics of the long term care population and the variety of institutions serving them. A broadly-based, high level advisory council on long term care, drawing from professionals, providers, and consumers, could serve a useful educational function and make a significant contribution to Federal policies in long term care which are now developed either in a vacuum by Federal bureaucrats or under pressure from special interest groups with narrow interests.

It is noteworthy that the current national advisory council for PSROs contains not a single physician knowledgeable about or experienced in dealing with the special health problems of the elderly. This is so, despite the charge given to the PSRO Council—to help develop criteria for determining "medical necessity" of services provided through Medicare funds, almost all of which go to the elderly, and Medicaid, which accounts for at least 60 percent of the long term care expenditures in the country.

There is no apparent effort being made by HEW to remedy this gap in representation on the PSRO Council in the appointments now under consideration, and there is every indication that the national advisory council to be created pursuant to the National Health Planning and Resources Development Act will also ignore representation from long term care.

We urge that the HIBAC Council be replaced by a special advisory council on long term care to give those concerned with policies in this area a more effective voice and channel of communication.

Procedures for Determining Reasonable Cost and Reasonable Charge: Disclosure of Ownership and Financial Information

S. 3205 contains a provision which would require prior review and advance approval whenever a provider arranges for a consulting, management, or service contract involving payments exceeding $10,000 and lasting twelve months or more.

We believe that this provision could result in homes getting bogged down pointlessly in awaiting state approval for contract arrangements necessary and appropriate to the provision of needed services, and we recommend that it be deleted from the bill.

We are also concerned about the effects of Section 1133(a)(2) of the bill, which calls for the setting of ratios relating to direct and indirect overhead costs and direct service costs. The full ramifications of this provision are unclear to us, but we hope that it will not work to the detriment of central management units which provide consultative services to homes and thereby increase their efficiency and quality of services.

SUMMARY OF RECOMMENDATIONS MADE BY THE AMERICAN ASSOCIATION OF HOMES FOR THE AGING, PRESENTED BY DAVID C. CROWLEY, EXECUTIVE VICE PRESIDENT

We support the intent of the administrative reorganization provisions of S. 3205, but urge caution that the distinction be made between the need for *uniformity and consistency in policy interpretation and the need for recognition of diversity and heterogeneity in the characteristics of the population and living arrangements of those served by Medicare and Medicaid.*

Section 30 of S. 3205 relates to methods for determining payment rates under Section 249 of P.L. 92-603, reasonable cost related reimbursement under Medicaid. HEW Regulations on Section 249 issued July 1, 1976, delay the implementation of a cost related reimbursement system until January 1, 1978. We believe that the delayed implementation date for Section 249 regulations on cost related reimbursement under Medicaid is illegal and we recommend that legislation be enacted to require retroactive adjustments in payments as a means of correcting this delay.

We strongly oppose the class-based method for determining payments to skilled nursing and intermediate care facilities under Medicaid and recommend that legislation be passed to prohibit class-based rates which are not truly cost related.

We support the provisions in S. 3205 aimed at improving state administration of Medicaid, particularly those sections relating to the time frame within which eligibility determinations and payment for approved claims must be made.

We oppose the provision calling for six-month, rather than annual, Medicaid eligibility determininations and payment for approved claims must be made. that the financial resources of the elderly do not change so drastically or frequently as to warrant the six-month re-determinations.

We support the provisions in S. 3205 aimed at opening up the regulation-writing and policy-development processes to the public.

We do not oppose the abolition of HIBAC, but propose in its stead the creation of a new, broadly-based advisory group to advise the Congress and the Administration on matters relating to long term care. We point out that high-level national advisory councils typically ignore representation from the long term care field, and cite the PSRO Advisory Council as one example.

We believe that the provision in S. 3205 requiring prior review and approval of provider contracts exceeding $10,000 and lasting twelve months or more will result in homes getting bogged down and curtail efficient management. We recommend that it be deleted from the bill.

We recommend that the Senate Committee on Finance hold another round of hearings relating specifically to those aspects of Medicare and Medicaid which relate to long term care as distinguished from acute care provided in the hospital setting.

Senator TALMADGE. Our next and final witness for today is Brenda Ballard, director, employee benefits, National Association of Manufacturers.

You may insert your full statement in the record and summarize it as you see fit.

STATEMENT OF BRENDA BALLARD, DIRECTOR, EMPLOYEE BENEFITS, NATIONAL ASSOCIATION OF MANUFACTURERS

Ms. BALLARD. My name is Brenda Ballard and I am director of employee benefits for the National Association of Manufacturers. In this capacity, I am responsible for all legislative and regulatory issues related to corporate employee benefit programs.

I appreciate the opportunity to appear here today on behalf of the NAM's membership of over 13,000 manufacturers and other business organizations to comment on S. 3205. The NAM is extremely concerned about the problem of escalating health care costs. This is an issue of such complexity that there simply is no single solution. Therefore, our approach has become one of trying to identify specific areas within the broad cost problem and then offering recommendations on these specifics.

In our recent statement on health care costs before the Council on Wage and Price Stability, we stated that we would like to move away from quoting "percent of gross national product" spent on health as an indicator of the seriousness of the problem. The fact that in fiscal year 1975 we spent 8.3 percent of GNP on health really doesn't tell us much. The point is we really don't know how much of our resources we should be spending on health. Maybe 8.3 percent is too much; maybe it is not enough.

The NAM believes that a better approach to discussing the cost problem is in terms of how much of that 8.3 percent is being used inefficiently and what part of that resource allocation is being wasted. We believe that the lack of adequate quality and cost controls in the medicare and medicaid programs contributes to the overall escalation of health care costs, and that too much of the money being funneled into these programs is being wasted.

On June 30, our task force on health met to evaluate S. 3205. This was our first meeting devoted to a consideration of this bill and our objective was to reach a general policy position on the bill and to plan for more extensive, in-depth study of its provisions. I would like to present to you today our initial general conclusions in regard to S. 3205.

The Need for Reform.—In all its statements on national health insurance legislation, the NAM has emphasized the fact that, before any national health insurance bill is enacted, an accurate and complete assessment of costs and financing must be made and a workable system of quality and cost controls must be included. In his remarks on introducing this bill, the distinguished chairman of this subcommittee stated that "The basic kinds of administrative and payment changes (contained in S. 3205) are absolutely necessary prior to any expansion of the Federal role in providing more health insurance to more people. That is true regardless of which national health insurance proposal is ultimately adopted. Without basic changes in the way we administer and pay for hospital and medical care under medicare and medicaid, any expansion would be an open invitation to fiscal disaster."

The NAM supports the objectives of S. 3205 as stated by Senator Talmadge, since these objectives are consistent with our belief that reasonable cost controls in the medicare/medicaid programs are an absolute prerequisite to any national health insurance legislation.

We commend the drafters of this bill for the conscientious and apparent intensive research into the problems of the medicare/medicaid programs and, while we anticipate refinement of the bill as it moves through the Congress, the NAM views S. 3205 as a good first step toward long-overdue medicare/medicaid reform.

The Methodology of S. 3205.—The approach taken through S. 3205 does not seem to us to establish unreasonable constraints on the health care industry. The incentive system which would be applied to hospital operations is compatible with the NAM's position on health care containment. In regard to reimbursement of physicians, we question whether or not the allowance of $1 will really provide any great incentive to doctors to accept assignments.

However, we have no strong objections to establishing regional limits on increases in prevailing charge levels. We believe that it is not unreasonable to apply some restrictions on variances of charges for a given procedure in a State.

When compared to the administration's proposal of establishing ceilings for increases in payments to health care providers, the NAM sees the approaches embodied in S. 3205 as being more flexible and much preferable.

Cost of Reform Versus Savings.—Our initial reaction to the administrative reform established by S. 3205 is one of tentative support. But before giving full support to the recommended changes, we would want to be sure that the cost of reform does not exceed the savings which would result. The establishment of an office of Central Fraud and Abuse Control is a very good feature of the bill, providing the cost of enforcement does not exceed the savings gained. We would suggest that, since S. 3205 stresses incentives for efficient performance, the budget and staffing of this office, after the first 3 years of operation, be tied to a percentage of the recoveries achieved through that office.

The Spill-over Effect.—NAM support of S. 3205 is contingent upon language being added which would prohibit health providers from passing on to the private sector any excess expenses which result from tightened cost control under the medicare and medicaid programs. In other words, industry cannot support a bill which leaves open the possibility of greater costs being shifted onto the private sector.

In his remarks upon introducing S. 3205, Senator Talmadge noted that preliminary work is being done on such a provision. We trust that the subcommittee will act quickly to remedy this flaw in the legislation which would have an adverse effect on the thousands of insured health care plans provided by NAM member companies.

The NAM Task Force on Health will continue its evaluation of this important and complex bill. We also plan to study the testimonies presented at these hearings in order to synthesize the various views of other groups, such as the insurance industry and the health care providers.

We know that some clear choices must be made in regard to these two Government-sponsored health care plans. Either we do something

to curtail cost escalation, we cut back on benefits, or we pay higher taxes. Of these three choices, the first is certainly the most difficult but it is by far the best.

The NAM fully recognizes the need for medicare/medicaid reform and will continue its support of the specific reforms embodied in S. 3205, provided language is added to prevent any shifting of costs to privately sponsored health care plans.

Again, I appreciate the opportunity to present the NAM views, general as they are at this point, on this important bill and I will entertain any questions you may have.

Senator TALMADGE. Thank you very much for your very constructive statement. I want to thank the National Association of Manufacturers for its support of S. 3205, as well as your helpful comments on ways of improving the bill.

You indicate that the incentive allowance for physicians to accept assignments might fail in its objective. Does the NAM have any recommendations as to a substitute approach which would be noninflationary?

Ms. BALLARD. We have discussed this to some extent and the one general recommendation that was tentatively agreed upon was that you might tie it to a percentage of the doctor's income through the program, income rather than a dollar per head.

Senator TALMADGE. Submit that proposal to the staff, will you?

Ms. BALLARD. Yes; we will be submitting detailed comments as we are able to formulate them.

[The material referred to above follows:]

The National Association of Manufacturers recommends that the physicians' allowance designed to encourage doctors to take assignments be tied to a doctor's billing under Medicare and Medicaid. The allowance should be relatively small, .5% or 1% perhaps. This approach, we feel, would be a greater incentive since it would serve to avoid the possibility of doctors accepting for assignment only patients in relatively good health and refusing those patients who might require substantial amounts of the doctor's time.

Senator TALMADGE. This concludes this phase of our work on medicare and medicaid reform. It is clear that the hearings this week have developed a comprehensive and forthright record with which to work. Starting Monday, with the help of the Congressional Research Service, we will carefully review the testimony. Many worthwhile changes have been recommended to us. I am anticipating incorporating most of these in the revised version of S. 3205.

It would be a mistake for anyone to conclude that these hearings have been simply an exercise. Hopefully in this Congress, and most certainly early in the next Congress, we will legislate and we will legislate, I believe, along the lines of S. 3025.

These hearings now stand in adjournment subject to the call of the Chair.

[Whereupon, at 9:25 a.m. the hearing adjourned, subject to the call of the Chair.]

COMMUNICATIONS RECEIVED BY THE COMMITTEE EXPRESSING AN INTEREST IN THESE HEARINGS

Statement of Hon. Jacob K. Javits, a U.S. Senator From the State of New York

Mr. Chairman: I am pleased to co-sponsor S. 3205, "Medicare and Medicaid Administrative and Reimbursement Reform Act of 1976", which seeks to make these programs more efficient and economical. The time has come to use the taxpayer's dollars spent for Medicare and Medicaid wisely and to bring about long overdue changes in the Nation's health care system. In my testimony, I shall highlight the constructive changes the bill would make in the current administration of these programs, and I present my suggestions to strengthen and improve the bill.

As you know, the present Medicare payment formula to hospitals and nursing homes reimburses retrospectively for their "reasonable costs." This is without regard to the necessity of these costs, or the efficiency of the management of the hospital. Payment of "reasonable costs" is inherently inflationary, because there are no effective limits on what costs recognized as reasonable, and there is no deterrent to managerial inefficiency.

The pending bill addresses this problem by redefining classes of hospitals, by establishing new performance-based reimbursement procedures, and by instituting a system of incentives, to reward hospitals for savings induced by better management. Moreover, hospitals would not be reimbursed for costs which are over 20 percent of the costs of hospitals within their class.

In my judgment, even these measures could be improved. Why should a hospital spend below its target rate, if in the following year, the new reimbursement rate includes and pays for these new costs. In short, this ceiling of 20 percent over the class average quickly becomes the floor for its reimbursement. Therefore, I recommend we institute a truly prospective reimbursement system under this bill so hospital lump-sum payments would be negotiated in advance, without regard to historical costs which may reflect merely a history of poor management.

It is a national disgrace that the amount of money the elderly must spend for medical services has tripled in the past decade. As you know, under the existing Medicare legislation, the elderly may be liable for additional physician charges, if the physician elects not to accept the "assignment" fee under the Medicare program. Now only about half of the physicians treating the elderly have elected to accept assignment and be bound to the Medicare reimbursed fee. This serious situation not only presents a financial barrier to medical care for the elderly but also contributes to to the continuing inflation in medical care costs. The existing Medicare program has no control over the fees which physicians charge for their services beyond their Medicare reimbursed fees and paid by the patient.

The pending bill seeks to improve this situation by streamlining the paperwork and reimbursement procedures many physicians find burdensome. Easing the red tape for physicians in Federal programs may encourage more of them to accept "assignment."

I recommend that we must go even further and that we should require physicians as a condition of participation in the Medicare programs to accept the Medicare reimbursed fee as payment-in-full.

I recognize that Medicare fees may have to rise to be sufficiently attractive to physicians.

Yet, we in the Congress can begin to have an effect on provider fees only when we determine what they are. Let us use the opportunity afforded by this bill to institute this overdue reimbursement reform.

Medicaid, as we know all too well, is plagued by the fragmented State-by-State approach which creates inconsistencies and inequities in patient eligibility, benefit coverage, differences in levels of quality health care and states' share of the matching funds. I support the bill's provision for technical and financial assistance to state Medicaid programs to remedy past deficiencies in their programs. But I think we should also extend Federal support to those financially hard pressed states, like New York, that have taken the initiative to try to develop a program of high quality with stringent controls for fraud and abuse.

This bill creates an Administration for Health Care Financing which will coordinate reimbursement policies and will establish and enforce standards for performance. I applaud this approach, an essential building block for future universal, comprehensive national health insurance as well as an important step to improve the present Medicaid and Medicare programs. For the first time, we will have a central, accountable source for policy development in this field.

We should take advantage of this streamlined administrative structure contemplated in the bill by using it to consolidate Parts A and B of Medicare. Under the present system, hospitalization and physician services are artificially separated, with different regulations, enrollment procedures, cost sharing, and payment mechanisms, creating confusion, administrative waste, and unnecessary red tape for patients.

I recommend that the pending bill require strict performance standards for the insurance company roles in these programs, the record of some to date all too often has been less than impressive.

I wish especially to commend you for the strong and effective anti-fraud provisions of the bill that boldly attack kickbacks and other illegal payments with respect to clinical laboratories. These provisions achieve significant cost controls and quality standards for this growing sector of the economy which now accounts for about $12 billion of our nation's health care expenditures.

These provisions are totally consistent—in spirit and substance—with those provisions of my Senate-passed "Clinical Laboratories Improvement Act of 1976" (S. 1737). I shall continue to work diligently to assure that these anti-fraud measures, which cruelly bleed our health care system, are retained in the version of the legislation now before the House.

For reasons of quality and economy, I support the changes in the bill which would prevent percentage billings, lease arrangements, and direct billings for the hospital-based specialties of radiology, pathology, and anesthesiology as now authored under Medicare and Medicaid. The present payment formulas have permitted these arrangements that have led to flagrant abuses and grossly excessive payments.

I have heard it said that the chief lessons of Medicaid and Medicare is that we cannot "afford" National Health Insurance. I believe the reverse is the case: we cannot afford to stand idly by. The beginning steps towards rationalizing the administrative and reimbursement policies of current federal programs, which this bill achieves will have benefits for the future of the entire health care system. I believe many of the provisions of this bill will dovetail with the "National Health Insurance for Mothers and Children Act," which I recently introduced with Senators Cranston and Brooke as a first, sensible step towards universal population coverage, and I request that the text of that bill and my introductory statement be made part of this hearing record.

Finally, I would like to share with you my overriding concern with respect to Medicare and Medicaid reform namely: how can we avoid penalizing the recipients of services—the poor, the elderly, those who need health care—when providers or administrators fall down on the job? I agree with Senator Talmadge, that price and wage controls here tend to become arbitrary and artificial. I agree that fraud and abuse must be vigorously addressed. I agree that reimbursement formulas can and must be improved to reflect reality and achieve quality, and the Talmadge bill goes far in doing so.

However, we have seen in recent years how difficult it is to apply sanction in our health care system. I am concerned that when we deny—Medicaid payments to states—even as provided in the pending bill with respect to administrative costs— the poor suffer. Can we retroactively deny claims for unnecessary services and hold the patient responsible? The question is a rhetorical one, and the answer is no.

I believe that the vast majority of our health care providers—institutional and individual—will respond to positive incentives rather than to the threat of punishment. While, when we set performance standards, we have every right to expect that they will be met, we must be certain that any penalty does not harm the people the program is intended to benefit.

[From the Congressional Record, 94th Cong., 2d sess., June 18, 1976, Vol. 122, No. 95]

(By Mr. Javits (for himself, Mr. Cranston, and Mr. Brooke))

S. 3592. A bill to provide for comprehensive maternal and child health care practices. Referred to the Committee on Labor and Public Welfare.

S. 3598. A bill to establish a national health insurance system of maternal and child health care. Referred to the Committee on Finance.

NATIONAL HEALTH INSURANCE FOR MOTHERS AND CHILDREN ACT AND COMPREHENSIVE MATERNAL AND CHILD HEALTH PRACTICE ACT

Mr. JAVITS. Mr. President, with Senators Cranston and Brooke as cosponsors, I introduce two bills, the National Health Insurance for Mothers and Children Act, which I send to the desk for appropriate reference, and the Comprehensive Maternal and Child Health Practice Act, which I send to the desk for appropriate reference, and I ask unanimous consent that the full text of both bills be printed in the Record at the conclusion of my remarks.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. JAVITS. Mr. President, I am very pleased that my distinguished colleagues Senator Cranston and Brooke are joining me in cosponsoring this important legislation.

Senator Cranston has long been a dedicated leader in seeking better health care for all Americans, both as a key member of the Health Subcommittee of the Committee on Labor and Public Welfare, where we have productively collaborated on health legislation for many years, and as chairman of the Health and Hospitals Subcommittee of the Veterans' Affairs Committee, Senator Brooke, as the ranking minority member of the Senate Appropriations Labor-HEW Subcommittee, has long been aware of and worked to meet the need to assure a strong financial and organizational base for cost-effective, high-quality care.

Mr. President, I believe that the time has come to take another step toward a major national goal: a comprehensive health program for all our citizens. Medicare and medicaid have provided health care coverage for our elderly citizens and for many poor citizens. Now is the time to provide for children and mothers

Accordingly, I introduce two bills. The first would establish a system of national health insurance for mothers and children, and the other would at the same time foster and develop the organizational framework for delivering comprehensive maternal and child health care.

I believe that such legislation represents the next logical step along the road to national health coverage.

Mr. President, while I continue to support the enactment into law of the Health Security Health Act (S. 3), it makes enormously good sense both in human terms and as national policy to begin on the road to universal national health insurance with comprehensive health care for mothers and children.

It is imperative to safeguard their health by providing accessible, comprehensive health services. At the same time, both the financial and organizational provisions of this legislation allow us to set into motion and to evaluate health systems with cost controls and a rational delivery system in which continuous, high quality health care may be provided.

While we provide the means of increasing access of mothers and children to health care that emphasizes the prevention of disease and the promotion of health, we shall have the opportunity to prove out my conviction that universal national health insurance is not only feasible but desirable and will foster important improvements in the quality and cost-effectiveness of the total health care system. The two bills work in tandem to do so.

The two measures I introduced today build upon, modify, strengthen, and integrate bills to the same effect introduced separately by Representatives James H. Scheuer and Andrew Maguire.

Healthy mothers and healthy children represent the fruits of truly preventive health services that are rendered at a crucial time during the human life cycle. Therefore, the children and mothers of our Nation cannot wait for the promise of national health insurance—a promise which has been on the legislative agenda for a long period of time. I believe the time is now for the Congress to be the effective advocate for the health and well being of the mothers and children. It is time to invest together in our Nation's health future. The major provisions of the National Health Insurance for Mothers and Children Act include:

Comprehensive ambulatory—including home health, rehabilitative, social and mental health services—and hospital care for children from birth up to the age of 18 with incentives for preventive children's health services included in the benefit package.

All appropriate prenatal and post-partum health care for women, up to 12 weeks after childbirth.

Support services—transportation, outreach, dependent care—for special populations or those persons determined to have a high risk of infant and maternal morbidity.

Only such limited cost sharing and special reimbursement incentives that would stimulate the development and acceptance by both provider and patient of maternal and child health group practices.

Payments for health professionals on the basis of specified and negotiated fee schedules, periodically adjusted according to such economic index or indices determined to be appropriate.

Payment for institutions according to budgets agreed to in advance—prospective budgeting.

Specific standards for health institutions and health professionals qualified for reimbursement under the maternal and child health programs.

Second consultation for certain surgical procedures.

Financing through payroll taxes and general revenues.

The major provisions of the Comprehensive Maternal and Child Health Practice Act include:

First. A program designed to foster the development of group practices for the delivery of maternal and child health care.

Second. Grants, contracts and loan guarantees—$93,500,000 authorized—for the initial planning and operational costs of group practices consisting of pediatricians, family practitioners, obstetricians/gynecologists and other health professionals—such as nurse practitioners and nurse midwives—who deliver maternal and child health services.

Third. Medical malpractice reinsurance for claims brought against a comprehensive maternal and child health practice.

Fourth. The sum of $30 million authorized for health professions educational programs related to providing health care through comprehensive maternal and child health group practice.

Fifth. Special consideration for assignment of national Health Service Corps personnel to those practicing in comprehensive maternal and child health practices.

UNITED STATES SENATE,
COMMITTEE ON LABOR AND PUBLIC WELFARE,
Washington, D.C., August 2, 1976.

HON. HERMAN E. TALMADGE,
Chairman, Subcommittee on Health, Committee on Finance, U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: Attached are two reports from the Library of Congress, dated May 29, 1975 and July 26, 1976, describing the status of HEW's implementing standardized health care billing forms for federal health insurance programs.

I would appreciate this information being included in the hearing record on Medicare and Medicaid reform, along with my letter to you dated July 23, 1976, discussing this matter, among other issues that I asked be raised during the course of the hearings.

Thank you.

Sincerely yours,

GAYLORD NELSON.

Enclosures.

THE LIBRARY OF CONGRESS,
CONGRESSIONAL RESEARCH SERVICE,
Washington, D.C., July 26, 1976.

To: Honorable Gaylord Nelson.
(Attention: Judy Robinson).
From: Education and Public Welfare Division.
Subject: Standardization of Health Care Billing Forms.

The following information on the development of standardized health care billing forms is provided pursuant to your request on this subject dated July 22, 1976. This report updates our previous report to you on the same subject dated May 29, 1975. A copy of that report is attached.

A standardized form for professional services called the Health Insurance Claim Form has been tested and is now being used by the Bureau of Health Insurance for the Part B portion of the Medicare program. In the latter part

of 1974, the Bureau of Health Insurance notified the carriers handling Part B claims that they could accept the Health Insurance Claim Form as well as the existing Medicare Claim Form SSA–1490. In addition, for areas where other third party payers agree, in addition to Medicare, to use the new standardized form, the new form could be used exclusively for Part B claims. In such cases, the exclusive use of the new form for Medicare would have to be approved by the Bureau of Health Insurance. Approval has been granted by BHI for the following reasons: (a) North Dakota; (b) South Dakota; (c) South Carolina; (d) Arkansas; (e) Kansas City; and (f) Topeka, Kansas.

An application has been submitted by the carrier for California and is pending approval.

According to a Bureau of Health Insurance representative, the form has been endorsed by the National Association of Blue Shield Plans. The Health Insurance Council, an entity supported by the insurance industry, has strongly endorsed the use of the form within the last three months.

To date, the Social Rehabilitation Service has not endorsed the use of the form. They have requested the American Medical Association, which has assumed a leadership and coordination role for the new form, to consider the inclusion of additional information necessitated by the Fraud and Abuse amendments to the Title XIX program. A representative of the Medical Services Administration within SRS estimates that the matter should be resolved in the next six months. If the changes were agreed upon by the parties involved, MSA then would be willing to send a letter to the States and other appropriate jurisdictions with Medicaid Programs, urging them to adopt the Health Insurance Claim Form.

The Civilian Health and Medical Program for the Uniformed Services (CHAMPUS) has not accepted the form, although they have participated in its development. The Federal Employees Health Benefits Program has not participated from the beginning.

The standardized hospital billing form referred to as the UB–16 is still in the development stage. According to a representative of the Social Security Administration, the form will be field tested in California, Arizona, and Minnesota. The criteria for the field tests are to be developed by August 15, and the field tests are scheduled to begin between January 1 and March 31, 1977. The same BHI representative estimated that the form may be ready for use by January 1, 1979.

The CHAMPUS program will participate in the field tests in Arizona and California. The Federal Employees Health Benefits Program has not participated in the development of the standardized hospital claims form. The Medical Services Administration, SRS, has requested the States where the field tests will occur to participate in the field tests. According to the aforementioned representative of the Bureau of Health Insurance, the commercial health insurers have expressed approval of the form as currently designed. Although the Blue Cross Association is supportive of a standardized form, a small number of Blue Cross Plans have questioned its use in their marketing areas, alleging that some of their subscribers have unique requirements which may not be able to be accommodated to the content of the new billing form.

We hope the information provided is sufficient. If we can be of further assistance, please let us know.

HERMAN SCHMIDT.

THE LIBRARY OF CONGRESS,
CONGRESSIONAL RESEARCH SERVICE,
Washington, D.C., May 29, 1975.

To: Hon. Gaylord Nelson.
(Attn: Ms. Judy Robinson).
From: Education and Public Welfare Division.
Subject: Standardization of medical claims forms.

Several attachments are provided which address the questions of standardizing both physician and hospital forms.

Based on conversations and information provided by the Social Security Administration, the American Medical Association, and the American Hospital Association, it would appear that efforts to standardize forms for physicians are further advanced than those for hospitals.

In South Carolina, the medical profession, Medicare, Medicaid, Blue Cross/Blue Shield, and the Commercial insurance companies are working with a standard claims form, as a pilot project. Such efforts are also underway in North

and South Dakota, Arkansas, the Kansas City area, and are being considered in Topeka, Kansas. The Social Security Administration has instructed its carriers to support such efforts, wherever possible.

Efforts to standardize hospital forms were stimulated approximately six years ago by the American Hospital Association. Both Medicare and Medicaid, as well as the private health insurers have also been involved. Some twenty forms have been designed and two are being tested by Blue Cross in Atlanta, Georgia, and Wyoming.

The American Hospital Association has recently designed another form and a meeting is scheduled in Chicago on June 5 to consider the form. Participating in this process are the insurers, Medicaid and Medicare. Apparently, the military, through its Champus program has expressed interest but has not been actively involved in efforts to standardize forms.

It would appear that the need for hospitals to standardize forms is more acute than that for physicians. In urban hospitals, according to the Social Security Administration, the administrative office of the hospital may have to deal with as many as 42 forms. Some insurers use more than one form. According to the Social Security Administration, there was some question as to whether it would be possible to standardize forms for claims for both public and private payers because of the special data requirements of public payers.

We hope this information is sufficient. If you need any further assistance, please let us know.

HERMAN E. SCHMIDT.

UNITED STATES SENATE,
COMMITTEE ON LABOR AND PUBLIC WELFARE,
Washington, D.C., July 23, 1976.

Hon. HERMAN E. TALMADGE,
Chairman, Subcommittee on Health, Committee on Finance, U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: In connection with the hearings that your Subcommittee is conducting the week of July 26, 1976, on Medicare and Medicaid reform, there are three issues of considerable importance to the beneficiaries and providers in the State of Wisconsin, as well as throughout the nation, which I would appreciate being raised at the hearings.

NURSING HOME PARTICIPATION IN MEDICARE

As you know, nationwide a large number of skilled nursing facilities have been terminating participation in the Medicare program, rendering many areas unserved by qualified Medicare facilities.

Between July 1974 and July 1975, 245 facilities (17,273 beds) were terminated, leaving 3,932 facilities (287,479) beds participating in Medicare. Attached is detailed information in this regard.

In Wisconsin, there were 125 Medicare-approved SNFs as of March 1972. Today, there are 64.

This raises serious questions as to whether remedial legislation is necessary to insure continued availability of this service throughout the country.

I would appreciate the following questions being raised before the appropriate witnesses, in this regard:

Question 1. What are the reasons for the termination of participation in Medicare by increasing numbers of skilled nursing facilities?

Is termination more prevalent among for-profit or not-for-profit nursing homes?

Nursing home operators have indicated to us that they are terminating Medicare participation for two reasons: massive paperwork, and low reimbursement levels.

However, as you know, the present law (section 249) encourages gearing Medicare payments for skilled nursing care to the State payment under Medicaid; and regulations to this effect were finalized July-1, 1976.

Question 2. Is Section 249 seen as adequate incentive to attract skilled nursing facilities back into the Medicare program?

Question 3. The HEW General Counsel's office, in a memo dated March 26, 1976 (which is attached) has ruled that "there is no absolute statutory impediment to states imposing" a requirement that skilled nursing facilities, which participate in Medicaid, also participate in Medicare. Several states, we understand, are considering such a requirement.

What would be the impact of statutorily imposing such a requirement at the Federal level, e.g. refusing to make Medicaid funds available to qualified homes that refused to participate in Medicare?

UNIFORM CLAIMS FORMS

HEW has for a number of years worked with physician provider groups, hospital provider groups, and the insurance industry in the development of standardized claims forms to be used for federal health insurance programs by both physicians and institutions.

The latest information on the development of such forms is that: a standardized form for physicians is now developed. It is not mandated for Medicare: however, physicians may use it as an option; and, where carriers in an area agree to use it, Medicare will use it exclusively for that area. Only six areas of the country now use it exclusively.

The Medicaid program has not implemented it, and the Social and Rehabilitation Service advises us that it believes SRS cannot require states to use such a form.

The Federal Employees Health Benefit Program does not use the form, nor has the Program ever even participated in negotiations to develop such a form for uniform use.

CHAMPUS has not accepted the form.

In other words, a standardized claims form for physician services is not in widespread use, nor is it required of all Federal programs, although such a form has been developed.

Question 4. Would it be advisable to mandate that such a form be used for all federal health insurance programs, in order to reduce the paperwork burden on physicians, insurance carriers, the federal government, and the individual beneficiaries?

As to a standardized form for hospital use, there is even less progress.

Standardized forms have been developed for hospital use, and have been field-tested in Atlanta, Georgia and Wyoming. Further field testing by the Social Security Administration for Medicare usage is planned, involving three states (California, Arizona and Minnesota). However, SSA advises that such forms may not be able to be utilized nationwide until approximately January, 1979.

Again, the Federal Employees Health Benefits Program has not participated in the development of the form.

Medicaid says that it can only encourage, not mandate, states to utilize such a form.

CHAMPUS, in this case, is participating in the new field tests.

Question 5. Why cannot such standardized hospital claim forms be put into nationwide use by all federal programs at an earlier date?

Is utilization of such a form in the interest of more efficient management of such programs?

FEE SCHEDULES

The discrepency between rural and urban physicians fees under Medicare and Medicaid programs has led the Social Security Administration to implement a reimbursement experiment in South Carolina, under which fee schedules for all physicians will be substituted for the regional fee screen.

Question 6. What would be the reaction of physician organizations in other states to the imposition of fee schedules statewide?

How could such fee schedule programs be designed?

I would appreciate your including this letter in the hearing record. Thank you for consideration of these matters, and for raising them during the hearings at the appropriate opportunities.

Sincerely yours,

GAYLORD NELSON.

Enclosures.

THE LIBRARY OF CONGRESS,
CONGRESSIONAL RESEARCH SERVICE,
Washington, D.C., July 20, 1976.

To: Judy Robinson.

The enclosures cover the in-and-out information of skilled nursing facilities through July 1974. During the 12-month period ending July 1975, 245 facilities (17,273 beds) were terminated. As of July 1975, 3,932 facilities (287,479 beds)

were participating in Medicare. I will send you the geographical breakdown for the fiscal year 1975 terminations as soon as I get them from Baltimore.

Bob Hoyer.

Sincerely,

Norman Beckman, *Acting Director.*

TABLE F.—PERCENTAGE DISTRIBUTION OF ADULT BEDS IN SHORT-STAY HOSPITALS PER 1,000 ENROLLEES BY STATE, JULY 1973 AND JULY 1974

Short-stay hospital beds per 1,000 enrollees	Number of States		Percentage distribution	
	July 1973	July 1974	July 1973	July 1974
Total	51	51	100.0	100.0
Less than 35	6	5	11.8	9.8
35 to 39.9	11	11	21.6	21.6
40 to 44.9	17	18	33.3	35.3
45 to 49.9	11	11	21.6	21.6
50 to 54.9	3	3	5.9	5.9
55 to 64.9	0	1	0	2.0
65 or more	3	2	5.9	9.3

TABLE G.—NUMBER OF SKILLED NURSING FACILITIES, BEDS, BEDS PER 1,000 ENROLLEES, AND PERCENT CHANGE BY DIVISION, JULY 1973 AND JULY 1974

Division	Skilled nursing facilities			Beds			Beds per 1,000 enrollees		
	July 1973	July 1974	Percent change	July 1973	July 1974	Percent change	July 1973	July 1974	Percent change
All areas	3,977	3,952	−0.6	287,606	294,000	2.2	13.8	13.9	0.7
United States	3,970	3,946	−.6	286,884	293,487	2.3	13.9	14.0	.7
New England	286	287	.3	21,004	22,203	5.7	16.1	16.9	5.0
Middle Atlantic	658	656	−.3	67,026	68,056	1.5	16.8	16.9	.6
East North Central	693	668	−3.6	44,239	43,133	−2.5	11.3	10.9	−3.5
West North Central	254	240	−5.5	11,004	11,671	6.1	5.6	5.9	5.4
South Atlantic	479	499	4.2	31,644	33,153	4.8	10.5	10.6	1.0
East South Central	250	240	−4.0	13,433	13,370	−.5	10.2	9.9	−2.9
West South Central	96	88	−8.3	5,979	5,753	−3.8	3.2	3.0	−6.3
Mountain	177	171	−3.4	8,801	8,420	−4.3	12.0	11.0	−8.3
Pacific	1,077	1,097	1.9	83,754	87,728	4.7	34.0	34.7	2.1
Outlying areas	7	6	−14.3	722	513	−28.9	3.8	2.6	−31.6

TABLE H.—PERCENTAGE DISTRIBUTION OF SKILLED NURSING FACILITY BEDS PER 1,000 ENROLEES, BY STATE, JULY 1973 AND JULY 1974

Skilled nursing facility beds per 1,000 enrolees	Number of States		Percentage distribution	
	July 1973	July 1974	July 1973	July 1974
Total	51	51	100.0	100.0
Less than 5	12	11	23.5	21.6
5 to 9.9	12	14	23.5	27.5
10 to 14.9	15	14	29.4	27.5
15 to 19.9	4	5	7.8	9.8
20 to 24.9	5	4	9.8	7.8
25 to 29.9	1	1	2.0	2.0
30 or more	2	2	3.9	3.9

TABLE J.—NUMBER OF HOME HEALTH AGENCIES AND INDEPENDENT LABORATORIES PARTICIPATING IN THE HEALTH INSURANCE PROGRAM AND PERCENT CHANGE BY DIVISION, JULY 1973 AND JULY 1974

Division	Home health agencies			Independent laboratories		
	July 1973	July 1974	Percent change	July 1973	July 1974	Percent change
All areas	2,211	2,248	1.7	2,929	3,029	3.4
United States	2,201	2,234	1.5	2,872	2,973	3.5
New England	338	33.8	0	185	192	3.8
Middle Atlantic	282	279	−1.1	492	495	.6
East North Central	326	327	.3	431	463	7.4
West North Central	216	225	4.2	136	144	5.9
South Atlantic	311	309	−.6	300	310	3.3
East South Central	269	285	6.3	86	92	7.0
West South Central	242	248	2.5	234	250	6.8
Mountain	80	84	5.0	150	160	6.7
Pacific	137	138	.7	858	867	1.0
Outlying areas	10	14	40.0	57	56	−1.8

TABLE K.—NUMBER OF FACILITIES PARTICIPATING IN THE HEALTH INSURANCE PROGRAM TERMINATED IN FISCAL YEARS, 1973 AND 1974 AND NET INCREASES, BY TYPE OF PROVIDER, TYPE OF TERMINATION, AND DIVISION

[Fiscal years]

Division and type of termination	Hospital						Skilled nursing facilities						Home health agencies (number)			Independent laboratories (number)		
	Number			Beds			Number			Beds								
	1973	1974	Net increase	1973	1974	Net increase	1973	1974	Net increse	1973	1974	Net increase	1973	1974	Net increase	1973	1974	Net increase
All areas	170	89	−81	13,261	10,448	−2,813	301	198	−103	15,697	11,545	−4,152	110	53	−57	200	122	−78
Voluntary	164	85	−79	13,122	9,802	−3,320	295	182	−113	15,333	10,076	−5,257	109	52	−57	195	120	−75
Involuntary	6	4	−2	139	646	507	6	16	10	364	1,469	1,105	1	1	0	5	2	−3
New England	8	5	−3	470	257	−213	15	13	−2	926	731	−195	11	5	−6	12	7	−5
Voluntary	8	5	−3	470	257	−213	14	10	−4	851	545	−306	11	5	−6	12	7	−5
Involuntary	0	0	0	0	0	0	1	3	2	75	186	111	0	0	0	0	0	0
Middle Atlantic	15	12	−3	2,020	2,377	357	32	29	−3	1,457	2,497	1,040	17	8	−9	39	30	−9
Voluntary	15	11	−4	2,020	1,795	−225	31	24	−7	1,361	1,906	545	17	7	−10	39	30	−9
Involuntary	0	1	1	0	582	582	1	5	4	96	591	495	0	1	1	0	0	0
East north-central	21	13	−8	1,695	1,329	−366	61	35	−26	3,520	1,745	−1,775	10	9	−1	20	14	−6
Voluntary	20	13	−7	1,675	1,329	−346	60	34	−26	3,508	1,695	−1,813	10	9	−1	17	14	−3
Involuntary	1	0	−1	20	0	−20	1	1	0	12	50	38	0	0	0	3	0	−3

West north-central	12	8	−4	851	279	−572	29	19	−10	1,145	660	−485	5	5	0	6	4	−2
Voluntary	13	8	−4	851	279	−572	28	18	−10	1,057	572	−485	5	5	0	6	4	−2
Involuntary	0	0	0	0	0	0	1	1	0	88	88	0	0	0	0	0	0	0
South Atlantic	17	10	−7	1,387	1,025	−362	55	30	−25	2,848	1,636	−1,212	33	17	−16	29	16	−13
Voluntary	17	10	−7	1,387	1,025	−362	55	28	−27	2,848	1,499	−1,349	33	17	−16	29	15	−14
Involuntary	0	0	0	0	0	0	0	2	2	0	137	137	0	0	0	0	1	1
East south-central	11	10	−1	470	491	21	22	17	−5	843	620	−223	4	0	−4	7	2	−5
Voluntary	8	10	2	392	491	99	20	17	−3	750	620	−130	4	0	−4	6	2	−4
Involuntary	3	0	−3	78	0	−78	2	0	−2	93	0	−93	0	0	0	1	0	−1
West south-central	22	13	−9	1,073	368	−705	20	12	−8	1,039	632	−407	22	4	−18	13	4	−9
Voluntary	21	10	−11	1,059	304	−755	20	12	−8	1,039	632	−407	21	4	−17	15	4	−9
Involuntary	1	3	2	14	64	50	0	0	0	0	0	0	1	0	−1	0	0	0
Mountain	11	6	−5	553	321	−232	10	8	−2	734	420	−314	4	1	−3	7	4	−3
Voluntary	10	6	−4	526	321	−205	10	8	−2	734	420	−314	4	1	−3	7	3	−4
Involuntary	1	0	−1	27	0	−27	0	0	0	0	0	0	0	0	0	0	1	1
Pacific	19	12	−7	2,320	4,001	1,681	53	32	−21	2,801	2,267	−534	4	4	0	64	37	−27
Voluntary	19	12	−7	2,320	4,001	1,681	53	28	−25	2,801	1,850	−951	4	4	0	64	37	−27
Involuntary	0	0	0	0	0	0	0	4	4	0	417	417	0	0	0	0	0	0
Outlying areas	34	0	−34	2,422	0	−2,422	4	3	−1	384	337	−47	0	0	0	3	4	1
Voluntary	34	0	−34	2,422	0	−2,422	4	3	−1	384	337	−47	0	0	0	2	4	2
Involuntary	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	−1

TABLE L.—NUMBER OF EMERGENCY HOSPITALS AND PERCENTAGE DISTRIBUTION BY DIVISION, JULY 1974

Division	Non-Federal		Federal	
	Number	Percentage distribution	Number	Percentage distribution
All areas	489	100.0	413	100.0
United States	377	77.1	410	99.3
New England	18	3.7	23	5.6
Middle Atlantic	57	11.7	35	8.5
East north-central	59	12.1	37	9.0
West north-central	7	1.4	42	10.2
South Atlantic	65	13.3	75	18.2
East south-central	51	10.4	29	7.0
West south-central	63	12.9	56	13.6
Mountain	25	5.1	52	12.6
Pacific	32	6.5	61	14.8
Other areas	112	22.9	3	.7
Puerto Rico	19	3.9	3	.7
Canada	89	18.2	...	...
Mexico	4	.8	...	...

TABLE D.—NUMBER AND TYPE OF FACILITIES PARTICIPATING IN THE HEALTH INSURANCE PROGRAM AND PERCENTAGE CHANGE, JULY 1971 AND JULY 1972

Type of facility	Facilities			Beds		
	July 1971	July 1972	Percent change	July 1971	July 1972	Percent change
Hospitals [1]	6,745	6,726	−0.3	1,188,013	1,155,982	−2.7
Short-stay	6,153	6,131	0.4	834,514	850,070	+1.9
Tuberculosis	95	80	−15.8	18,995	15,065	−20.7
Psychiatric	335	346	+3.3	300,696	259,329	−13.8
Other long-stay	162	169	+4.3	33,808	31,518	−6.8
Skilled nursing facilities [1]	4,287	4,041	−5.7	307,548	291,636	−5.2
Home health agencies	2,284	2,222	−2.7	...	...	...
Independent laboratories	2,751	2,873	+4.4	...	...	...

[1] Excludes 17 Christian Science sanatoriums.

TABLE E.—NUMBER OF HOSPITALS AND ADULT BEDS PARTICIPATING IN THE HEALTH INSURANCE PROGRAM AND PERCENTAGE CHANGE, BY DIVISION, JULY 1971 AND JULY 1972

Division	Hospitals			Beds		
	July 1971	July 1972	Percent change	July 1971	July 1972	Percent change
All areas	6,745	6,726	−0.3	1,188,013	1,155,982	−2.7
United States	6,643	6,656	+.2	1,178,430	1,146,556	−2.7
New England	370	363	−1.9	76,600	71,219	−7.0
Middle Atlantic	799	808	+1.1	276,541	267,154	−3.4
East north-central	1,104	1,088	−1.5	231,862	207,251	−10.6
West north-central	920	914	−.7	108,480	107,305	−1.1
South Atlantic	858	869	+1.3	161,564	164,791	+2.0
East south-central	507	508	+.2	58,668	59,621	+1.6
West south-central	857	863	+.7	100,702	103,325	+2.6
Mountain	390	396	+1.5	37,977	38,998	+2.7
Pacific	838	847	+1.1	126,036	126,892	+.7
Outlying areas	102	70	−31.4	9,583	9,426	−1.6

TABLE F.—PERCENTAGE DISTRIBUTION OF ADULT BEDS IN SHORT-STAY HOSPITALS PER 1,000 ENROLLEES, BY STATE, JULY 1971 AND JULY 1972

Short-stay hospital beds per 1,000 enrollees	Number of States		Percentage distribution	
	July 1971	July 1972	July 1971	July 1972
Total	51	51	100.0	100.0
Less than 35	5	8	9.8	15.7
35 to 39.9	15	11	29.4	21.6
40 to 44.9	11	13	21.6	25.5
45 to 49.9	12	13	23.5	25.5
50 to 54.9	5	3	9.8	5.9
55 to 64.9	1	1	2.0	2.0
65 or more	2	2	3.9	3.9

TABLE K.—NUMBER OF FACILITIES PARTICIPATING IN THE HEALTH INSURANCE PROGRAM TERMINATED IN FISCAL YEARS 1971 AND 1972, AND NET CHANGE, BY TYPE OF PROVIDER, TYPE OF TERMINATION, AND DIVISION

[Fiscal years]

Division and type of termination	Hospitals						Skilled nursing facilities						Home health agencies (number)			Independent laboratories (number)		
	Number			Beds			Number			Beds								
	1971	1972	Net change	1971	1972	Net change	1971	1972	Net change	1971	1972	Net change	1971	1972	Net change	1971	1972	Net change
All areas	141	156	+15	13,914	11,131	−2,783	708	476	−232	39,016	26,975	−12,041	170	128	−42	124	178	+54
Voluntary	132	137	+5	13,695	10,316	−3,379	689	461	−228	37,648	26,072	−11,576	168	127	−41	121	166	+45
Involuntary	9	19	+10	219	815	+596	19	15	−4	1,368	903	−465	2	1	−1	3	12	+9
New England	12	6	−6	1,114	296	−818	59	26	−33	3,491	1,671	−1,820	6	15	+9	8	11	+3
Voluntary	12	6	−6	1,114	296	−818	59	24	−35	3,491	1,560	−1,931	6	15	+9	7	9	+2
Involuntary								2	+2		111	+111				1	2	+1
Middle Atlantic	13	4	−9	2,712	344	−2,368	47	25	−22	2,836	1,482	−1,354	12	12	0	17	23	+6
Voluntary	13	4	−9	2,712	344	−2,368	46	24	−22	2,800	1,466	−1,334	12	11	−1	16	19	+3
Involuntary							1	1	0	36	16	−20		1	+1	1	4	+3
East north-central	22	26	+4	2,857	3,684	+827	111	81	−30	6,237	5,675	−562	13	16	+3	17	34	+17
Voluntary	22	26	+4	2,857	3,684	+827	107	75	−32	5,902	5,193	−709	13	16	+3	16	29	+13
Involuntary							4	6	+2	335	482	+147				1	5	+4
West north-central	12	15	+3	405	718	+313	81	50	−31	3,047	1,653	−1,394	13	8	−5	3	6	+3
Voluntary	11	12	+1	380	550	+170	81	49	−32	3,047	1,648	−1,399	13	8	−5	3	6	+3
Involuntary	1	3	+2	25	168	+143		1	+1		5	+5						
South Atlantic	15	19	+4	3,261	1,091	−2,170	78	77	−1	5,069	4,640	−429	23	26	+3	12	18	+6
Voluntary	13	17	+4	3,188	1,037	−2,151	+76	77	+1	4,961	4,640	−321	21	26	+5	12	18	+6
Involuntary	2	2	0	73	54	−19	2		−2	108		−108	2		−2			
East south-central	14	7	−7	1,419	456	−963	25	35	+10	1,241	1,452	+211	10	4	−6	6	7	+1
Voluntary	14	4	−10	1,419	407	−1,012	25	34	+9	1,241	1,409	+168	10	4	−6	6	6	0
Involuntary		3	+3		49	+49		1	+1		43	+43					1	+1
West south-central	28	26	−2	881	1,277	+396	117	72	−45	6,080	3,791	−2,289	53	24	−29	13	14	+1
Voluntary	23	16	−7	773	849	+76	111	70	−41	5,753	3,704	−2,049	53	24	−29	13	14	+1
Involuntary	5	10	+5	108	428	+320	6	2	−4	327	87	−240						
Mountain	7	2	−5	186	37	−149	49	26	−23	2,782	1,489	−1,293	6	7	+1	9	10	+1
Voluntary	7	2	−5	186	37	−149	48	26	−22	2,698	1,489	−1,209	6	7	+1	9	10	+1
Involuntary							1		−1	84		−84						
Pacific	14	15	+1	656	1,734	+1,078	141	81	−60	8,233	5,019	−3,214	34	16	−18	37	48	+11
Voluntary	14	15	+1	656	1,734	+1,078	136	79	−57	7,755	4,860	−2,895	34	16	−18	37	48	+11
Involuntary							5	2	−3	478	159	−319						
Outlying areas	4	36	+32	423	1,494	+1,071		3	+3		103	+103				2	7	+5
Voluntary	3	35	+32	410	1,378	+968		3	+3		103	+103				2	7	+5
Involuntary	1	1		13	116	+103												

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
March 29, 1976.

PAUL WILLGING,
Deputy Commissioner, MSA,
GALEN D. POWERS,
Acting Deputy General Counsel:

SNF PARTICIPATION IN MEDICARE AS A CONDITION FOR PARTICIPATION IN MEDICAID

This memorandum is submitted at your request to set forth the General Counsel positions concerning whether SNF's participating in Medicaid may also be required to participate in Medicare. Our conclusions are as follows: The federal government may not require that homes participating in Medicaid also participate in Medicare. The federal government may not prohibit States from so requiring if they choose. (The situation which arises in New York is somewhat distinguishable, since the state has (as we understand it) made the facility's application to participate in title XVIII a condition of state licensure.)

As you undoubtedly know, the Human Resources Division has written two memorandum on this subject. First, on November 20, 1973, Arthur Shapiro wrote to Albert Richter of MSA. The Shapiro memorandum recognized that "a state would reasonably require that all participating providers of skilled nursing care meet the title XVIII standards for participation. . . ." Shapiro concluded, however, that "it would be an unreasonable and arbitrary limitation on recipient's right of freedom of choice if he were not permitted to use the services of a facility which meets all applicable title XVIII standards but voluntarily chooses not to participate under that program." The freedom of choice provision, §1902(a)(23), refers to "any institution. . .qualified to perform the service or services required. . . ." Thus, in New York, institutions not applying to participate in Medicare are simply not qualified under state law to provide the services required. The New York statute would therefore comply with federal law even under the criteria set forth in the Shapiro memorandum. More significantly, I now believe that the Shapiro memorandum crossed the boundary between legal advice and policy advice.

It is clear that § 1902(a)(23) has never been read in its most literal sense as requiring certification of each home that meets federal and state standards. In fact, a state need not certify as a title XIX provider even homes actually participating in title XVIII.[1] Accordingly, a Medicaid recipient is not permitted unrestricted freedom of choice. He is only permitted freedom of choice among those qualified providers which have been certified by the state. Accordingly, while the Federal government cannot itself mandate that all title XIX providers also participate in title XVIII since this would be an illegal infringement upon the state's right to certify title XIX providers, so can the federal government not prohibit states from refusing to certify otherwise qualified SNFs if they do not participtae in title XVII. Since section 1902(a)(23 does not require states to certify all SFNs which meet minimum federal criteria and state standards for licensure, the determination of what other prerequisites for certification (if any) are so unreasonable that they infringe upon recipient freedom of choice is one which is for the agency to make within extremely wide limits. Only the most egregious additional prerequisites can justify a statement, that, as a matter of law, recipient freedom of choice has been unduly interferred with.[2]

On January 23, 1975, (in a memorandum which was not transmitted to Dr. Weikel until December 12, 1975), Mr. Jaye purported to affirm the conclusion of the Shapiro memorandum. However, you should note that Mr. Jaye first mischaracterizes the Shapiro memorandum before affirming it: "Mr. Shapiro concluded that it was legally impermissible for us to require states (in turn) to require all SNFs participating in Medicaid to participate also in Medicare." As so characterized, the conclusion remains correct; we cannot mandate such dual participation.

We believe, however, that there is no absolute statutory impediment to states imposing such a requirement, although you could prohibit it if you had reason to believe that it would unduly restrict recipient freedom of choice. In any con-

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[1] The legislative history refers to the possibility that the State might determine that a particular area is overbedded with respect to title XIX homes.

[2] This is not to say that otherwise acceptable conditions might not operate in practice to deny recipient freedom of choice. In such event, § 1904 is available to eliminate the particular condition which empirical data indicates has improperly restricted freedom of choice.

formity hearing requested by the state, SRS would have the burden of establishing that proposition.

TESTIMONY OF HON. BRENUAN BYRNE, GOVERNOR, STATE OF NEW JERSEY

Mr. Chairman, I am pleased to submit for the Committee's record New Jersey's position regarding Senate bill 3205, the Medicare-Medicaid Administrative and Reimbursement Rate.

As Governor of the State of New Jersey, I have taken an active interest in the containment of health care costs not only through administration of the State's Medicaid program but also through implementation of a state hospital reimbursement program for Blue Cross and other government payors. However, despite our conscientious efforts, the problem is larger than any one state's ability to control. Since the federal government is the single largest purchaser of health care in this nation, we must look to this sector if we are to have any major success in our battle to control health care costs. These proposed amendments to the Social Security Act are, for the most part, proper steps toward this goal.

Recognizing the importance of this legislation and the complex technicalities inherent in these amendments, I asked staff of both the Medicaid program and the hospital reimbursement program to submit comments of which the following are a distillation.

The proposed bill contains three major sections of concern to New Jersey:

PROGRAM CONTROLS

New Jersey favors the concept of reorganization within DBES as detailed in Section 2 and 3 of this bill. This reorganization—including establishment of a health care financing administration and an Office of Central Fraud and Abuse Control—should accomplish improved fiscal control over the Medicare and Medicaid programs. We do believe that a centralized fraud and abuse operations is a good concept if it lends itself to a coordinated effort with states. However, this office should not prevent intermediaries and carriers from continuing to investigate suspected program abuses. It is important, as well, that this office be subject to a limited budget and staff in order not to develop a large organization in competition with the Department of Justice. We trust that the function of an Inspector General, whose title should be changed to something less militaristic, and the office he manages, will be supportive of, not parallel to the role of this primary law enforcement agency.

We are concerned however, that the Inspector General should exert a coordinative influence on states, which must also relate to HEW regional staff and HEW auditors in addition to many other local reviewers, or they may well be in a state of continuous audit or investigation.

Not only are administrative controls necessary at the federal level, we agree that better controls are also needed at the state level in order to ensure program integrity.

However, as Section 4 is presently drafted, there are several deficiencies from New Jersey's perspective. First, in the area of program eligibility, the bill requires that this determination be made within thirty days for all categories of eligibility with the exception of disability. This section must exclude federally determined eligibility processes from the limited time periods now specified. Second, in the area of quality controls, we suggest consideration of a range for normal error rates, rather than the 50th percentile of base year error rates for all states. Some states would have to exceed the 50th percentile as proposed in the bill; compliance with error rate requirements should be phased in over a reasonable period.

HOSPITAL REIMBURSEMENT REFORMS

From New Jersey's experience implementing rate setting process, Sections 10, 11 and 12 of this bill are centrally important to the proposed cost-containment effort in hospitals. These sections would add additional criteria for determining reasonable costs of hospital services under Medicare and Medicaid. Based upon our experience, however, several aspects of each of these sections require further consideration.

Section 10

First, this program does not attempt to encourage states to establish reimbursement mechanisms for all payors for patient care in hospitals as a required condition for payment of federal matching funds to the states for Medicaid programs. Accordingly, these amendments may reduce the increase in costs to the Medicare and Medicaid programs but they will not contain total hospital costs. Thus this program will shift the burden of payment from Medicaid and Medicare to other third party payors and fee-paying patients while failing to contain total hospital related expenditures.

While standardization of classification schemes makes interstate comparisons far easier, the proposed classification of hospitals is unnecessarily complex. Furthermore, allowing medical schools only one primary affiliate could cause New Jersey very real problems. Similarly, the proposed accounting classifications are undesirable, based upon our State's rate setting experience.

Basing the entire system on routine operating costs raises serious questions about the integrity of the system. Unless a very carefully developed set of uncontrovertible definitions is used with follow-up auditing, any system which covers only part of hospitals' expenses is likely to encourage "creative accounting" rather than cost-containment by hospital administrators. Furthermore, the division of these routine costs into personnel and non-personnel components is problematic as the New Jersey Department of Health discovered in 1975 rate reviews. Rather than requiring hospital management to decide the appropriate trade-offs between labor and capital, or wages and productivity, the State is required to confront the problem head-on.

Section 10 has additional problems. First, the role of the JCAH indicated in part D is most inappropriate, since it sustains the role of an industry-oriented body, subject to no public controls, as a quasi-public agency. Second, the lack of specificity is disturbing regarding price indices for reimbursement of personnel and waivers due to changes in the hospitals' patient mix. With respect to price indices in particular, the rate of increase in personnel costs is determined from hospital industry data. This fact places no incentive on the hospitals to reduce costs, for if the average costs can be forced up, all hospitals will be reimbursed accordingly. Depending upon the distribution of hospital costs, most hospitals might benefit from employing such a strategy. In New Jersey, the state uses an "economy-wide" index.

Section 11

We appland the bill's attempt to incorporate occupancy considerations with the rate setting process in Section II. However, we believe that the Health Systems agencies and the State Health Planning and Development Agency created pursuant to PL 93–641 should be specified as having a relation to this system. There is no question that underused facilities should be closed where possible however, this decision should be part of the planning process and reinforced by reimbursement progress. Although HSA's vary in scale and function across the nation, their required input in this process will assist in developing a common role and will clearly support the intent of PL 93–641. Establishing a Board to do this evaluation on a National basis in unrealistic. A five-member board could not possibly handle the workload or appreciate complexities of load area problems.

Section 12

This provision would increase the allowable return on equity to be included in determining reasonable costs by proprietary hospitals. New Jersey does not feel this should be implemented because the current return on equity is quite adequate, providing an 11% to 12% return. However, if this section should be retained, the States should have the option, not the obligation of paying up to twice the average rate of interest. Clearly, money market conditions vary in different regions of the counry.

PHYSICIAN REIMBURSEMENT REFORMS

We recommend that existing law be changed to provide for the updating of physician profiles and prevailing charges on a semi-annual basis. The current systems of annual updating on July 1 of each year based on charges rendered

during the prior calendar year produces an excessive time lag. This is a disincentive for the physician to consider whether to accept assignment of benefits. We anticipate that the impact on beneficiaries will be significant and should be weighed in the cost-control calculus. If the proposed approach does, in fact, further limit annual increases in prevailing charges, with further decreases in the assignment rates, the elderly beneficiary will be even harder hit than he now is for out-of-pocket expenses. We recommend that this proposal be deferred until impact on beneficiaries can be quantified and evaluated. Alternative payments under Medicare should also be investigated to arrive at the best possible solution from the beneficiary's perspective.

Further modifications should be made in Section 21 to stimulate physicians' acceptance of assignment. As the bill is presently drafted, incentives for acceptance to assignments by physicians under Medicare are not strong enough. We believe that physicians should be compelled to accept assignment as a condition of participation in the Medicare program. Until such a requirement is executed, Medicare beneficiaries will continue to experience soaring out-of-pocket medical expenses.

Furthermore, the concept of "participating" and "non-participating" physicians as defined in this bill will be counter-productive if implemented. The "all or nothing" approach to assignments may drive the assignment rate down because the "incentives" in this section are not sufficient to achieve a high rate of participation. In fact, the billing and payment procedures may be a disincentive which will not be overcome by the $1.00 per patient "incentive."

Furthermore, we envision terribly difficult administrative problems under the proposed modified billing form if all other requirements under existing rules and regulations must be met. Also, the partial payment to the physician within five days followed later with the many individual adjustments with respect to the deductible, reasonable charges, utilization, and eligibility determinations will create more record keeping problems for the physician's office assistant. An alternative approach which would be to provide that reasonable charge determination for participating physicians be based on the 90th percentile rather than the 75th. To improve administrative procedures, it might be required that participating physicans code all clams.

As for physicians affiliated with hospitals, described in Section 22, we find that there is a need for further control. Some clarification is necessary to define the term "reasonable" and the limiting provisions for anesthesiologists. We do not agree with the payment of benefits without coinsurance for participatory physicians. We also believe that this section should apply to all hospital-based physicians. Consideration should also be given to providing that reimbursement to all hospital associated physicians be made on the basis of reasonable cost to the hospital with payments under Part A of Medicare. All provisions of this section should apply to Medicare as well.

Finally, Section 23 should improve the quality of care rendered under the Medicare program and should decrease utilization problems. There is the potential, however, that this provision might cause problems for states, such as New Jersey, which face difficult financial straits, if it did not concurrently bring a reduction in the use of costly facilities such as hospital rooms. Despite this drawback, New Jersey supports this provision to overcome present tendencies to prescribe higher treatment more frequently than necessary.

In conclusion, Mr. Chairman, may I reiterate that New Jersey supports the proposed legislation in large measure. We are pleased to have had this opportunity to contribute our comments for the record. We look forward to supplying whatever assistance you might need to develop amendments consistent with those noted in this statement.

U.S. Health Care Spending—An Alternative Analysis of Increases

American Enterprise Institute Seminar on Regulation

(By John R. Virts, Ph. D., Corporate Staff Economist, Eli Lilly and Co.)

Introduction

Legislators, businessmen, politicians, economists, analysts in the government, current and former government administrators have all been examining, express-

ing concern, and prescribing for our nation's increasing costs of health care. It has been that from fiscal year (FY) 1965 to FY 1975 such spending increased some 79.6 billion dollars and grew to 8.3% of GNP. These numbers, of course, are as close to facts as we can get—but some of the inferences drawn from these facts may need deeper analysis before they are used within the arena of public policy formation. For example, the proportion of GNP (or of personal incomes after taxes) devoted to personal medical care spending has been on an increasing trend for as long as we have national income statistics—the increase has been clear and consistent since World War II.

Any analysis of medical care spending should begin with a recognition of two basic facts of U.S. society's relationship to its health care system:

(1) We seek health care as a "solution" to problems whose genesis is such that explicit medical care represents a relatively inefficient solution (e.g. malnutrition, accidents, violence, tension, etc.).

(2) Much of our spending for health care is *not* associated with the application of resources to the solution of problems in a way that should lead us to expect significant impact on *today's* "objective health status" (e.g. birth control or abortions, custodial care, much cancer treatment, essentially research and development activities, etc.).

Even if the output and productivity of medical care were not so intimately concerned with human pain, comfort, life and death, these two facets of our consumer relationship to providers of care would make cost-effectiveness a very difficult concept to test.

Analysts of our health care system have noted four characteristics of that system which, in the opinion of the author, are absolutely correct and of great significance in shaping the economics of medical care and expenditure levels and patterns for those goods and services. These characteristics are:

(1) He who prescribes does not pay; he who pays does not choose his treatment modality.

(2) Third-party pay systems tend to reduce financial constraints, and thus cost-effectiveness consciousness, for both providers and patients.

(3) There has been a near explosion of medical technology since World War II—a great deal of which has tended to increase costs, unlike the perceived results of new technology and innovation in other economic sectors.

(4) The markets for medical care are different from typical markets for consumer goods and services—not only because of the institutional factors just discussed but also because of the difficulty of defining and placing a value on outputs as opposed to inputs. The consequent impact on the ability to analyze productivity or cost-effectiveness of medical care is very significant.

It seems doubtful that any serious analyst of health care would disagree that these are very significant characteristics of our system of medical care provision and financing. It is, however, frequently overlooked that these important "coins" in the analyst's pocketbook of observations each has a "head" as well as a "tail." The obverse of each of these characteristics might be stated, in turn, as follows:

(1) In no other area of consumer decision making does the consumer have such highly trained and professionally motivated "purchasing agents" as he or she has in facing the markets for medical care goods and services.

(2) Financial constraints are not entirely absent. Financial constraints do not necessarily need to be present in the *entire* market in order for prices and quantities to respond reasonably efficiently (as efficiently, perhaps, as elsewhere in today's world) in the direction of resource allocation consistent with "operable" consumer sovereignty. In addition, both provider and patient face nonfinancial constraints even in a zero-price environment for explicit health care. Providers are principally professionals with constraints imposed by both professional considerations and peer pressure. Prospective patients face time-trouble-discomfort costs.

(3) In every line of economic endeavor some new technology leads to innovation which reduces costs while other new technology creates new markets. Perhaps more so than in other areas, medical care decision makers still have available for any production problem faced today the alternative technology of two, ten or one hundred years ago—laying professional and legal constraints aside. When technology is changing rapidly and the development stage is long, fraught with uncertainty, and perhaps truly optimal only relative to the very specific potential health problems and characteristics of 220 million human beings, it is reasonable to expect differences in professional opinion about the

relationship of new technology to cost-effective innovation. However, it would seem very doubtful that *any* physician would consider practicing today entirely with the technology of even five years ago. If so, this is testimony that the results of the *process* of medical care technological development has added something positive in every physician's professional judgment. We face the age old problem of knowing that 50% is wasted but not knowing which half is which—with the additional problem of no true, objective, consensus view of what the "output" of the explicit medical care process is supposed to be.

(4) Every market is different from every other market. Such differences require flexibility, care, and selectivity in the analytical tools chosen for analysis. If the basic tenents of market orientation, private ownership and free enterprise are accepted as the imperfect but best available route to individual freedom with economic development, then differences in markets call for tailored analysis of behavior and performance—not the rejection of the viability of market orientation for markets which differ by some degree from some concept of normality or for which analysis may be especially difficult.

Most evidence available and utilized by both sides in today's debate about medical care and "health policy" is anecdotal. It would appear that this is caused much more by the nature of the subject debated than by any lack of skill or knowledge on the part of the debaters. However, there are certain empirical studies that can be done. This paper will present the results of some preliminary measurements germane to a macro or global look at U.S. health care expenditures in order to test the following hypothesis:

The bulk of the increase in health care spending in the decade 1965-1975 can be accounted for by either:

(1) Forces external to health care industries themselves; or

(2) Long established trends within markets for health care goods and services themselves which are consistent with the concepts of consumer sovereignty, competition and social welfare in a free society.

Acceptance or rejection of this hypothesis will tend to lend support to the relative importance for analysis and public policy of one or the other of the macro interpretations of the character of the U.S. health care delivery and financing systems discussed above. Preliminary acceptance of the hypothesis should clearly expose the need for at least further study before public policy calling for greater government intervention into, or control of, those systems is implemented because of the implied highly specific, rather than general, nature of causes of increased costs.

The very preliminary nature of many of the estimates reported here must be emphasized. An appendix of technical notes is available from the author. These notes comment on essentially every measurement presented with the source of the basic data, the analysis of the derivation of the reported estimate and, in some cases, a discussion of alternative estimates and the thinking that leads the author to believe that the reported estimates are the best possible, preliminary estimates at the present time. Each reader or user of this analysis will have to judge the quality and usefulness of individual estimates from an assessment of the appendix. If the usefulness of the *pattern* of analysis is accepted, it will take concerted effort by perhaps several research groups in and out of government to analyze and finalize estimates like many of those presented here.

The following analysis examines the SSA reported increase in U.S. health care spending between Fiscal Years 1965 and 1975, some $79.6 billion, and attempts to determine empirically the magnitude of the contribution to that increase of identified sources and causes. The forces at work on health care spending have been social, demographic, legal, governmental and economic as well as medical-scientific. Necessarily, an "unexplained" amount generated by "other factors" remains and guesses or orders of magnitude are examined to attempt to assess whether the causes or sources of this residual are consistent with the above hypothesis.

The preliminary data and analysis to follow lead to at least a temporary acceptance of the hypothesis. Such acceptance, indicative but not conclusive in its substance, must lead to a strong conclusion that a great deal more study in directions somewhat different than past directions is needed before public policy conclusions are drawn concerning the need for controls of, or government intervention in, health care. The implications for any NHI proposal are

also very important. Government controls in any system as complex as health care have far reaching effects difficult to foresee. It is essential that we develop a clearer understanding of the existing forces that influence health care costs before deciding on any direction for public policy.

THE BASIC SOURCES OF INCREASED HEALTH CARE SPENDING[1]

Inasmuch as Medicare-Medicaid represented a substantial change in our nations' system of financing health care, a study of today's patterns should begin before these programs were put in place. We have, therefore, selected the period 1965–1975 for our analysis. We have also used data for the fiscal years (FY) since government information, which is essential to our study, is reported in this way.

The following table provides the data required to calculate the spending increase due to population growth, price inflation, and the combination of greater utilization and quality improvements in health care.

TABLE 1

	Fiscal year 1965	Fiscal year 1975	Increase	Percent increase	Growth factor
U.S. total health expenditures	$38,900,000,000	$118,500,000,000	$79,600,000,000	204.7	3.047
Population	196,700,000	216,000,000	20,000,000	10.1	1.101
CPI medical care price index (1967=100)	88.3	160.2		81.5	1.815
Per capita consumption (in fiscal year 1965 dollars)	$197.70	$301.40	$103.70	52.5	1.525

Total spending in 1975 can be viewed as the product of 1965 per capita spending (in 1965 dollars), the 1975 population, the increase in prices, and the increase in utilization. Symbolically:

$$\$118.5 \text{ billion} = \$197.70 \times 216.6 \text{ million people} \times 1.815 \times 1.525$$

Extending the notion, the *increase* in spending between two periods must then be the product of the *increases* in per capita consumption, price, and population. This permits calculation of the amount of increase due to each factor. There is a selection of methods for such calculations. Using the methodology[2] which is most used by the SSA and other government analysts we find the following:

TABLE 2

	Contribution to increase (fiscal year 1965 to fiscal year 1975	
	Percent	Dollars (billions)
Population growth	8.6	$6.8
Inflation	53.5	42.6
Utilization increase and quality improvement	37.9	30.2
U.S. total health expenditures increase	100.0	79.6

Noting that nearly 9% of the total increase came simply from a larger population, we will examine both the inflationary and utilization aspects of expenditure growth in some detail.

INFLATION OF MEDICAL CARE GOODS AND SERVICES PRICES

All consumer prices rose from 1965 to 1975. In such an inflationary period, one would expect medical care prices to rise. The CPI for consumer goods, less medical care goods, rose 60.4% from FY 1965 to FY 1975. The CPI for

[1] See appendix, technical note 1.
[2] See appendix, technical note 1.

all services, less medical care services, rose 71.7% during the decade. Within the CPI for medical care, goods are weighted at about 17% while services are weighted at about 83%. Since medical care is a relatively small sector of the economy and since our price measurements are all "input" prices for this sector,[3] there is no reason to expect that prices in this sector should have risen less than those in the rest of the economy. The expected increase can thus be calculated by using the above parts of the CPI with medical care prices removed and then using the medical care mix of goods and services. This "general inflation" index for medical care prices was 169.8 for FY 1975 (FY 1965=100). Since medical care prices actually rose 81.5% during the period, the CPI index for medical care was 6.9% higher than should have been expected from general inflationary forces alone. Symbolically:

Medical Care CPI=General Inflation Index[4]×Medical Care Specific Inflation
181.5=169.8×1.069

Using this approach, the contribution of inflation to the increase in medical care spending from 1965–1975 can be broken down as follows:[5]

TABLE 8

	Billions
General inflation	$37.8
Additional specific medical care price inflation	4.8
Total (see table 2)	42.6

In other words, had the government's fiscal and monetary policies prevented all general inflation, special forces acting on medical care prices would have caused expenditures for health care goods and services to increase by $4.8 billion during the decade. This is approximately 4% of the $118.5 billion spent in FY 1975 and 6% of the increase in spending under investigation here.[6]

Among the special forces acting on medical care prices during the decade was the rapid increase in malpractice legal actions and the accompanying increase in both usage of, and premiums for, malpractice insurance. Such premiums increased from about $180 million in 1965 to well over $1 billion in 1975. Remembering that these costs were, of necessity, "passed through" to consumers via medical care prices, we have accounted for $1 billion of the "specific medical care price inflation."

The total professional incomes of virtually all interns and residents appear in the U.S. system as hospital costs.[6] Since all such expenditures are passed through to hospital prices, any increases contribute to the specific medical care inflation. The number of such physicians in training rose from about 42,700 in 1965 to approximately 63,700 in 1975, an increase of about 16,700 beyond that expected from population growth alone. This increase was stimulated, at least partly, by explicit federal initiatives. The average annual pay of such professionals also increased much faster than inflation, growing from $3870 to $7360 in FY 1965 dollars. The total resultant contribution to medical care inflation would appear to have been about $300 million.

Every physician and hospital has had increased paperwork because of Medicare and Medicaid and the changing requirements of private insurance carriers.[7]

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[3] The possible importance of this point in assessing the "inflation" of health care prices is great. See pp. 15–16 below.

[4] See appendix, technical note 1.

[5] Medicare-Medicaid programs contributed to deficit spending throughout most of the decade under study including fiscal year 1975. This is especially true of the "unexpected" costs of the program's early history. Hence these programs, and thus the medical care sector, bear some of the burden for the general inflation as calculated here. Furthermore, since this contribution via deficit spending inflated *all* prices, the consequences to general inflation were significant. In fact, in some years of the period the expenditures on these programs were greater than the total federal deficit. The same would be true, however of any significant government program. Even with hindsight the allocation of general inflation as defined here to any particular private sector would, at a minimum, be difficult. The fact remains that if these programs had not been instituted and had government expenditures thus been reduced there would have been significantly less general inflation. "Charging" this cost to this sector for purposes of this analysis would add nothing to our understanding of the specific causes of health care spending growth as those causes relate to public policy toward the provision of medical care goods and services.

[6] See appendix, technical note 2.

[7] See appendix, technical note 2.

[8] With medical goods and services weights.

Providers have added people to handle such administrative burdens and the costs have been passed through as price increases. If the average hospital added two bookkeepers and the average physician added .455 such persons since 1965, and if such positions paid $8,000 in 1975, the total contribution to specific medical inflation was about $1 billion.

The possible sources of specific medical care inflation can now be summarized as follows:

TABLE 4

	Billions
Malpractice premiums	$1
More and higher paid doctors in training	.3
Increased administrative costs	1
Unexplained	2.5
Total (see table 3)	4.8

Much has been written about the "rapid" rise in medical care prices. These increases have been labelled as "out of control," or alternatively, have been attributed to increased demand resulting from third-party payment systems (such as Medicare-Medicaid or employer sponsored group programs). Whatever the source of such unexplained specific inflation, it has accounted for some $2.5 billion (or 3.1%) of the spending increase during the decade. Undoubtedly, some part of this $2.5 billion resulted from increases in real demand generated by Medicare and Medicaid in the face of relatively inelastic short-term supply. However, no numerical estimate of this impact is known to the author.

INCOME GROWTH [8]

We will turn now to a discussion of increased spending generated by greater "utilization" of medical care goods and services rather than more population or price inflation. The first of these is the growth in household incomes available for spending on all sorts of goods and services.

Economists say a consumer good or service is "relatively income elastic" if it stimulates a spending increase greater, in percentage terms, than any increase in consumer income itself. Medical care spending has been identified by some economic theorists as "relatively income elastic" in this sense. Since disposable per capita income increased 21.4% from FY 1965 to FY 1975, we would expect that some portion of the $30.2 billion increase in health care utilization came from the simple fact that people had higher incomes. If health expenditures are "relatively income elastic," the expected increase would be no less than $8.3 billion which is 21.4% of FY 1965 health spending. It is difficult, or perhaps impossible, to make a really accurate measure of the increase caused by larger incomes.

The technical note describes a series of historical studies on the relation between changes in real per capita income and medical care spending. The periods studied go back as far as 1935 but generally exclude data from the 1965–1975 decade. In no period was the percentage change in spending less than the growth in income. Indeed the data indicate that the increase could have been as high as 14% for each 10% of income growth. The use of such studies for our purposes, however, is fraught with difficulties. Simultaneous changes in technology, prices, and other factors cloud the picture. Yet in the period that, intuitively, seems the best for such estimates (because of its stability, lack of government intervention, and low level of third-party payments), the income elasticity value is $1.29. This indicates a 12.9% increase in medical care spending for each 10% growth in income.

Estimates of demand response to changes in income, isolated from all other changes, are probably best done through consumption studies of different families with varying incomes during the same time period. Such "crosssectional" studies have yielded estimates of a 5% to 7% increase in health spending from a 10% change in income—indicating less "elasticity" than reported above. For our purposes, however, such estimates of income elasticity must be combined with a measure of the effect of any price changes that occurred during the same period. FY 1965 to FY 1975, the increase in third-party payment systems brought significant reduction in out-of-pocket medical prices for the average consumer.

[8] See appendix, technical note 3.

Thus, in spite of greater than average inflation for health care, the consumer ended up paying relatively less for specific goods and services.

Empirical studies show a significant positive response of health care spending to such a reduction of relative prices. This price related increase, of course, is in addition to that generated by income growth. When we combine these income and price elasticity effects, we get a $6–$12 billion estimated of increased health care utilization. The range here is consistent with that derived from the "historical" studies of income growth alone.

As a preliminary estimate, therefore, we have attributed $8.3 billion of increased utilization to the combination of price reduction and income growth. This represents a rate of increase just equal to that of consumer income itself.

SLOWLY INCREASING AVERAGE AGE OF THE U.S. POPULATION [9]

It is well known that advancing age increases the need for, and consumption of health care. In FY 1965 the proportion of the total population 65 years of age or over was 9.55% while in 1975 it was 10.2%. Using the 1965 data on real per capital spending, by age group, one finds that a 1965 population with the 1975 proportion of older citizens would have spent about $230 million (in 1965 dollars and health care patterns) more for health care than was actually spent. Such increased spending is part of the 1975 pattern.

THE GROWTH IN EXPENDITURES FOR CUSTODIAL CARE [10]

Unlike the health spending statistics for some other countries, U.S. statistics include all expenditures within "nursing homes" as part of health care spending. Over the decade 1965–1975 the growth in expenditures for such care expanded markedly. While this growth includes the cost of some new technology applied to custodial care and a consequent increase in quality, most of the increase came from a general tendency to shift care of the sick and aged from family dwellings to nursing homes. Payment for such services also tended more and more to be made through third-party systems.

To avoid double counting when estimating the impact of this process, one needs to correct the increase in overall nursing home costs for both population factors (aging and growth) and inflation. Such a procedure reveals a spending increase over the decade of about $3 billion from this "monetization" of services previously supplied outside of formal health care channels.

THE PRACTICE OF "DEFENSIVE MEDICINE" [11]

A result of widespread malpractice suits is the practice of so-called "defensive medicine" to protect the physician in case of court actions. It is thought that more procedures, more hospitalization, and more goods and services are used because of this environment for medical practice. While the magnitude of these extra expenditures is not known with any precision, it has been reported by Dr. Roger O. Egeberg (Coordinator of the DHEW effort to study the problem) at from $2 to $10 billion in time periods close to 1975. A conservative estimate of $4.5 billion (the average of the two lower of three estimates reported by Dr. Egeberg) may not be an unreasonable figure for our preliminary analysis. The practice of defensive medicine really began after 1965, plus the entire cost is assumed to be part of the increased utilization of health care goods and services.

MEDICARE-MEDICAID

The institution of Medicare and Medicaid (as well as the growth in private forms of third-party payment) increased the utilization of health care goods and services in several ways beyond those already estimated:

(1) People received more diagnosis and treatment for more conditions than they otherwise would have since Medicare and Medicaid were designed to achieve such "new consumption." There were also some fairly significant management inefficiencies associated with the Medicaid programs in various states.

(2) The administrative costs of providers were increased over what they were in earlier periods (estimated above as a $1 billion contribution to specific medical care inflation).

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[9] See appendix, technical note 4.
[10] See appendix, technical note 5.
[11] See appendix, technical note 6.

(3) Since state and federal administrative costs for these programs are included in health care spending statistics for FY1975, these costs must also be reckoned as part of the increase in "utilization."

It should also be noted that Medicare and Medicaid have caused a shift in expenditures from the target population to federal, state, and local governments. In addition, these programs have "monetized" some 1965–1975 consumption that was achieved in earlier periods through "charity" or "bad debts." The extent to which consumption by the Medicare-Medicaid target populations was actually recorded in these earlier periods is not known. To whatever extent it was understated, of course, the increase in "utilization" of health care as reported here would be overstated.

Two parts of the Medicare-Medicaid contribution to increased "utilization" in FY1975 are capable of reasonably founded empirical estimation:

(1) SSA data show $1.1 billion as the federal and state costs for administering these programs.[12] Such administrative costs appear as increased utilization of health care regardless of their actual contribution to patient care.

(2) The management of Medicaid programs has also been somewhat inefficient. Use by ineligible persons and overcharging have been common occurrences. To estimate the impact of these forces on increased spending, we can use one state with a well managed program providing quality care as a model and then apply its cost experience to all Medical recipients in the national program.[13] On the basis of qualitative assessments in the public record, the Texas program would seem to represent a reasonable model since it has apparently achieved a balance between the interests of recipients, taxpayers, and providers. If all state programs were monitored and managed as well as the one in Texas, a saving of nearly $1.2 billion in the national Medicaid program might be achieved with no significant reduction in the quality of care provided.

SUMMARY OF IDENTIFIED AND QUANTIFIED CAUSES OF INCREASED HEALTH CARE SPENDING

U.S. medical care spending increased $79.6 billion from FY1965 to FY1975. This very preliminary analysis has identified many causes of the increase and has quantified the contribution from a number of them. The following table groups the various factors into three major categories (price inflation, population change, and increased utilization of health care goods and services) and lists the dollar contribution of each.

TABLE 5.—SOURCES OF INCREASED U.S. HEALTH CARE SPENDING

[Fiscal years 1965-75]

	Billions
Price inflation for medical care goods and services:	
General inflation [1]	$37.8
Malpractice insurance premiums	1.0
Hospital costs for interns and residents	.3
Hospital and physician administrative costs	1.0
Other medical care price increases [2]	2.5
Subtotal	42.6
Population characteristics:	
Population growth	6.8
Population aging	.2
Subtotal	7.0
Per capita utilization of health care:	
Not principally medical or health system related:	
Because of income growth	8.3
Custodial care monetization	3.0
Defensive medicine	4.5
Subtotal	15.8

[12] See appendix, technical note 7.
[13] See appendix, technical note 8.

TABLE 5.—SOURCES OF INCREASED U.S. HEALTH CARE SPENDING—Continued

[Fiscal years 1965–75]

	Billions
Medical or health system related:	
Government program related:	
Medicaid inefficiencies	$1.2
Government administration	1.1
New consumption	?
Private sector related:	
New technology	?
Private 3d party pay	?
Subtotal	30.0
Grand total	79.6

[1] Excluding medical care goods and services. Based on CPI data for goods and services weighted as goods and services are weighted in the CPI for medical care.
[2] Possibly due to the demand growth induced by Medicare and Medicaid in the face of relatively short-term inelastic supply.

Recognizing all the difficulties with the data, it may be that the following breakdown of the 1965–1975 expenditure increase is more useful for public policy purposes:

TABLE 6.—CAUSES OF INCREASED U.S. HEALTH CARE SPENDING (FISCAL YEARS 1965-75)

	External to health care system	Within health care or unidentified
Inflation	$39.8	(1)
Population changes	7.0	[2] $2.8
Income growth	8.3	[2] 11.9
Institutional changes	7.5	
Government program costs [4]	2.3	
Total	64.9	14.7
Total increases	79.6	

[1] Specific medical care goods and services.
[2] Price inflation—Assumes that the costs associated with higher paid and greater numbers of interns and residents were generated within the health care systems.
[3] Other factors—Classified as Within health care because the source or cause is not quantified by analysis above.
[4] Administrative costs and induced inefficiency.

UNQUANTIFIED, BUT IDENTIFIED CAUSES OF INCREASED SPENDING FOR HEALTH CARE

The $11.9 billion of increased "utilization and improved quality" left unaccounted for by the preceding analysis represents about 15% of the total increase in medical care spending from FY 1965 to FY 1975 and about 10% of total FY 1975 expenditures. This figure could increase or decrease, of course, through estimating errors in the quantified portions of the analysis. The residual covers the impact of at least the following programs, data characteristics, and socio-economic forces:

(1) New government programs for such diverse things as hospital construction and kidney dialysis have added, in one way or another, to total expenditures for health care goods and services. This spending appears as "increased utilization" in the statistics reported here.

(2) The analysis of medical care spending is complicated by the fact that we can only measure input—not output—prices. Associated with, and similar to, the problems of quality change inherent throughout measures of changes in prices like the CPI, the problem is especially great with assessing medical care expenditures. It is virtually impossible to define and study "output" when dealing with such things as greater relief from pain, a quicker recovery, or a longer life. Thus many improvements in quality and productivity must be left out of our calculations. The assumption in this analysis is that productivity has not changed either upward or downward. *If* the overall "productivity of medical care" actu-

ally increased in the decade under study, then the increase in utilization of goods and services is understated and the inflationary effect is overstated. If productivity declined, the reverse is true.

(3) The purpose of Medicare-Medicaid was to provide more effective health care for their target populations. This brought an increase in consumption that represents a significant part of the $11.9 billion of unallocated spending. Actually, the more successful these programs are, the more they contribute to increased spending for health care. (See below.)

(4) "Technology change" also played a role in the spending increase. Some new devices, procedures, or goods (such as drugs) represented more efficient replacements for older items or systems and thus tended to increase health care productivity. Other developments, however, added directly to expenditures because the diagnosis or treatment was previously not available (brain scans or cobalt treatment are examples). Much research and development is also performed in institutions the provide care or goods used in care. Most expenses of this kind are "passed through" to health care prices.

The increase in spending for new, or more medically effective technology (in the sense of patient safety, comfort, or recovery) has been very substantial over the decade 1965–1975. Such technology may or may not appear to be "financially efficient" if we employ the usual methods of analysis. However, the use of these techniques does represent a direct expression of consumer sovereignty. *All* such expenditures for new technology, whether cost-effective or not, appear as "increased utilization" and represent the most important quality-expenditure for medical care. No estimate of this spending is available, although empirical studies of income elasticity provide some insight into an order of magnitude. (See below.)

(5) Third-party payment systems weakened the financial constraints on both patients and providers and thus added to the "utilization" of medical care. The total demand induced by these forces is not known with any precision. From 1965 to 1975, however, third-party payments grew from 47.5% to 67.4%[14] of total health care expenditures. Weakened financial constraints also had an impact on other factors in our analysis such as the use of custodial care and the tendency to practice defensive medicine. Nonetheless, there is always a time-trouble cost to patients in seeking medical care. In addition, the provider professions—particularly physicians—are bound, to some extent, by professional ethics and peer pressure. Consequently, it is possible that the role of weakened financial constraints in increased spending has been overstated in recent years.

To get a "feel" for how important these five factors might be to the $11.9 billion residual, we can at least make some rough estimates. If, for example, the consumption increases sought by Medicare and Medicaid where 20% and 50%, respectively, this would account for $4.8 billion[15] of the $11.9 billion total. Our best historical estimate of income elasticity for health care is 1.29. If we attribute the .29 portion of the increased demand to the pull of new technology, then $2.4 billion[16] is a reasonable estimate of the increased expenditures from this source. As you will note, our estimates for Medicare-Medicaid new consumption and new technology have accounted for the $7.2 billion of the $11.9 billion residual. This result is based partly on intuition and partly on sheer guess. However, it should at least emphasize that such forces as weakened financial constraints may be of less significance to part increases in spending than presumed by some analysts.[17] It might even be argued that the current combination of

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[14] Technical note 3 reports published economical studies that yield data leading to estimates of increased spending of from $2.9 billion to $7.4 billion from such consumer-apparent price reductions.

[15] Medicare: $14.8 billion x 20%=$3 billion; Medicaid: $13 billion x 50%=$6.5 billion. The total of $9.5 billion must be corrected to $4.8 billion to avoid double counting of price inflation and population growth factors.

[16] Income elasticity. 1.29—1=.29. Growth in real per capita income from fiscal year 1965–fiscal year 1975: 21.4% (.214 x $38.9 billion fiscal year 1965 expenditures=$8.3 billion contribution to expenditure growth from "income" growth.) .214 x .29 x $38.9 billion=$2.4 billion possible contribution from greater-than-average technology growth of health care goods and services.

[17] *If* $4.7 billion (6% of the $79.6 billion increase over the decade) were to be considered as caused by the positive response in demand to the apparent reduction in and out-of-pocket consumer price caused by increased third-party payment over the decade, a "price elasticity" of about —.3 would be implied. (See technical note 3.) Such a response to price declines is clearly in the range estimated by cross-sectional analysis—but further refinement of all of these estimates would be required before any reliance can be placed on this estimate. This value of $4.7 billion also includes the net of all estimating errors and omissions in this study.

market forces plus financial and non-financial constraints still provides a reasonable balance between cost-effective medicine and the needs and desires of consumers. Nonetheless, as an economist, I would urge a rigorous analysis of any program—public or private—that makes "prices" or "costs" appear to be zero to any provider or patient.

CONCLUSION

If the data presented here are anywhere in the ballpark, then U.S. health care costs don't seem to be "out of control" in any special sense that calls for new public policy initiatives. This is not to say, however, that there is no room for improvement. Several obvious areas needing immediate attention are the malpractice situation, the administration of Medicare and Medicaid, public education in the use of health care, and the use and administration of private insurance. Yet, if the goal is to control costs, this study does seem to belie the wisdom of bringing either the provision or financing of health care under greater government control. Indeed, the data could easily be interpreted as showing a need for less rather than more government intervention.

It seems likely that Fiscal 1976 will show an increase over the previous year in the contribution to increased spending of specific medical care inflation. However, we must remember that, from April, 1974 through April, 1976, CPI services prices, less medical care services, increased more than 19%. This alone could account for approximately 80% of the medical care inflation during the two years following our last adventure with price control. My own estimates for FY 1976 indicate that *specific medical care inflation* will represent 6% of the spending increase since 1965, the same pattern as reported through FY 1975. In addition, I find no indications that malpractice insurance, hospital expenses for physician training, or induced administrative costs will have any less inflationary impact than during the FY 1965–FY 1975 period.

I believe that the preliminary conclusions of our study call for additional investigations in at least the following areas:

(1) An in-depth critique and extension of the estimates and analysis presented here.

(2) An empirical study, possibly econometric, of the income elasticity of medical care spending (i.e. the relation between income and spending with all relevant price effects and income subsidizations accounted for). Most importantly, this investigation should be expanded to evaluate whether such elasticity is consistent with operable consumer sovereignty.

(3) An analysis of the data bases used to calculate health care spending in other countries. This should be accompanied by an in-depth study of the economic, demographic, medical, legal, and governmental forces that have caused such outlays. It is as important to understand these spending levels and social forces as it is to understand similar events in our own country. International comparisions, after all, have been an important part of the rhetoric for increased government intervention.

(4) A sector-by-sector study of U.S. health care spending to identify and quantify the causes of expenditure growth.

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The Memphis Chronic Disease Program

Comparisons in Outcome and the Nurse's Extended Role

(John W. Runyan, Jr., M.D.)

In previous communications, the service program in Memphis and Shelby County (Tennessee) for the continuing care of patients with selected chronic diseases has been described. [1–5]

Since the report in 1970, [2] more than 140,000 patient-visits to the decentralized facilities have been made, and patients under regular care now exceed 9,000. The number of urban and rural neighborhood and satellite clinics, which are operated by the Health Department, has been increased to 20, with several more planned.

Although the main efforts have been service oriented and directed toward meeting the medical needs of a large chronically diseased population, some measurements of the effectiveness and acceptability of continuing care to patients in the program and its effects on the course of the chronic illness have been

presented recently. [5] This report extends these observations but is primarily concerned with making certain comparisons between patients receiving care in decentralized facilities staffed by specially trained nurses and those rendered care in a more conventional manner in the outpatient clinics of the City of Memphis Hospital.

PATIENTS AND CLINIC SETTINGS

These observations were made on two groups of patients with combinations of three conditions: diabetes mellitus, hypertension, or cardiac disease. The group who received their maintenance medical care principally in the decentralized facilities is called the "study group" and those who received their care in the hospital outpatient clinics are referred to as the "control group." Included in the first group were the 1,006 patients transferred from the hospital clinics to the decentralized facilities located closest to their home over a period of a year beginning Sept. 1, 1969; the 498 patients who comprised the second group included all patients who met the following criteria: they had adequate records, sufficient duration of observations, the observations had been made in the same period in a hospital outpatient clinic for chronic disease, and the clinic was staffed by internists. Patients in the hospital outpatient clinic (the medical facility most convenient to their home) had been referred for continuing care after their conditions had been stabilized in various other clinics in the hospital. Some had been participants in phase three drug-evaluation studies (antihypertensive and antidiabetic drugs) in the past. None of the patients was a participant at the time of these evaluations. The first clinic visit in the year beginning Sept. 1, 1969, was considered the reference date or point of "transfer" of the patients. Observations extend for two years before and after transfer. As the need arose, both study and control patients were referred to the various hospital specialty clinics or to the General Medicine Clinic if a detailed reevaluation was indicated.

TABLE 1.—POPULATION CHARACTERISTICS

	Number of patients	
	Study group [1] (n=1,006)	Control group [2] (n=498)
Men	231	124
Women	775	374
Diabetes [3]	797	410
Hypertension [3]	515	409
Cardiac disease [3]	555	226

[1] Maintenance care principally in decentralized facilities; mean age of patients, 59 yr (range, 12 to 93).
[2] Maintenance care principally in the hospital clinic; mean age of patients, 64 yr (range, 15 to 94).
[3] The sum of these numbers exceeds the total patients because of multiple diseases in the same patient.

TABLE 2.—DIABETES-CARDIAC DISEASE-HYPERTENSION CATEGORY—DIASTOLIC BLOOD PRESSURE IN THE STUDY AND CONTROL GROUPS (mm Hg)

	Study group					Control group				
Age group, year [1]	Mean before transfer	SE	Mean [2] change	SE	P [2] value	Mean before transfer	SE	Mean change	SE	P value
30 to 39	92.0	3.4	18.7	4.7	NS					
Number	3					1				
40 to 49	103.0	3.8	−13.6	4.2	<0.01	95.0	3.9	−2.3	3.5	NS
Number	17					8				
50 to 59	95.8	2.1	−7.1	2.7	<.02	95.9	2.8	.5	2.7	NS
Number	45					35				
60 to 69	92.4	1.7	−7.3	2.1	<.01	88.5	1.8	.3	2.6	NS
Number	52					38				
70 to 79	84.1	2.7	−6.2	2.9	<.05	86.1	2.4	.8	2.4	NS
Number	27					44				
Over 80	90.0	6.7	−18.7	8.2	NS	80.4	4.1	−.8	3.8	NS
Number	6					15				
Mean age, year	61.2	.9				66.4	.9			
Number	162					143				

[1] No patients in age group 10 to 29 yr had blood pressure data analyzed.
[2] Probability of a mean change this different from zero; NS indicates not significant at the 0.05 level.
[3] Mean change derived from after-transfer minus before-transfer blood pressure, mm Hg.

The two populations were of similar socioeconomic backgrounds, with comparable men-to-women ratios (Table 1). Hypertension was more prevalent in the control group while cardiac disease was more prevalent in the study group. The mean age of the study group was 59 years and of the control group, 64 years. Because of the frequent occurrence of multiple diseases in the same patients and incomplete data on some patients, the totals in the analysis of blood pressure and blood glucose vary from the figures given in Table 1.

STATISTICAL METHODS

Preliminary testing indicated minimal base-line variable differences between the study and control groups and also few differences by sex. Consequently, all comparisons were made with men and women combined. However, there were significant differences in age in some of the patient subgroups and to allow for these, age-adjusted comparisons were made. Our major interest was in the analysis of variable changes, ie, after-transfer values minus before-transfer values in the study and control groups. The significance of these variable changes within the two groups by decades of age was tested with the paired t test. Age-adjusted comparisons of variable changes in the study and control groups were made by the analysis of covariance with patient age as the control variable.

TABLE 3.—ANALYSIS OF AGE-ADJUSTED CHANGES IN DIASTOLIC BLOOD PRESSURE AND BLOOD GLUCOSE, ALL PATIENTS

Disease categories	Number of patients		Blood pressure		Blood glucose	
	Study	Control	F value [1]	P	F value	P
Diabetes only	94	20			13.11	<0.001
Hypertension only	139	36	31.14	<0.001		
Diabetes-cardiac disease	14	26			.05	[2] NS
Diabetes-hypertension	132	17			4.37	<.05
	158	26	6.87	<.025		
Cardiac disease-hypertension	216	194	21.27	<.001		
Diabetes-cardiac disease-hypertension	123	114			.17	NS
	150	141	15.87	<.001		

[1] With significant F values, the study group reductions in blood glucose and blood pressure were always greater than those in the control group.
[2] NS indicates not significant at the 0.05 level.

TABLE 4.—HOSPITAL DAYS PER 1,000 PATIENTS PER YEAR

	Study			Control		
	Before	After	Percent change [1]	Before	After	Percent change
Diabetes	3,319	1,680	−49.4	1,261	2,107	+67.1
Hypertension	2,509	1,196	−52.3	1,966	2,671	+35.9
Cardiac disease	3,074	1,560	−49.3	2,129	3,084	+44.9
Total	3,439	1,603	−53.4	2,499	3,573	+43.0

[1] Percent change = (after value − before value)/(before value) × 100.

TABLE 5.—TOTAL HOSPITAL DAYS—ANALYSIS BY AGE DECADES, STUDY VERSUS CONTROL

Age decade	Study			Control		
	Before	After	Percent change	Before	After	Percent change
10 to 29	204	77	−62.3	60	155	+158.3
30 to 39	486	210	−56.8	80	169	+111.3
40 to 49	864	256	−70.4	271	167	−38.4
50 to 59	1,370	725	−47.1	504	471	−6.5
60 to 69	1,383	680	−50.8	602	707	+17.4
70 to 79	797	365	−54.2	597	1,199	+100.8
Over 80	321	138	−57.0	236	274	+16.1

RESULTS

Clinic visits and professional contacts

As previously reported, [5] professional contacts increased in frequency in the study group after transfer from the medical center to decentralized facilities with home visits. In contrast, clinic visits were found to decrease after the transfer date in the control group, with 6,488 visits/1,000 patients/yr before transfer and 5,503 visits after transfer. Accurate information on emergency room use is not available for the control group, but in the study group this use decreased. [5]

Blood glucose and diastolic blood pressure levels

We analyzed the data relating to diastolic blood pressure and blood glucose for patients in the following disease groups: hypertension only, diabetes only, diabetes-cardiac disease, diabetes-hypertension, hypertension-cardiac disease, and diabetes-cardiac disease-hypertension.

The method of analysis of the data relating to diastolic blood pressure and blood glucose is illustrated by Table 2, which gives the data on diastolic blood pressure for the diabetes-cardiac disease-hypertension category of patients. The mean blood pressures prior to transfer and the mean changes in blood pressure following transfer are shown by age decades. The mean change in blood pressure is calculated from the patients' distribution of after-transfer values minus before-transfer values. Hence, a negative (—) value for mean change shows that the patients, on the average, had a lower blood pressure after transfer. The standard errors (SEs) of the means are also shown. The *P* values indicate whether the mean changes within a particular age decade differ significantly from zero.

Table 2 shows that the study group of patients in all age decades except the 30- to 39-year-old age group (only three patients) had lower blood pressures after transfer and that these reductions were significant in all ages except among those 30 to 39 and over 80 years of age. In the control group blood pressures were reduced among those 40 to 49 and over 80 years of age, but none of the changes differed significantly from zero. Overall, the control group was significantly older than the study group ($P<.05$).

The data for the variable changes in Table 2 and for the other five disease groups listed above are summarized in Table 3, which shows the age-adjusted comparisons between the study and control groups.

Table 3 shows that study patients with hypertensive disease always experienced significantly greater age-adjusted reductions in diastolic blood pressure as compared to the control subjects. Reductions in blood glucose levels were found in the study group in all disease categories that included diabetes when compared to control subjects, but the F values were only significant in two disease categories: diabetes and diabetes-hypertension.

Hospital inpatient utilization

The number of hospital days/1,000 patients/yr for patients in each disease category in the study group for the two-year period before transfer was greater than in the control group (Table 4). In the two-year period after transfer, the study group, who were provided maintenance care in decentralized facilities, utilized approximately 50% fewer hospital days, while the control group showed an increase in hospital days for each disease category. The data relating to total hospital days in the study and control groups by age decades are shown in Table 5 and the age-adjusted changes are shown in Table 6. The analysis of the changes in hospital utilization (Table 6) after transfer in the study group showed that utilization was reduced in all age decades, whereas the control group only experienced reductions in the 40- to 59-year-old age groups.

TABLE 7.—HOSPITAL DAYS PER 1,000 PATIENTS PER YEAR

	Study			Control		
	Before	After	Percent change	Before	After	Percent change
Diabetes:						
All causes	3,319	1,680	−49.4	2,728	4,838	+77.3
Diabetic acidosis-infections	900	350	−61.1	587	688	+17.2
Peripheral vascular disease and amputation	626	201	−67.9	436	379	−13.1
Renal, cardiovascular	388	505	+30.2	355	1,523	+329.0
Hypertension:						
All causes	2,509	1,196	−52.3	2,395	3,238	+35.2
Stroke	281	102	−63.7	72	201	+179.2
Myocardial infarction	54	56	+3.7	80	239	+198.8
Renal	56	139	+148.2	0	93	.....
Organic heart disease and congestive heart failure	136	131	−3.7	411	699	+70.1
Cardiac disease:						
All causes	3,074	1,560	−49.3	2,594	3,739	+44.1
Myocardial infarction	89	87	−2.2	80	269	+236.3
Renal	87	216	+148.3	0	60	.....
Organic heart disease and congestive heart failure	366	212	−39.6	465	857	+83.3

For an overall comparison of the two groups, we tested the age-adjusted changes in hospital utilization by the analysis of covariance with the age of each patient as a control value (Table 5). The changes consisted of the number of hospital days after transfer minus before transfer hospital days in the study and control groups. This calculation showed that in all three main disease categories, the study patients had significantly reduced hospitalization compared to the controls.

Primary causes for hospital utilization

The three major disease categories—hypertension, diabetes, and cardiac disease—were examined without regard to associated diseases (Table 7). We analyzed the data in these broad categories because of the relatively small numbers of patients hospitalized when broken down into the previously analyzed categories plus cardiac disease only. For the study group, some of these data in a different form have been presented but without the control group data.[5] In the study group wtih *diabetes*, hospital days devoted to the categories of (1) diabetic acidosis and severe infections, and (2) peripheral vascular disease and amputations declined (61% and 68%, respectively) after transfer, while in the control group the number of hospital days for the first category increased 17% and for the second category, decreased 13%. Number of hospital days resulting from vascular and renal diseases increased in both study and control groups but increased to a greater extent in the control group.

TABLE 6.—TOTAL HOSPITAL DAYS—ANALYSIS OF AGE-ADJUSTED CHANGES, STUDY VERSUS CONTROL

Disease group	Number of patients		F [1] value	P
	Study	Control		
Diabetes	223	103	24.73	<0.001
Hypertension	271	170	17.09	< .001
Cardiac disease	205	181	18.44	< .001

[1] The F values reflect a greater decrease in hospital utilization in the study patients following transfer.

In the study group with *hypertension*, hospital days for stroke, organic heart disease, and congestive heart failure decreased after transfer, while an increase occurred in the control group. Both study and control groups showed an increase in hospital utilization after transfer for patients with renal insufficiency and myocardial infarction. In those with *cardiac disease*, hospital utilization in the study group for organic heart disease and congestive heart failure decreased after transfer, while a significant increase in hospital utilization occurred in the control group. Also, hospital days for myocardial infarction increased in the control group.

Mortality

Although a two-year period of observation has limited value in terms of mortality data, 7% of the study population and 11% of the control population died in this period. As would be expected, those 70 years of age and older had the higher death rates in both study and control populations. However, there were no statistically significant differences in death rates in the two populations when examined by age decades.

COMMENT

A number of factors may have contributed to some of the differences in the measurements, observations, and patient-care experiences in the two populations with combinations of the three conditions: diabetes, hypertension, and cardiac disease. Were the study and control populations dissimilar enough to account for these differences? The mean age in the control group was significantly higher than that in the study group. However, comparisons were made by age decade and analysis of covariance that removed age differences as a factor in the observed outcome. On the other hand, in examining some of the clinical features of the diabetic population in the preceding two years, it was seen that incidence of a history of diabetic acidosis and amputations was higher in the study group than in the control group; also, the study group had higher blood glucose levels before transfer and more days spent in the hospital. In both the *hypertensive and cardiac disease* populations, hospital utilization was greater for the two-year period before transfer in the study group than in the control group. Hospital utilization for renal disease with its recognized relationship to both diabetes and hypertension was more prevalent in the study population before transfer. Although the problems of relating two populations with multiple risk factors are recognized, the data do not suggest that the study population were at less risk than the control population, and there is evidence that the opposite may have been the case.

Those in the study group received maintenance care in decentralized facilities by nurses, and therefore, several factors were introduced that are considered to have favored the outcomes observed. Professional care and advice are easier for the patients to obtain when the barrier to care of a rigid appointment system, characteristic of the hospital clinic, is removed. Patients are given the opportunity to call, if in need of medical assistance, and appropriate advice is given or home visits are made, if found advisable. During 1973, more than 8,000 home visits to these chronically diseased patients were made. The same medical protocols and opportunities to obtain selected laboratory tests prevail whether the patient is seen in the decentralized clinic or home. Missed appointments are followed up. Drugs are actually dispensed directly to the patient when being seen by the nurse, which gives the opportunity for patient education and counseling, and it is believed that patient compliance is greatly enhanced as a result. Goals of therapy for hypertension and diabetes and the means to achieve them are stipulated in the protocols used by the nurses. Physicians' attitudes toward hypertensive therapy have been commented on, [6] even though the benefits of therapy have generally been recognized since reports of the Veterans Administration study on hypertension conducted by Freis. [7, 8] In in-service training sessions and the protocols, the early recognition of cardiac failure and digitalis intoxication with appropriate follow-up action is emphasized to the nurses, and this factor may contribute to the favorable experience with patients with cardiac disease in the study group.

Prevention of diabetes and essential hypertension is not a reality at present. Control of these diseases, which is possible but not always attained in a public hospital setting leads to a reduction in those complications that are associated with increased mortality, morbidity, and hospital utilization. [7–9] The Memphis Chronic Disease Continuing Care Program makes available to patients in a systematic manner the basics of good medical practices: accessibility to care, patient education and counseling, follow-up, home visits, selected effective medications, laboratory test monitoring at intervals, realistic goals of therapy, and appropriate referrals and contacts with the back-up physicians and the medical center.

The observations in this report give further support to the concept introduced nearly 12 years ago that nurses can effectively share a large and increasing responsibility in chronic disease care. In the EDITORIAL in THE JOURNAL [3] relating to the Memphis Program, the question was asked "should the nurse, even after special training, have this much autonomy in the regulation of un-

controlled glycosuria, the delicate balancing of blood pressure between too high and too low with potent antihypertensive drugs and the adjustment of digitalis dosage?" With detailed protocols and physician and medical-center backup, the data presented here indicate that this question can be answered in the affirmative.

Note

These investigations were supported in part by a grant from the Robert Wood Johnson Foundation.

George S. Lovejoy, MD, Director of the Memphis and Shelby County Health Department and the staff of City of Memphis Hospital, helped in program development and collection of data. Marion G. Baker assembled the data. Harry Robinson, ScD, assisted with statistics.

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Prepared Statement of Chris Burns, C.P.A., Hospital Financial Consultant

Although I was unable to attend your July hearings relative to S. 3205, the "Medicare-Medicaid Administrative and Reimbursement Reform Act", I would like to present my viewpoints for consideration as called for in your press release dated July 7, 1976. In so doing, I will try to be as brief as possible, using the enclosed exhibits to elaborate my points. (2) below describes my most meaningful point.

(1) Generally, I believe your proposals to be superior to the present controls implemented by the Social Security Administration, and particularly the incentive provisions described under Section 10(aa)(4)(B)(ii) (Page 35, Lines 20, etc.). I hope that these cost incentives will not create, shall we say, profiteering on the part of hospitals at the expense of quality health care. This concern relates primarily to profit-oriented hospitals as contrasted to the majority of hospitals, those which are "not for profit".

(2) The most important point I have to make relates to Section 10(aa)(3)(E) (Page 32, Lines 8, etc.) This section indicates that the personal component of average per diem routine operating costs shall be adjusted by a general wage index in each hospital's area; it also provides (Line 22) that "if the Secretary finds that . . ., for the fiscal year ended June 30, 1976, the wage level for hospitals is significantly higher than the general wage level in such area, then the general wage level in such area shall be deemed to be equal to the wage level for hospitals in such area". It then goes on to say that this will be considered only for the first year that this is effective; I don't understand why it will apply only to the first year.

It is true that there are some areas of the country where hospital wage levels are higher than those prevailing generally, and I agree *totally* that this factor should be determined in setting the per diem routine operating cost amount for hospitals in such areas. However, unless the Secretary changes his perspective, from present perspective, I believe that budgetary constraints will, as a practical matter, influence the Secretary not to do this.

At present, DHEW policy is directly contrary to this idea. I quote from a letter dated July 26, 1976 which I received from Thomas Tierney, Director of the Bureau of Health Insurance within the Social Security Administration. He says, "Also, in some areas, hospital wages are out of proportion to either the

general economy or productivity of the workers. It would be poor public policy to give advantage to an area where such a situation exists". Exhibit "A" is a copy of his letter.

Unfortunately for us, the San Francisco-Oakland area is one of these where hospital wage levels are higher than those prevailing generally. However, this problem was made worse than it otherwise would have been by Federal intervention in mediating a nurses strike here in 1974. Essentially the hospitals were doing a good job of holding the line, but the final settlement mediated by Mr. W. J. Ussery was much higher than would have resulted absent Federal intervention. Details are included in Exhibit "B" my reply to Thomas Tierney dated August 4th. In essence, the problem here was intensified by the Department of Labor's goal to end the strike without regard to which party "won" or the cost thereof, and now DHEW refuses to pay these costs for Medicare and Medicaid patients, making up the majority of hospital patients.

Thank you for considering my viewpoints. I would appreciate receiving a full copy of the Subcommittee's report.

EXHIBIT "A"

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL SECURITY ADMINISTRATION,
Baltimore, Md., July 26, 1976.

Refer to: IHI-631.

MR. CHRIS BURNS, C.P.A.,
Hospital Financial Consultant,
Emeryville, Calif.

DEAR MR. BURNS: This is in further response to your letters to the Commissioner and also in reply to me. You wrote asking if we compared pay levels of registered nurses in various communities.

When Social Security Administration promulgated the limits on general routine costs of hospitals, it was decided not to use hospital wages as a classification factor. The goal was to compare hospitals in similar economic environments. Since the major part of a hospital's routine costs are directly related to wages, we believe per capita income is a good economic classifier of wages and costs in an area. In addition, it is also a measure of the amount which people in an area are willing to spend on medical care and related savings. This is consistent with congressional intent as stated in the reports accompaying section 223 of Public Law 92-603 that: "Health care institutions, like other entities in our economy should be encouraged to perform efficiently and when they fail to do so should expect to suffer the financial consequences."

To base a hospital classification system on hospital wages promotes the circular conclusion that a hospital should be paid more because it spent more. Also, in some areas, hospital wages are out of proportion to either the general economy or productivity of the workers. It would be poor public policy to give advantage to an area where such a situation exists.

In regard to your second question, the hospital data arrays which were used to establish the cost limits for cost reporting periods beginning on or after July 1, 1975, are available upon payment of $17. These arrays do not identify hospitals by name but only by provider number. The arrays which were used to establish the limits which become effective for cost report periods beginning on or after July 1, 1976, are available for $14.10. These arrays do identify hospitals by name and location. If you wish to receive either or both sets of arrays, you should send a check in the appropriate amount made payable to the Social Security Administration. The request should be directed to the Division of Provided Reimbursement and Accounting Policy, Bureau of Health Insurance, Attention: Provider Reimbursement Policy Branch, Room 405, East Highrise Building, 6401 Security Boulevard, Baltimore, Maryland 21235.

Your comment that the criteria used by the Office of Management and Budget (OMB) to establish Standard Metropolitan Statistical Areas (SMSA's) does not relate to hospital costs shows that you misinterpret the reason for the use of the SMSA. In our system, the SMSA is used only to separate metropolitan from nonmetropolitan areas and, thus to identify similar metropolitan economic environments. Use of the SMSA is not related to hospital input costs.

You also stated that San Francisco hospitals are being compared to Richmond, Virginia and West Palm Beach, Florida and that this is an invalid comparison.

Actually, as we previously advised you, the hospitals in San Francisco are compared basically to New York City and Chicago hospitals. Only a relatively few high per capita income hospitals from areas such as West Palm Beach are included in Group I which has the high cost hospitals and higher per capita income areas grouped together. As you may know, occupancy in San Francisco appears to run about 10 percent less than New York City, but the personnel per bed in San Francisco seems to be higher than for comparable sized hospitals in New York. (See the American Hospital Association's Guide to the Health Care Field, 1974 Edition.) It may be that these factors contribute significantly to the high cost of hospital care in California.

Concerning your comment on the bed size group, we agree that, when considering total services provided, a 350-bed hospital differs from a 120-bed hospital in almost every case. However, our limits only apply to routine services and not to ancillary services. The differentiation between routine services and total services is important. Our analysis of median routine service costs of the three groups which were combined to make the 100–404 bed-size category showed no significant difference between the groups. Therefore, we believe the combination of these bed-size groups is appropriate.

Regarding the relationship between hospital costs and charges, providers make individual cost center charge determinations based on decisions of what areas they believe should be subsidized, what the traffic will bear and how much can be made up on high charges for ancillary services.

In discussing the exceptions process, you stated, exceptions are only granted after the fact. This statement is incorrect. We do grant exceptions on a prospective basis, subject to revision when actual costs are known, since we may not pay more than actual cost. However, the most interesting point which you made was that many hospitals do not have the stated bases for exceptions. We believe that this is strong support for our view that the high costs of these providers are not due to the atypical needs of their patients, atypical educational activities, nor to any circumstances beyond the provider's control.

Sincerely yours,

THOMAS M. TIERNEY,
Director, Bureau of Health Insurance.

EXHIBIT "B"

CHRIS BURNS, C.P.A.,
HOSPITAL FINANCIAL CONSULTANT,
Emeryville, Calif., August 4, 1976.

Re: IHI–631.

Mr. THOMAS M. TIERNEY,
Director, Bureau of Health Insurance, Department of Health, Education, and Welfare, Social Security Administration, Baltimore, Md.

DEAR MR. TIERNEY: Thank you for your reply dated July 26th to our various correspondence relating to the determination of cost limits under Section 223 of P.L. 92–603. I appreciate your taking the time to give serious attention to my viewpoints. I found your reply to be most enlightening, but really, frightfully disturbing.

Your letter indicates that, in your words, "per capita income is a good economic classifier of wages and costs in an area", and therefore your department "decided *not to use hospital wages* as a classification factor" in setting limits on *hospital costs*. In essence, you said that, if hospitals in a given area have allowed their salary levels to exceed those prevailing generally in their own area, then those hospitals have been inefficient and should "expect to suffer the financial consequences". This theory is probably valid in many areas of the country, but not necessarily everywhere. The remainder of this letter will deal with the extremely high salary levels in the San Francisco-Oakland area, and the role the Federal Government played, quite directly, in making this situation much worse than it would otherwise have been, absent Federal intervention in salary negotiations between hospitals and nursing personnel here in the Summer of 1974.

In this connection, I will directly quote one sentence from your third paragraph. You say that, "in some areas, hospital wages are out of proportion to either the general economy or productivity of the workers". I couldn't agree *more* with this statement; certainly this is true of the San Francisco-Oakland area, and one of the major reasons therefore is Federal intervention into wage

negotiations here resulting in mediated salary levels much higher than would have resulted otherwise. I will elaborate in the following comments.

In June 1974 the California Nurses Association (CNA—a union) was engaged in salary and other negotiations with the hospitals. They basically refused to negotiate, instead setting a strike to begin coinciding with the annual meeting of the (national) American Nurses Association (ANA). This strike was to be an example and model to be later used in other areas of the country.

The hospitals believed the demands to be unreasonable and excessively inflationary and hence, they did not yield to the demands. Accordingly, the strike began, being the first strike of nursing personnel in over 30 years in this area; the hospitals were holding their ground.

After about three weeks, the strike became more severe than it was initially because the CNA announced that it would no longer cover intensive care patients and other critically ill patients. At this time, the national ANA apparently prevailed upon Federal officials (evidently including DHEW) to interject themselves into the situation.

Shortly thereafter, Mr. W. J. Ussery arrived in San Francisco. As you probably know, Mr. Ussery is now the U.S. Secretary of Labor, and at that time was the head of the U.S. Mediation and Conciliation Service. As far as the hospitals were concerned, this Federal intervention was not welcome; negotiations had been continuing between the parties involved with a State mediator accepted by both sides, and agreement was expected shortly.

To make a long story short, Mr. Ussery became the mediator, and the State mediator washed his hands of the matter. The mediated settlement was much more severe to hospitals than had been expected; according to some of those participating in the settlement, there was, shall we say, a certain amount of "arm twisting" injected by the Federal mediator which resulted in a much higher (and more inflationary) settlement than would have resulted absent Federal intervention. Literally, the settlement was forced "down the throats" of the hospitals. The Federal mediator was, in effect, dispatched to end the strike by settling the differences between the parties by whatever means, *without concern about the costs* thereof to either party to the dispute. His only concern was to end the strike.

This brings us to the critical point. Official Federal policy implemented by the Department of Labor encourages collective bargaining, and the Federal intervention into this local dispute was an extension of that policy—and they are more concerned about mediating a settlement than they are about the costs involved. On the other hand, DHEW is concerned with cost containment in the San Francisco-Oakland area. The hospitals have been caught in a cross-fire between (1) one agency that refuses to pay for adequate services and (2) another agency that has participated and been instrumental in creating hospital salary levels in the San Francisco-Oakland area proportionately higher than those existing in the area generally. *Isn't there any way we can get DHEW and the Department of Labor to act in a uniform way that will make some sense?*

In conclusion, I suggest you reappraise your initial position with respect to this particular area. To the extent that this or other areas are affected by such matters as described above, which are really beyond the control of hospitals therein, exceptions to the limits should be created for these areas based upon the known facts, much as you have created exceptions for Alaska and Hawaii based upon your Civil Service Commission cost-of-living differences. For fiscal 1976, it's still not too late; the $111.00 basic limit for San Francisco-Oakland hospitals in SMSA Group I (100 to 404 beds) should be increased, as soon as possible. We are now becoming aware of many hospitals here that are reducing personnel without regard to health care considerations, merely to meet the price that the major "customer" (Medicare-Medicaid) will pay. We have become increasingly aware that many hospitals are just now learning the disastrous consequences of the limits for fiscal 1976. Further, I have heard unofficially that there may have been errors in the input or computations establishing the $111 limit.

I hope that you can correct these inequities very soon before more harm is done.

Sincerely yours,

CHRIS BURNS.

CHRIS BURNS, C.P.A.,
HOSPITAL FINANCIAL CONSULTANT,
Emeryville, Calif., August 6, 1976.

Re IHI-631—Medicare cost limits unfair to northern California hospitals.

Mr. THOMAS M. TIERNEY,
Director, Bureau of Health Insurance, Department of Health, Education, and Welfare, Social Security Administration, Baltimore, Md.

DEAR MR. TIERNEY: In follow-up to my August 4th reply to your July 26th letter, I have two further comments to make.

Your letter mentions that occupancy in San Francisco (I don't know whether the Oakland area is included) "runs about 10 percent less than in New York City," but the personnel per bed in San Francisco "seems to be higher than for comparable sized hospitals in New York."

Without questioning, at this moment, why we are only being compared here to New York instead of the other 40 urban areas in our group, I believe your observation may be correct. However, there are some relevant reasons why this is so, and they imply that Northern California hospitals may be more efficient than those in New York.

Simply, the average length of stay, in terms of days per incident of illness, is about 30% less here than on the East Coast, thereby creating lower charges per stay to the Medicare (or any other) program. Industry studies have clearly indicated that the intensity of routine nursing care (in terms of nursing hours required per day of care) decreases as length of stay increases. If West Coast hospitals did have a higher "length of stay" per admission than they have now, occupancy would obviously increase to be on par with New York, and costs to the Medicare program would also increase. There are probably many reasons why the West Coast hospitals are more efficient in this regard; one of them is probably the very active utilization review programs in effect here.

The time to correct the inequities relative to the cost limits for the San Francisco-Oakland area is *NOW*.

Thank you for your continued considerations of my viewpoints.

Sincerely,

CHRIS BURNS.

PREPARED STATEMENT OF THE AMERICAN OPTOMETRIC ASSOCIATION

Although the economy of our country is reportedly not optimumly suited for the introduction of new health benefits programs, the needs of our citizens in this area continue to grow. These immediate needs cannot be allowed to lie unanswered regardless of the state of economic affairs in the Nation. To answer these immediate needs, our attention should be directed *now* toward making existing programs more cost effective and administratively streamlined.

The American Optometric Association, an organization of over 19,000 specialized vision care professionals, has long held that one of the major yardsticks necessary to attain good working health programs is that such programs be financially sound and fiscally responsible. Therefore, we noted with pleasure Senator Herman Talmadge's introduction of S. 3205, a bill designed to make those necessary improvements in the existing Medicare and Medicaid programs to obtain more effective administrative and cost control features.

Our Medicare/Medicaid programs are grossly inadequate in certain vital areas, notably that of vision care. As the current programs stands, costs are rapidly becoming prohibitive for these additional badly needed benefits. If, however, the current program is tightened up to exclude current fraud abuse and extraneous administrative costs, conceivably the program could be made more attentive to the needs of the citizenry for whom it was originally established.

Specific areas of this bill we have noted are especially needed steps toward accomplishment of this goal:

(1) Establishment of specific performance criteria which would, among other things, assure a solution to a problem facing many providers: timely payment of claims.

(2) A longer time period of commenting on proposed Social Security Act regulations, which will alleviate the occasional reality that thirty days is not a sufficient period.

(3) Tighter regulation of Medicaid HMO's, a step which a number of our affiliated state associations have advocated on the state level.

(4) The incentive of rewarding simplified paperwork with a shared portion of the dollars saved by the provider and the government.

(5) Establish a reasonable floor on state Medicaid reimbursement rates, with the effect of countering another factor which discourages provider participation.

(6) Provide for a combined Medicare and Medicaid administrator which would promote uniform policymaking and administrative efficiency.

The current attention of Congress toward making PSROs a vital and more realistic part of the health benefits program will also serve to reduce drastically any services that are needed by the patient on an individual basis and serve to provide better care in addition to strengthening program effectiveness. It is important that all health care professionals delivering services under federal programs be a part of the PSRO structure to make the PSROs an acceptable and effective means of a peer review structure.

Optometrists' services have been for some time an integral part of state and federal programs in health. Therefore, we feel it incumbent upon us to respectfully request amendment of S. 3205 to secure consistency in terminology in the bill in two places to utilize the federal government's established definition of "physician" rather than to cover only doctors of medicine and osteopathy in these places. Specifically:

(1) On page 52 in line 14, strike out "doctor of medicine or osteopathy" and insert "physician."

Intent.—to make certain that language defining criteria for determining reasonable charges for physicians' services in physician shortage areas applies to all providers who are defined as physicians under Section 1861(r) of the Social Security Act, rather than solely to doctors of medicine and osteopathy. This amendment will conform to the use of the term "physician" throughout the balance of this proposed section, which generally defines criteria for determining reasonable charges for physicians' services.

(2) On page 53, line 19 and page 54, line 1, strike out "doctor of medicine or osteopathy" and insert "physician."

Intent.—To cover all providers defined as physicians, rather than solely doctors of medicine and osteopathy, under provisions pertaining to agreements of physicians to accept assignment of Medicare claims. This amendment would be consistent with the use of the term "physician" throughout this proposed section.

Senator Talmadge succinctly noted the rationale behind the obvious need for legislative attention Medicare/Medicaid reform, "The choice is a simple one . . . either we make Medicare and Medicaid more efficient and economical or we reduce benefits."

As an association of concerned health care specialists we recognize the need to, if anything, increase the health benefits offered to the elderly of this country, not decrease them. To do so in these inflationary times means that we have to increase the availability of services within a current or only minimumly increased budget. By attention to correcting widespread abuses of the current Medicare/Medicaid program, much can be accomplished within our current economic confines. There is no reason for our efforts to provide health care to all Americans to come to a grinding halt because of the current economic strata. We can work within the current structure as best as possible until such time as our economic picture lightens. The needs of our elderly do not come to a standstill and our attention to these needs should not regress. With noted amendments, we urge prompt consideration of S. 3205.

PREPARED STATEMENT OF THE PROFESSIONAL FACTORING ASSOCIATION

To the Honorable Members of the Senate Finance Committee, we appreciate the opportunity to submit the following statement in opposition ot the prohibition against Factoring as appears in Section 26 of S. 3205.

The Professional Factoring Association of New York is an association of factoring companies who do business in the State of New York. The respective members of this association purchase *medicaid* invoices from more than 850 providers in New York State. The members of this association in the year 1975 purchased approximately $30,000,000 worth of such receivables.

We hereby object to the proposed legislation on the ground that it would be a violation of constitutional law to prohibit a provider of medical services who is

paid in accordance with a fixed fee schedule from assigning or selling that claim after he has professionally completed his services; and moreover, because its adoption would impair and perhaps even destroy the operation of the medicaid program in the New York area.

When Congress enacted the Medicaid Program, it was believed that the program and fee schedules should be broad enough so as to attract the participation of 66⅔% of all classes of providers. It is our belief that current HEW figures show that in the New York area, less than 10% of all medical professionals participate in the program. The main reasons for this failure to attract providers are:

(*a*) The voluminous amount of paper work that is required of a provider for him to obtain payment for his services; and

(*b*) The fact that payments are long delayed, sometimes for periods exceeding 6 months.

It was for these reasons that finance companies entered into the business of financing and/or factoring of these accounts receivables. The factoring company by providing the services of immediate cash payment to the provider and relief from the voluminous paper work, recordkeeping and cumbersome procedures effectively attracts providers to participate in the program. As will be later pointed out, the factoring companies provide many other services to medicaid providers which contribute to the efficient working of the program.

Factoring as practiced by members of this Association operates in the following manner:

(1) The factoring company purchases the invoices that have been prepared, audited, completed and *signed by the provider*. When entering into a factoring agreement, the provider signs a designation directing the local Social Service District to mail the check to the factor. At no time is there any provision nor request that the check be made payable to the factoring organization. It should be also noted that this designation requires a notarization of the providers signature. At no time does any factoring company alter or in any way change any invoice.

It should be also noted that most factoring contracts and/or agreements are cancellable on thirty days notice by either party to the agreement.

(2) The following services are generally provided by members of the factoring association to the providers whose accounts receivables they factor.

(*a*) Pick up invoices at Doctor's office on a weekly schedule.

Invoices are picked up at the doctor's office to reduce his need for mailing large quantities of papers. It assures him of delivery to the factor of irreplaceable x-rays, written approvals from the Department of Social Services, patient signatures, and/or invoices.

(*b*) Invoices are delivered to the factor and are recorded, batched, sorted by doctor and office location and edited for clerical errors.

The work of sorting invoices by office location and identifying it by a batch number, enables the doctor that practices in many locations to know the amount of work done in each location, and later when payments are received, the doctor is able to know which invoices have been paid and which rejected.

The invoices are edited by a trained staff that not only knows the basic items to be filled out and signed, but is aware of the latest revisions in billing practice and guidelines by the local Department of Social Services. Invoices requiring correction are returned to the doctor with appropriate notations for corrections. When the auditing is completed the factor immediately pays the provider. In some instances as the providers request the monies are actually deposited in the provider's own bank account which gives him immediate dollars.

(*c*) The invoices are scheduled on a complete listing that includes the Doctor's Certification number, date invoices received, batch number, office code, all invoice numbers, amounts and totals, and patient information.

The listing is done in duplicate. One remains in the Factor's files and the copy is sent to the doctor with a check. Some factors also create computer files with this information.

(*d*) Clear and permanent records are created for the following future uses of the invoices. (Some factors use microfilming for this purpose):

(i) All unpaid invoices over six months old must be resubmitted in the seventh month with proper requests for payment and a good copy of the invoice.

(ii) If a doctor needs copies of his invoices some time after he has submitted them because he has lost his records, or they were destroyed or he has moved locations and the previous medical group refused to allow him to take his records, the factor's records are available.

(*c*) The invoices are hand delivered to the Department of Social Services and a receipt is obtained.

This is necessary in the instance where the Department of Social Services should ever deny payment because the invoices were not received on time, or never received, the doctor would have proof that it was delivered on time.

(*f*) Along with the check from the Factor for the invoices purchased the *original vender statement* is also sent to the doctor's office for his staff to do reclaims or for his own review of disallowances and payments against invoices.

(*g*) A ledger file is kept for every provider.

The ledger provides a history of every provider's work and is kept for years. It stores information on the weekly, monthly and yearly billing work of the doctor; the discount taken before payment to him, and of all checks sent to him. It also records checks received by the Factor in the provider's name, the Department of Social Services' disallowances and account balances.

This information is useful in preparing yearly summaries for the providers to be used when filing tax returns.

The providers have also used this information successfully defending their tax returns.

(*h*) All invoices are kept on the factor's records; some factors use computers for this purpose.

The factor maintains monthly listings of all open invoices, aged to show the length of time that the invoices have been waiting for payment.

(*i*) There are many other small services that full service factors provide for their accounts which are done upon request. Among them might be:

(i) Visit the Department of Social Services to intercede for provider on small clerical or billing problems or to get information necessary to complete billing.

(ii) Locate additional offices for doctors that would like to practice in a different group or want additional hours in another practice.

(*j*) Find competent staff for the doctor to help with billing or medical assistance.

Apart from the foregoing, it should be noted that the factors, by keeping detailed records of all invoices submitted to the local Social Services District, is fully aware of overpayments that have been made, and when overpayments have been made the factor has promptly refunded the overpayment directly to the Social Services Department (verification of this can readily be obtained from the New York City Department of Social Services).

It appears that the intent of the proposed legislation is to preclude the possibility of provider's bills being inflated or otherwise altered by the provider's assignee. To correct such improper practices, it is certainly not necessary to have a "total ban on assignment". All that need be done is to require that each item on an invoice be signed or initialed by a provider and that the provider draw a line from the last item to the end of the invoice form so no items can be added after he has signed it. Such a simpler requirement would cure the possible evil sought to be corrected, while leaving intact the sound, proper and necessary procedure of factoring as it is practiced in the New York area.

In addition, the members of this Association would be willing to be licensed, bonded, and be financially responsible for any impropriety done by them.

It is submitted that the charges made by factoring companies are fair and reasonable under the circumstances, taking into consideration the availability of immediate cash payments, recordkeeping and technical expertise that the provider is afforded. The alternative of a provider borrowing from a bank, using a billing service and the hiring of additional help, will be at least equal to the charges made by a factoring company who is providing all the services outlined herein.

If the legislation is enacted in its present form so as to bar factors from participation in this field, the result inevitably would be that the number of doctors in the New York area willing to participate in the medicaid program would be so drastically reduced as to make the medicaid program in this area no longer viable.

Finally, it should be noted that as factoring is done by the members of this association, all responsibility for professional services to the patient remains with the provider. All disputes and reviews of work practices, ethics, conduct, etc. are handled directly by the Local Department of Social Services with the provider and the factor or functions only to provide increased cash flow, bookkeeping, accounting, and recordkeeping services.

For all the foregoing reasons, we respectfully submit that the proposed legislation as to bar or prohibit factors should not be adopted.

PREPARED STATEMENT SUBMITTED BY JOHN B. SMITH, ESQ., CORPORATE ATTORNEY, MEDICAL PERSONNEL POOL

Mr. Chairman and members of the Committee, I am John B. Smith, Corporate Attorney for Medical Personnel Pool, a Division of Personnel Pool of America, Inc. which is a national temporary help service. Medical Personnel Pool provides hospital staff relief and home health services through one hundred offices nationwide.

We are concerned, Mr. Chairman, that S. 3205 deals primarily with fraud and abuse in the Medicare and Medicaid programs and with hospital reimbursement. In the first place, fraud and abuse is now a major effort at the federal regulatory level. Secondly, your efforts to reform hospital reimbursement seem to come too long after the fact and bear the risk of being too "unpopular" to be implemented.

We suggest that a more positive approach to Medicare and Medicaid reform would be more likely to succeed, both in terms of Congressional passage and in terms of long-range benefits for the program.

We believe the most important proposal in S. 3205 is Section 11 which provides a transitional allowance incentive to hospitals for eliminating excess beds, discontinuing underutilized services or substituting some other needed service. This allowance will free the hospital from "reimbursement detriment" and cover the debts of a non-profit hospital if it is forced to close.

Why does the bill stop there? It is the same as it was with the PSRO legislation. You have provided increments for the institution to shift its resources, but you haven't set up an alternative system that will absorb the victims of these shifts. To wit: if the PSRO determines that patients are inappropriately institutionalized and must get out of the institution, where do they go? There is no provision for that in the law. Under Section 11 you have provided money to ease the institution's pain when it must close down or trim down, but you haven't organized a place for these patients to go. The system as it is currently structured under Medicare and Medicaid cannot absorb all of the patients that you would have released from institutions. There simply are not enough providers and there is not enough emphasis on covering an appropriate level of skill to fit the patient's needs.

We refer, of course, to home health which is bound by a Medicare definition of the need for skilled services tied to prior hospitalization, a lack of coverage for homemaker services, an arbitrary division between the social and medical components of health care, and the arbitrary and discriminatory practice of keeping proprietary home health agencies out of Medicare and Medicaid. The only federally-funded health programs where this is so.

S. 3205 ignores the differing sets of standards between the Medicare and Medicaid programs and the different treatment of providers under both of those programs.

All of these issues have been thoroughly discussed in the past year or more—at HEW, in Committee hearings, in meetings on both sides of the Hill, and in industry conferences across the nation.

Medical Personnel Pool finds it very surprising that the Senate Finance Committee should lag so far behind these developments.

Most of the fraud and abuse that has been uncovered is in the Medicaid program. Most of the reasons for the fraud and abuse can be laid at the door of state administration. We wonder why you haven't proposed federalizing the Medicaid program as have several other industry representatives in order to bring the administration of it under federal control. We wonder why you haven't appropriated more funds to HEW to implement an effective fraud and abuse control unit earlier than now.

Perhaps now is the time for this Committee to consider federalizing Medicaid and providing for a broad expansion of the home health program in order to give it a chance to prove what it can do by way of cost effectiveness and appropriate quality care before national health insurance is dealt with.

While you stated, Mr. Chairman, in your June 1975 floor speech that you were drafting legislation to resolve some of the reimbursement problems in Medicare and Medicaid and "some of the more arbitrary and inequitable regulations which have been promulgated by HEW" we don't see that you have dealt with the hard core of these issues. That is the reimbursement structure itself. In addition, you certainly haven't provided for proprietary home health providers under the Medicaid program which is one of the more arbitrary regulations promulgated by HEW. Even HEW has tried to correct that in the past year and you, yourself, have opposed their action. You have also not dealt with the issue of what is a non-profit organization. The loose definition of this in both the IRS and in state and federal laws has led to a number of abuses in the home health area in recent months.

Which brings us back to Section 11. At the minimum, Medical Personnel Pool recommends strengthening Section 11 to include an administratively streamlined home health care package for Medicare and Medicaid.

Mr. Chairman, we feel there are three major problems with the home health program as it currently operates. The first is the cost reimbursement structure which invites inefficiency and abuse as the Senate Government Operations Committee has discovered in its Florida investigations. Parenthetically, I should add that the cost reimbursement philosophy affects all of Medicare's heath programs, nursing homes and hospitals, not just the home health industry. There is certainly something wrong with a system that allows, for example, depreciation and re-depreciation on equipment which was originally donated. The cost reimbursement structure in the home heath field has encouraged high costs, visit overutilization, and agencies that serve only Medicare patients in order to have their costs 100% reimbursed. The really damaging result of cost reimbursement in the home health field is that the industry is potentially a long range, cost effective and appropriate way of taking care of people; but until the reimbursement practices are revised, home health is not going to have a chance to prove that.

Medical Personnel Pool would, therefore, like to propose some experimental reimbursement projects. We would like to see prospectively negotiated flat fees with mandatory written quality of care reports from the patient or his family and from the patient's physician. This proposal would preclude year-end cost reporting, auditing and all of the other paraphernalia which have helped to hike the cost of this program. If what we are concerned about is the delivery of quality care at a good price, it seems to me that such a simple experimental structure should be given a chance to prove its worth.

Furthermore, we would like to suggest that a procedure be implemented immediately requiring all Medicare home health providers to furnish to each patient a copy of each billing made by the provider to its intermediary. This would be a simple, inexpensive procedure through which the patient could have input into the quality and utilization review process.

The second major problem is that the home health program has not had the natural controls inherent in a competitive market. I have never understood the justification for the battle that now rages about keeping proprietaries out of the home health field. It's the only federally-supported program where this is so. We have a ten-year history of offering quality care at reasonable prices. If we're good enough for the private market, why aren't we good enough for the government? If Medicare regulations could somehow force the non-profit providers to compete in the private market so that perhaps from 30% to 50% of each non-profit agency's business must be in the private sector, and should Medicare regulations further adopt cost reimbursement on the basis of customary charges in the private market, I believe the program would be significantly benefited through greater efficiency and lower overall costs.

In 1974, Medical Personnel Pool employed nearly 30,000 nursing and health care personnel and rendered approximately ten million hours of patient care. With offices in about 100 cities throughout the country, Medical Personnel Pool could become an effective additional source of quality home health services under federal licensure standards which would apply to all agencies regardless of sponsorship.

Almost daily, we receive calls from prospective clients who lack sufficient resources to afford home health care, and whom we are unable to serve due to present limitations on provider eligibility and funding. In some cases, we are able to successfully refer these persons to an appropriate community or private non-profit agency. However, we are convinced that the needs of a substantial number of these persons for home health care are not being adequately met or are not being met at all. This may be due to a number of factors such as excessive case loads, inadequate manpower resources, maldistribution of home health agencies, excessively strict and confusing eligibility requirements, burdensome administrative procedures and delays, and inadequate funding. Nevertheless, we believe that it is evident that a significant segment of the community, and particularly the senior citizen, has been denied access to a readily available, quality, low-cost source of home health care.

Most discussions of the proprietary organization's role in the home health care delivery system center around the question of cost containment, quality of service, and the suggestion that proprietary organizations are "skimming the cream" by accepting only cases that can afford to pay for services and forcing the non-profit sector to provide free service. We believe that a careful examination of the true facts would place these questions in their proper perspective. In the first place, a careful examination of some of the executive salaries of some of the so-called private non-profit agencies might lead one to question whether some of these agencies are in fact proprietary agencies in disguise. We must also remember that there is really no such thing as free medical service. The cost of such service must have some ultimate source of support whether it be profits generated by proprietaries, tax dollars, or private or charitable donations. Of course, proprietaries do not have access to the source of private or charitable dollars and, in fact, contribute to the tax dollars which are used to support the non-profit agencies; and since they do contribute to these tax dollars, and since they have demonstrated their ability to provide quality home health care to low cost, we believe that proprietary organizations should have access to Medicare and Medicaid funding mechanisms.

Adoption of the Social & Rehabilitation Service's proposed regulations which you have opposed, Mr. Chairman, would give state Medicaid agencies access to a substantially greater supply of home health service personnel, yet under conditions and standards regulating utilization and quality of care.

It is important to note that those proposed regulations authorizing certification of proprietary agencies under Medicaid will not directly increase Medicaid program costs, since the regulations do not create or broaden existing services or require expenditure of additional funds. There merely enlarge the source from which home health services can be obtained, and eliminate unfair discriminatory conditions presently imposed on proprietary providers.

In fact, we submit that adoption of the proposed regulations may, in fact, result in a reduction in Medicaid program costs, or at least result in a reduction of unit costs for equivalent levels of service.

Someone should be brought up to date on the real issue: "How will this nation's elderly ever receive home services provided appropriately, accessively and at a price that people and government can afford under the present uncontrolled, unregulated cottage industry? I use the term "cottage industry" because it is a small and declining industry—from 2,248 certified agencies in December, 1974 to 2,209 agencies a year later.

The third major problem with the home health program as currently structured under Medicare and by inference under Medicaid is that eligibility for the service is tied to the need for acute care and the history of prior hospitalization. This has mandated utilization of registered nurses to provide in-home care which has also increased the cost of the program. We believe it is not necessary to have a registered nurse go into the home to give a bath or change the sheets. There is no question, however, that the home health aide who does go into the home to perform these tasks should have supervision. She should also have training. We also believe that homemakers' services ought to be covered under the Medicare program since in many cases if there were just someone in the home to prepare the elderly patient's meals, this one simple service would keep the patient from going into an institution.

I know that both the Congress and the individual state Medicaid agencies are concerned that an expanded home health benefit will greatly increase health costs. But what is at issue is, if the Professional Standards Review Organiza-

tions take up their responsibilities in effective utilization review, they will undoubtedly release thousands of people who are currently unnecessarily institutionalized, and where will these people go if there are no home health agencies and no federally-supported coverage for their care? Home health care has been proven effective in the health maintenance organizations as one way to exercise budgetary responsibility while maintaining commitments for comprehensive preventive health care. We are convinced that over the long range you will see a lowering of cost per case if home health is provided and utilized.

In formulating a delivery system for home health care services to the aged, we urge the Committee to carefully consider and adopt standards for quality care. Insist that all home health agencies meet the same certification criteria. Congress and the federal agencies certainly have a legitimate need to focus on standards affecting the utilization of services. Most of the Medicare conditions of participation are directed toward utilization rather than toward the quality of care. In our opinion, quality of care and concern for the patient has been secondary to proper utilization.

We urge the Committee, in revising S. 3205, to consider our suggestions and agree that they go a long way toward developing a more rational approach to the Medicare and Medicaid programs along with realistic and adequate safeguards for the protection of the patient in the quality of care rendered as well as reducing health care costs over the long range.

PREPARED STATEMENT OF THE AMERICAN DENTAL ASSOCIATION

We appreciate this opportunity to discuss this complex legislation which would make major changes both in the administration of, and the methods for determining levels of reimbursement under, the medicare and medicaid programs. The dental profession was active during the development and initial implementation of these programs and currently provides a significant amount of services under each of them. We are vitally concerned with problems which have developed with these programs and with the efforts which are and will be made to resolve these problems. Above all we are concerned that these programs provide the best care possible to eligible persons.

Before addressing specific provisions of S. 3205, we would like to discuss two issues which are of major concern to the dental profession. The first of these pertains to a situation which exists under the medicare law relating to the provision of covered services which legally can be provided by both physicians and dentists. Under medicare, there are certain services which dentists are specifically authorized to provide. Dentists are reimbursed for the provision of these services. However, there are other services which dentists are authorized by state licensing laws to perform but which, if provided by a dentist, are not paid for under the medicare program even though physicians are reimbursed for providing the same services. We urge you to amend the medicare law to provide that those services which a dentist is legally authorized to perform and which are covered under the medicare program should be paid for by medicare when provided by a dentist as they would be if a physician had performed them. Not only is the present situation inequitable for the dentist, it also reduces the opportunity for choice by patients. Legislation to correct this inequity in the medicare law has been introduced by Representative James Corman (D-Calif.) as H.R. 11288. We should point out that this amendment does not authorize additional medicare benefits, it simply makes the system of reimbursement for covered services more equitable. We strongly urge inclusion of the relevant provisions of H.R. 11288 in any medicare reform legislation which is developed by your committee.

The second major concern of the dental profession is the cutbacks which many states are now implementing in the medicaid program. These cutbacks, which are supposedly being made in the name of economy, have resulted in reductions or total deletions of adult dental care benefits in at least nine states. We strongly oppose the deletion or reduction of these benefits and are hopeful that mechanisms can be developed to prevent further reductions and to help restore dental benefits to the medicaid programs in those states where these cutbacks have occurred.

One of the effects of this reduction in dental benefits has been the development of a problem under medicaid which is similar to that which we discussed

above with regard to medicare. In those states where dental benefits have been eliminated from among those offered under the medicaid program, services which are covered under medicaid if performed by a physician are not considered as covered services when performed by a dentist. Therefore dentists are not being reimbursed for providing these services. Correction of this inequity will not result in additional services being covered under medicaid. Instead correction would result in a much more equitable situation with regard to the provision of services under this program. All that is needed to correct this inequity is legislation providing that dentists be reimbursed for the provision of services which are included under the medicaid program when provided by physicians and which the dentist has the training and authority, under the state practice acts, to perform.

Again we emphasize that correction of this so-called overlap problem under the medicare and medicaid programs can be accomplished by making relatively technical changes in the medicare law and does not require the development of additional benefits under either of these programs. We have attached to this statement a copy of an amendment to accomplish these needed changes.

HEALTH CARE FINANCING ADMINISTRATION (SECTION 2)

The bill calls for the establishment of a separate organizational unit within the Department of HEW to be known as the Health Care Financing Administration. This unit would be under the direction of an Assistant Secretary for Health Care Financing. The unit would include the functions and personnel of the existing Bureau of Health Insurance, Medical Services Administration, Bureau of Quality Assurance and Office of Nursing Home Affairs. The new Assistant Secretary would report directly to the Secretary and would have policy and administrative responsibility for the medicare, medicaid, professional standards review organization and renal disease programs established under the Social Security Act.

The American Dental Association is keenly aware of administrative difficulties which have arisen in the implementation of the various Social Security Act health care programs. We can agree that greater coordination in the implementation of these programs would be helpful. However we are strongly opposed to the creation of an administrative unit which would not be under the specific direction of the Assistant Secretary for Health. It must always be kept in mind that the programs under consideration are health care programs and that it is the delivery of quality health care which is of paramount importance. Although administrative and other improvements can be made, these should always be accomplished under the guidance and direction of those who are responsible for insuring that the programs provide the highest level of care possible. We are very concerned that the establishment of an administrative unit which is headed by an individual of equal position to the Assistant Secretary for Health and which is given policy and administrative responsibility for these health care programs will lead to a decreased emphasis on the quality of health care and an overemphasis on the important, but not overriding, issues of controlling program costs and administration. We would support appropriate mechanisms for improved administrative and other efficiencies in this program, particularly at the operational level. However the overall responsibility for these health care programs must reside in the Assistant Secretary for Health and not in an individual who is primarily concerned with financing and with cost control. We urge that the reforms as specified in Section 2 not be implemented.

OFFICE OF CENTRAL FRAUD AND ABUSE CONTROL (SECTIONS 2 AND 3)

The bill would establish within the Department of HEW an Office of Central Fraud and Abuse Control which would be under the direction of an Inspector General for Health Administration. This Office would have general responsibility for monitoring fraud and abuse control activities of the various Social Security Act health care programs and initiating and conducting direct investigations with respect to alleged, actual, or potential fraud or abuse in these programs.

The Inspector General for Health Administration is given quite extensive and specific authority with regard to control of fraud and abuse. The bill makes

clear that the Inspector General is to be under the control of no person in the Department of HEW other than the Secretary. The Inspector General is to carry out reviews, inspections, and audits of the medicare, medicaid and any other Social Security Act health care programs to determine the extent to which these programs are in compliance with applicable laws and regulations, to make recommendations for the correction of deficiencies in or for improving the organization or other aspects of these programs, and for evaluating the effectiveness of these programs in attaining the objectives and purposes of the provisions of law authorizing them. The Inspector General also is authorized to spend up to $100,000 a year for confidential expenditures to aid his inspections, audits or reviews. A report of these confidential expenditures would be made to Congress.

It should go without saying that the American Dental Association strongly abhores any level of fraud or abuse in these and any other health care programs. We are ready to assist in any appropriate ways in the detection of fraud and abuse and to support efforts of the Department of HEW and of others in eliminating abuse of these programs. However, we are very much concerned with the extent of authority contained in this bill and with the seeming overemphasis on the issue of fraud and abuse control.

We understand that the Department of HEW has recently greatly expanded its own fraud and abuse control activities. We support such efforts. We do not believe that an independent Office of Central Fraud and Abuse Control with the extraordinary authority granted to it and its Inspector General director are necessary or appropriate in view of these already instituted efforts. We urge that the provisions for this Office and for the Inspector General be deleted from S. 3205. We further urge full support for the activities of the Department as it steps up its efforts against fraud and abuse.

STATE MEDICAID ADMINISTRATION (SECTION 4)

The provisions of this section of the bill are salutory in that, if states are able to comply with them, administration of the medicaid program would be significantly improved. Certainly one benefit resulting from the requirements that claims be paid quickly would be an improved cash flow for health professionals. Also it is certain that proper implementation of the requirements for periodic determination and redetermination of eligibility for medicaid benefits would assist in insuring that only eligible persons are receiving medicaid benefits. The information required relating to quality control, claims payment, and utilization of services also could be helpful in the long-term implementation of the medicaid program.

Our concern with these provisions is that they may prove too burdensome for the states to meet, although obviously this is a judgment which can best be made by those who are administering the program. We would be concerned that if the provisions are too strict, resulting in reduced federal payments to the states, this could further result in reductions in the benefits which are offered by the states and/or a reduction of payments under the medicaid program. In either instance the overall effectiveness of the program would be seriously hindered. We are very much concerned that the penalties authorized by this section could be very deleterious to attainment of the overall goals of the medicaid program and believe that a much greater understanding of the ramifications of such penalties should be developed before they are authorized.

CLAIMS PROCESSING BY CARRIERS (SECTION 5)

The provisions relating to procedures for the processing of claims by carriers are ones which in terms of feasibility and resultant improvements in the program are best addressed by representatives of the carriers. However, we reaffirm the need to insure that any legislation which relates to the processing of claims or transfer of medical and other health information include strict and appropriate protection of the confidentiality of these records.

REGULATIONS OF THE SECRETARY (SECTION 7)

One of the major difficulties which we have faced with regard to rules and regulations promulgated by the Secretary of HEW has been a lack of appropriate time for comment on these rules. The current normal procedure is that a proposed rule is published and a comment period of 30 days is allowed. HEW then

reviews these comments and promulgates a final regulation which is normally effective upon publication. In many instances the complexity of HEW regulations makes a 30 day comment period completely inadequate. We understand that the Department is implementing changes in the regulation writing process to allow greater input from interested parties. We hope that these changes will be beneficial.

From the language in section 7 of S. 3205, we are not certain whether the provision relates to the minimum comment period which is to be allowed with regard to proposed regulations under the Social Security Act or if it relates to the amount of time which must be allowed between the publication of a proposed rule and its final promulgation. If the language is intended to relate to the latter situation, we would have extreme concerns both in terms of the shortness of comment time which would result and with regard to the rapidity with which HEW would be expected to review and decide upon comments which are made on federal regulations. We are in support of this provision if it is intended that at least a 60 day comment period on proposed regulations is to be required. However we would urge that if this interpretation is correct, the provision be redrafted to clearly reflect this intent.

In addition, we have concern with the requirement in the bill that regulations implementing S. 3205 would have to be promulgated and effective not later than 18 months following enactment of this bill. Although there have been times when the regulation development process has seemed to become bogged down leaving the implementation of various programs in a state of confusion, we would be opposed to a strict time limitation being statutorily mandated for the development of regulations. The development of federal rules and regulations is a complex process, particularly with regard to major legislation such as is proposed in S. 3205. While we commend efforts to assure the expedient development of rules and regulations, we would oppose any provision which mandates that regulations be developed within a time frame which may be unrealistic and may result in a lack of thoroughness in the development of these regulations.

TERMINATION OF HIBAC (SECTION 8)

It has been our belief that the existence of an advisory council to the Secretary for the medicare program, such as the Health Insurance Benefits Advisory Council, which can bring to the Secretary the advice and recommendations of individuals who are involved with the program, is most commendable. With adequate financial and staff support, we believe that this body could contribute more to the solution of problems faced by medicare and other national health programs. We understand that there have been criticisms of the effectiveness of HIBAC but feel that the major problems of this Council are based on a lack of adequate support within the Department of HEW. We recommend that HIBAC be retained and provided with adequate staff and financial support.

CONVERSION OF UNDERUTILIZED FACILITIES (SECTION 11)

Without being able to comment upon the specific mechanics and practicality of such a provision, the Association is in favor of support being provided to institutions to assist them in converting unnecessary, high cost hospital beds to needed, less expensive facilities. We raise the question as to whether the full costs of this conversion are to be met by the federal government or will these costs be allocated to private paying patients of the facility as well?

PHYSICIAN REIMBURSEMENT (SECTION 20)

Before discussing the several sections of S. 3205 which address reimbursement to individual practitioners under medicare and medicaid, we want to stress that provisions for reimbursement to dentists under these programs should be consistent with provisions for the reimbursement of physicians.

The American Dental Association is well aware of problems which have been raised because of different payment levels for services which are provided in metropolitan areas as opposed to payment for those same services when provided in rural areas. The medicare reimbursement mechanism, which is loosely based on the usual, customary, and reasonable (UCR) fee system, which is supported by the American Dental Association, has divided the nation into regions for which reimbursement levels are determined. Most states contain more than one

region. Although it is true that an argument can be made that a single program should pay the same amount for any given services no matter where provided, it is also true that costs for providing those services do differ from one area to another, even within a single state.

We believe that the usual, customary, and reasonable fee system reflects differences in reimbursable amounts, based on provider costs and other similar factors, between urban and rural areas. While preferring the UCR system, we feel that the system being used in the medicare program, which is inequitable in many ways, does reflect these differences in the costs of providing services. We do not feel that it is appropriate that the lid which is proposed by S. 3205 in section 20 be adopted. Although this section would not automatically grant uniform payment for services regardless of where they are provided, it would dictate allowable reimbursement levels under the medicare program on a basis which is unrelated to the usual. customary and reasonable charges made by health care providers in the area.

Our reading of this bill leads us to conclude that section 20, subparagraph E, is a further infringement on the usual, customary and reasonable charge system in that it reduces the allowable prevailing charge level in states with two or more charge localities from the 75th percentile to the 50th percentile of charges made in the state. This is an unreasonable and improper provision. We fail to understand the reasoning behind this suggested change. We would point out that the placing of arbitrary limits on physicians reimbursement might adversely affect the quality and accessibility of care under this program.

INCENTIVES TO ACCEPT ASSIGNMENT OF CLAIMS (SECTION 21)

The provisions of section 21 of S. 3205 are restricted to doctors of medicine or osteopathy. These provisions authorize certain administrative and financial incentives to participating physicians, who would be defined as physicians who agree: (1) to accept assignments for all claims made for treatment of individuals under part B of medicare, and (2) that the reasonable charge as determined under the medicare law would be the full charge for services. We feel that the incentives offered in this section to participating physicians, may be attractive to certain providers. At the same time, we are opposed to the requirement that this provision apply to all claims or to none at all. A mandate that all claims be on an assignment basis could further reduce, rather than increase, the level of acceptance of assignments by physicians.

MEDICAID PHYSICIAN REIMBURSEMENT (SECTION 23)

It is the Associations' position that reimbursement mechanisms. particularly in public programs in which these mechanisms are determining the practitioner's total compensation, should be founded upon the practitioner's usual fee. Acceptance of this principle in the design of a public program is essential to assuring the program's beneficiaries access to the full range of health services available to the community's total population.

Further, the Association believes there should be a single system of reimbursement for all health services. Because benefits provided under medicaid and medicare are not identical, a system which relates one program's determination of reasonable fees for specific services to determinations made under the other is susceptible to the creation of certain inequalities, and therefore is undesirable despite the probability of its providing increased levels of reimbursement for many services under the medicaid program.

We thank you for this opportunity to present our views on this most complex and comprehensive proposal. In summary, we have particular concerns with current restrictions on reimbursement to dentists for services which are reimburseable under medicare and medicaid if provided by physicians. Beyond that we are in support of many of the goals contained in this legislation although we feel that some of the drastic administrative and other steps which are proposed are not needed and that these goals can be met through the Department of HEW under the direction of the Assistant Secretary for Health.

SUGGESTED AMERICAN DENTAL ASSOCIATION MEDICARE AND MEDICAID AMENDMENTS

The following suggested amendments are designed to assure that services provided by physicians which are covered under either the medicare or medicaid

programs, or both, which also can be provided legally by a licensed dentist are treated as covered services under those programs when provided by a licensed dentist. Section (1) of these amendments is based on Section (1) of H.R. 11288 which was introducel by Rep. Corman (D-Calif.).

Section 1.—That clause (2) of section 1861(r) of the Social Security Act is amended to read as follows: "(2) a doctor of dental surgery or of dental medicine who is legally authorized to practice dentistry by the State in which he performs such function or action, and who is acting within the scope of his license when he performs such function or action, or for purposes of the certification required by section 1814(a)(2)(E) of this act, or"

Section 2.—Section 1905(a)(5) of the Social Security Act is amended by deleting the phrase "as defined in section 1861(r)(1)" and inserting in lieu thereof "as defined in section 1861(r)(1) except that physicians services include, and reimbursement shall be made for, those services for which reimbursement will be made when provided by a physician and which may be provided by a doctor of dental surgery or of dental medicine who is legally authorized to practice dentistry by the state in which he performs such services and who is acting within the scope of his license when he performs such services.

Prepared Statement of American Medicorp, Inc.

SUMMARY

American Medicorp, Inc., headquartered in Bala Cynwyd, Pennsylvania, is one of the nation's largest and most experienced publicly-owned hospital management companies. It was formed in 1968 to provide quality health care services on an economically sound basis through the ownership and management of acute care community hospitals. American Medicorp shares Congress' concern with the development and maintenance of equitable and cost-effective practices in the Medicare and Medicaid programs. Indeed, one of American Medicorp's functions is to upgrade the quality and efficiency of hospital patient care. American Medicorp generally endorses S. 3205 as a decisive and significant step forward in the effort to ensure efficient delivery of needed health care services to Medicare and Medicaid beneficiaries. However, American Medicorp strenuously objects to § 40 of S. 3205 which requires advance approval by the Secretary of Health, Education and Welfare of management and consulting contracts. American Medicorp believes that this provision is unnecessary and threatens to drastically curtail or delay the utilization of valuable cost-saving management services by hospitals—a result which is counterproductive to the proposal's purpose of bringing about reasonable cost controls and improved administration of health services.

American Medicorp owns or leases numerous hospitals and is in the process of building several more which it will own. These hospitals are investor-owned and therefore are tax-paying members of the communities which they serve and do not burden their respective communities with requests for funds to finance expansion or other projects. Hospitals owned by American Medicorp realize significant benefits from such affiliation. Centralized purchasing, centralized planning employing the company's skilled planners, and the sharing of problem-solving experiences, all enable American Medicorp-managed facilities to provide high quality medical care at greatly reduced costs.

In addition to owning hospitals, American Medicorp enters into contractual arrangements with hospitals owned by others to furnish management or project management services. Under management contracts, American Medicorp assumes complete management of existing hospitals and furnishes services which encompass all aspects of hospital administration. Pursuant to project management agreements, American Medicorp plans, designs, and coordinates construction activities and equipment procurement for new hospitals as well as for renovation or expansion of existing hospitals owned by others. The histories of many of the hospitals which the company has undertaken to manage under both types of agreement, reveal the significant improvements in the quality of patient care and the substantial cost savings that have resulted from American Medicorp's efforts.

The improvements which management and project management contract are able to secure are jeopardized by a single provision in S. 3205, § 40. This section provides that the Secretary of Health, Education and Welfare must review

and give prior approval to any contract which meets certain specified conditions. American Medicorp vigorously opposes this provision for several reasons. First, § 40(b) of the bill is not necessary because the total cost approach of proposed § 10 of S. 3205 precludes the necessity for individual examination of the cost of management and consulting contracts. In addition, the reasonableness of the cost of such contracts is currently reviewed by Medicare and Medicaid intermediaries on an annual basis as a part of the current system of cost reporting. Second, § 40(b) is drafted too broadly and encompasses management and consulting contracts for which there is no history of abuse or unwarranted diversion of Medicare funds. Third, requiring the Secretary of Health, Education and Welfare to give prior approval to all management, consulting, and service contracts will frustrate efficient hospital administration, require both management groups and the hospitals to incur unnecessary additional administrative expenses, and will effectively preclude necessary financial planning and materials management. Finally, because of the uniqueness of each management and consulting contract, it will be impossible for the Secretary of Health, Education and Welfare to fairly, efficiently, and expeditiously review the thousands of agreements which necessarily fall within the scope of § 40(b).

In general, American Medicorp commends Senator Talmadge for the important and long-overdue reforms in Medicare and Medicaid administrative and reimbursement practices which are proposed in S. 3205. However, for the reasons set out above, American Medicorp recommends that § 40(b) of the bill be deleted, or in the alternative, that it be amended to specifically exclude management and consulting contracts.

STATEMENT

American Medicorp, Inc., headquartered in Bala Cynwyd, Pennsylvania, is one of the nation's largest publicly-owned hospital management companies. Since American Medicorp was founded it has shared Congress' concern for the development and maintenance of equitable and cost-effective practices in the Medicare and Medicaid programs. Indeed, one of American Medicorp's functions is to upgrade the efficiency with which hospitals furnish quality health care. American Medicorp generally endorses S. 3205 as a decisive and significant step forward in the effort to ensure efficient delivery of needed health care services to Medicare and Medicaid beneficiaries. American Medicorp also agrees with the comments and suggestions concerning S. 3205 made by Dr. John A. Bradley, President of the Federation of American Hospitals in his testimony before this Subcommittee on July 27, 1976.

American Medicorp's purpose in this statement is to describe the type of management services it provides under contract and how these services have a substantial impact on controlling costs and minimizing waste in the delivery of quality health services. More importantly, this statement focuses on § 40 of S. 3205 which requires advance approval by the Secretary of Health, Education and Welfare of most such management and consulting service contracts. It is American Medicorp's position that this provision is unnecessary and threatens to drastically curtail or delay the utilization of such valuable cost-saving services by other hospitals. Such a result is certainly counterproductive to the proposal's purpose of bringing about reasonable cost controls and improved administration of health services.

American Medicorp was formed in 1968 to provide quality health care services on an economically sound basis through the ownership and management of acute care general community hospitals. The fundamental premise underlying the company is that the principles of good business management and the traditional incentives of the free enterprise system could be combined and applied to the delivery of quality health care.

American Medicorp has grown into one of this country's most experienced and respected publicly-owned hospital management companies. American Medicorp is listed on the New York Stock Exchange and, at the end of 1975, its assets totalled $412,000,000 and 1975 operating revenues were $331,800,000. Currently, American Medicorp owns, leases, and/or manages 46 hospitals in 13 states. These hospitals have a total of 8,650 licensed available beds, are affiliated with more than 9,000 physicians, and have over 13,500 employees. The facilities owned or managed by American Medicorp average 188 beds and include hospitals as large as the 486-bed Sunrise Hospital in Las Vegas, Nevada and the 458-bed Biscayne Medical Center in Miami, Florida.

American Medicorp presently owns or leases 35 hospitals and is in the process of building two more which it will own. All eligible American Medicorp hospitals are investor-owned and therefore are taxpaying members of the communities which they serve, thereby helping to support necessary community services and projects. In 1975 alone, American Medicorp hospitals incurred liability of $10.1 million in state and Federal income taxes, $3.5 million in real estate taxes, and $.5 million in personal property taxes. In addition, because they are investor-owned, these hospitals do not burden their respective communities with pleas for funds to finance building or expansion programs or to purchase new equipment.

An important difference between typical non-profit hospitals and American Medicorp's facilities is that the Company's administrators must furnish better patient care and manage their hospitals with greater efficiency in order to ensure an adequate return for the investor-owners and to preserve the competitiveness of the hospitals. Thus, by their nature, American Medicorp's hospitals must deliver higher quality health care services more efficiently and economically than non-profit, community supported hospitals.

Hospitals derive numerous significant benefits from being affiliated with American Medicorp. Centralized purchasing, centralized planning employing the company's skilled planners, and the sharing of problem solving experiences all enable American Medicorp facilities to provide high quality medical care at greatly reduced costs. For example, American Medicorp's national purchasing program has resulted in service, supply, and equipment savings for affiliated hospitals of as much as 20 to 25%. Similarly, the company's trained management engineers conduct a detailed analysis of each hospital to determine and implement that facility's most effective scheduling and staff-to-patient ratio. Savings and efficiencies such as these free badly needed funds which may be used to improve existing health care services or to establish new needed services. The ultimate result of planning such as this is to provide better patient care at lower costs for patients and hence for the Medicare and Medicaid programs.

The patient costs incurred in American Medicorp facilities are often lower than those prevailing in competing, non-profit hospitals. At American Medicorp's Rancocas Valley Hospital in Willingboro, New Jersey, the total expense per adjusted patient day includging ancillary services was considerably below the industry average. Similarly, a survey recently conducted in San Antonia, Texas revealed that American Medicorp's San Antonio Community Hospital has semi-private room rates which average 8% lower than the other hospitals in the San Antonio area. Another survey performed in Las Vegas, Nevada, showed that for the great majority of ancillary services available, the in-patient charges for such services by American Medicorp's Sunrise Hospital were lower than those of the other hospitals in the area.

In addition to owning hospitals, American Medicorp enters into contractual arrangements with hospitals owned by others to furnish management or project management services. Hospitals which engage American Medicorp for such purposes receive all of the benefits of the company's expertise and experience which are described above.

Under a management service arrangement, American Medicorp assumes complete management of an existing hospital and furnishes services which encompass all aspects of hospital administration including, *inter alia*, community health planning, financial planning and control, systems engineering, materials purchasing, risk management, and other support services such as capital formation. One of the most important services performed by the company is the implementation of effective accounts receivable collection procedures to reduce the length of a facility's receivable periods, thereby strengthening the financial position of each hospital operation.

Hospitals which have entered into management service contracts with American Medicorp have experienced dramatic improvements in their financial condition while simultaneously improving the quality of care to their patients—improvements which would be totally precluded by a single provision of S. 3205, § 40. The nature and extent of such improvements are evidenced by the histories of several of the hospitals which the company has undertaken to manage.

St. Mary Hospital in Philadelphia, Pa., a non-profit facility, owned by the Third Order of Sisters of St. Francis, has been the primary source of health care to the Kensington-Fishtown community for over 115 years. However, the increasingly complex operational and financial problems faced by the hospital

culminated in losses of $184,000 in 1972, $95,000 in 1973, and $224,000 in 1974. In April of 1974, American Medicorp was selected by the Sisters to manage the hospital. As a result of the company's efforts, the hospital's operating losses were eliminated and by the end of the fiscal 1975 an operating surplus of $100,000 had been generated and a new vitality created in the institution.

American Medicorp's efforts for St. Mary Hospital were not limited to financial matters, but also extended to improvements in the quality of patient care. In 1974, the hospital was seriously understaffed but since that time, American Medicorp's recruitment and professional relations programs have added nearly 50 registered nurses and over 30 physicians to the staff. Further, under its new management, the hospital added several new services, including podiatry and industrial medicine, strengthened existing services, and has made plans to renovate and to add a 132-bed patient tower to the present plant.

Another example of American Medicorp's success is the 160-bed Braintree Hospital in Braintree, Massachusetts. This special care facility for chronically ill patients opened in June, 1975 and immediately experienced cash flow, cost control, and financial control problems. On December 1, 1975, American Medicorp assumed responsibility for management of the hospital. By the end of June, 1976, the total operating cost per patient day had been reduced from $197 to $143.

American Medicorp also succeeded in bringing Sebastian River Medical Center from the brink of bankruptcy into solvency. The hospital opened in early 1974 and quickly was in default on $4.7 million of first mortgage bonds. Physicians and community confidence in the facility declined and the hospital's foreclosure was imminent. In September, 1974, the trustees for the bondholders contracted with American Medicorp to manage the medical center. By October, 1975, the hospital was solvent, its cash flow had significantly improved, 8 physicians were added to the staff, the hospital and its staff gained the confidence of local physicians thus avoiding the necessity for patients in the area to travel to distant hospitals for care, and the medical center's occupancy rate rose from 25% to 62%.

American Medicorp has experienced similar successes with its project management services. Project management services include planning, design, coordination of construction activities and equipment procurement for new hospitals in addition to the renovation or expansion of existing hospitals owned by others. Prior to initiating any design or construction project, American Medicorp makes an extensive study of the community's health needs to determine what types of service are needed and whether renovation of existing facilities will meet prevailing demands or whether a new or expanded facility is required.

For example, the non-profit Cooper Medical Center, Camden, New Jersey, sought to renovate some sections of the hospital while simultaneously replacing others with expanded facilities—all on an extremely limited site and without disruption of existing services. Initially, the hospital had been advised that the project would require an eight-to-ten year multi-phase program that could not be completed for under $60 million. An extensive Medicorp feasibility and planning analysis, based on the company's experience in developing dozens of other expansion and new hospital construction projects, however, determined that Cooper's needs could be met on the same site—without interrupting services—in a single-phase, three-year program, at a projected cost of $30 million. Planning and design are now underway and proceeding on schedule. Upon completion, Cooper Medical Center will serve as a primary teaching affiliate for the new South Jersey Medical School.

The 460-bed, non-profit Allentown and Sacred Heart Hospital Center which opened in September, 1974 also illustrates the substantial cost savings that are realized through American Medicorp's management of construction projects. The original estimate of the cost of the facility was $30 million but American Medicorp built and equipped the hospital on a turnkey project basis at a guaranteed cost not to exceed $18.7 million. This figure was 40% below the national average of per bed construction costs of comparable hospitals, and 40% below the original estimate. The resultant savings in construction, equipment, and financing costs amount to $8 per patient day.

The foregoing demonstrates that American Medicorp through its management and project management service contracts has secured substantial reductions in the cost of delivering health care services while at the same time contributing to a general improvement in the quality of patient care. These reduced costs are not ony reflected in the cost to the patient but also in lower costs to the Medicare and Medicaid programs. American Medicorp submits that the efficiency and cost

effectivenssss which it achieves with its management contracts is precisely the type of cost containment sought to be gained through S. 3205. Yet, American Medicorp finds that the effect of § 40(b) of S. 3205 will be to substantially curtail its ability to make such improvements in the future.

Section 40(b) provides that the Secretary of Health, Education and Welfare must review and give prior approval to any contract which (1) constitutes an element of cost of any health service for which payment is authorized under Medicare, etc., (2) is a "consulting, management or service contract", and (3) involves payments "with respect to any consecutive period of twelve months which aggregate $10,000 or more." For the reasons set out below, American Medicorp vigorously opposes this provision.

First, § 40(b) of the bill is not necessary because § 10 of S. 3205 precludes the necessity for an individual examination of the cost of management and consulting service contracts. Section 10 establishes a per diem target rate for hospitals for routine operating costs. Under proposed § 10, a hospital is encouraged to keep its actual per diem routine operating cost below its target rate because it receives as an incentive one-half of the difference between its actual cost and its target rate with the maximum bonus payment equal to 5% of the target rate. A hospital whose actual cost was not greater than its target rate by more than 20% is paid its actual cost. Similarly, a hospital whose actual cost is more than 20% higher than the target rate is reimbursed only to the extent of 120% of target rate.

The effect of this incentive system is to force hospitals to negotiate contracts which are as cost-effective as possible. Since management, consulting and service costs are integral components of a hospital's total operating costs, it is reasonable to assume that such costs will be a prime cost control target. American Medicorp submits that such pressure obviates the need for the type of line-by-line budget examination proposed in § 40(b).

The lack of necessity for prior review of management contracts is further evidenced by the fact that the costs to the hospitals of such contracts are reviewed for reasonableness by Medicare and Medicaid intermediaries on an annual basis as a part of the current system of cost reporting. American Medicorp submits that this procedure is sufficient for determining reimbursable amounts for management and consulting contracts and that other cost control requirements would merely be duplicative and conflicting. The final result of pyramiding cost-control measures will be to confuse providers of services, escalate administrative costs for both the outside suppliers and providers, and preclude the type of long-range planning which American Medicorp has proved to be so beneficial.

Second, § 40(b) is drafted too broadly and thereby encompasses management and consulting service contracts such as those offered by American Medicorp for which there is no history of abuse or unwarranted diversion of health care funds. The section-by-section analysis of S. 3205 which accompanied the publication of the bill in the *Congressional Record* states:

"The limitations on payments under Social Security Act programs [contained in Title IV] . . . are in large part based upon the investigative work, hearings and reports of the Senate Permanent Subcommittee on Investigations and the House Government Operations Committee. These limitations are designed to close reimbursement loopholes, prevent diversion of Medicare or Medicaid funds to non-public purposes." Cong. Rec., March 25, 1976 at S. 4207.

A careful review of the hearings and reports mentioned above demonstrates that the Congressional investigators were not concerned with management contracts.[1] Instead, they were interested in contracts which are basically unrelated to management services. For example, the hearings and reports detail extensive abuses perpetrated by companies formed for the specific purpose of implementing prepaid health plans. In addition, the investigations document less than arms length agreements to provide janitorial, linen, dietary, and other services to nursing homes, illicit factoring arrangements between collection agencies and physicians, and pervasive patterns of hidden ownership of nursing homes with the attendant potential for abuse.

American Medicorp recommends that should Congress find that § 40(b) is necessary in addition to the total cost approach of § 10, § 40(b) should be amended to specifically exclude management and consulting service contracts.

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[1] *See e.g.*, Tenth Report by the Comm. on Gov't. Operations on Prevention and Detection of Fraud and Programs Abuse, H.R. No. 94–786, 94th Cong., 2d sess. (1976); Hearings before the Permanent Subcomm. on Investigations of the Comm. on Gov't. Operations, 94th Cong., 1st sess. (1975); and Hearings before the Intergovernmental Relations and Human Resources Subcomm. of the Comm. on Gov't. Operations, 94th Cong., 1st sess. (1975).

Third, requiring the Secretary of Health, Education and Welfare to give prior approval to all management, consulting, and service contracts will frustrate efficient hospital administration and preclude necessary financial planning and materials management. It is conceivable that the entire administration of a hospital could grind to a halt while the Secretary reviews the multiplicity of service contracts into which hospitals must enter, including *inter alia*, therapy services, security guards, building maintenance, food catering, and linen supplies to name but a few. Effective materials management may also be disrupted because regardless of the manner in which review is conducted, no hospital will know in advance of the Secretary's decision whether it can rely on a particular source of supply. Furthermore, prior approval would prevent hospitals from taking advantage of temporary market conditions which are advantageous to large volume purchasers.

With respect to management and consulting services such as those offered by American Medicorp, the ramifications of § 40(b) are even more onerous. In the first part of this statement, American Medicorp illustrated the significant cost savings for hospitals and therefore for the Medicare and Medicaid programs which flow from the timely implementation of effective mangement programs. The success of such arrangements is often contingent upon immediate recognition and rectification of unproductive or inefficient conditions. For example, as described above, American Medicorp was able to rescue St. Mary Hospital and Sebastian River Medical Center from insolvency only by the *immediate* implementation of broad cost control measures. Since the cost of American Medicorp's services in these cases (as in most) exceeded $10,000, the Secretary would have been required to pass on the contracts before corrective action could have been taken. Given the delays which are inherent in any such review, it is possible that neither St. Mary nor Sebastian River could have been saved.

As noted above, American Medicorp is also able to reduce the cost of patient care through aggressive service and materials management programs. Such programs are predicated on American Medicorp's ability to coordinate services and purchases required by the hospitals. American Medicorp contends that should approval of each major service contract be mandated the possibility for such coordination will be destroyed and any possibility for significant savings through service and materials management will thereby be eliminated.

Finally, American Medicorp has serious reservations about the ability of the Secretary to fairly and efficiently review the thousands of agreements which fall within the scope of § 40(b). The management and consulting agreements undertaken by American Medicorp are comprehensive, complex, and of necessity are the result of extensive negotiations between the contracting parties. In a very literal sense, each management arrangement is "custom-built" to meet the demands and objectives of the contracting hospital. For instance, one facility may require American Medicorp to advance a subsidy while another may have to have payment of the management fees deferred until it is in a financial position to make such payments. The greatly disparate community health needs, fiscal conditions, and levels of patient care which every management contract must take into account effectively precludes any equitable and expeditious administrative determination of whether a given contract should be approved.

American Medicorp believes that the substantial improvements in the delivery, efficiency, and quality of patient care which results from high calibre administrative controls should not be jeopardized by even the possibility of delays in contract approval. Therefore, for the reasons delineated above, American Medicorp recommends that § 40(b) of S. 3205 be deleted. Or, in the alternative, it recommends that § 40(b) be amended to specifically exclude management and consulting contracts.

OHIO STATE MEDICAL ASSOCIATION,
Columbus, Ohio, August 2, 1976.

Hon. HERMAN E. TALMADGE,
Chairman, Subcommittee on Health, Senate Committee on Finance, Russell Senate Office Building, Washington, D.C.

DEAR SENATOR TALMADGE: The Ohio State Medical Association respectfully submits for the hearings record the following comments regarding S. 3205, the Medicare-Medicaid Administrative and Reimbursement Reform Act of 1976.

This Association most certainly supports efficient expenditure of Federal tax dollars.

The Association heartily endorses your stated intent of improving efficiency and containing skyrocketing expenditures in Medicare and Medicaid. However, there are some serious reservations about sections of this bill, reservations based upon the practicalities of medical practice and patient care.

One of our major concerns is over the direct conflict between S. 3205 and that very basic and fundamental section of the original Medicare Act, Section 1801, Title 18, Public Law 89-97, which states:

"Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency or person."

In this clear and graphic statement, the Congress distinctly recognized the Constitutional and civil rights of physicians.

Bearing that statement in mind for future reference, please permit me to offer suggestions and recomendations on various sections of S. 3205.

Section 2. Establishment of Health Care Financing Administration.—The bill would consolidate into a single agency the Bureau of Health Insurance, Medical Services Administration, Bureau of Quality Assurance and Office of Nursing Home Affairs. While such consolidation may seem an efficiency move, would it not be better for each of these functions to maintain its own individual, high profile identity, rather than being submerged into a larger agency. By maintaining separation, the positive and negative factors of each program could be more readily identified and augmented or corrected accordingly.

In face of the growing move to separate the Department of Health, Education, and Welfare into smaller, independent departments, it does not seem logical to be creating, at the same time, a significantly large administration.

Another stated purpose of this section, to eliminate fraud and abuse, is indeed meritorious. Medicine most certainly opposes fraud and abuse in any program. However, present authority of HEW and of the Justice Department is indeed adequate to pursue these matters. This present authority should be exercised more positively, rather than creating the proposed Office of Inspector General.

Likewise, there is a dangerous precedent in the establishment of an HEW General Counsel to prosecute any civil fraud cases, (page 4, lines 14-18) ". . . when *in his opinion* the Department of Justice has not acted in timely fashion following referral of such case to the appropriate United States Attorney and when *in the opinion* of the General Counsel such prosecution is appropriate. (Emphasis added.)"

Establishing such a precedent could lead to an epidemic of general counsels in the various governmental departments, all initiating legal action on the basis of their own opinions. It is recommended that, in lieu of this language, there be an expression of the intent of Congress that the administrators of these programs work closely with the Department of Justice in cases of suspected fraud and abuse.

The proposed establishment of an "Inspector General for Health Administration" (Section 3) simply creates another bureaucracy to do those things which present administrative and executive offices have the authority and responsibility to do.

Section 4. State Medicaid Administration.—The Ohio State Medical Association compliments and supports your efforts in the bill to expedite the determination and accuracy of Medicaid eligibility. This is a serious problem in the Medicaid program. Significant increases in administrative funds will be required if the States are to meet the responsibilities delineated in this section.

Medicaid financing and administration have gone from crisis to crisis. This Association has worked and continues to work diligently with the Ohio Department of Public Welfare in attempting to help arrive at viable solutions.

For effective cooperation by and input from the medical profession, we would recommend that completely adequate avenues and periods for comment be assured under those sections of the bill that deal so extensively with administrative matters in Medicaid. It has been our unfortunate experience in the past to find regulations adopted with little advanced notice and little or no consideration for the recommendations and concerns of medicine.

Section 8. Termination of Health Insurance Benefits Advisory Council.—Again, there is concern over the removal of an avenue of communication between medical professionals and Medicare. Readily recognizing that HIBAC's performance has been less than one might expect of an effective advisory group, we would urge consideration of the retention of this council, with the reconstitution of its membership to provide for more seats for practicing physicians—*those professionals who actually deliver the medical services* for which payment is being made.

As in other government programs, we have frequently observed that advisory groups are treated by the various bureaus and agencies rather condescendingly, usually being approached after the fact than before the fact.

Section 10. Improved Methods for Determining Reasonable Cost of Services Provided by Hospital.—While this section deals more directly with hospital services than with medical services. I am compelled to point out some dangers involved in enactment of this section, dangers that could work undue hardship upon consumers.

I refer to the highly restrictive methods by which hospitals may increase their rates to meet cost increases. Hospitals are no more immune to rising costs than is government or manuacturing. The stringent and restrictive requirements in the present language could and probably will force other hospital patients and third parties to subsidize further Medicare and Medicaid. How? Since hospitals cannot regain their full costs of providing care for Medicare and Medicaid patients, they must increase their charges and per diem rates for private patients in order to survive financially. It is a certainty that the language proposed would further increase such subsidization, working additional unfair hardship on the consumer. It is, in reality, a form of indirect taxation.

This Association supports whole-heartedly that section of your bill (page 30, lines 6, 7, 12 and 13), which would exclude from "routine operating costs" the the costs of physician training programs. Just because a person has the misfortune of becoming ill does not mean he should be forced to help pay for the education of another person.

Section 20. Criteria for Determining Reasonable Charge for Physicians' Services.—The Ohio State Medical Association must officially express its gravest concern and strongest opposition to this section.

This section is a direct and outright violation of Section 1801 of Title 18. The implementation of such language in the law would drive physicians from the program, rather than encourage their participation.

It is the right and the responsibility of the individual physician to determine his own usual, customary and reasonable fee for the specific professional medical service he has provided or intends to provide.

The language in this section would attempt to fix fees under the guise of the prevailing fee concept, would lead eventually to a statewide Medicare fee schedule and lead ultimately to a national Medicare fee schedule.

The proposal would establish a fixed fee system based on an artificial formula that would be discriminatory and probably unworkable. The establishment of a prevailing fee schedule does nothing more than reduce the Federal obligation to the Medicare recipient, an obligation wholly assumed by the enactment of P.L. 89–97.

Section 21. Agreements of Physicians to Accept Assignment of Claims.—The Ohio State Medical Association is most gravely concerned over this section. The entire section should be deleted from the bill.

The attempt to establish two classes of physicians, the so-called "participating physician" and the "non-participating physician," is negative and counterproductive.

The determination of the Social Security Administration to force all physicians to accept assignment is a matter of record. This section is an outright effort to sow the seeds of destruction of direct billing. It "locks in" the physician who signs such an agreement so that he forfeits his right to determine which of his patients shall be billed on an assignment basis and which of his patients shall be directly billed.

Most physicians in Ohio directly bill their patients while, at the same time, they accept assignments in selected cases, particularly when Medicaid also is involved.

Sec. 1868(d)(2)(A).—Offering a "participating physician" a $1 per capita billing fee for submitting claims on a batch, multiple listing basis is very likely an invitation to violate the Principles of Medical Ethics. Those Principles state

that a physician should limit the source of his professional income to medical service actually rendered by him, or under his supervision, to his patients. The physician is expected to render original claim forms as a regular part of his service, and without collecting a fee for the form.

The implementation of this "$1 a head bounty" also would unnecessarily increase the cost of the Medicare program. We urge that this section also be deleted.

The intent of expediting payment of claims is most commendable. However, we would strongly recommend that this be accomplished through expanded use of the Part B Carrier operating on a level such as we have in Ohio, where the mean average between the time a claim is received and payment is made is 8.7 *days*, according to Nationwide Insurance Companies statistics. The carrier's administrative efficiency is better than direct government administrators.

For more efficient and more economical review and processing of Medicaid claims, we would recommend the use of a carrier similar to Medicare's Part B carrier which could, in fact, serve both Title 18 and Title 19.

Section 22. Hospital-Associated Physicians.—The Ohio State Medical Association urges that this entire section be eliminated for a number of good and cogent reasons.

First, the so-called hospital-associated physicians are not second class citizens, either in the medical community or in the community of America. They always have been, are and will continue to be doctors of medicine, just as much as the family doctor, the pediatrician or the surgeon.

The fact that these physicians devote most of their time to in-hospital patients has made them the unwarranted targets of some rather inaccurate public statements and charges.

Also, these medical specialties do not generate the medical services they provide patients. Instead, their services are generated by the direct, written requests of other medical practitioners.

Second, the so-called high average income attributed to such practitioners represents gross income, and their net incomes are appreciably reduced because of significant overhead.

The burgeoning and critically serious malpractice problem in the United States has compelled the primary physician on the case, such as the internist or the surgeon, to order more and more services from the hospital-based practitioners. This is the defensive medicine that must be practiced in these troubled times.

The language in this section would be a direct violation of Section 1801 of Public Law 89-97, which prohibits Federal interference in the practice of medicine.

The section attempts to dictate medical decision-making, which is better left to medical professionals rather than to Federal administrators.

The arrangements whereby the physician reimburses the hospital for making available to him space and certain equipment are matters that should be determined by the two contracting parties, and not by legislative or regulatory dictates.

This Association most readily agrees that there should be no room in this program or in any other health care program for unjustified costs or for fee-splitting. If such do exist, then it would be more positive and more productive to identify each case and have it corrected accordingly.

Furthermore, if there are unnecessary services, this section would in no manner reduce such services. It simply would transfer, or attempt to transfer, payment from the physician provider of the service to the hospital, in no manner reducing costs if, in fact, such costs are reducible.

Would it not be better to leave the question of utilization to the Professional Services Review Organizations, whereby both quality and necessity of service are identified?

The enactment of this section also would work particular hardship on the smaller and rural hospitals. About 60 percent of the nation's hospitals are of 100 beds or fewer, a great number of them being in rural areas. They lack the size and patient census to provide for full-time departments of those specialties usually identified as hospital-based.

To bring to patients in such hospitals the necessary services of these specialists, methods were developed by the medical profession whereby these physicians could share their time and professional attention among several hospitals. This

system, developed after World War II, helped bring high quality medical care to the smaller and rural hospitals, all for the benefit of the patient.

In the area of pathology, for example, these physicians have developed regional laboratory systems that assure swift, high quality services for groups of rural hospitals at reasonable costs.

The determination of the fee charged by the hospital-associated physician should remain a matter of his own professional decision.

The personal identification of the physician directly and finally responsible for the medical service provided is too important an element in good medical care to be submitted to the vagaries of institutional control. Medical decisions and physician services are the responsibilities of individuals, not institutions.

Section 24. Payments for Certain Antigens . . . Under Part B of Medicare.—The Association supports this section as you explained it in your speech on the Senate floor March 25, 1976:

"Where an allergist prepares a reasonable supply of antigens which are then forwarded to the patient's primary care doctor for administration at proper intervals, the bill provides that the allergist be directly compensated for the reasonable charge of preparing and supplying the antigen. Of course, the administering physician would not be paid for the cost of the antigens again, but only for administering or dispensing the medication. The purpose of this recommendation is to avoid an allegation of fee-splitting or confusion of medical roles."

This Association shares your concern and commends your remarks regarding Section 24.

Section 25. "Payment . . . of Fees on Account of Services Furnished to a Deceased Individual."—This Association supports this amendment, which would provide greater flexibility to survivors of the deceased recipient in obtaining payment for services to the decedent.

Section 26. Prohibition Against Assignment of Fees by Physicians and others.—This Association must oppose this section on the basis that it interferes with the physician's right to contract. While the purpose of this section is to prevent factoring, the best, most effective way of preventing such a practice is for the Congress to insist and to make certain that payment for services is made in a reasonable time. This, in turn, eliminates the conditions that cause factoring. To eliminate the cause is to eliminate the effect.

The Ohio State Medical Association is deeply concerned about the overall effects that would result from enactment of S. 3205. It would create a larger bureaucracy, interfere in many aspects of the practice of medicine and the doctor-patient relationship, and would tend to discourage physicians from providing services to Medicare and Medicaid recipients.

It would do very little to reduce unnecessary utilization and abuse, inasmuch as it does not alter the present system, which offers payment for services on demand of the recipient. There must be some restraints and guidelines fashioned to curb the "service on demand" policy of Medicare and Medicaid.

There have been many public pronouncements over the years regarding abuse and fraud in these two programs. The public has been led to believe that the tremendous cost overruns are the direct result of abuse and fraud. Actually, the cost overruns are more directly attributable to the under-estimation of program costs, the under-estimation of utilization and the under-estimation of costs. This has been chronic in these programs since their inception.

The Ohio State Medical Association has repeatedly informed the Congress, the public, the news media and the administrators of Medicare and Medicaid of its willingness to investigate charges of misconduct made against any of its members.

This Association is cooperating whole-heartedly with forthcoming Medicaid investigation in Ohio to be conducted by a select committee established by the Medical Services Administration of the U.S. Department of Health, Education and Welfare.

It is our belief that the most productive solutions to Medicare-Medicaid problems could best be developed in two phases—first, by such investigations as the one to be launched in this state on or about August 15.

The second phase would be an in-depth study and analysis of the two programs, including, the recommendations and findings of investigatory committees.

But the study and analysis should be carried out by those sectors responsible for the provision of and payment for goods and services under Medicare and

Medicaid, namely, the medical profession, the hospitals, the nursing homes, the Part A administrators and the Part B carriers.

The observations, tremendous scope of experiences, and the expertise represented by these groups offer the best opportunity of solving the many problems these programs encounter.

This study should be conducted by the actual persons who deliver these services, provide the goods and facilities, review claims and administer the programs.

The results of the study and the subsequent recommendations then could be used to fashion effective, positive legislation, rather than continuing the bits and pieces of legislation that have characterized the programs since their inception more than a decade ago.

To that end, the Ohio State Medical Association seriously recommends that S. 3205 be tabled at this time, that the Congress authorize and direct such a study, and that subsequent corrective legislation, based on actual experiences and informed observations, be written.

Thank you for your kind attention to this necessarily involved written statement. I respectfully request that it be made a part of the record of the current hearings on S. 3205 now before your committee.

Sincerely,

GEORGE N. BATES,
President, Ohio State Medical Association.

UNION OF AMERICAN PHYSICIANS,
San Francisco, Calif., July 26, 1976.

Hon. HERMAN E. TALMADGE,
U.S. Senate, Washington, D.C.

DEAR SENATOR TALMADGE: On rereading your presentation speech on S. 3205 to the Senate, I once again pick up the good will and common sense contained in it. I intend to respond in the same manner with several suggestions regarding the problems as I see them from my position. It is necessary to summarize briefly my own background for you to evaluate my position.

I come from a long line of Southerners and share with Senator Ervin a common ancestor from the Revolutionary period, whom I admire greatly. I graduated from Vanderbilt Medical School in 1934, spent six years in post graduate training, completing the Chief Residency in Surgery at the University of California Medical School in 1940. I then spent five years on active duty in the Army Medical Corp and began the private practice of General Surgery in San Mateo, California in January 1946. One year ago the mounting costs of malpractice insurance was such that I could not afford to taper off my surgical practice as planned so I closed my surgical practice and took a job in rehabilitation medicine with the County of San Mateo, California. Of note is the fact that I have never even had a complaint of malpractice made against me, much less a suit.

I have served a term as Chief of Staff of Mills Memorial Hospital in San Mateo, Chief of Surgery in each of two hospitals, President of the County Medical Society Judiciary Council, and am past President of the Naffziger Surgical Society. I have just been appointed by the Governor to the Fourth District Medical Quality Review Committee, Board of Medical Quality Assurance. I will be 65 years of age in September. I am justly proud of these honors and achievements but mention them only to give weight to my words.

In the Union of American Physicians and Dentists I have been Chairman of the Insurance Grievance Committee for the four years since its founding. My Committee deals principally with member (provider) complaints but we also assist the members in supporting complaints made by their patients.

In the section of your speech on Federal and State Administration you refer to "people running off in all directions." This is accurate and results from lack of knowledge of the regulations, many of which are conflicting. Until the Freedom of Information Act was passed, interpretive guidelines, Intermediary Letters, and even the Part B Medicare Intermediary Manual were all secret from the physicians and other providers. An inquiry regarding a payment was answered with a curt "Not in Accord with Policy Guidelines" with a refusal to explain further. At the present time indices are lacking or are inadequate or out of date. So now for my first recommendation:

1. I recommend that you add to your legislation the requirement that all pertinent statutes, HEW regulations, Intermediary Letters, directives, and the like be promptly and thoroughly indexed and cross-referenced and computerized for access by all providers. This is now done for the Worlds Medical Literature by the National Library of Medicine, National Institutes of Health, Bethesda, Maryland, 20014 and made available to all parts of the Country by direct wire (Enclosure 1)[1]. This experienced library could readily devise and implement a computer program incorporating all the references described above and include similar details from all the State plans, for use over existing equipment. Refer to correspondence with Robert B. Mehnert, Chief, Office of Inquiries and Publications management which indicates that such an index does not now exist, at least for the physician.

There would be many benefits to such a program. All legislative committees would have immediate access to the means by which the law is applied through the myriad of guidelines, regulations, and directives. Conformity with statistics and court decisions would be evaluated and corrective action taken. Deficiencies would be conspicuous whether in Federal Administrative regulations or regulations derived from them. State plans would be compared in design and performance by HEW. In your own words "Apples could be compared with apples."

The National Library of Medicine would no doubt require additional staff but the cost would be infinitesimal compared to the potential savings in money. The benefits from insuring equal access to the law cannot be measured in dollars. My guess is that here, too, there would be savings in dollars.

Definitions in the various service codes now used are too vague and subject to personal interpretation. Levels of care for which hospitals and skilled nursing facilities bill are similarly poorly defined. There is a crying need for a uniform code to be used nation-wide. Mr. Thomas M. Tierney, Director of the Bureau of Health Insurance, Department of Health, Education & Welfare is working on this very difficult problem at the present time. I enclose copies of correspondence which describe some of the problems (Enclosure 2).[1] I urge you to consult his office. I also enclose a copy of my study on the subject entitled "The Changing of RVS Codes by Intermediaries, a Pernicious and Possibly Criminal Practice." (Enclosure 3).[1] Without a proper tool for coding services delivered, true fraud is very difficult or impossible to identify.

2. I recommend the adoption of a uniform descriptive code for all medical services and that its use be required nation-wide in all government claims, both in the submission of the claims and the processing for payment. Conversion into other codes for calculation of payments would be prohibited.

The tentative code should be published in the Federal Register and one year to be allowed for testing in the field, submission of constructive criticisms, and public hearings before adoption and publication in its final form as an administrative regulation.

This is an absolutely essential tool, long overdue, and well worth the cost. The delay in its construction has already cost money, probably in the millions of dollars. Once the tool is developed relative values of the services in terms of billings can be calculated in a very short period of time; quality and costs of delivery by various Health Service Delivery Systems can be compared in the same fashion.

I think it unlikely that a service code can be so perfect that there will be no differences in opinion regarding the service delivered. This would be the proper concern of the proposed Inspector General in his protective role as opposed to the punitive. You must realize that the intermediaries are mercenaries and at most pay only lip service to the protective role of government. For all practical purposes they have assumed control of the appeals process, and a major reason for physician refusal to "accept assignment" with Medicare claims is the intermediaries arbitrary procedure.

The problems are even greater with Medi-Cal (Medicaid) patients since the physician, if he accepts Medi-Cal patient, is required to "accept assignment." As a result those physicians most likely to contribute care to the poor are now alienated from the system. Refer to copies of my testimony before California State Department of Health on June 28, 1976 with regard to Medi-Cal (Medicaid) reimbursement in California (Enclosure 4).[1] According to our information publication of these new regulations came about through a court decision

[1] This was made a part of the official files of the committee.

ordering it because of vagueness of previously existing regulations. At the hearing the presiding officer noted submission of a written statement by California Blue Shield that the "new" regulations represented existing practices. These practices began during Mr. Reagan's terms as Governor, hence my opening statement to the effect that "it is ironical that the present Director of Health is blamed for them when he inherited them from his predecessor." Be that as it may, this is the procedure under which the Medicaid Program has been administered in California and as of this date still is. My considered opinion is that the procedure was devised by the intermediary and recommended to the Governor.

On page four of your speech you propose a minimum fee on Medicaid: "Medicaid payments for outpatient medical care should not be less than 80% of the reasonable charge for similar care or service." First of all I recommend that you include surgical care. Minor surgery in a properly equipped office can be carried out with enormous savings in time and cost. It saves the cost of emergency room or operating room (or ¾ of it, anyway), It also saves the surgeon's time. It generally saves an office visit. I speak from 30 years of personal experience in this area. At first Blue Shield and Blue Cross were reluctant to pay for my office surgery but after they inspected the setup they never failed to recognize a claim and their savings.

Second, I applaud your setting a minimum fee. I will point out, however, that it discriminates against the poor and the physicians who care for them. I speak as one who has treated large numbers of Medi-Cal patients. In fact I have never turned away a Medi-Cal patient; I treated them personally when I was professionally qualified to do so or referred them elsewhere in exactly the same fashion I referred any other private patient. I will comment on Medi-Cal patients as a class. A high percentage of them are on assistance because of the "Aid to Totally Disabled" (ATD) Program, sometimes for physical ailments, sometimes for mental. A large number are poor because they cannot hold jobs because of alcoholism or undiagnosed emotional problems. Some are just unfortunate. A few, very few, are con-artists. As a class these patients require more care and are more difficult to care for than the non-disadvantaged. The minimum fee should equal the reasonable Medicare fee. I see no justification for making it lower. Furthermore the Medicare fees are, at this time, pegged to 1972 levels. The Economic Indices of 1972, implemented in 1975 pushed fees into the period of the recent price freeze with prices frozen at the calendar year 1971 level (Enclosure 5).[1] You will do better by having a published area fee schedule after conferring with providers in that area. Refer to Testimony before California State Department of Health, specifically the recommendations (Enclosure 4).

3. I recommend that in addition to a standard, nation-wide system of descriptive service codes, there be published for each area standard conversion factors, and that these be reached after negotiation with provision for collective bargaining by physicians.

On page four of your speech you say "the question of frequency of the patient's home visits should be left to the judgement of the physician." From the emphasis given, this is important to you. It is to me, working as I do in a rehabilitation center, preparing them for returning home; for others it is a welcome break in long term care provided at great sacrifice by family and friends. Refer to Section 33 (1) ". . . but such visits and the frequency and length thereof shall be taken into account, together with other evidence, in determining whether such individual is in need of such service." This final sentence nullifies your intent. At the present time if a physician allows a hospital patient receiving Medicare benefits a pass, the reviewer almost without exception will terminate benefits on the date of the pass. You can check this with any hospital in this area. If you want patients to have passes, you must be specific on the standards.

4. I recommend that 33 (1) be revised to reflect the intent expressed in your speech on page 4, second section, on the right of the patient to leave the facility. This is not easy and I will leave the wording to you. But as it now stands the patients will be prisoners or lose their benefits.

I heartily endorse your suggestion for an Inspector General's Department responsible to a high ranking officer and free of undue influence, but I suggest that it recognize the dual role of government which is protective as well as punitive.

The medical profession as a whole and the Union of American Physicians and Dentists in particular in no way encourages or condones fraud. We will wel-

[1] This was made a part of the official files of the committee.

come punishment of those guilty. If this requires a special department by all means establish one. I suspect, however, that the difficulty lies in the legal process itself rather than in the availability of competent officers in HEW willing to proceed.

I have no idea how much fraud exists among physician providers, and even less idea about that among other providers. I issue one strong warning. The fiscal intermediaries make loud noises about protecting the public from provider fraud. This justifies their existence and is biased. Much of this noise relates to an honest difference of opinion regarding the extent of the service or level of care delivered.

The entire Social Security legislation lacks adequate provision for provider appeals, though beneficiary appeals are carefully considered. The entire complex of fiscal intermediaries, utilization, PSRO's, HMO's needs a provision for administrative appeal under uniform just standards. This would properly function under the jurisdiction of your Inspector General's department. Justice requires that the punitive and protective departments be separated completely. At the present time most provider complaints are smothered and concealed by fiscal intermediaries or by low echelon representatives of Medi-Cal Field Offices. This system deprives upper echelons of HEW from the benefits of criticism. There is no way of determining at this time how much of the rise in costs of delivering medical services is attributable solely to change in delivery process by HEW itself. If the providers have access to the regulations through a computerized index in conjunction with an unbiased hearing process incompatibilities and insufficiencies will be exposed and corrected. There are many expensive administrative demands made on providers which hinder the delivery of health care in the system. The goal for any change is to make the entire process better, or easier, or cheaper, preferably all three. Enclosure 6 is an example of the way this information is made available to the physician. There is a mixture of materials. There is no provision for binding. It is poorly adopted to referencing. The appeals procedure is not mentioned.

5. I recommend that there be mandated in the law minimum standards for provider appeals procedure applicable to all government programs dealing with delivery of health care services, and that the process be outside the jurisdiction of the agency involved. This would appear to be an appropriate function of the Inspector General's department envisioned in your speech, though in a department separate from that responsible for prosecution.

A copy of the appeals process used for Medi-Cal providers in California is enclosed (Enclosure 7).[1] It is not bad but could be improved, particularly with regard to developing a control process with identification numbers and a locator file. There is no way at present for an inspector to determine the number of complaints or to evaluate a sample by category or other criteria.

At present HMO's and HSA's are largely unknown but there cannot fail to be provider complaints against them.

Until this point I have not commented on costs of the delivery of medical care related to "malpractice" because it appears to lie outside of the scope of your bill. My considered opinion is that at least one third of the total cost of medical care services results directly from this problem, the greatest portion being in the area of "defensive medicine". I trust you will direct some of your energies toward this disastrous and unnecessary burden which eventually, one way or other, falls on the public.

CLINTON V. ERVIN, Jr. M.D.

PREPARED STATEMENT OF THE UNIHEALTH SERVICES CORPORATION, SUBMITTED BY CARL E. B. MCKENRY, PRESIDENT

We appreciate this opportunity for Unihealth Services Corporation to place a statement in the record in regard to S. 3205, the Medicare-Medicaid Administrative and Reimbursement Reform Act. Senator Talmadge observed at the time of introducing this bill: "None of the proposed changes is frozen in concrete. They are all intended to deal with real problems. Hopefully, he hearing process will lead to refinements and modifications enhancing equitable and effective solutions to those problems. It is in this spirit that these comments are made.

Unihealth Services Corporation is a firm serving as consultants in the health field, primarily to home health care agencies, in areas of computer and data processing services, financial consulting and services, management consulting,

[1] This was made a part of the official files of the committee.

and professional health services consulting. The chairman of our company is a physician and my background is in management and administrative law. We have over twenty affiliated agencies in some 14 states and the District of Columbia. The agencies are all Medicare-certified, private, non-profit, independently and locally owned and operated. Together, they provide services to approximately 12,500 patients daily involving one-half million home visits per year. The goals and services of our affiliated agencies are based on two fundamental philosophical principles: the belief in the innate worth of the aged and disabled individual; and the belief that each individual, regardless of age, sex, race, or religion, is entitled to maximize his potential as a human being and as a member of society. A more detailed statement of our background, purposes, and capabilities is available upon request.

We agree with Senator Talmadge's observation in the Congressional Record of March 25, 1976: "The choice is a simple one—either we make Medicare and Medicaid more efficient and economical, or we reduce benefits."

We recognize that the proposed legislation is conceived and designed to achieve these companion goals of greater efficiency and greater economy in the area of heaviest Medicare and Medicaid cost and possible overutilization, i.e., the hospital. By contrast, it is our understanding that less than 1 per cent of the total Medicare/Medicaid expenditures last year were directed to home health care. But, nevertheless, the home health agency is included under this bill without recognition of its particular problems, needs, and opportunities for full service. It is in the context of home health care that my remarks today in regard to S. 3205 are made.

Our primary concern with the proposed legislation is that it does not consider the potential opportunities that expanded home health care, under proper regulation, affords for those expressed goals of efficiency and economy in Medicare and Medicaid expenditures, not to mention the added benefits in human dignity and accelerated rehabilitation which studies have shown the home environment provides. These are major considerations about which we believe the Congress needs to know more.

There are two major factors preventing the expansion of home health care that should be addressed in this remedial legislation.

First is the limitation of proper access to hospital patients eligible for home health benefits in many hospitals. Within an orderly system, which would not place an undue burden on the hospital administration, the eligible patient should not be deprived of proper and adequate discharge counseling, including full information on those benefits to which he or she is entitled. These information services are provided at no charge by most home health agencies, through skilled and licensed nursing personnel. The Social Security Administration spends large sums of money utilizing radio, television, printed materials, and direct letter mailings to advise our citizens of their benefits or coverage since this program is intended to be one in the nature of insurance. Medicare/Medicaid eligibility information and proper planning of the transition from the institution to the home should not be thwarted because the hospital either desires to avoid the administrative detail or desires to maintain its own affiliated home health facility.

Accordingly, we recommend that a provision be included in this bill requiring that hospitals which hold provider numbers and participate in the Medicare/Medicaid programs be required to allow properly licensed and Medicare/Medicaid participating home health agencies to provide information and counseling to the hospital patient—if desired by the patient—under reasonable rule, regulations, and controls which might include some rotational system if more than one agency desires to provide this service.

A second limitation to the development of home health agencies is the field application of Section 1122 of the Social Security Act. This certificate-of-need provision in regard to capital expenditures is directed primarily toward hospitals and skilled nursing facilities. However, it is considered to include the establishment of home health care agencies as well. We do not object to this in those areas where a large number of home health agencies are operating. A proliferation or concentration of agencies in a given area may keep the number of patients for each agency so low that economies of scale can not be utilized, resulting in higher per patient visit costs.

However, experience to date and the regulations reflect a great reliance by the State Agency designated by DHEW upon the recommendation of the local Health System Agency as to determination of need. Usually, an existing home

health agency is directly or indirectly represented within the HSA constituency and serves to encourage a negative need recommendation which prevents a second or third agency from becoming established in urban or some suburban areas which could support another home health agency. This resulting restraint of legitimate competition does not save money, rather it stifles the goals of efficiency and economy—a lesson which our American system has demonstrated over and over again.

Therefore, our second recommendation would be an amendment to Section 1122 that would require in those areas where only a single full-service home health agency is located (or in heavily urbanized areas, a second or third agency) a negative recommendation be supported in specific detail as to the present plan of home health coverage which the HSA has considered to be adequate.

From the standpoint of the home health agency, the existing provisions of the bill would generally strengthen the system. We do see, however, two areas which, while desirable to eliminate or control perceived abuses, may cause an unintended hardship in certain cases.

Both of these items appear in Section 40 of the bill, which establishes Section 1133 of the Social Security Act, as amended, more specifically in Sections (a) and (b). While we have read conflicting interpretations of these provisions, we can understand the reasons for their proposal. However, one interpretation advanced would create undue and unreasonable hardship without any corresponding benefit to the Medicare/Medicaid system.

The first is in Section (a)(1) of the new Section 1133 which would apparently render any fee determined "wholly or in part as a percentum, fraction, or portion of the charge or cost attributed to any health service" to be unreasonable. If it is the intent to limit this application to: "(A) a commission, finder's fee, or for a similar arrangement, or (B) an amount payable for any facility (or part or activity thereof) under any rental or lease arrangement, we understand the purpose for it although, in fairness to "arms length" agreements which may have been entered in good faith, we believe there should be a "grandfathering" of existing agreements for a reasonable period of time. However, if this provision is intended to proscribe all contracts which have a relationship to revenue or cost of service, it will result in a hardship without attendant benefit. For example, data processing services are to some degree related to volume and a fair and equitable fee schedule for such services may be related, at least indirectly, as a percentage of the volume or cost of service. Other forms of services may be related to a percentage of the volume or revenue, but adjusted by a sliding scale to allow for economies of scale. To indiscriminately force such agreements into some other billing arrangement could result in higher costs, most certainly no reduction in cost, thereby providing no greater economy and no greater efficiency to the Medicare/Medicaid system.

Accordingly, we recommend that this provision be clarified and in that clarification the percentage fee arrangement be limited to those situations specifically set forth in Section 1133(a)(1) (A) and (B).

The second area of concern which we have is in regard to Section 1133(b)(1) regarding advance approval of contracts over $10,000 per annum involving consulting and services. Again we understand the purpose of the requirement for advance approval and, in fact, it is mutually beneficial in order to avoid subsequent disallowance by the intermediary. However, services and consulting contracts can include a range of necessary services from legal and accounting services on retainer to data processing. A $10,000 exemption limitation, because it is unrealistic, would swamp DHEW with requests for approval without a corresponding benefit in efficiency or economy to Medicare/Medicaid. We believe that an exemption limitation of $100,000 to $150,000 would be workable and realistic.

There is, however, a more serious deficiency in our judgment regarding this provision. There presently exists a carefully structured procedure moving from the determinations of the designated financial intermediary to an appellate mechanism which, in the case of amounts in controversy of over $10,000, go to a Provider Reimbursement Review Board (PRRB). There is a provision for review of PRRB decisions by the Secretary of HEW and beyond that judicial review by the U.S. District Court. Therefore, any advance approval requirement must be harmonized with the existing intermediary system.

We thank you for the opportunity to present our views on this important, indeed vital, legislation and would be happy to respond to any inquiries that members of the Subcommittee or Subcommittee staff may have.

AMERICAN COLLEGE OF NUCLEAR PHYSICIANS,
Washington, D.C., August 9, 1976.

Hon. HERMAN E. TALMADGE,
U.S. Senate,
Washington, D.C.

DEAR SENATOR TALMADGE: The ACNP wishes to offer comments on Senate Bill 3205 entitled the "Medicare-Medicaid Administrative and Reimbursement Reform Act."

The American College of Nuclear Physicians (ACNP) represents 1,000 nuclear physicians and scientists engaged in the practice of this particular specialty. Nuclear medicine is defined as that field of medicine which uses radioactive drugs for the diagnosis and treatment of disease.

In the original version of S. 3205 it appears that it would not be possible for physicians carrying out in-vitro laboratory procedures to be compensated under Part B of Medicare.

The ACNP believes that the specialized in-vitro procedures of nuclear medicine (frequently termed radioimmunoassay) do in fact represent a consultative service to individual patients for several reasons.

1. The physician is required to be certain of the quality of the antigens and antibodies, their specificity and adequate labeling with radioactive isotopes. These procedures, however, are not dissimilar to the preparations of antigens as noted in Section 24(a), Section 1861(s)(2), page 64, lines 19-24 of S. 3205.

2. The performance of these tests require special competence and constant review and supervision, particularly in difficult cases for the patients and their referring physicians with whom the nuclear medicine physician is intimately engaged in consultation.

3. The nuclear medicine physician as a consultant is required to interpret the special tests which are performed in his laboratory for the referring physician and therefore, participates directly in the care of these patients.

Several other comments follow.

It would be the hope of the ACNP that S. 3205 would be modified to permit some type of percentage arrangement or relative fee schedule of such a nature that reasonable compensation can be paid to physicians without inordinate and continual adjustment of fee schedules as presently seems to be required.

We are also concerned about Section 40 (Procedures for Determining Reasonable Charge) that the review and advance approval of consulting or service contracts could be construed to include services by physicians rendered to patients whether or not any form of payment had been agreed upon in advance and further, that if so construed, the physician would be severely limited in his arrangements with a given hospital by the contractual requirements so imposed. If physician services are to be excluded from Section 40, an explicit statement to that effect is required for clarification.

In general, the ACNP agrees with the substantive proposals of S. 3205 and wishes to commend you for its content. It is our hope that under this bill, as modified, the needs of our important, specialty field of nuclear medicine will receive the adequate consideration as requested above.

Thank you for your consideration in this important matter. If you have any questions or comments, please contact Ken Nicolas at our National Office.

Sincerely,

JACK K. GOODRICH, M.D.,
President.

EUGENE L. SAENGER, M.D.,
Chairman, Governmental Affairs Committee.

STATEMENT OF CARTER BURDEN, COUNCILMAN, MANHATTAN, 7TH DISTRICT

Medicare and Medicaid, since their inception over a decade ago, have proven to be uncontrollably expensive systems of reimbursing providers for servicing the health care needs of the poor and elderly. In New York City these open ended programs have promoted expansion and overutilization of hospital beds and services without regard for costs or the needs of the public.

New York City has the largest and most comprehensive local program of medical assistance and by far the most expensive. Last year the city's medicaid

bill alone cost the Federal government, the state and the city $1.9 billion—with the city's share being 25 percent or nearly $500 million.

S. 3205, the Medicare and Medicaid Administrative and Reimbursement Reform Act is a long overdue attempt to encourage health care providers to be more efficient and eliminate abuse and fraud which cost taxpayers tens of millions of dollars each year. A uniform national system of prospective reimbursement clearly is needed to control health care costs. However, that uniform system should be carefully developed relying on data gathered from existing prospective reimbursement systems such as New York's.

Based on New York's experience I believe this bill's proposals would do little to control rising hospital costs which account for over 50 percent of Medicaid and Medicare expenditures. For the past five years New York used a loosely applied prospective reimbursement system for Medicaid. During this period health care costs for the area escalated 4.5 percentage points higher than the general Consumer Price Index.

As Chairman of the New York City Council Health Committee and as a member of the Finance Committee I have been keenly aware of the impact of rising health care costs on the city's budget. New York City is one of the few large cities in the country required to contribute anything to Medicaid and the only urban locality contributing as much as 25 percent—which is equal to the state's share. If separated from the rest of New York State, the city spends more for Medicaid that any entire state. In 1974, New York City's Medicaid bill was $100 million more than the entire state of California. Further, if this local Medicaid burden was picked up entirely by the state and Federal government as it is in most other cities, we could almost cover our current budget deficit which stands at $686 million.

In the last six months the Health Committee has held a series of three hearings on New York City hospitals. Every year millions of city dollars go through the Medicaid program into these hospitals—both public and private. The hearings disclosed that much of this public expenditure in the private sector is going to extravagant administrative and medical personnel salaries, toward the further expansion of already large hospitals and unfortunately to greedy medical entrepreneurs who are more interested in profits than in practicing good medicine. Cost plus reimbursement, whether to hospitals or physicians paid on a percentage of the gross basis, only results in more expensive, less efficient health care—not in higher quality.

This wasteful and fraudulent abuse of public money must end. That is we must do away with open ended reimbursement and effectively monitor a system of reimbursement which encourages providers to hold down costs. S. 3205 in its present form does away with cost plus but goes only part way toward achieving its goal of curbing rising hospital costs. By introducing national prospective reimbursement as well as tougher abuse monitoring and penalties, S. 3205 is a significant improvement over the present Medicare/Medicaid system. However, it does not recognize the realities or the overwhelming implications of establishing a nationally supervised hospital reimbursement system.

Specifically, the hospital reimbursement system proposed in this bill does not place tight enough reimbursement ceilings on hospital's operating costs and thus is several years behind New York State's system. This legislation's incentive system is very similar to the so-called prospective reimbursement method used by New York for the past five years, which in practice turned out to be a system of deficit financing. Each hospital spent the maximum on high administrative and medical salaries and expansion of facilities and services knowing that next year's rate would be adjusted to what was spent. New York's experience showed that allowing a hospital to be reimbursed up to 20 percent over their group average—as S. 3205 does—gave hospitals no incentive to spend at or below the target rate and thus beat inflation.

According to a recent Social Security Administration report on prospective reimbursement in New York and five other states, "the magnitude of savings per year that could be attributed to the systems would not even approach bringing hospital cost increases into line with inflation in other sectors of the economy. In this sense, prospective reimbursement is no panacea."

This report documents the fact that New York's five year loosely applied reimbursement system was found only moderately successful at best. During this period, our prospective system managed to lower the average cost per case by a mere 0.5 percent per year.

The current New York State system, is a flat 100 percent reimbursement of all routine costs including energy and medical personnel. Since ancillary costs such as X-rays and laboratory work vary substantially from hospital to hospital, these services are placed under a separate 100 percent ceiling. Most importantly, this system bases cost increases on established criteria not set by the providers themselves. New York State and City unfortunately learned the hard way that major expenditures such as medical personnel salaries and ancillary services must be controlled within the reimbursement system and that all inflationary increases must be tied to the rate of the general economy.

Although New York State's new system has only been in effect for the last eight months, there's evidence that substantial savings of public funds will result. Out of the 332 per diem rates calculated by this new system, over 50 are lower than last years rate.

To implement a loosely applied prospective reimbursement system nationally at this time would be a dangerously regressive move. In view of the likelihood of National Health Insurance within the near future, it's imperative that an effective system of third party reimbursement be devised. We can't hope to succeed in the fight for cost control on a national level if we insist on making the same mistakes that were made at a state level.

The effect of this deficit financing system over the last five years on New York City hospitals—especially the already large so called nonprofit hospitals, speaks for itself. During this period the number of non-profit hospital beds have increased by over 1600 while the number of specialty services multiplied without regard to community need. Large non-profit hospitals have pumped excess funds into new beds, specialty services and the purchase of elaborate equipment rather than much needed ambulatory and home health care services. New York City's Health Systems Agency recently estimated that we have some 4,000 excess hospital beds. Times have been so lucrative for some of the large, more prestigious hospitals that they now own vast real estate holdings and millions of dollars worth of sophisticated medical equipment. The combined real estate holdings of three large non-profit hospitals; Beth Israel Medical Center, Columbia Presbyterian and Mount Sinai make them one of the largest landlords in Manhattan, if not in the city.

It's time hospitals got out of the real estate business and back to the business of providing good quality and cost efficient health care. Our experience has shown that this can be done by implementing a mandatory prospective reimbursement system based on established cost criteria. In order to be effective, tight ceilings on all routine hospital costs and ancillary services must be applied with exceptions made on a case by case basis. Both the system itself and the appeals process should be closely monitored.

Again, before setting up a national rate-setting system, this subcommittee would do well to examine New York's monitoring and appeals problems and improve on a proven ineffective system rather than make the same mistakes on a much larger, more expensive scale.

New York City hospitals, including so called private institutions now receive approximately 60–70 percent of their funding from Medicare and Medicaid with the remaining mostly coming from quasi-public Blue Cross funding. Hospitals which are predominantly publicly funded, in my opinion, should be publicly accountable for their expenditures. Some of the other findings from our City Council Health Committee inquiry in this area are as follows:

Uniform financial reports.—It is not possible to determine from the Uniform Financial Reports hospitals are now required to file with the New York State Department of Health exactly how much salary administrators or medical personnel receive. Fringe benefits such as college educations, thousands of dollars worth of life insurance, city apartments, cars and maid service are often hidden anywhere depending on the hospital in these so called uniform reports.

Auditing.—Once filed and certified by an independent auditing firm, only Blue Cross auditors complete an on-site audit of the hospital to verify costs reported. In the most recent SSA assessment, Blue Cross's auditing performance was rated "unsatisfactory," yet New York State sets Medicaid rates by relying entirely on these audits.

Appeals on rates.—The Division of Health Economics in the State Department of Health is deluged with from 150 to 250 hospital appeals for reimbursement rate adjustments each year. Understaffed and overworked, the state has been hopelessly slow and unpredictable in handling this appeals process.

Reimbursement inequity.—Applying the same reimbursement criteria to all hospitals regardless of ownership rewards the private and non-profit hospitals at the expense of public hospitals. Even though most hospitals are predominantly publicly financed, non-profit and proprietary hospitals "cream" the less sick, more profitable patients leaving the more difficult and more expensive cases to the public sector.

The sections of S. 3205 dealing with Medicaid abuse and fraud are well developed and sorely needed. However, once again our experiences with abuse and fraud in New York City lead me to believe that these provisions underestimate the wide ranging problems that will arise within the scope of a national program. I applaud the new penalties for Medicare and Medicaid fraud and the proposal to authorize the HEW general counsel to prosecute civil fraud cases in some instances. Yet the abuses found with the New York City Medicaid program are often more subtle than outright fraud—but in the aggregate just as costly.

Specifically, based on estimates by the New York State Department of Social Services, at least $160 million is improperly skimmed from New York City's Medicaid program each year. Experience data provided by the city Medicaid program indicates that fraud represents less than 5 percent of all unacceptable provider practices while the other 95 percent are for overutilization, improper administrative and billing practices and a variety of quality of care issues. The point I am making is that Medicaid abuse takes many forms and cannot always be easily identified.

The federal government should find more effective ways of assuring that Medicaid funds are not subject to provider abuses. I believe it will take more than the traditional methods of accounting and reporting to detect these abuses. The more subtle forms of utilization abuse should be eliminated in the effective review by the Professional Standards Review Organizations set up throughout the country. Further, federal planners should even question the standard methods of reimbursement.

According to the city Medicaid program "the most important single factor contributing to the occurrence of fraud and abuse in the health industry is the nature of existing financing and payment practices." I believe S. 3205 provides an excellent opportunity for experimentation with other reimbursement and cost control techniques including:

A test reimbursement system on a per case rather than a per diem basis. Given the fact that it's extremely difficult to control all hospital expenditures by set per diem rates since then lengths of stay tend to rise, we should evaluate hospital expenses by cost per case.

New methods of increasing consumer participation in third party reimbursed health care should be tried. While a system of deductibles scaled to ability to pay may not be appropriate for Medicare and Medicaid patients, some attempt should be made to improve patient awareness of cost.

Incentives for hospitals to operate on a 7-day week rather than the present inefficient 5-day week should be tried. This would eliminate the hospitals' temptation to fill beds needlessly when services aren't provided over weekends.

Making hospitals and physicians operate more efficiently while meeting the public's need for accessible and good quality health care is not an easy task. It will take time, adequate resources and an unprecedented commitment to ridding the system of abusive and fraudulent practices. In my opinion S. 3205 does not yet demonstrate that degree of commitment.

Excessive hospital reimbursement and abuses of inefficiency as well as those of criminality are the crux of the skyrocketing health care cost problem. Frankly I do not think S. 3205 in its present form can make hospitals operate more cost efficiently. Further, it should require hospitals to be more accountable for vast amounts of public funds they now spend before they become fully publicly funded under National Health Insurance.

The ways of large non-profit hospitals who now cry poverty and not unlike the ways of New York City a year or so ago. They've been living well off financial gimmickery and hiding the fat skillfully. Under the tight new reimbursement system in New York, these hospitals are complaining bitterly, just as New York complained when the banks shut off the money supply. Yet like New York, these hospitals can cut the fat and fringes and continue to provide quality services. We overspent and had to learn to live within reasonable limits and now so must health care providers.

STATEMENT OF THE NATIONAL ASSOCIATION OF HOME HEALTH AGENCIES

The National Association of Home Health Agencies appreciate this opportunity to comment on S. 3205, the Medicare-Medicaid Administrative and Reimbursement Reform Act. Started in 1970, our Association membership includes home health agencies, individuals, state associations and national organizations interested in home health care. Our purpose is twofold: (1) to foster high standards of patient care, and (2) to promote methods of financing home health care and encourage the development of quality home health services through the nation.

Our Association concurs with the sponsors of S. 3205, that without improved controls with Medicare and Medicaid the future of expanded benefits to beneficiaries is limited. We wholeheartedly endorse the reform of procedures that must be followed by providers, and, we in general, are most supportive of the effort to improved the program as set forth in S. 3205.

Our Association cannot over-emphasize our support for necessary expanded federal control over the provision of home health services. While our members share the apprehensions of other providers that controls may be too cumbersome and detract from service delivery, we are even more apprehensive of the dangers which lurk without a more uniform application of Federal program monitoring.

We have been shocked by the disclosures of abusive practices within our delivery mechanism, and, we fear a negative reaction to such fraudulent behaviors. Only through constructive reform can these incidences of abuse be overcome. While the analogy between the abuses in nursing homes and in home health has been worn thin, there is some merit in establishing similar control mechanisms between the two service delivery components so as to prevent a shifting of investments from the controlled to the uncontrolled sector. One of the failures of Public Law 92-603 was that Congress did not adequately predict the growth of home service, and therefore, it did not impose sufficient controls. This Congress must write legislation to establish necessary controls. The National Association of Home Health Agencies envision three essential components of such legislation: (1) uniform Federal standards of home health providers for certification and participation in Medicare, Medicaid and Title XX Social Services; (2) effective disclosure and conflict of interest provisions; and (3) requirement of a certificate of need for entry and expansion in delivering home health services.

In our previous conversations with the staff of this committee we have spelled out a comprehensive program for the liberalization of the Medicare home health benefit and expansion of the Medicaid home health benefit. Because we share the concerns of the sponsors of S. 3205 that without improved administrative procedures benefit liberalizations will not materialize, we shall focus the entirety of this testimony to the necessity for administrative and reimbursement reforms. This should not be construed as a consession that benefit improvements are not important, but as an overt attempt by our members to emphasize to the members of this committee that we welcome constructive reforms.

In an attempt to underscore our basic support for the Medicare-Medicaid Administrative and Reimbursement Reform Act and to point out where we believe the legislation can be strengthened or clarified, we present the following section-by-section analysis of those provisions which impact upon the delivery of home health services:

Our Association sees much merit in the proposed Section 2 of S. 3205 reorganizing the government management of health reimbursement and health monitoring programs. As many members of this committee know, the confused management of present programs has contributed greatly to retarding the natural growth of home health services in general, and, it has stalled the positive response to the 1974 General Accounting Office recommendations on Medicare and Medicaid home health services in particular. We hope that the attempt to bring the various health efforts of the Bureau of Health Insurance, Medical Services Administration, Office of Long-Term Care and the Bureau of Quality Assurance under one central direction will improve program responsiveness.

At the same time, however, we must candidly point out to the members of this committee that centralized management will not bring the necessary consistency of quality service delivery of the home health benefits unless additional steps are taken to provide for uniform definitions and standards for home health agencies. We would encourage this committee to include within S. 3205 provision for such federal uniform standards for home health providers. Our Associations cannot emphasize the importance of such a measure to overcome the confusing incon-

sistency of service requirements in Medicare, Medicaid and in Title XX Social Services. Many of the abusive practices in the provision of home care which have received media attention are directly attributable to the lack of a single uniform definition of a home health agency being applied across the board with standardized requirements as conditions of participation.

While central management may overcome the confusion of the separate reimbursement and monitoring programs, such steps of themselves do not ensure administrative conformity of the benefit. Inasmuch as home care does present a unique opportunity for those who would abuse the privileges of program participation, a strong argument must be made for uniform federal standards in the reimbursement programs.

Some may argue that this approach restricts provider entry and forces the agency to provide a range of services, some of which may not be applicable to each patient's needs; however, the reimbursement mechanism is the control on utilization with the patient receiving such services as prescribed. If we are to build a continuum of health care services then it is certainly within the public interest to concentrate efforts at the development of home health agencies which provide a full range of services. We advocate a certificate of need requirement as the test for entry. Certainly, NAHHA would support amendments to allow waiver provisions for a limited period to assist agencies, especially in rural areas, to improve their capacities to meet the uniform standards.

Likewise, the National Association of Home Health Agencies is supportive of Section 3 of S. 3205 establishing an Inspector General for Health Administration. The development of an independent reviewer within the Department to monitor program performance may prevent a repetition of the neglect which home health care has received in the Medicare and Medicaid reimbursement programs. The most objective viewers of the documented abuses in the provision of home care services attribute such abuses to lax management by the Bureau of Health Insurance and lack of interest in such services by the intermediary. Such beliefs, i.e., that home health care is not important enough to be bothered with by government administrators and programs intermediaries, set the stage for abusive practices.

We can only overcome disinterest by establishing an overseer to monitor program performance.

As with the previous two sections, NAHHA supports Section 4 of S. 3205 reforming the State Medicaid administration. We emphasize to the committee that within the efforts to improve the administrative management of the State Medicaid programs consideration be given to strengthen the uniformity of benefit and consistency of reimbursement. While the development of the home health benefit has been seriously retarded in the state Medicaid program for a variety of reasons (many of which were pointed out in the 1974 General Accounting Office report) the failure of the states to provide consistency in program application has breached the spirit (if not the statute) of the statewideness requirement.

While the other provisions of the general administrative reforms have limited bearing upon the delivery of home health care, we do wish to set forth our support for Section 7 of S. 3205. The prompt promulgation of regulations by the Secretary while ensuring sufficient time for interested parties to comment upon the draft regulations is in the public interest. Many of the last regulations to be promulgated under the authority of Public Law 92-603 were those Congressional directives regarding long-term care.

NAHHA has particular interest in the provisions of Section 10 of S. 3205. While Section 10(c) exempts the Part A home health providers from the improved methods for determining reasonable costs of services directed for hospitals, consideration must be given to the specifics of hospital based home health providers. Inasmuch as the apparent intent of Section 10(c) is to allow time for analytic studies on the impact of such controls on the extended care benefit, we believe a more accurate accounting of home care benefits would occur if hospital-based home health servies were accounted for in the same manner as other providers of those services. Thus, Section 10(b) should be specific in requiring the separate accounting of home health services from other services delivered by hospitals. Evidence from the Cost of Living Council and the Economic Stabilization programs, while tentative, indicate there is a tendency for ancillary servreal shifting of funds giving an allusion of services delivery that is less than accurate. Inasmuch as we can appreciate that such separate accounting can be difficult in certain instances, we would urge the committee to provide for waivers

where the institution can prove that compliance with the separate accounting would be a hardship.

Section 10(c) should be strengthened to provide for a series of test projects to develop a range of options for policy markers. As you know, home care is delivered by a variety of provider types, and, we anticipate that without test data imposed reimbursement procedures may disadvantage some agencies. For instance, while many costs are similar among different agencies, transportation costs are more severe in sparsely settled rural areas than in urban areas. How should the reimbursement system account for this variable while holding other data comparative?

Turning to the long-term care provisions of S. 3205, our Association note that limited attention is given to home health providers in any of these three sections.

NAHHA believes that the improved certification and approval procedures set forth for skilled nursing facilities participating in the Medicare and Medicaid programs should also be applicable for delivery of home health. We have testified on numerous occasions for a more vigorous monitoring of the quality of care rendered. Our members are conscious of the fact that some individuals who have exploited the weakness of the nursing home reimbursement system have given thought to entering the home health marketplace to escape the ever increasing scrutiny of institutional services. Likewise, we are concerned about the developing trend of for-profit management consultant services establishing control arrangements over non-profit home health agencies. Controls must be imposed, and, we urge they be imposed uniformly and at the Federal level.

Certainly the recent decisive action by the Under Secretary of Health, Education and Welfare requiring the Medical Services Administration to promulgate in final the revised home health services regulations for Medicaid point to the need for an expanded monitoring system. The revised regulations (if we can rely upon the Under Secretary's directive) will provide for certain single service agencies to deliver Medicaid reimbursed home care services. Who is going to monitor such provision and who will ensure that such limited single service agency growth will not proliferate? Allow us to reiterate NAHH's basic belief that the proliferation of differing standards for Medicare and Medicaid is wrong, and that the proliferation of single service agencies is a step backwards. But even accepting the Under Secretary's decision, where are the controls to prevent abuse? The federal government must have reviewed responsibility.

With specific reference to the upcoming Medicaid home health regulations, our Association urge this committee to require a geographic limitation on the proposed use of single-service agencies. While we can appreciate the rationale for allowing the use of single-service nursing agencies in underserved areas, there is no excuse for the utilization of such services in metropolitan areas. Congress must continue to move toward developing home health providers that will provide a broad range of services thereby upgrading the ability of these agencies to meet patients needs.

While Section 30 of the legislation is responsive to the profit motivations of skilled nursing providers, such limited language fails to address the more serious problem of cash flow encountered by nonprofit home health providers. While we believe certain non-profit institutions encounter similar problems, there is a major difference between the capital requirement and equity return issues of such facilities and the cash flow difficulties encountered by the less capital intensive home health provider. A facility often can rely upon its capital investment as a source for funds to meet short-range deficits. Home health providers seldom have the base from which to secure marketplace financing to overcome short-range cash flow deficits. Many of our members have often been forced to write personal notes to meet cash flow. Serious attention must be given to this issue if expanding the home health benefit is to be a priority. NAHHA encourages the committee to explore efficiency incentives bonuses for nonprofit providers as a possible solution to the problem. We further point out that this particular problem has been exacerbated by the policies of most charitable organizations that underwrite home care services. Many of these groups, such as United Way, will not pay for services in advance, and, therefore, the home health agency is left to meet cash demands until the reimbursement is forthcoming. Obviously, PIP has been an incentive for Medicare participation, but such limited advance funding has also been an incentive for 100 percent Medicare agencies.

NAHHA supports Section 33 of S. 3205, however, we would point to the committee that many of the beneficiaries of home visitation may be inappropriately

placed in the institution in the first place. It would appear that this provision could be a flag to cases of inappropriate setting and that the regulations which implement this section should encourage a monitoring of its use. The necessity for extensive home visits from the institutional setting may be symptomatic of the reimbursement system skewing service delivery to nursing homes, rather than facilitating proper placement with adequate reimbursement. While we pledged not to reiterate our previous statements to this committee for expansion of the benefit package vis-a-vis home health care, the necessity for home visits from the institution could be evidence of inappropriate patient placement.

From the viewpoint of our Association, the most important provision of S. 3205 is section 40. We cannot underscore our support for these necessary monitoring controls. Certainly, our member agencies are concerned that the control procedures may be cumbersome, but we trust Congress will design a system that is both effective and efficient to the government and the provider.

Consideration should be given to the inclusion of Title XX health-related services to the requirements of Section 40, The ever expanding role of Title XX in procuring homemaker, chore and home management services becries the need for monitoring. Even without the uniformity in provider standards which NAHHA believes is vitally necessary, controls must be placed on potential conflicts of interest and possible over-utilization schemes.

We urge the committee to be cognizant of the paperwork requirements which are imposed upon providers in the Medicare and Medicaid programs. Reference is made to consolidate cost-reporting in this section. Our Associations urge the adoption of consolidated cost reporting as a means of improving efficiency while maintaining sufficient monitoring of reimbursements, and, we strongly support its implementation.

In addition to expanding the coverage of such control mechanisms, NAHHA has several suggestions to improve the application of Section 40. We share the expressed concerns of several of the public witnesses who testified that the dollar limitations may be too low within the legislation. Rather than set hard and fast dollar limits, we suggest consideration should be given to a sliding scale for contract review predicated on a percentage amount for instance 5 percent of gross business. Dollar limitations are relative, while, a percent figure captures the importance of the contractual obligations to the agency.

Consideration should also be given to expanding the definition of related organizations. During recent years, several patterns have emerged in home health management. One of these variations has centered on the control of information as a mechanism of management. Through the use of a centralized information system, contro's have been imposed over agencies while avoiding present definitions of related organization for purposes of disclosure and reimbursement. Hence, a for-profit organization can effectively operate through non-profit subsidiaries conflict of interest and disclosure provisions should be reviewed to ensure that potential conflicts and third party involvements are sufficiently monitored. Finally, consideration should be given to the application of such controls within sparsely served areas. Certain waiver criteria from the imposed reporting requirements should be allowed in underserved areas as a possible incentive for agency expansion.

One of the prime ommissions from S. 3205 is a certificate of need requirement for home health services. While NAHHA can appreciate that the legislation was in the final stages of drafting when the Department promulgated regulations revising the Section 1122 rules to eliminate a certificate of need requirement for home health services, we hope the committee will attentively consider the issue. Attached to our statement is a copy of our response to the Health Services Administration regulations. Rather than repeat the language of the letter, allow us to just emphasize that entry into the home health market must be restricted through federal guidelines, administered at the local level where needs can best be assessed and decisions properly structured. To allow for uncontrolled entry and exit from the home health sector by removing the certificate of need requirement is to invite massive exploitation of the marketplace at tremendous public costs and human suffering. If our goal is to build home health agencies within the continuum of health services, then we must cultivate their expansion.

Public Law 92-603 provided authority for consultants to assist skilled nursing facilities upgrade administrative skills. Such a provision should be expanded to provide for such assistance to home health agencies.

Attention should be given to the role of the fiscal intermediary in managing the home health benefit. Our membership continues to point out differing deci-

sions among intermediaries with respect to coverage. Uniform definitions must be instilled. An equally important problem, especially in light of the recent oversight interest in the administration of home benefits, has been the increasing reluctance of certain intermediaries to work with home health agencies. Inasmuch as the program gives the intermediary broad latitude in program management, this trend could cripple the advances which our agencies have made in encouraging home benefit utilization by beneficiaries. Likewise, with recently promulgated regulations for Section 228 of Public Law 92-603, concerning presumed coverage, there is a danger that intermediaries will construe the program minimums set forth in the rules as maximums, thus effectively reducing home health service development.

In conclusion, the National Association of Home Health Agencies wish to commend the sponsors of S. 3205 for drafting an effective piece of legislation that goes a long way toward improving through administrative and reimbursement reforms the prospects for benefit liberalizations. We stand ready to assist in perfecting S. 3205, and we urge the Senate Committee on Finance to expedite consideration of the measure so we may see necessary controls imposed by this Congress.

NATIONAL ASSOCIATION OF HOME HEALTH AGENCIES,
LEGISLATIVE COMMITTEE.
Portland, Oreg., May 3, 1976.

HOWARD B. KELLY,
Director, Office of Policy Coordination, Bureau of Health Planning and Resources Development, Rockville, Md.

DEAR MR. KELLY: The National Association of Home Health Agencies (NAHHA), representing the concerns of certified Medicare home health providers, vigorously opposes the suggested deletion of home health agencies from coverage under Section 1122 as proposed in the revisions to CFR Part 100 promulgated in the Federal Register (Volume 41, No. 55) March 19, 1976.

We find that the Department in recommending the deletion of the certificate of need requirement for home health agencies is advocating a policy of chaos in the health sector which can only lead to pre-emption of the home health field by economic interests, threatening the availability and quality of services to the patient, and leading to adverse cost consequences in the long run.

The argument which has been advanced to remove the certificate of need requirement from home health is based on clearly speculative economic theory. The logic is steeped in classical textbook theory devoid of attention to the realities of the situation. While on paper it may appear that competition in the marketplace might stimulate rapid expansion of home health services, little attention is being given to (1) the question of costs of such policies, and (2) the implications of chaos upon the quality of services to the patient. The textbook approach to growth dissolves when consideration is given to these externalities.

With respect to the cost of unbridled competition in the home health sphere, attention must be given to the patterns which are emerging with the liberalization of the home health benefit under reimbursement programs. The past several years have witnessed the establishment of new control modalities in home health premised on the exploitation of the marketplace. To ignore the potential for abuse which accompanies these developments is to ignore the realities of the circumstances which the Department is monitoring in Regions IV and X. The cost of unchecked exploitation and an increased concentration within the health sector by a handful must be viewed in the longrun consequences of conscious government policy: Can we afford to dissolve our community based service agencies in lieu of nationally controlled economic conglomerates?

The marketplace theory toward development might have credence if it could be proven that development is stimulated to meet the needs of underserved populations. Growth trends in recent years have clearly indicated the opposite. Rather than stimulating growth in underserved areas, the marketplace mechanism which encourage exploitation also forces focus on population centers which will support profit. Thus, new agencies are sprouting up where old agencies exist forcing a vigorous competition; not in price, but in marketing. And, unfortunately, community based home health agencies are no match to the Madison Avenue marketing techniques.

Consideration must be given to the effect of unchecked service expansion upon the quality of services to the patient. Should the recipient of services be subjected to abusive practices while the marketplace mechanisms adjust to a

Darwinistic survival of the fittest? Consumer preference in the health sector has already been proven as a weak protection from fraud and abuse to the patient because so many of the decisions related to placement are third party mandates. How can the patient avoid being pushed into a less than qualified service if the government tolerates poor care?

To say that present agencies want certificate of need protection in order to secure their market is a misstatement of our Association's position. We view the orderly development of quality home health services within the continuum of health services as basic to meeting patient needs. The prime purpose of our association is to support the delivery of high quality, cost effective services to those who would benefit from such services. The absence of uniform Federal and state standards for licensure, the absence of disclosure information and the absence of adequate controls are antithetical to this purpose. Since the laws of supply and demand have not proven adequate in creating a proper distribution of home health services, NAHHA supports intervention through provision for Certificate of Need for participation in Titles XVIII, XIX, and XX.

We believe that local controls must be encouraged not circumvented by federal regulations. Effective home health service programs require that local consumers, providers and government officials share the responsibility of improving local services to meet the unique needs of the individuals in their community. Such controls as state licensure, certificate of need and contract review should be supported by all federal agencies.

Clearly, we are concerned by the often stated analogy to nursing home development that shows that textbook economic theories often turn out to be bad government policies. Unchecked development conforming to the marketplace theory hardly serves the needs of patients and the economic best interests of the government. Rather, the experience shows exploitation with little regard to constraint. In fact, Section 1122 was in part stimulated by the recognition that marketplace factors have limited control on the health sector.

The preamble to the regulatory change suggests that the states are encouraged to develop their own mechanisms for controlling home health services. We find it unrealistic to assume that states will ambitiously extend health planning to home health unless prodded by federal government action and specific guidelines requiring state actions. The fact that the House Ways and Means Committee has set discussion of clarifying Section 1122 to ensure Department conformity with previous intent for attention to all health services, is clearly an indication the Department has errored in its proposed revisions.

Our Association urges the Department to reconsider its position and to rule that certificate of need requirements must be met by home health agencies.

Sincerely,

DONALD D. TRAUTMAN,
Chairman.

KENNETH WILLIAMSON ASSOCIATES,
Washington, D.C., August 5, 1976.

Hon. HERMAN E. TALMADGE,
Chairman, Subcommittee on Health, Senate Finance Committee, U.S. Senate, Washington, D.C.

DEAR SENATOR TALMADGE: I was very interested in the hearings which you held last week on S.3205. It seemed to me you did a dandy job making a record of some of the critical issues that need to be faced.

As a participant in the hearings, the American Association of Nurse Anesthetists gave testimony dealing with the whole field of anesthesia and the role of the Nurse Anesthetists in particular. Their testimony was followed by that of Dr. John W. Ditzler, President of the American Society of Anesthesiologists.

At the conclusion of Dr. Ditzler's testimony, you questioned him about a statement made by the Nurse Anesthetists, i.e., "In 40 percent of the hospitals in the United States a Nurse Anesthetist is the sole provider of the anesthesia service, working as a member of the operating team along with the surgeon in performing a highly essential service to hospital patients."

I am writing you because I believe Dr. Ditzler's answer to you may be quite misleading. It seemed to me he suggested that the 40 percent referred to only represents a very small number of hospital beds and hospital patients out of the total of all hospitals and all patients, and was, therefore, of limited importance.

I point out that the Nurse Anesthetists also stated that of the approximately 16,486,045 surgical procedures in 1974, CRNAs provided the anesthetic in 48.5 percent of all of these cases. This means, of course, that Nurse Anesthetists gave the anesthetic in a great many larger hospitals.

I think you will be interested to know that in hospitals of less than 50 beds, the Nurse Anesthetists gave 67 percent of the anesthetics; in hospitals with 50–99 beds, they gave 65 percent of the anesthetics; in hospitals of 100–249 beds, they gave 50.4 percent of the anesthetics; and in hospitals of over 250 beds, they gave 42.5 percent of the anesthetics.

I am worried, as I am sure you would be, by any suggestion that somehow patients in small hospitals are somehow of less significance or their care less important than patients in larger hospitals. A year ago I checked and found that 50.9 percent of all general hospitals are 100 beds or less. In other words, they are small. 1,486 hospitals are 49 beds or less and 1,504 hospitals are 99 beds or less. The average daily census for this group of small hospitals indicates that 98,838 patients are being cared for each day. The care of these 100,000 patients is just as important as the care of any other 100,000 patients.

As indicated above, the anesthetics provided to those patients requiring surgical operations within this total group is, in the main, provided by Nurse Anesthetists, and it is to the Nurse Anesthetist that the surgeon looks for responsible competency in handling this phase of an operation.

There was a further statement by Dr. Ditzler which, I believe, would be helped by some further clarification. His statement was to the effect that the medical practice acts specify that a physician will always be in charge of patient care. This, of course, is particularly true in the area of surgery. I wish to point out that a physician always is in ultimate charge. However, when it comes to the anesthetic, there is no requirement that the individual providing the anesthetic be an Anesthesiologist, a physician. The surgeon is the one who is in charge and the Nurse Anesthetist, of course, understands this responsibility in relationship to the services she performs. The laws specifically do not require that the anesthetic be provided by a physician or in fact that an Anesthesiologist (M.D.) be present. I believe it is most essential to keep the relationships in proper perspective.

Sincerely yours,

KENNETH WILLIAMSON.

AMERICAN NURSES' ASSOCIATION, INC.,
Kansas City, Mo., August 5, 1976.

Hon. HERMAN E. TALMADGE,
Chairman, Subcommittee on Health,
Senate Committee on Finance, Washington, D.C.

DEAR SENATOR TALMADGE: Due to the great number of witnesses appearing on behalf of S. 3205, we ask that this statement be made part of the hearing records.

The American Nurses' Association represents over 200,000 Registered Nurses. Professional nurses comprise, by far, the largest professional labor component in the health care industry. As such, nurses believe that they have significant comments to make regarding any type of health care reform. The Medicare and Medicaid programs are of particular interest to the Profession and we appreciate this opportunity to speak to S. 3205, Medicare-Medicaid Administrative and Reimbursement Reform Act.

There are a number of Sections in the Bill which, we believe, require clarification. I refer first to Section 2 which establishes the Health Care Financing Administration. This section would combine the facilities and functions of the present Bureau of Health Insurance, the Medical Services Administration, the Bureau of Quality Assurance, and the Office of Nursing Home Affairs into this centralized agency. We believe that a division and fragmentation of responsibility could occur if all HEW health programs are not under the same administration. Quality of care might then be lost in reimbursement reform or be compromised because of financial pressures due to a different ordering of priorities.

With the amendments to the Social Security Act, large segments of the population became eligible for health care services under both the Medicare and Medicaid programs. Not only did the enactment of these amendments create a

demand for additional health care services to accomodate the needs of newly eligible groups, but also, in order to qualify for provider reimbursement status, institutions were forced to upgrade the quality of the health care services they would be providing.

We ask this Committee to carefully weigh and consider the consequences of opting for a reimbursement reform focus at the expense of jeopardizing the evolution of meaningful quality assurance programs. Quality Assurance endeavors are just beginning to have the desired impact on the health care industry. It would be premature to curtail the federal support system for these programs at this time by forcing the Bureau of Quality Assurance to compete for funds and personnel resources under the Health Care Financing Administration. This is a particularly critical concern since S. 3205 equates Quality Assurance more with making eligibility determinations for covered benefits than with upholding appropriate standards of health care. ANA sees this as an unfortunate direction for this piece of legislation to take. Certainly, legislative efforts could attend to both areas, quality assurance and reimbursement reform, without sacrificing one for the other.

Section 3 would establish an Inspector General for Health Administration. His duties would include the performance of such audits, reviews, etc., as deemed necessary for continually ascertaining the efficiency and economy of the Medicare and Medicaid programs. ANA believes that increased legislative clarity regarding the roles of Inspector General and the Assistant Secretary for Health Care Financing and the relationship between these roles would enhance their final execution and prevent confusion and duplication of duties. We would also like to see these new roles delineated in light of the existing role of the Assistant Secretary for Health. We continue to have concern with the separation of responsibility and authority between such things as the Office of Policy Development and Planning within the Social Security Administration.

Requirements relating to recipient mobility and residency have always created many grey areas in the administration of Medicaid progrmas. They leave countless persons in extreme hardship. These areas also undermine the efforts of health care professionals such as nurses who want to provide a comprehensive, humanitarian approach to the patient and his health care needs. Continuity of care through discharge planning becomes an impossibility under such confused circumstances, especially as regards persons who are institutionalized for illness outside their state of residence, migrant workers who need health care services, and elderly individuals who become ill and must live with a son or daughter. Mental Health nurses also experience a great deal of difficulty in helping certain clients secure medicaid reimbursement. Clients with long-standing alcohol, drug, or mental health problems are often without a fixed address. Section 4 attempts to establish some consistency in state Medicaid administration but does not make clear the direction for solutions to problems of recipient mobility and residency. We suggest that this section speak to these issues clearly and specifically.

Section 10 would establish a new method of reimbursement for routine operating costs for hospitals under the Medicare and Medicaid programs. As stated in the language of the bill, this is an attempt to more fairly and effectively determine the reasonable cost incurred in the provision of hospital services. Under routine operating costs, intern, resident, and medical personnel cost are excluded. Nursing personnel costs are considered a part of routine operating costs. We would like to call your attention to the fact that there is no present way to examine nursing costs because they are hidden in routine hospital costs. Any professional service must have, by definition, a degree of autonomy, and identity which sets it apart from other types of services. This "setting apart" facilitates professional accountability and responsiveness to the consumer. The consumer, likewise, is in a better position to evaluate the care he is receiving. Separation of the professional nursing service component from housekeeping and maintenance services, and other routine operating costs would provide a truer financial picture which should further the bill's purpose to accurately assess and restrain rising health care costs. We strongly recommend that nursing services not be hidden in the routine operating costs category. Several hospitals in the Phoenix area have set up separate cost accounting and billing for nursing services. Nurses report that awareness of accountability to the patient/consumer has been enhanced as a result. We hope that you can facilitate the continuation of this process.

Section 10 also provides for the use of a wage index based on general wage levels (including fringe benefit costs) in the areas in which the hospitals are located so as properly to adjust such component to the general wage level (including fringe benefit costs) prevailing in the respective areas. If, in a given area, the wage level for hospitals is significantly higher than the general wage level in such area, then the general wage level in such area shall be deemed to be equal to the wage level for hospitals in such area, but only during the first year. How this discrepancy will be dealt with the second year is not clear. The plight of the health care employee has only recently begun to be alleviated. These employees have been forced to accept the unilaterally determined substandard wage package for decades. With the advent of collective bargaining, many hospital employees have upgraded their salary and working conditions. Some hospitals have been more progressive in these areas than others. ANA would hope that the employees who have obtained greater economic and general welfare status would be protected from salary cut-backs (correlative to the general wage level in the area) past the first year.

Section 11 creates a Hospital Transitional Allowance Board. Clarification is needed as to this Board's relationship to Health Systems Agencies. In reviewing applications for transitional allowances for a qualified facility conversion, the Hospital Transitional Allowance Board appears to be duplicating an HSA function.

Section 20 sets out criteria for determining reasonable charge for physician's services. No mention is made of reimbursement for non-physician providers. In hearings on the Social Security Amendments of 1972, Senator Curtis called attention to the untapped potential for utilizing the services of nurse practitioners in rural settings where the physician shortage is especially acute. Senator Curtis at that time called attention to a paper entitled "A New Look at the Visiting Nurse," by R. Paul Hoff, M.D. of Seward Clinic, Seward, Nebraska. Doctor Hoff's article pointed out both the opportunities available in utilizing the services of nurse practitioners and the problems involved for the nurse in obtaining third-party reimbursement for services rendered. The inability of the nurse to obtain third-party reimbursement under Medicare/Medicaid was cited as a major obstacle to utilization of the nurse practitioner in easing the physician shortage.

Such future problems could be avoided by changing the title of Section 20 to read, "Criteria for Determining Reasonable Charge for Professional Providers." This section could specify reimbursement for non-physician professional providers. As regards professional nurse providers, care would be rendered by licensed registered nurses within the scope of their practice as defined by State law.

We believe this bill represents a significant effort to deal with the complex issue of Medicare-Medicaid administrative and reimbursement reform and we hope our suggestions are helpful in achieving that objective.

Thank you.

Sincerely,

ANNE ZIMMERMAN, R.N., *President.*

THE NATIONAL ASSOCIATION FOR MENTAL HEALTH, INC.,
Arlington, Va., August 6, 1976.

Hon. HERMAN E. TALMADGE,
Chairman, Subcommittee on Health,
Senate Finance Committee, Washington, D.C.

DEAR SENATOR TALMADGE: The Mental Health Association strongly supports your action to improve the administration of Medicare and Medicaid, and to prevent abuse of those plans. Therefore, although we are not competent to pass judgment on all the details, we endorse S. 3205 in principle.

We also urge the Subcommittee on Health, while it is taking up amendments to Titles XVIII and XIX of the Social Security Act, to consider S. 3642, introduced July 1 by Senator Stafford, and now before the Committee. We also urge the Committee to consider S. 3708, introduced on August 3, 1976, by Senator Brock.

S. 3642 would amend Titles XVIII and XIX by removing the discrimination against the mentally ill now incorporated by law in both Medicare and Medicaid. S. 3708 would amend Title XVIII to make Community Mental Health Centers qualified providers of Services under Medicare.

We are enclosing a statement on this subject, and hereby request that this letter and the accompanying statement be inserted in the hearings on S. 3205 when they are printed.

Thank you very much for your courtesy.

Sincerely,

HILDA ROBBINS,
Chairperson, Public Affairs Committee.

AMENDMENTS TO MEDICARE AND MEDICAID, TITLES XVIII AND XIX OF THE SOCIAL SECURITY ACT, RECOMMENDED BY THE MENTAL HEALTH ASSOCIATION

MEDICARE

Medicare, Title XVIII of the Social Security Act, discriminates against mentally ill persons. It discriminates directly by setting forth more restrictive limitations on the coverage of mental illness than on all other forms of illness; It discriminates indirectly by failing to recognize Community Mental Health Centers per se as primary providers of health care.

Direct discrimination

In Part A, hospital insurance, which is provided automatically to all Medicare eligibles, Section 1812(b)(3) sets a lifetime limit of 190 benefit days in a psychiatric hospital. There is no lifetime limit on time in other hospitals. Section 1812(c) provides that anyone who is a patient in a psychiatric hospital at the time his Medicare coverage begins shall have his first benefit period reduced by the number of days already spent in the hospital. No such reduction applies to patients in other hospitals.

In Part B, the supplemental medical insurance available on payment of monthly premiums, Section 1833(c) limits reimbursement for treatment of "mental psychoneurotic, and personality disorders" to 50 percent of the doctor bills and related costs, after the deductible. Treatment of all other illnesses is reimbursed at 80 percent after the deductible. In addition, Section 1833(c) places an annual ceiling of $250 on reimbursement for treatment of mental illness ($202 if the deductible is also for mental illness). No annual ceiling is placed on reimbursement for treatment of any other illness.

Indirect discrimination

The indirect discrimination lies in the failure of Title XVIII to recognize Community Mental Health Centers per se as primary providers of health care.

This omission presumably stems from the fact that the centers did not exist in their present form prior to 1965, the very year Congress created Medicare. Today there are some 600 centers in operation and upon fulfillment of the program set up by Congress there will ultimately be 1500, one for every 150,000–175,000 Americans. In the Community Mental Health Centers Amendments of 1975 (Title III of PL. 94–63) Congress mandated that to qualify for federal funding a Center must serve the 65-and-over age group, essentially the Medicare population, as well as all others.

If a CMHC is operated as part of an accredited hospital, it qualifies under Part A as a primary provider of hospital care. If, however, the center is "free standing" it does not qualify unless it meets the same accreditation standards required of a full operable general hospital or a large state psychiatric hospital, standards far beyond any reasonable requirements for a facility treating only ambulatory patients. As a consequence, only seven percent of the free-standing CMHCs have been able to obtain Medicare reimbursement for inpatient treatment.

Most mentally ill, of course, do not require hospitalization but are seen on an outpatient basis. Part B of Medicare will generally reimburse for outpatient treatment in a hospital setting. In other cases, however, reimbursement is available only on a fee-for-service basis and then, quite often, only if the patient is seen by a physician (rather than any other member of the mental health team) or, ludicrous as it may seem, only if there is a physician somewhere on the premises at time of treatment. The net result is that only twenty percent of the free-standing CMHCs qualify under Medicare as providers of outpatient services.

The concern of the Mental Health Association is of course for the patient, not the provider, but it is manifest that it is the patient—or the emotionally disturbed elderly man or women who should be a patient—who suffers when the most logical, best qualified, and usually least costly provider is ineligible. It may

also be noted that Congress to date has appropriated more than $1.3 billion to help establish Community Mental Health Centers and, as of this writing, is in the process of appropriating additional funds for the coming fiscal year.

Recommended amendments

To end Medicare discrimination against mentally ill persons, the Mental Health Association recommends amending Title XVIII as follows:

1. Repeal those sections of Parts A and B that place more restrictive limitations on mental illness than on all other forms of illness, specifically, Sections 1812(b)(3), 1812(c), and 1833(c).

2. Insert language recognizing as primary providers of health care those Community Mental Health Centers which (whether or not actually receiving federal grants) meet the definitions and operating standards specified by Congress in PL. 94–63 and which comply with the implementing regulations issued by the Secretary of Health, Education and Welfare.

S. 3642, introduced July 1 of this year and now pending in the Senate Finance Committee, would amend Title XVII exactly as we propose. Sections 1 and 2 of S. 3642 would insert language throughout Title XVIII to assure that qualified Community Mental Health Centers are recognized under Medicare as primary health care providers. Section 3 of S. 3642 would repeal Sections 1812(b)(3), 1812(c), and 1833(c), as we are recommending.

If the Committee cannot accept the revision of S. 3642, we hope that it will support S. 3708, introduced by Senator Brock on August 3, 1976, which "amends Title XVIII of the Social Security Act to include Community Mental Health Centers among the entities which may be qualified providers of services for Medicare purposes and to redefine terms used in such Title so as to reflect such inclusion." The Mental Health Association strongly supports this bill.

Costs

The Mental Health Association is fully aware of the skyrocketing costs of Medicare and is no less concerned than Congress. Fortunately there should be no additional cost and possibly some slight saving in recognizing Community Mental Health Centers per se as primary providers.

Undeniably there would be some added cost in equalizing the benefits through repeal of the three sections listed above. The added cost of striking the 190-day lifetime hospitalization limitation should not be great because of the small number of patients affected. The same may be said of the provision requiring the initial benefit period to be reduced by time already spent in a psychiatric hospital. But the fact remains that there would be additional cost and it would seem prudent for the committee reports, if not the law itself, to make it plain that coverage is intended only for active treatment and not for custodial care.

The most noticeable impact (and it would be noticeable only in actual dollars, not as a percentage of total Medicare costs) would follow repeal of Section 1833(c) inasmuch as that would increase reimbursement for doctor bills and other outpatient services from 50 to 80 percent after the deductible, and would remove the $250 annual ceiling, making reimbursement for mental illness the same as that for all other forms of illness. Should the Congress feel that because of the current economic picture this is not the time to repeal Section 1833(c) outright, several intermediate steps suggest themselves. One would be to limit this year's amendment to eliminating the discounting of doctor bills and the like so that reimbursement for mental illness would be at the same 80 percent as for other illnesses. Another would be to strike out the annual ceiling. This would not be as open-ended as it might seem, for fewer than five percent of all CMHC patients require more than twenty visits. Or, if that were unacceptable, raise the ceiling to $500 this year, which should cover the great majority of cases and defer until a later date its complete elimination. Here too, as a matter of cost control, it would be well to write into the committee reports or the law itself that Medicare is intended to cover active treatment of mental illness, not custodial care.

Legislative history

The intent of Congress in placing more restrictive limitations on mental illness coverage than on other coverage is not spelled out in either the House or Senate committee reports on HR. 6675, the 1965 bill creating Medicare. The only clue to Congressional intent is found in a single sentence in the House report (No. 213, 89th Congress, 1st Session) explaining the reason for reducing the initial benefit period of one who was in a psychiatric hospital at the time his Medicare

coverage began: "This provision is in keeping with the intent of the plan to cover only the active phases of treatment of mental illness and not to cover . . . a person who may have been institutionalized for many years."

In the absence of any other explanations, it seems reasonable to deduce that the other restrictions in Title XVIII are for the same purpose—"to cover only the active phase of treatment." That is precisely what the Mental Health Association is seeking. However, the existing restraints in Title XVIII not only preclude coverage of custodial care, in keeping with the intent of Congress, but also work to preclude adequate coverage of "active phases of treatment" of America's aged mentally ill, which is contrary to the expressed intent.

There is no legislative history regarding failure of Title XVIII to recognize Community Mental Health Centers as primary providers. At the time Congress created Medicare, the network of CMHC's simply did not exist. Although construction grants were first authorized in 1963, it was not until 1965, the same year Title XVIII was enacted, that Congress authorized operating grants for centers. Thus they were an unknown, if not actually an unheard of, commodity.

For a number of reasons, including until 1975 the lack of any Congressional mandate to treat the elderly, the matter did not get to the legislative stage in the intervening years. Recently there were discussions at the staff level but the subject did not get beyond that stage primarily due to inability to agree on specific criteria.

Today this situation no longer obtains. In PL. 94–63, the Congress itself incorporated a detailed definition of a CMHC and set forth a number of specific requirements for its operation. Several of these requirements are especially germane: a center, to be eligible for federal funding, must serve the elderly as well as all others; a center must set up a peer review system to insure quality performance by all staff; a center must have a system of utilization review in order to assure that each patient is getting the treatment he needs and that no patient is being seen more often or longer than necessary.

Finally, the Congress in the preamble to Title III of PL. 94–63, declared: "The Congress finds that (1) community mental health care is the most effective and humane form of care for a majority of mentally ill individuals; (2) the federally funded Community Mental Health Centers have had a major impact on the improvement of mental health care . . . and thus are a national resource to which all Americans should enjoy access."

In essence, the Mental Health Association is asking that Title XVIII, which reflects the views of Congress as of 1965, be updated to conform to the judgment of Congress in 1975.

MEDICAID

Title XIX of the Social Security Act, Medicaid, as it is now written, makes it unusually difficult for Community Mental Health Centers to serve the indigent with any hope of reimbursement through Medicaid. Yet the Community Mental Health Centers amendments of 1975, Public Law 94–63, in effect makes the centers themselves responsible for obtaining Medicaid reimbursements to offset the phasing out of direct Federal grants under P.L. 94–63.

The Mental Health Association is fully committed to the concept of step-by-step decrease in Federal funding of the centers over the eight-year period set by law. It was our expectation—as well as that of Congress—that much, if not most, of the difference would be made up by increasing third-party payments, including not only patient fees and insurance proceeds but also—and most certainly—Medicare and Medicaid reimbursements. It is self-defeating to enact P.L. 94–63 on the one hand and fail to enact implementing amendments to Titles XVIII and XIX of the Social Security Act on the other hand.

As we have already noted, Sections 1 and 2 of S. 3642 would make the necessary changes in Title XVIII to make it consistent with the 1975 centers amendments. Sections 4 and 5 would do the same for Title XIX, Medicaid. The Mental Health Association urges the Committee to incorporate the provisions of S. 3642 in the bill reported out as a result of these hearings.

PREPARED STATEMENT OF LYLE H. NELSON, M.D.

This testimony is submitted by Lyle H. Nelson, M.D. I am a family physician practicing in Crete, Nebraska, a village of approximately 5 thousand located near

Lincoln, Nebraska. I am an assistant professor of Family Practice of the University of Nebraska College of Medicine.

This testimony is submitted as an individual on behalf of approximately 131 physicians who practice in 61 counties with county populations of less than 10,000, which encompasses 5 percent of the state's area, thus representing about 10 percent of the total office practicing physicians in the state of Nebraska. There is no specific organization to speak solely for rural physicians. Most of us belong to the American Medical Association, American Academy of Family Practice, State and local Medical Societies. You must appreciate, however, that there is no way to organize such a geographically wide spread group of rural physicians. When we are gone our patients are without care, therefore, seldom do we as a group attend meetings outside of our local or state societies. Usually arrangements must be made with an adjacent practitioner so that one might attend such meetings without leaving a county without a physician.

I, therefore, speak as an individual hoping to express the feelings of the 15.3 percent of all practicing physicians in the United States who practice in areas of non-metropolitan counties. These physicians number 41.9 physicians per 100,000 population in the rural areas of the United States and represent in Nebraska 1 physician for every 2,366 rural residents; corrected for semi- and retired physicians, this probably represents more closely one physician for every 2,500 rural residents.

I am particularly interested in those parts of S. 3205 which may improve the chances of equal benefits to rural resident recipients of Medicare and Medicaid by equalizing the profile of rural physicians with urban physicians (Section 20-E).

I doubt that it was the intent of Congress to have the Medicare and Medicaid program administrated in such a way so as to have differential of benefits based on the location of residents or practice. I am much in agreement with Section 20–E, page 52, which changes profile areas to only one profile per state. I strongly object to dropping the prevailing charge level to 50 percent from 75 percent. This approach to correction to a previous error by restriction of all physicians would serve only to cause much disagreement and argumentations to occur between rural and urban physicians.

I would also request that the area of the nation with the lowest usual and customary rates be rewarded by improved re-imbursement systems (for example, a full 80 percent without discount up to the national means). This would discourage the current situation where doctors tend to relocate to an area of higher profiles, higher prevailing or customary charges in order to improve their collection standards. There are many instances within our state where well established family physicians in physician short rural areas have relocated. In almost every circumstance they have relocated to areas that have higher profiles and higher salary or customary charge levels.

Regarding Section 20–F, item I, criteria for physicians shortage areas should be outlined more precisely by Congress to preclude the misuse of regulatory prerogatives by HEW agency. Numerous statistics have been accumulated by governmental agencies, AMA and definitions previously established should be utilized to provide outlines of physician shortage areas. I would suggest that the following criteria be considered: The National Statistics regarding physician-patient population ratios by county should be utilized. A rural community has been defined in previous studies as being one in which a county population of less than 10,000 is reported. Statistics show that less than 1 percent of the total non-federal physicians in the United States practice in counties with less than 10,000 population, only 15.3 percent of all practicing physicians in the United States practice in areas of non-metropolitan counties. The national doctor-patient ratio is 41.9 physicians per 100,000 population in rural areas. In 1972 there were 167 physicians per 100,000 population in the United States as a whole or in other words, there was one physician for every 600 people in the general population but only one physician for every 2,500 rural residents. I would suggest that when the patient-doctor ratio in a community exceeds 1.5 times the national average patient-physician ratio, a shortage area is anticipated. In those areas where such ratio is 2 times the national average, a critical shortage area is in existence. In arriving at these statistics an effort should be made to delete from the statistics the non-practicing or semiretired physician. For example, (A) a county of 9,000 population with three actively practicing physicians, the patient-doctor ratio would be 3,000 to one, and a critical physician shortage is in existence. (B)

In a county of 9,000 residents with six physicians, a patient-doctor ratio of 1,500 to one would be found and a shortage of physicians compared to the national average would be in existence. (C) In the same county with 12 actively practicing physicians the patient-doctor ratio would be considered to be acceptable.

Regarding Section 20–F, subsection II, this paragraph should be deleted. It will cause many problems in that established physicians will not be treated equally as a new physician in the same area. The established physician will be encouraged to relocate to achieve equal benefits for his patients. I can foresee many circumstances where a doctor would move his office potentially five or ten miles down the road in order to achieve a 15 to 20 percent increase in benefits for his patients. You must remember that it is not after all of great benefit to the physician to practice in any area of high profiles but it is in actuality a benefit to the Medicare recipient.

If the intent of Congress is to encourage improved distribution of M.D. and equal Medicare and Medicaid benefits to the beneficiaries then: (A) All physicians new and established should have equal usual and customary and prevailing charge levels within the state; and (B) In physician shortage areas any fee that is below the national prevailing average fee should be regarded as reasonable to encourage the location of new young physicians in this area; (C) The prevailing fee for a state should be based upon 75 percent of the state charge levels with the profile areas not restricted to sub-geographic areas based on rural-urban or other criteria.

I. I have read the testimony of the College of American Pathologists and I agree and appreciate the position of the College of American Pathologists to improve the quality of the pathological consultations in rural areas, (see page 8, summary statement and page 55 of general statement).

II. I disagree with their statement on page 62, item four, where the College of American Pathologists are opposed to changing the criteria for determining reasonable charges and I do not believe that the College of American Pathologists fully appreciate the problems of the minority group of rural physicians who have so unfairly had fee profile restrictions. I do not believe that they can speak for us and understand our problems any better than I can speak for them.

III. I find it difficult to be sympathetic with their concern for a possible minimal change of reasonable fees in urban areas, if the rural M.D.'s fees are re-evaluated to establish a new state wide prevailing rate. Surely, the re-evaluation of less than 15 percent of the total physicians in the nation could not statistically vary the other 85 percent profiles very much and it would go a long way in correcting the errors that have occurred over the past ten years of the Medicare and Medicaid programs. On Page 65 of their testimony they state that they want the same pathological services to be considered the same as all physicians, yet in their testimony regarding changing the resasonable charges they seem to request denial to rural physicians their request, too, for equal treatment.

IV. The College of American Pathologists on Page 2 of Appendix A, state that proposed section 1861–Q3 of the Social Security Act, section 22, creates two classes of physicians, this time singling out pathologists for special and unequal treatment. I agree that this should not occur, however, the rural physicians of the United States have been treated unequally, since the onset of Medicare in 1966 in many states of our nation and it is well past the time that this error should be corrected. The correction of this error will not in itself be a financial boom for the rural physician. It will only, in fact, be a equalization of Medicare/Medicaid benefits for the rural residents who seek medical care from rural physicians and it will act as a very strong inducement to newly trained young family physicians to locate in physician poor rural areas. It is my firm opinion that only Congressional action can correct this error caused by HEW regulations.

I have read the testimony of the American Medical Association and I disagree, in part, with pages 15 and 16 of their testimony. Again, it is their conclusion that a re-evaluation of the state to develop state-wide prevailing charges would result in a great decrease in the state-wide prevailing charge for the urban physician. But so few physicians practice in physician short areas that the minor statistical change in the prevailing charge for the urban areas would be barely felt. It has been suggested that if no medical fees at all were paid to rural physicians, the total overall savings to the Medicare program would probably amount to less than 1 percent. In justification of the position taken by the American Medical Association on this particular issue, I would suggest again that it is likely that the majority of the elected representatives serving the Associa-

tion do in a democratic fashion speak more strongly for the majority of physicians who live in the urban area.

We should not do anything in this modification to decrease the benefits or prevailing usual and customary charges of urban areas but only to increase those benefits in the rural areas. Why do we have to consider modifying the prevailing charge levels by dropping it to 50 percent instead of the current 75 percent? Why do we have to worry at all about changing the urban prevailing charge rate when it would be so easy to merely raise the state-wide prevailing rate to be equal to that in the urban areas. The AMA's suggestion that Section 20 not be adopted represents a position taken by the majority of members of the AMA who are in the urban areas. As I have previously stated, no specific organization speaks for the minority of rural physicians who would stand to strongly benefit by section 20.

JUSTIFICATION OF CURRENT INFLATED MEDICAL FEES

The following summary is extracted from page 32 of a report on "Socio-Economic Factors Related to the Problems of Rural Health Care in Nebraska" which I completed in 1973.

In all honesty much of the current state and federal legislation and taxations may have some discriminatory effects on the profession of Medicine where almost all of the income is taxable in 100 percent of its total value. A physician has spent ⅛ of his life training to be a physician and thus utilize his education and spent all of his working time in an effort to specialize in a specific field of Medicine. The average working hours per week as a physician greatly exceeds that of the common laborer in the nation and labor unions are trying to decrease their hours. The physician's rates are generally based upon his time with additional time rates for weekend and night calls. There are certainly no rewards other than emotional ones for continuing health care delivery beyond a point of extortionary taxation. The incentive of the individual to continue production beyond the average production rate should not be discouraged by taxation methods. One can imagine positive influencing factors that would be granted to the location in doctor poor areas if new physicians locating there were permitted the opportunity to retain a greater percentage of their earnings for differential taxation.

It seems unusual that we should have established such a high priority of medicine in our country, have so much wide spread political and press publicity against medicine as being over-priced when probably less than 1/20th of the working day is spent to pay for medical care, nearly ⅜ths of the working day is spent to pay for federal and state taxation. I do not personally believe that it is excessive to spend 23 minutes out of a working day to pay for our medical care when 19 minutes are spent to pay for our recreation, 25 minutes is spent to pay for our clothing and 38 minutes to pay for transportation. I personally believe that social reformers have taken the position that, perhaps, by inflating emphasis on cost of medical care they can justify their goals of attaining total socialized medicine. All should be reminded in all honesty only 14.5 percent of the total Medicare dollar is spent for physician services, of this it is quite likely that the hospital based services, specifically surgery, pathology, radiology account for probably 12 percent. It is quite possible that if none of the benefits of the Medicare program were to go to primary care physicians, there could be only a savings of 3 percent in the total Medicare costs. It is also quite possible that if no fees were paid to rural physicians at all that the total cost of the Medicare program would probably be less than 1 percent. It is, therefore, quite possible that if no fees were paid to rural physicians for any services that the total savings to the Medicare program would probably be much less than 10 percent reduction in the administrative costs of the Medicare program itself. I would greatly suggest a maximum publicity and political effort be made to decrease the administrative costs of the Medicaid program which probably accounts for well over 30 percent of the total Medicare expenditure.

The rural resident must pay the same tax rates as every one else but his re-imbursement for Medicare services is going to be based on a rate that is different than his urban contemporary. Many people in rural areas have found that it is less expensive for them to get in their car, bypass their local physician and drive to an urban area with a higher accepted payment rate, than it is to go to their own physician. In 1971 the national average for an initial office

visit for general practice was $9.67, yet in our area we were being told by our insurance carrier for Medicare, Medicaid that the usual and customary fee in our area was limited to $4.50. It is hard for me to imagine how this figure could be considered to be inflationary.

Since statistics also show that the immediate income of rural medical practice is more than $2,000.00 less than annually in urban areas, perhaps some system of granting a $10,000.00 a year tax deduction for practicing in physician poor areas would be a major incentive factor towards the re-location of physicians in physician short areas. Although I generally agree with the testimony of the American Medical Association and College of American Pathologists and the Anesthesia Association regarding their positions taken on the bill, I feel that there were certain specific areas of difference that justified my submission of this report. Even if Congress is not able to pass S. 3205 in its entirety, I would strongly urge them to make modifications to improve circumstances for the rural resident and rural physician.

In general, I have limited my testimony on the S. 3205 to primarily that section regarding the criteria for determining reasonable charges for physician services and specifically those areas of modification which would improve the re-imbursement rate for rural residents and the prevailing charge levels for rural physicians.

Socioeconomic Factors Related to the Problem of Rural Health Care in Nebraska

(By Lyle H. Nelson, M.D., Crete, Nebr.)

* * * * * * *

III. BASIC CRITERIA AND NEEDS WHICH AFFECT THE PHYSICIAN'S DECISION AS TO WHERE TO LOCATE

Interest in the factors which influence the location decision of a physician has increased due to intensified discussion of the supply and geographical distribution of physicians. Understanding the motivational process behind a location decision will clarify the broader supply and distribution issues.

Since numerous factors enter the typical decision process, one convenient method for approaching the topic is to group the factors according to categories of influence. Five major categories of influence on physician location can be distinguished:

1. Prior exposure—those events in the life of the physician which have allowed contact with a community.
2. Environmental factors—those attributes which contribute to the quality of life in a community: generally, non-professional attractions such as cultural and social opportunities, educational system, quality of community.
3. Medical environment—those practice-related aspects contributing to a satisfying and successful professional life: hospitals, medical schools, other physicians, school of allied health personnel.
4. Economic factors—those visible quantities influencing practice net income directly (i.e., gross income, costs, excess demand.)
5. Demand determinants—those characteristics (primarily demographic and economic) often associated with the generation of demand for medical services: population size, population composition by sex, race and age, per capita income, level of educational attainment.

A physician about to make a decision to locate his practice refers to his entire scheme of preferences, not only as a physician but also as a private citizen: he assesses alternative locations according to his preferences subject to the information available to him.

Among these five categories, the most comprehensive and concerted research effort has been devoted to the role of prior exposure in the decision process, with the results being insightful and stimulating for further investigation."

Statistics already presented tend to suggest that the demand determinants mentioned above in Mr. McFarland's quotation have been more than met by the shortage of physicians in rural Nebraska. Certainly a lack of demand for medical services is not present in our rural areas. Mr. McFarland also mentions prior exposure and it is my opinion that the Admissions Committee from the

University of Nebraska have done a very good job in the past few years selecting a great number of applicants who have a rural background for admission to the Medical College. The environmental factors, both medical and non-medical, mentioned by Mr. McFarland are probably no different in the state of Nebraska than they are in many other areas; although it is true Nebraska is, generally speaking, not a resort area. There is not much we can do to change our climate, our geography, our pattern of living. It certainly is not in the realm of this committee to modify significantly the governmental or educational or social or cultural opportunities within the rural committee other than to perhaps point out their importance to communities looking for physicians.

The writer has personally practiced medicine in states bordering the Pacific Ocean, the Gulf of Mexico, Canada and has been closely associated with a physician who practiced on the East Coast and this is my personal opinion that the state of Nebraska need not apologize for its medical environment, its medical schools, its specialty capabilities or its School of Allied Health personnel. Nebraska physicians and Nebraska personnel medical graduates are in good demand in all areas of the United States.

This leaves as a major unexplored and difficult to evaluate factor in the physicians decision to locate-socioeconomic problems. More specifically, we are dealing with those factors which affect the physicians gross and net income, his costs, his working hours and his ability to receive comparable reimbursement for his services.

Importance of various factors in the location decision

Factors rated as "very important" or "important":	*Percent of respondents*
General economic conditions in area	77
Cultural and social opportunities	72
Education opportunities for children	68
Availability of hospital appointments	63
Preference of spouse	50
Postgraduate training opportunities	47
Openings for my specialty	46
Area's need for a physician	46
Opportunity to join other doctor or group	38
Born and/or raised in area	37
Place of residency	34
Place of medical school	32
Medical school appointment	30
Place of internship	27

Source: Education in the Health Fields.

As you can see from the above Table, 77 percent of the respondents rated General Economic Conditions as the most important factor in the decision to locate. Confirming this theory of changes in the order of importance of factors according to speciality, a recent study by John W. Hambleton: "Determinants of Geographic Differences in the Supply of Physician Services," Doctoral Dissertation, University of Wisconsin, 1971, shows that for the general practitioner who is selecting a county in which to practice availability of good housing is a major consideration while the presence of hospitals is comparatively negligible. Since physicians in general practice are relatively less restricted by the need for an elaborate and technologically complex medical environment, factors descriptive of community environment and economic conditions tend to dominate the site selection process.

Physicians net income and expenses.—In almost any discussion concerning medicine, the subject will usually get around to the exorbitant fees charged by physicians. However, I would like to request that the members of this committee pay particular attention for a moment to the fact that in many rural communities it costs more for a house call by a TV repairman, plumber, or electrician than by a family physician. In fact, the visiting-nurse program of County Health Departments frequently budget more per nurse visit than the current fee profile will provide for a similar visit by a physician under Medicare or welfare. The levels of, and variations in, physicians' incomes represent some of the most widely misunderstood subjects of public concern.

Net income from medical practice depends on three factors, fees being only one of these. Overhead expenses and the volume of work done are the other two

important factors of which the lay public has very little knowledge. Changing patterns of health care delivery have required that family physicians in rural areas provide a more total type of care with a great deal of emphasis on preventive care. This has increased the overhead costs of the rural physician.

Recommendations by health planners that physicians should increase their work output by seeing more patients rather than by increasing their rates have reached an impractical level within the rural areas of Nebraska. Most physicians do not care to work more than 60 hours per week in their primary field nor do they care to see more patients than they are seeing at the present time. They have, therefore, in many cases, reached a point where if fees are not raised, their income net and gross will probably decrease. (In many cases this has already occurred.) A recent Harris poll reported in February 1973 revealed 42 percent of doctors and nurses to have above average productivity (highest of all groups reported in U.S.).

While variations in net incomes by medical specialty might superficially parallel variations in fees for services common to all specialties, such variations are not explained on the basis of simplified comparisons. Types of fees and the quantities of services are unique within each specialty. Fees tend to respond to, rather than to cause the fundamental differences between medical specialties and geographical areas. In the time span from 1969 to 1970, there was a 5.2 percent increase in physicians net income and a 20.4 percent increase in physicians professional expenses. These increases were apparently not distributed evenly among specialties, geographic locations or types of practices. The net income increase between 1969 and 1970 was a minus 2.5 percent for general practitioners during the same time in which there was a 64 percent increase for professional expenses. In our West North Central region, expense levels are above the national average while net incomes in this area were below the national average. In other words, the regions with above average expense levels were not the same as the regions with above average income. The precise reasons for these differences cannot be determined readily since the factors affecting the income levels might be quite independent of those which determine levels of expenses.

Simple generalizations concerning these variations in expenses by medical specialty are difficult to make. Expenses were not always above average in the specialties who reported above-average net incomes. It is obvious that certain influencing external factors have come into play in this area of medicine, which to the enlightened physician or enlightened medical student will be a deterrent to the practice of medicine in rural areas. Further, it would also be a deterrent to the decision to go into a "low income specialty of medicine". To quote Steve G. Vahovich, "Variations in net income and expenses among specialties and geographical regions cannot be explained on the basis of simple generalizations. The nature of medical practice, control of expenses, regional wage and price levels, and a number of independent factors undoubtedly help to explain the relative levels of expense incurred in the conduct of medical practice. Similarly, the demand for varying services and additional independent factors must be considered in any explanation of net income variations. The data presented here should demonstrate the diversities inherent in any profile of physicians' net income and expenses."

In the year 1969, the average physician's net income was $39,727 which rose to $41,789 by 1970. During the same time span, the general practitioner's income dropped from $34,734 to $33,859.

TABLE 29.—AVERAGE NET INCOME BY SPECIALTY, 1969 AND 1970

Specialty	1969		1970	
	Amount	Observations	Amount	Observations
Total	$39,727	3,928	$41,789	2,712
General practice	34,734	855	33,859	597
Internal medicine	37,630	649	40,251	495
Surgery	48,848	877	50,701	822
Obstetrics—Gynecology	43,690	270	47,094	205
Pediatrics	31,812	256	34,799	175
Psychiatry	33,916	294	39,896	110
Anesthesiology	39,647	174	39,432	114
Other	40,283	533	44,294	194

TABLE 31.—AVERAGE NET INCOME BY CENSUS DIVISION, 1969 AND 1970

Census division	1969		1970	
	Amount	Observations	Amount	Observations
Total	$39,726	3,928	$41,770	2,713
New England	36,488	268	38,019	141
Middle Atlantic	36,461	865	37,618	478
East north-central	40,746	648	47,000	403
West north-central	41,288	294	41,057	192
South Atlantic	39,730	546	42,577	326
East south-central	44,772	188	41,963	168
West south-central	43,322	299	43,457	224
Mountain	38,469	175	39,359	145
Pacific	40,848	647	44,049	636

TABLE 32.—AVERAGE NET INCOME BY CENSUS DIVISION AND LOCATION, 1970

Census division	Total		Location	
	Amount	Observations	Nonmetropolitan	Metropolitan
Total	$41,770	2,713	$40,447	$42,024
New England	38,019	141	[1] 35,289	38,429
Middle Atlantic	37,618	478	[1] 40,395	37,454
East north-central	47,000	403	50,315	46,625
West north-central	41,057	192	40,176	41,502
South Atlantic	42,577	326	36,711	44,469
East south-central	41,963	168	43,883	41,000
West south-central	43,457	224	39,273	45,454
Mountain	39,359	145	38,734	39,537
Pacific	44,049	636	41,136	44,379

[1] Based on fewer than 30 observations.

From Tables 31 and 32, one can readily see that although the West North Central area physicians had an above average income for 1969, they had a below average income in 1970. Non-metropolitan physicians were even lower.

TABLE 35.—AVERAGE PROFESSIONAL EXPENSES BY SPECIALTY, 1969 AND 1970

Specialty	1969		1970	
	Amount	Observations	Amount	Observations
Total	$21,225	3,948	$25,560	2,713
General practice	24,172	858	25,719	598
Internal medicine	21,352	650	26,247	495
Surgery	25,475	890	28,557	822
Obstetrics-Gynecology	23,303	271	29,388	205
Pediatrics	18,898	256	24,657	175
Psychiatry	9,258	292	13,032	110
Anesthesiology	9,095	174	11,132	114
Other	19,867	557	25,901	194

TABLE 36.—AVERAGE PROFESSIONAL EXPENSES BY SPECIALTY AND LOCATION, 1970

Specialty	Total	Observations	Location	
			Non-metropolitan	Metropolitan
Total	$25,560	2,713	$26,859	$25,330
General practice	25,719	598	27,378	25,039
Internal medicine	26,247	495	28,674	26,035
Surgery	28,557	822	26,802	28,839
Obstetrics—Gynecology	29,388	265	28,184	29,581
Pediatrics	24,657	175	[1] 25,089	24,620
Psychiatry	13,032	110	[1] 15,511	12,968
Anesthesiology	11,132	114	[1] 10,204	11,204
Other	25,901	194	[1] 24,748	26,083

[1] Based on fewer than 30 observations.

Even more important is the fact that the professional expenses of the general practitioner in these areas was higher in the same time span.

TABLE 37.—AVERAGE PROFESSIONAL EXPENSES BY CENSUS DIVISION, 1969 AND 1970

Census division	1969		1970	
	Amount	Observations	Amount	Observations
Total	$21,225	3,948	$25,548	2,714
New England	15,767	269	19,502	141
Middle Atlantic	16,937	879	20,384	478
East north-central	21,872	648	26,250	403
West north-central	23,431	298	26,256	192
South Atlantic	20,574	548	24,435	326
East south-central	22,549	186	28,040	168
West south-central	24,967	297	31,903	224
Mountain	25,860	656	30,172	637
Pacific	25,868	650	30,172	637

Along with the good chance of a higher gross overhead in rural areas of Nebraska, the young physician has to look forward to an increased number of weeks worked. Physicians in non-metropolitan areas worked an average of 47.7 weeks per year as compared to 47.5 weeks for physicians in metropolitan areas. During each of these weeks the non-metropolitan physician averaged 56 hours per week and the metropolitan physician averaged 53.2 hours per week, with a higher percentage of these total work hours involved in direct patient care. The same statistics reveal that of all areas of the United States, the West North Central region general practitioners average more number of hours of direct patient care per week than their contemporaries in any other part of the nation. As a group, only the internal medicine specialists spends more average number of hours per week in direct patient care throughout the nation. As a group, the general practitioner in the West North Central area spends more weeks per year in working than his contemporaries in all other areas except for the South Atlantic coastal region. This ability to work more total hours, longer weeks per year, and see more patients per unit time, causes the non-metropolitan general practitioner to have 199.1 total patient visits per week as compared to 135.8 total visits per week by the general medical population.

The preceding comments and many other observed facts and data have convinced this author of the hypothesis that socioeconomic factors have become a major deterrent to the location of MD's in rural Nebraska, a fact that requires research and development.

COOPERS & LYBRAND,
Washington, D.C., August 5, 1976.

HON. HERMAN E. TALMADGE,
Chairman, Subcommittee on Health,
Senate Finance Committee, Washington, D.C.

DEAR SENATOR TALMADGE: Coopers & Lybrand appreciates the opportunity to submit comments and recommendations on S. 3205, the Medicare-Medicaid Administrative and Reimbursement Reform Act. We share the Finance Committee's concern about the burgeoning costs of Medicare and Medicaid and recognize the need to develop constructive measures so that these programs can be administered and operated on a more cost effective basis.

By way of background, it should be pointed out that Coopers & Lybrand is one of the largest international public accounting and management consulting firms. We have 80 offices in the United States, employing approximately 7,000 people, and have thousands of clients, large and small, among virtually all industries, including numerous health care clients.

Our partners and professional staff serve as auditors and consultants to hospitals, skilled nursing facilities, physicians and other health care providers, third party payors and governmental bodies concerned with financing and the delivery of health care. As a result, we believe the Firm is well qualified to furnish impartial and objective comments on S. 3205. This statement is submitted solely on behalf of Coopers & Lybrand and not on behalf of any clients.

We have carefully studied S. 3205 and will limit our comments to certain selected portions of these provisions: Establishment of Health Care Financing Administration; regulations of the Secretary; savings provision; improved methods for determining reasonable cost of services provided by hospitals; return on equity in determining "reasonable cost" of services; hospital-associated physicians; and procedures for determining reasonable cost and reasonable charge; disclosure of ownership and financial information.

Attached to this letter are specific comments on each of the above provisions.

It must be noted that we experienced difficulty in evaluating the meaning of certain sections of the bill because of the absence of definitions of key terminology used within. For example, we believe that the following terms are representative of some of the items that need clarification and/or definition: routine operating costs; capital costs; direct personnel costs; energy costs; indirect vs. direct personnel costs; uniform system of accounts; the cost of the mix of goods and services; and the criteria for exception process, under Section 10.

Such vagueness of terminology was also present in the original Medicare Law. Subsequent definitions were promulgated by the Bureau of Health Insurance which have led to confusion and general dissatisfaction with the present program. To avoid misinterpretation and misunderstanding of Congressional intent, we recommend that clear definitions be developed and included in the bill.

The greatest emphasis of this bill seems to direct itself toward reducing the cost of health care. When considered in light of existing requirements, many of the proposed changes may result in an increase in "total" costs because they are administrative in nature and will therefore be in addition to the present cost incurred by both the providers and those agencies administering the program. A serious question should be raised whether potential new administrative cost increases will be more than offset by the savings which are to be achieved through implementation of the provisions of this bill.

Medicare has operated for more than a decade under complex and controversial concepts of "reasonable cost" reimbursement. These proposed changes are very complex and will surely result in more differences of opinion as to the validity and equity of the criteria employed. Moreover, there is no assurance that the implementation of these modifications will result in the containment of costs as desired so we would encourage your consideration of other primary alternatives. Such alternatives might include:

(1) Apply the proposed reimbursement reforms to a limited number of representative hospitals, on a "hold harmless" basis with the existing system, for an experimental period of three years. This should be done to accurately determine what administrative problems, if any, will surface when these changes are implemented. At that time, the beneficial aspects of such reform can be evaluated in terms of total net cost containment achieved.

(2) Evaluate the possibility of applying a "charge control" system (such as the Indiana Hospital Association/Indiana Blue Cross Program) to a limited

number of representative hospitals on a trial basis of three years to quantify net cost reductions or containment which can be compared with other alternatives.

(3) Develop prospective cost-related rates of payment (similar to the provisions made for skilled nursing and intermediate care facilities as described in Section 30 of the bill) for individual hospital services or procedures. These would be appropriately modified for types of hospitals and geographic areas and adjusted on a semi-annual basis and not subject to retroactive adjustment. Such rates could be applied to a representative group of hospitals for a three year period to determine the effects of reduced administrative costs compared to other alternatives.

Our intent then, in expressing our views on this matter, is to suggest that extreme caution be taken before moving into a new reimbursement method by thoroughly testing its practicality and measuring its effectiveness. Obviously, total hospital costs result from many complex medical judgments such as quality of care, length of stay, developing new technology as well as other factors such as patient mix and service levels. All of these must be taken into consideration before developing practical, reasonable and effective target rates, incentives and penalties.

Coopers & Lybrand would welcome the opportunity to meet personally with the professional staff of the Finance Committee to elaborate further on our observations. We appreciate this opportunity to present our comments and sincerely hope that they are considered in the constructive sense in which they are intended. If we can provide further information please communicate with Mr. William P. McHenry, Jr., at the above adress or Mr. Bernard F. O'Neil, Jr., 222 South Riverside Plaza, Chicago, Illinois 6060, AC 312/648–1133.

Very truly yours,

COOPERS & LYBRAND.

COOPERS & LYBRAND COMMENTS ON S. 3205

SEC. 2 ESTABLISHMENT OF HEALTH CARE FINANCING ADMINISTRATION

In establishing the Office of Central Fraud and Abuse Control under the direction of an Inspector General for Health Administration, the bill designates a responsibility for initiating and conducting alleged, actual or potential fraud or abuse.

In our view the inclusion of the word "potential" is inappropriate because it is tantamount to adopting a policy of presumed guilt on the part of participating providers. Given such a broad mandate, presumably the Inspector General could construe virtually any act or event as potential fraud or abuse. This would permit the Inspector General to engage in endless "fishing expeditions" with statutory authority to do so. We question whether Congress wants to confer upon any federal official, this type of power. We recommend therefore that the word "potential" be stricken and the word "suspected" be inserted in its place.

SEC. 7 REGULATIONS OF THE SECRETARY; SAVINGS PROVISIONS

Section 7 would initiate a minimum 60 day comment period for proposed rules and regulations except in urgent situations.

It should be recognized that the present 30 day system is not enough time to transmit the information through the mails, carefully review complex changes, analyze their potential effects and develop construction recommendations for Department consideration. We support the proposed minimum 60 day comment period because it should permit the development of more reasonable and realistic administrative procedures.

SEC. 10 IMPROVED METHODS FOR DETERMINING REASONABLE COST OF SERVICES PROVIDED BY HOSPITALS

Uniform system of Accounts and cost reporting

We believe that it is not practical to require the Secretary to establish a uniform system of accounts which is intended to assure that operating and capital costs will be determined in the same manner for each hospital. A uniform system of accounts is not necessary to accomplish uniformity in reporting and finding.

A mandated system of accounts would be unlikely to meet the objectives of the various hospital boards and their management in terms of each institution's role in the community it serves. A significant effort has been expended by most hospitals toward the establishment of accounting systems that meet their needs and also yields the necessary detail for Medicare cost reporting. This has been a tremendous task and has involved numerous changes in the accounting systems of hospitals since enactment of P.L. 89-97.

To impose a uniform system of accounts contemplated in S. 3205 would simply add to the costs already incurred by the hospitals to develop their present systems. It is our opinion that the uniqueness of each institution does not preclude its ability to report uniformly even though the accounting systems are different.

For these reasons, the reference to the establishment of a uniform system of accounts should be deleted from the bill.

Further, requiring the development of uniform procedures for allocation of costs will be detrimental to those hospitals that have already developed sophisticated methods which result in more precise cost determination. This level of sophistication would most likely be impractical for many of the smaller hospitals which have less complex operations. The development of uniform procedures for allocation of cost would ultimately result in less precise determination of costs than presently exist.

We recommend that the Secretary be authorized to develop minimum requirement for allocation of costs and be authorized to permit more sophisticated procedures when it can be demonstrated that a more precise determination of cost results.

System of hospital classification

The proposed hospital classification criteria does not suggest a need for differences attributable to geographic location. Ostensibly, the exclusions from routine operating costs and segregation of the personnel component would result in the remaining costs being comparable regardless of where the hospital is located.

It is unlikely that the remaining nonpersonnel costs would be completely comparable since there are geographic differences in prices of raw food, casualty and general business insurance, transportation costs for supplies and a wide spectrum of other expenses.

Furthermore, acute short-term general hospitals located in the same area may not be comparable from a cost standpoint because of differences in length of stay due to quality and intensity of service, patient mix and flow, and levels of service. In particular, there are some hospitals that, for a variety of reasons, have managed to reduce the average length of stay of their patients. Under the cost per day measure, their average daily cost might appear to be higher than other hospitals in the same classification. However, the same hospital on a cost per case basis may be much lower than its peers. Additionally, the extent to which each hospital is involved in providing outpatient services could cause extensive variations in what otherwise would be comparable hospitals.

Because of variations like those mentioned above, many hospitals will be able to legitimately justify why they are not comparable within the framework of bed size only. He would recommend that the criteria of bed size be supplemented to include the additional criteria outlined above.

Routine operating costs

Routine operating costs should exclude costs attributable to malpractice insurance inasmuch as this cost varies considerably between institutions. Malpractice insurance costs compatible with the other excludable costs enumerated.

The definition of energy should be broadened to include lighting, or other energy sources required to maintain operations.

Consideration for exemption should be given to new hospitals which bear the abnormal costs of start up expenses and high costs attributable to low initial occupancy for a specified time period or until a certain occupancy level is obtained.

It should be pointed out that a careful review of each and every type of cost incurred may well have its own justifiable basis for being excluded and treated differently from other costs.

In segregating the personnel and nonpersonnel components of the "routine operating costs", consideration should be given to the amount of contract serv-

ices which one hospital might employ as opposed to another. The cost data in one hospital contracting for dietary, laundry, housekeeping services, etc. will not be comparable to the hospital which uses its own employees to perform these functions.

In determining the "average per diem routine operating costs", the data from a "significantly understaffed" hospital has been excluded. To our knowledge, no equitable staffing standards have been established from which this determination can be made. Perhaps accurate data on which to base such a decision could be developed by conducting a considerable number of work measurement studies on various hospitals within each classification.

In determining "routine operating costs", S. 3205 implies a distinction in service (routine vs. ancillary), defines type of costs (personnel vs. nonpersonnel), and type of activity (capital, educational, energy, etc.) but does not address itself to the determination of inpatient vs. outpatient routine operating costs.

Finally, the method of determining the actual allowable "routine operating costs" as defined in the bill will tend to be determined well after the end of a hospital's fiscal year. Most hospitals have financing arrangements on their long-term debt, which contain provisions requiring audited financial information on a timely basis. Independent certified public accountants may be prohibited from issuing an unqualified opinion on a timely basis if the Medicare-Medicaid utilization of the hospital is significant and if the results of operations cannot readily be determined within a reasonable length of time after its fiscal year end. Similarly, and more importantly, appropriate planning and budgeting will be made even more difficult by this delay, and result in forcing management to operate in a less efficient manner.

Because of reasons enumerated above, we strongly urge the Finance Committee to consider the proposed new method of reimbursement as experimental and aggressively pursue alternative reimbursement approaches such as those mentioned in our cover letter.

SEC. 19 RETURN ON EQUITY TO BE INCLUDED IN DETERMINING "REASONABLE COST" OF SERVICES FURNISHED BY PROPRIETARY HOSPITALS

We recommend providing a factor similar to "return on equity" for not-for-profit hospitals. This factor would be used to recognize a need for increased working capital and for preservation of a capital base, both essential for the economic viability of the institution during periods of inflation and technological change.

SEC. 22 HOSPITAL-ASSOCIATED PHYSICIANS

The imposition of limitations on the compensation paid to hospital-associated physicians does not provide for relief to those hospitals who are legally obligated under existing contracts with such physicians. If determinations by the Secretary operate to the financial detriment of the hospital, the unreimbursable portion of these costs will necessarily be borne by other patients who are not covered by the program. We would recommend that this potential problem be addressed by the bill and that further definition be provided as to the criteria to be used by the Secretary in determining the reasonableness of physicians' compensation.

SEC. 40 PROCEDURES FOR DETERMINING REASONABLE COST AND REASONABLE CHARGE; DISCLOSURE OF OWNERSHIP AND FINANCIAL INFORMATION

An administrative nightmare will surely result from requiring the Secretary to give prior approval on all contracts involving $10,000 or more. An endless list of such contractual arrangements exists within most hospitals and the daily operation of a hospital would be seriously impaired by the delay which would be caused by requiring the Secretary's approval prior to the execution of a contract for needed services.

There are already numerous controls in the present regulations, such as the "prudent buyer concept", which adequately ensure the reasonableness of such expenditures without infringement upon the prerogatives of the governing board and the administration of the institution. We recommend that this provision be deleted from the bill.

STATEMENT OF ROBERT J. KENNETH, PRESIDENT OF KENNETH ASSOCIATES, SAN FRANCISCO

SUMMARY

Section 26 of S. 3205, which will prohibit assignment of payments to providers, should not be enacted as it stands. The arguments in favor of this proposal, which focus upon resulting frauds and program costs, do not properly take into account the marginal benefits and costs arising from the use of this security device. I respectfully submit that:

(1) There will be no increased opportunity for fraud attributable solely to the allowance of assignment, because the requisite audit procedures will more easily detect fraud by an assignee than fraud by a provider.

(2) Program costs will necessarily be decreased, not increased, if an assignment is used to secure payment by the provider, because the provider will choose the more economical arrangement.

(3) Any increase in administrative problems will be minor.

(4) Alternative security devices will not be as effective.

(5) Streamlined processing by the government is not a feasible solution.

Furthermore, I urge Congress to adopt the alternative amendments included herein which will clarify existing law and expressly allow assignment of provider accounts subject to safeguards to protect the government's interest in the ease of administration of an assignment system.

INTRODUCTION

Mr. Chairman and members of the Subcommittee: My name is Robert J. Kenneth. I am the President of Kenneth Associates, the leading firm in the San Francisco Bay Area in the field of hospital business office management. My office is located at 1704 Irving Street, San Francisco, California 94122.

The views on S. 3205 expressed herein are based upon extensive experience working with providers in the Medicare and Medicaid programs, including twenty-four hospitals, which utilize our services in connection with processing and collecting their accounts receivable.

My primary concern is with Section 26 of S. 3205, which will prohibit assignments of Medicare Part B and Medicaid payments, except in connection with the provision of billing services for a fee not related to the amount of billings or collections and not dependent upon actual collection. The effect of this change will be to prohibit use of an assignment or power of attorney (which are in essence security devices) in connection with loans against provider accounts, outright purchase of such accounts ("factoring"), or the provision of billing services under an incentive fee arrangement. I believe, in light of my experience and contacts with providers, that all of these can be beneficial services to providers in solving their very real cash flow problems and that the greater security of the agent or lender provided by an assignment can only lower the cost of these services to the provider.

My presentation first analyses and rebuts the arguments in favor of enactment of Section 26 as it stands. The key reason for the prohibition of certain assignments in previous legislation (Public Law 92-603 of 1972) was concern about whether assignment contributes to fraudulent practices in billing for program services; it will be demonstrated that the opportunity for fraud is a function of the degree of auditing integrity and is not related to the assignability of accounts. Similarly, other supposed problems such as added costs and recovery of overpayments will be shown to either be imaginary or to arise from causes other than the allowance of assignment. Furthermore, the proposed bill's solution to these cash flow problems—mandated 30 day payment under Medicaid—in my view will not work.

Even apart from the proposed changes, there is a need to clarify existing law. I propose herein alternative amendments which will expressly allow assignments of Medicare and Medicaid accounts, but which incorporate safeguards to satisfy the government's interest in ease of administration of assignments by providers.

I respectfully urge that Section 26 not be enacted as it stands and that serious consideration be given to the advantages provided by assignments and to passage of amendments along the lines herein proposed.

SECTION 26 OF S. 3205 SHOULD NOT BE ADOPTED

The original Medicare and Medicaid laws (Public Law 89-97 of 1965) did not prohibit assignment and in fact assignments were accepted in the programs until 1972. In that year, amendments to Medicare Part B and Medicaid were adopted (Public Law 92-603) which prohibited payments to "anyone other than" providers of services. The legislative history indicates that this prohibition of assignments did not apply to payments "based on the reasonable cost of the services" of a provider. These aspects of existing law are discussed more fully hereinafter.

Section 26 represents a more precise attempt than was evident in the 1972 amendments to prohibit factoring. It will amend the same two subsections which were amended in 1972 (Social Security Act §§ 1842(b)(5), 1902(a)(32), 42 U.S.C. §§ 1395u(b)(5), 1396(a)(32)) by adding to each a sentence which expressly bans the use of assignments and powers of attorney in relation to program payments, while at the same time creating an exception for assignments in connection with provision of billing and/or collection services for a fee that is not related to the amount of the billing and is not dependent upon actual collection. Thus, the section changes existing law by shifting the focus of the exception from the reasonableness of the *provider's* charges to that of the *agent's* charges. As the following discussion will make clear, both attempts were based upon erroneous analysis of the problems and solutions in the area of the providers' need for prompt reimbursement of claims.

Assignment and factoring of accounts receivable have been common business practices in virtually all industries for many years. They enable a business to improve its cash flow (thus reducing interest expense) and place the billing and collection efforts in the hands of specialists who ordinarily can perform these functions much more economically than can an individual business. While lending and collection are separable functions, they are also naturally combined. In my own case, hospitals for whom I presently provide billing services have asked if I might also arrange advances against accounts so as to reduce even further their payment delays. I must emphasize that the cash flow squeeze is particularly acute in the health care industry.

Despite the economic advantages to providers that factoring allows, several arguments have been raised to support an outright ban on assignments, and hence a ban on services that rely on the security provided only by that device. There are two principal statements of the policy analysis behind the 1972 amendments and, therefore, behind section 26:

(1) Senate Finance Committee Staff Report, "Medicare and Medicaid—Problems, Issues, and Alternatives," 91st Cong., 2d Sess. 130 (1970) (Exhibit A hereto); and

(2) Senate Finance Committee Report, "Social Security Amendments of 1972," to Accompany H.R. 1, 92d Cong., 2d Sess. 204-05 (1972) (Exhibit B hereto). These documents reveal five principal arguments against allowing assignments of accounts:

(1) Assignments present an opportunity for greater fraud and abuse, by way of incorrect and inflated claims.

(2) Assignments create an additional cost to the provider which is indirectly passed on to the programs.

(3) Assignments create additional administrative problems for the government, principally in the area of recovery of overpayments.

(4) Providers can borrow against their Medicare and Medicaid receivables anyway without resort to outright assignment of claims.

(5) The proper solution to the provider's desire for prompt payment lies in streamlining processing of claims by the government and intermediaries.

These five arguments are rebutted hereafter in turn.

(1) There Is No Increased Opportunity For Fraud Attributable Solely To The Allowance Of Assignments.

The legislative history places primary emphasis upon past abuses as a rationale for abolishing assignments. It is argued that since Medicare and Medicaid frauds have involved both overbilling and assignments, therefore overbilling will be reduced if assignments are prohibited. Yet in this syllogism the premises do not support the conclusion. Although in a simplistic sense an assignee is one addi-

tional person in the chain of claims submission, no significant increase in attempted program fraud is likely to be created thereby because a sound auditing program will detect fraud by whomever it is committed. The audit process for detecting abuses by dishonest billers and punishing the offenders is essentially the same, whether it be providers or assignees who are billing and collecting for the services rendered. No greater level of auditing intensity will be required with assignments than without; in fact, it appears that fraudulent billings by assignees would be detected more easily than those by providers.

The prevention of fraud in Medicare and Medicaid billings is not essentially different from any other type of crime prevention—the potentially dishonest party has to be aware that he or she has a good chance of being caught, and that the penalty will be severe enough to make it unwise to commit the crime. This requires a sound auditing theory and design, plus credible communications to all involved about the effectivenes of the system and the penalties for violation. The Office of Central Fraud and Abuse Control, provided for under Section 2(b)(2)(A) of S. 3205, and the Inspector General for Health Administration therein created, should be charged with responsibility for establishing such audit procedures to the extent necessary to preclude most abuses.

I will make a few suggestions as to the necessary audit measures, dealing first with those related to hospitals and then with those related to physicians. I will also illustrate why these functions are totally unaffected by the party doing the billing, whether provider or assignee.

The audit of the propriety of the hospitals' billings should consist primarily of a visit to the hospital and examination of medical records and physician authorizations for services rendered, including review of the "utilization review" function at any given hospital. This could be done for all billings if deemed necessary but, more practically, it would be limited to a percentage of cases selected by a reliable statistical sampling technique. Additionally, confirmations could be requested from program beneficiaries that they received the service billed.

However, this may not be as satisfactory because many program beneficiaries are not aware of the charges for services received in a hospital. An additional technique would be to ascertain that a claim for a particular patient's hospital stay was not submitted twice. This should ordinarily be easily detected by the programs' fiscal intermediary by matching claims for a given patient to see that payments made for a specific stay or date of service were not duplicated. Moreover, advance approvals are now obtained from the programs for each stay.

There are at least two audit techniques for physicians available. The most productive technique would be to ask program beneficiaries, probably on a test basis, to confirm services received. Such a confirmation might list the amounts paid to and services provided by a certain doctor in a certain month, together with a request to the patient to please notify the Department of any discrepancies "so that your Medicare (Medicaid) account can be properly adjusted." This type of confirmation should uncover incidents of overbilling or billing for services not rendered. For example, if a patient had a finger x-rayed, but the program had been billed for a chest x-ray, the patient might reply something like "no chest x-ray done, my left index finger was x-rayed once," a reply which would lead to further investigation.

The second technique useful for an audit of physicians would entail visits to their offices and inspection of their medical records, but this would probably not be as effective.

The important point is that *the above procedures would not be any different for a provider of service who assigns accounts receivable than for one that does not assign.*

Actually, a fraudulent assignee could probably be more easily detected than a fraudulent provider. Consider the possible methods that could be used by an assignee to defraud the programs: (1) the amount of the charges could be raised from those submitted by a provider; (2) the assignee could bill for services not rendered; or (3) the assignee could double bill for services rendered. In case (1), as soon as an auditor visited the provider's office and discovered that the provider's bill for services was greater than the records showed, the fraud would be immediately discovered. Or, in case (2), if a nonexistent hospital stay is billed, that fact would become immediately obvious. In all cases the provider has the greater opportunity to initiate fraud and the mechanism needed to detect fraud is the same.

No double audit will be involved because the above auditing techniques can be carried out solely at the offices of the provider, and with the proper audit system, there is absolutely no increase in opportunity for fraud due to the assignment of claims. A provider has a much greater ability to manipulate medical records than an assignee has to raise amounts supplied to him by the provider. While we do not have access to any details of the frauds referred to in the Staff Report and Committee Reports, we are convinced that the key problem in all of them was a defect in the basic auditing system rather than any problem arising from assignments. The corrective legislation needed for this problem relates to audit design, not the identity of the payee.

(2) Program Costs Are Necessarily Decreased, Not Increased, If Assignments Are Used.

The second reason for the denial of assignment, that the Medicare and Medi-Cal programs would pay additional costs because of the assignments, is patently false. If the provider determines that assignment is financially advantageous to him, after evaluating the costs of assignment and/or factoring against the costs of not doing so, it is obvious that the cost to the government programs will also be proportionately less, in terms of interest expense and billing and collection expense. In most cases experienced assignees are specialized and can do a more efficient job of billing than is possible by most service providers. The assignee's charge is counterbalanced by these efficiency improvements; furthermoere, the agent's fee can only be lower if it is secured by an assignment than if the agent is taking more risk of nonpayment. Likewise, there must be interest expense savings to the provider in the case of factored accounts, or else the services will not be used.

The language in Section 26 infers that a problem is created by an agent (or assignee) charging in proportion to the amount billed. This manner of charge is common business practice. The fee arrangement does not change the conclusions relative to fraud or cost discussed above. Presumably, the provider will have concluded that for his operations (whether hospital or otherwise) the arrangement is financially advantageous.

I will illustrate the factors that go into this cost calculus by reference to the typical service which my organization provides. Our overall objective is to increase hospital cash flow. This is done by developing effective policies and procedures for a hospital's business office operation and its interface with other hospital departments. Specifically, Kenneth Associates assist hospitals in developing and implementing improved procedures for the preparation and submission of billing claims, principally (but not exclusively) Medicare and Medicaid (Medi-Cal) claims. Our own personnel sometimes perform the hospital's billing operations and may also perform follow-up services, such as revision of claims, contesting claims, and collection agency referrals. More frequently, our staff trains a hospital's personnel to perform these functions. Another variation in service involves specific oversight of billing operations. Our usual method of operation is to establish a target figure of average days revenue outstanding and then to reach the target by a combination of improvements in internal efficiency and improvements in approaches to government and third-party payors.

Our success has been outstanding. For example, since 1971, we have recovered twenty million dollars ($20,000,000) for San Francisco General Hospital, at a cost to the hospital not exceeding three hundred thousand dollars ($300,000).

Our customary fee arrangement for billing services is based upon a specified percentage of the billings and is conditional upon successful collection of the accounts. This formula is advantageous to the provider because it gives the agent an incentive to increase the accuracy and timeliness of claims submissions, which is after all the principal benefit which the agent provides. If these two incentives are taken away, as Section 26 would do in situations where the agent desired to take an assignment to secure his fee, the agent must be paid either at an hourly rate or on a piece-work basis, neither of which have any built-in incentives to the agent which would be attractive to a provider. The structure of the proposed exception operates on the premise that claims submission is a routine clerical process, while in truth the amount to be recovered from any given billing is very much in flux and the skill which the billing agent brings to this task, both in terms of accurate filing (to avoid subsequent resubmission) and of proper categorization (so as to maximize revenue), is what creates the value or benefit of his services in the eyes of the provider.

I will concede that the taking of an assignment is not necessary to an incentive fee arrangement as just described. To date we have conducted our business

without assignments to secure our fee and we could continue to do so under the proposed Section 26. My points are that the fee with an assignment could only be lower because of a lower risk of nonpayment, and that there is no logic to the structure of the exception written into this bill.

A similar cost calculus is involved in the cases of pure factoring and/or lending on the security of accounts. While we do not presently provide such financing services, we have devised a plan to provide such, in order to assist hospitals in coping more effectively with the current payment delays, which average sixty days under Medicaid. Under the plan, we would arrange an immediate advance of money to hospitals on the security of an assignment of their Medicare and Medicaid accounts. Alternatively, we would arrange the outright purchase of such accounts at a discount, commonly known as "factoring." Using such services, a hospital could receive cash proceeds (less a specified discount) within a matter of days after patient services are performed, rather than months later when the claim is paid. Kenneth Associates is in a position to obtain the necessary financing for this plan through reputable banks at favorable rates because the value of a hospital's accounts receivable is enhanced by the hospital's utilization of our billing services.

It is evident that providers, especially hospitals, currently face a seious cash flow situation and that in many cases they are already engaged in unsecured short-term borrowings against their receivables, or borrowing by such means as delaying payments to suppliers. My proposed factoring plan would be a more economical substitute for such existing financing, rather than a new and unnecessary cost to providers and the programs.

In conclusion, the present cost to providers of delay in receiving payment from the government and intermediaries is very real and is already being passed on to patients and the programs in increased charges and decreased service. *The issue to be decided is which cost is greater.* In my view, the decision on this issue should be left to each hospital and physician, to be made in light of each one's own immediate economic realities. The only conceivable situation where this type of arrangement would result in higher overall costs to Medicare would be where the agent or assignee were related to the provider of service; in such a case the existing regulations on "related organizations" (20 C.F.R. § 405.427) provide a means to limit the portion of such costs which will be reimbursed.

(3) Any Increase In Administrative Problems Will Be Minor.

Specific problems mentioned in the Committee Reports were those related to "determinations of reasonable charges and recovery of overpayments." The former matter is but one element of the fraud problem and the solution is the audit system discussed above. Since the claim must in all cases have attached to it documentation generated by the provider and be supported by the provider's internal records, the assignment adds nothing whatsoever to the problem of evaluating the claim, any more than it increases the likelihood of fraud.

Recovery of overpayments is not affected by whether the overpayments were made to a provider or to an assignee. Essentially the government's ability to recover overpayments will always depend upon its inherent control over the provider. The first recourse would be to hold back on those accounts already in the pipe line and due to the provider or assignee. In most cases the amount of this backlog would be far more than enough to cover any retroactive adjustment of payments already made. Assuming that payments are made on the average within thirty days of billing, the uncollected amount at any given time, when considered along with those services rendered but not yet billed to the programs, would approximate ten percent of the annual total volume. As a further control over the provider, the government has the threat of disqualifying the provider from participation in the program. For most hospitals, the Medicare and Medicaid programs constitute such a large percentage of their business that they could not operate without these programs: this threat would receive instant attention.

The important point here, once again, is that the government's remedies are *the same* whether overpayments were made to a provider cr an assignee. The remedy of offset against the provider's bill in process will be effective even in the event that the provider terminates from th programs or the assignee terminates his participation in the assignment, so long as a certain notice period is required during which the government can hold up payments pending a final settlement of accounts. Finally, our information is that program overpayments have in fact become more rare in recent years.

The impact of the Federal Assignment of Claims Act (31 U.S.C. § 203 and 41 U.S.C. § 15, as amended) on administrative problems has generally gone unnoticed. Even if Congress allows assignments under Medicare, the general federal provisions will still govern the mechanics and will impose administrative safeguards on the practice of making assignments. For instance, an agent supplying billing services will still not be able to take a blanket assignment of all claims but will be limited to taking an assignment of each payment *after* the check has been issued. A bank or factor will not be able to take assignment of some claims but not others, and will not be able to reassign a claim to still another party.

Most of the administrative problems which have been postulated are not serious obstacles. Strangely enough, Section 26 allows assignment of payments to a certain type of collection agent without any provisions for meeting these alleged administrative problems, indicating that the Staff does not see these as serious matters. I, however, see that the administrative mechanics should be the principal focus of regulatory effort. In my suggested amendments and related comments I have outlined procedures which will make an assignment system workable.

(4) Alternative Security Devices Are Not As Effective.

One argument against the need for factoring is that providers can effectively borrow against their Medicare and Medicaid accounts receivable by means of devices which do not entail outright assignments. For instance, in the Committee Report, it is stated that even after the 1972 amendments, a provider may have a payment check in his name mailed to some other organization, such as to a bank, for deposit in a special account. Another possibility is that a provider may "list" his receivables as an asset for the purpose of persuading a bank to lend him working capital. Blue Cross Association, Provider Release Bulletin, No. 58-19.

Although the above devices do provide some potential for borrowing against receivables, they do not provide the nearly-perfect security which an assignment offers and hence they entail either lower loan proceeds or higher interest rates than would otherwise be the case. Speaking directly from my experience, I can say that the banks with which I have discussed my proposed factoring arrangement have stated that they would *not* advance the necessary funds to allow the operation *unless* a binding assignment can be obtained, while with an assignment they will advance the funds at a favorable interest rate because the value of the accounts is enhanced by the hospitals utilization of our regular billing services. Thus the assignment is the key hinge of the whole service, and the value of the supposed alternatives is, in fact, illusory.

These arguments do, however, point up a key fact in the debate about the wisdom of assignments, which is that all of the services herein discussed (processing and lending) and all of the potential abuses connected therewith will continue to exist even if assignments are prohibited. That is, submission of claims by an agent and lending against accounts receivable can and will be carried out without the use of an assignment as a security device. The difference that Section 26 will make is that more legitimate agents and banks will be deterred to varying extents, relative to those who will provide the services taking more risks for a greater return.

(5) Streamlined Processing By The Government Is Not A Feasible Solution.

The Staff's response to the genuine need for "immediate cash," admitted in its 1970 Report, is that "streamlining administration and processing" will make factoring unnecessary. Section 4(a) of S. 3205, adding subparagraph (39)(A) to Section 1902(a) of the Social Security Act, attempts to implement this solution by mandating that State Medicaid programs must provide procedures which assure that 95% of "clean claims" shall be paid within 30 days of receipt of the claim from the provider, and 99% within 90 days. If a State does not meet such targets, after notice of deficiency and up to six month's opportunity for correction, it may, under Section 4(c) (adding subsection 1903(n) to the Act), have its Federal matching funds for administrative costs reduced by 50% or terminated, while a State which substantially exceeds this and one target may have its Federal matching increased to 75%.

My experience with the Medicaid program in California (California Medical Assistance Program, or Medi-Cal) leads me to believe that this 30 day target for payment may be impractical and infeasible. On the average, claims are paid by Medi-Cal after about 60 days and this has been the average for several years.

Medicare payments are generally made by SSA in less than four weeks, but Medi-Cal is much slower. Furthermore, California has had a requirement since 1965 that contracts between the Department of Health Care Services and fiscal intermediaries shall provide that payments will be made within 30 days from receipt of documentation. Cal. Welf. & Inst'ns Code § 14104.3 (1971), replacing § 14104(c)(6) (1965). This requirement has been ignored in practice and has never been consistently met in my experience. In fact, § 14104.3 was amended in 1972 (1972 Cal. Stats., ch. 1019, p. 1889, § 1) to provide that notice shall be given to the provider within 60 days if the bill is "held for peer review" beyond 30 days. Even this loophole in the statute has not been complied with, in my experience, although the theoretical penalty for noncompliance was termination of the contract with the carrier. Cal. Welf. & Inst'ns Code § 14106 (1965, repealed 1972).

While I cannot be certain that the proposed Sections 4(a) and 4(c) will be ineffective, I would suggest that there are serious problems arising from the nature of Medicaid claims evaluation which cannot simply be legislated out of existence. At the least, such a 30 day requirement even if it works is no substitute for a financing plan which provides cash to the provider within a matter of days.

SUMMARY

The policy arguments in favor of abolishing assignments are misdirected because they do not bear upon the incremental costs attributable solely to the taking of an assignment as a security device (which are minimal) and they ignore the benefits to providers which this device allows (which, based upon an assessment of the particular economic situation may be great). I urge Congress not to adopt Section 26 of this bill.

EXISTING LAW SHOULD BE CLARIFIED

Even if Section 26 is not enacted, there remain serious uncertainties in existing law relating to the status of assignments of Medicare and Medicaid accounts. We feel that Congress should, based upon a full review of the merits discussed above, clarify the law in these respects and expressly state that there is no general policy against legitimate assignments and factoring.

DHEW has taken the position that all assignments of claims under Medicare are prohibited, based upon the language of § 1814(a)(1) of the Social Security Act, 42 U.S.C. § 1395f(a)(1), and that commercial assignments of Medicaid payments are also barred. Our research indicates that the Department was fully in error when it first adopted its position and remains, despite amendments to the Act, partially in error.

1. *Medicare part A*

The original Medicare law, enacted as Public Law 89-97 (79 Stat. 286) on July 30, 1965, created sections 1814(a) and 1835(a) of the Social Security Act (42 U.S.C. §§ 1395f(a), 1395n(a)), which provided that payment for covered services under Parts A and B "may be made only to providers of services" that have an agreement with DHEW under Section 1866 of the Act and only if certain procedural steps are followed. There was no similar language for the Medicaid program.

We respectively submit that this language was not intended to bar assignments for the following reasons:

(a) This language, on its face, does not bar assignments. It merely limits providers who may participate in the program to those who have an agreement with DHEW and who follow certain procedural steps. It is amenable to the interpretation that payment to an agent or assignee of the provider satisfies its terms. The legislative history repeats the statutory language, but without the word "only", thus further negating the inference that the language was meant to bar assignments. There was no discussion of the problem of assignments at that time.

(b) The applicable DHEW regulation (20 C.F.R. § 405.150) recites that amounts payable under Medicare Part A are payable "only to a participating provider of services." This regulation is compatible with the above, if it is understood merely as defining certain providers who could claim payments and not as having anything to do with the subject of assignments.

(c) Subsequent legislative material indicates that DHEW did, in fact, honor assignments in the early years of the programs. Senate Report No. 92-1230 (1972) recites, at pages 204-05 (Exhibit B hereto):

"The law is silent with respect to reassignment by physicians or others who provide services of their right to receive payment under these programs. The Department of Health, Education, and Welfare makes such reassigned payments under medicare without specific legislative authority."

In addition, DHEW comments on Medicaid (Hearings of the Senate Subcommittee on Medicare and Medicaid, 91st Cong., 2d Sess., pt. 1, at 165, 189 (1970)) recite:

"Assuming that independent collection and bill discount agencies now operate legally, legislation will be required to prohibit States from making vendor payments to such agencies from Title XIX program funds."

The premise of this statement is that the original Medicare and Medicaid law did not prohibit assignments, even with the language about "only to providers."

(d) On October 15, 1969, HEW Secretary Finch submitted the "Health Cost Effectiveness Amendments of 1969." They were discussed in the House Ways and Means Committee Hearings on "Social Security and Welfare Proposals," 91st Cong., 1st Sess. at pages 133, 1058 and 2108. The amendments embodied many changes designed to improve efficiency of administration, but they did not include a ban on assignments. Thus, as of that date, the Administration did not view assignments as a problem.

(e) Section 236 of the 1972 amendments to the Social Security Act, discussed below, made no change in Medicare Part A.

Therefore, our analysis of the law shows that assignments of payments under Part A are *not* prohibited by law, despite the position taken by DHEW.

2. *Medical part B. and medicaid.*

In 1972, Public Law 92-603 changed the law to add provisions to the Medicare Part B and Medicaid law to the effect that no payment can be made to "anyone other than" a provider. These changes are now found at 42 U.S.C. §§ 1395u(b)(5) and 1396(a)(32). They are followed by regulations at 20 C.F.R. § 405.1680 and 45 C.F.R. § 249.31, respectively, adopted in early 1974. Although the stated language does not differ linguistically from the original ("only to providers"), the accompanying legislative history clearly indicates that a partial ban on assignments, particularly in the context of factoring, was intended.

I have two key points to make about these 1972 amendments. First, they were not preceded by a thorough discussion in the public record of the merits of a ban on assignment. Second, the legislative intent was limited to a ban on fraudulent assignments.

The effort to prohibit assignments originated with a Staff Report of the Senate Finance Committee, entitled "Medicare and Medicaid: Problems, Issues and Alternatives," dated February 9, 1970. The key paragraphs of this Staff Report are set forth in Exhibit A attached hereto. No proceeding House or Senate hearings dealt with this aspect of the Report; apparently the information upon which it is based was directed to the Staff informally. Clearly the Staff Report operates on the assumption that, as of that time, assignments were permitted. The principal points made by the Staff analysis are dealt with in the above analysis of Section 26 of S. 3205.

The Staff recommendations were incorporated as Section 234 of H.R. 17550 in January, 1970. The Senate Finance Committee held hearings on this bill under the title of "Social Security Amendments of 1970" (91st Cong., 2d Sess.) on June 17 and July 14, 15, 1970. The testimony was remarkably muted with respect to the issue of assignments. The American Public Health Association endorsed the ban (page 712), on the grounds that "it will guard against unethical—even immoral—practices." The Blue Cross Association omitted any comment on this change (page 777), as did the American Medical Association (page 1083). The Senate Finance Committeee Report on the bill, S. Rpt. No. 91-1431, dated December 11, 1970, sets forth the text of Section 234 without comment.

H.R. 17550 did not pass in 1970, but was reintroduced virtually unchanged as H.R. 1 in the first session of the 92nd Congress. The ban on assignments was designated Section 236. This bill became Public Law 92-603, enacted on October 30, 1972. Hearings on the bill before the Senate Finance Committee, under the title of "Social Security Amendments of 1971," on July 27, 29 and August 2, 3, 1971, contained no discussion on the question of assignments.

The relevant committee reports on this bill are: House Ways and Means Committee Report No. 92-231, dated May 26, 1971: Senate Finance Committee Report No. 92-1230, dated September 26, 1972; and House Conference Report No. 92-1605, dated October 14, 1972. The key paragraphs from the Senate

Report are set forth as Exhibit B attached hereto. The wording is nearly identical to that used in the House and Conference Reports, set forth in 1972 U.S. Code Congressional & Administrative News at pages 4989, 5090-91 and 5370, respectively, and the earlier House Report No. 91-1096 dated May 14, 1970. The concerns expressed are similar to those in the above Staff Report.

We cannot find any foundation for the Reports' comments, or even any discussion of the matter, in prior hearings. In short, this important amendment was adopted without a public disclosure of the alleged abuses and without a full discussion of the pros and cons of factoring from the provider's point of view.

The critical sentence in the committee Report, which is not reflected in the statutory language, states that the ban on assignments does not apply to payments "based on the reasonable cost of the services." Logically this could mean that the cost of the agent's or factor's services must be reasonable, but gramatically the terms "the services" in that paragraph can refer only to services *of a provider*. Thus, the Congressional intent as expressed in the Committee Reports is that only "incorrect and inflated claims" are not assignable. This is a peculiar proposition, because the remedy for fraud *in any case* is, immediately, to stop payment and, over the long term, to improve auditing. Yet this reading of the intent relates directly to the concern for fraud expressed in the preceding paragraph of the Report. Any administrative problems arising from the legitimate assignment of claims based upon reasonable costs of the provider were evidently not operative concerns in the 1972 amendments.

Once again, a thorough analysis of the law reveals that the position taken by DHEW—that all assignments are banned—is not supported by the legislative history. I ask that Congress now consider the issues raised on the merits. The following section contains my suggestions about the form of an optimal amendment.

PROPOSED AMENDMENTS SHOULD BE ADOPTED

Exhibit C attached hereto sets forth a revision of section 26 in the form which I believe best responds to the issues raised above. The principal emphasis in drafting, once it is recognized that assignments do fulfill a need of providers, is to devise safeguards to maximize the public benefit of factoring.

As was stated above, the principal concern—fraud—is logically an unrelated problem, for which the solution is auditing integrity. There is little that legislation can do to provide safeguards against certain abuses that are possible with or without assignments.

An assignment should be permitted pursuant to a court order, in which case any potential problems would be subject to public scrutiny. My amendments allow assignments to be made, in addition, to either the billing agent or a financing institution, but to no other parties, because the incremental benefits to providers are greatest in relation to these two kinds of services, and because allowing other miscellaneous assignees will increase the costs of administering an assignment system. An assignment will not be allowed between two related organizations, as defined in the regulations, so that the fee and interest arrangements will always be the result of arm's-length negotiation.

I considered including percentage limitations on discounts allowable for billing service fees and interest, in order to satisfy the public interest, but have concluded that the existing program limitations provide adequate protection against unreasonable costs and charges. The determination of disallowance of interest or collection expenses is best left to be handled on a case-by-case basis. Furthermore, setting a fixed maximum discount to cover all situations would be infeasible, in light of the differences, for instance, between the collectibility of in-patient and out-patient accounts.

The Federal Assignment of Claims Act provides a satisfactory solution to problems relating to administrative simplicity of assignments. The standards of that general Act (differing as they do as applied to regular agents and financing institutions) are incorporated into my suggested Medicare amendments. These standards briefly provide that any regular assignment of a claim against the United States, or any power of attorney of receiving such claim is *void unless* made after the allowance of the claim, as ascertainment of the amount due (which could in the case of these programs be an estimated amount), and the issuing of a check for pyament, and unless executed before two witnesses and acknowledged before a public officer (*e.g.*, a notary public). However, assignments of claims to a "bank, trust company, or other financing institution" need not comply with the above procedures, *if* the contract under which the claim

arises allows such assignment and provides for payments aggregating at least $1,000 and if (unless the contract excepts these) the assignment covers all unpaid amounts payable under the contract and is not made to more than one party or made subject to further assignment (but it may be made to an agent of two or more parties participating in the financing). In the event of such a bank assignment, written notice and a copy of the assignment shall be filed with the contracting agency and the surety and disbursing officer, if any.

Because Medicare provider contracts are open-ended in duration, it is impractical to assign "all amounts" payable until the end of participation in the programs. In order to conform with these federal provisions, the contracts will have to be revised to permit assignment of less than all amounts payable. My suggestion is contained in the amended text: the contract will permit only assignments that cover all amounts payable either until a fixed date or until a fixed number of days (at least 90) after notice of termination is given to the payor.

In the case of Medicaid accounts, the law of the State in which the assignment is made should provide comparable protections.

CONCLUSIONS

This presentation of the pros and cons of assignments and factoring has shown that most of the incremental costs of an assignment system are insubstantial when compared with the potential benefits of such a system during the current cash flow crisis faced by providers, and that in any case such an economic decision should be made on a case-by-case basis at the level of the individual facility. The only true incremental cost to the government is the administrative expense of keeping track of assignments. Legislation should attempt to minimize this factor without abolishing a practice which fulfills such an urgent need of providers. Therefore, I urge that the approach embodied in Section 26 should be abandoned and that amendments along the lines I have suggested should be adopted.

EXHIBIT A

Excerpt from Senate Finance Committee Staff Report, "Medicare and Medicaid—Problems, Issues and Alternatives," 91st Cong., 2d Sess. 130 (1970):

END PAYMENTS TO COLLECTION AGENCIES

Prohibit making of vendor payments (under medicare as well as medicaid) to independent collection and bill discount agencies—to anyone other than the person or institution rendering the service.

The staff's attention has been called to the increasing usage by physicians, pharmacists, and some hospitals of independent collection agencies to whom they assign their medicaid and medicare billings.

Apart from the opportunity for fraud and abuse which sanction of such agencies affords—criminal indictments have been handed down in New York in one such case—the costs of using those agencies are obviously indirectly passed on to the program.

Such agencies are employed because they offer to relieve physicians, pharmacists, dentists and others of cumbersome paperwork and provide immediate cash for medicaid due bills which the practitioners might otherwise have to wait months to collect.

The solution, however, lies in streamlining administration and processing—including making timely payment—rather than use of costly and problem-creating outside collection and discount organizations.

EXHIBIT B

Excerpt from Senate Finance Committee Report, "Social Security Amendments of 1972," to Accompany H.R. 1, 92d Cong., 2d Sess. 204–05 (1972):

PROHIBITION AGAINST REASSIGNMENT OF CLAIMS TO BENEFITS (SEC. 236 OF THE BILL)

Under present law, payment for services furnished by a physician or other person under the supplementary medical insurance program is made: (1) to the beneficiary on the basis of an itemized bill, or (2) to the physician or other person who provided the services on the basis of an assignment under the terms of which the reasonable charge is the full charge for the service. Present law also

provides that payment for such services under the medicaid program is made to the physician or other person providing the services. The law is silent with respect to reassignment by physicians or others who provide services of their right to receive payment under these programs. The Department of Health, Education and Welfare makes such reassigned payments under medicare without specific legislative authority.

Experience with this practice under these programs shows that some physicians and other persons providing services reassign their rights to other organizations or groups under conditions whereby the organization or group submits claims and receives payment in its own name. Such reassignments have been a source of incorrect and inflated claims for services and have created administrative problems with respect to determinations of reasonable charges and recovery of overpayments. Fraudulent operations of collection agencies have been identified in medicaid. Substantial overpayments to many such organizations have been identified in the medicare program, one involving over a million dollars.

The committee concurs with a provision in the House bill which seeks to overcome these difficulties by prohibiting payment under these programs to anyone other than the patient, his physician, or other person who provided the service, unless the physician or other person is required as a condition of his employment to turn his fees over to his employer, or unless the physician or other person has an arrangement with the facility in which the services were provided under which the facility bills for the services. Also, direct payment could be allowed to a foundation, association, plan, or contractor which provides and administers health care through an organized health care delivery system. An example of this type of organization would be a prepaid groups practice or other system recognized by the State title XIX agency. It is not the intent of the committee that this provision apply to payments to providers of services that are based on the reasonable cost of the services.

This provision would not preclude a physician or other person who provided the services and accepted an assignment from having the payment mailed to anyone or any organization he wishes, but the payment would be to him in his name.

The provision would in no way interfere with the fiscal relationships between physician and hospitals in the case of hospital-based pathologists and radiologists, for example.

This provision as it applies to medicare would be effective with respect to bills submitted after the enactment date. For medicaid the provision would be effective January 1, 1973, or earlier if the State plan so provides.

EXHIBIT C

ASSIGNMENT OF FEES BY HOSPITALS, PHYSICIANS AND OTHERS

SEC. 26. (a) Section 1815 of the Social Security Act is amended by adding at the end thereof the following new subsection: "(c) Any payment for a service, which under the provisions of this section and the preceding section may be made directly to the hospital or other facility furnishing such service, may be made to a person claiming such payment under an assignment, including a power of attorney, if (but only if): the assignment is established by or pursuant to the order of a court of competent jurisdiction from such hospital or other facility furnishing such service; *or* the assignment is in favor of an agent of the hospital or other facility furnishing such service (who is not related to such provider), is pursuant to an agency agreement under which compensation is paid to the agent for his services for or in connection with the billing and/or collection of any such payment, and complies in all respects with the Assignment of Claims Act (31 U.S.C. §203 and 41 U.S.C. § 15, as amended); *or* the assignment is in favor of a bank, trust company, or other financing institution (within the meaning of said Act), and complies in all respects with the exception provided therein, but the assignment may provide for a portion of the discount to be attributable to services of an agent who provides billing and/or collection services. For these purposes only, the provider's contract shall be deemed to provide for payments aggregating $1,000 or more and shall be deemed to permit an assignment of all amounts payable under the contract until a fixed date at least 90 days after the date of assignment or until a fixed number of days (at least 90) after notice to the payor of intention to terminate the assignment."

(b) Section 1842 (b) (5) of such Act is amended by adding at the end thereof the following new sentence: "Any payment for a service, which under the provisions of the preceding sentence may be made directly to the physician or other person furnishing such service, may be made to a person claiming such payment under an assignment, including a power of attorney, if (but only if): the assignment is established by or pursuant to the order of a court of competent jurisdiction from such physician or other person furnishing such service; *or* the assignment is in favor of an agent of the physician or other person furnishing such service (who is not related to such provider), is pursuant to an agency agreement under which compensation is paid to the agent for his services for or in connection with the billing and/or collection of any such payment, and complies in all respects with the Assignment of Claims Act (31 U.S.C. § 203 and 41 U.S.C. § 15, as amended); *or* the assignment is in favor of a bank, trust company, or other financing institution (within the meaning of the Assignment of Claims Act, 31 U.S.C. § 203 and 41 U.S.C. § 15, as amended), and complies in all respects with the exception provided therein, but the assignment may provide for a portion of the discount to be attributable to services of an agent who provides billing and/or collection services. For these purposes only, the provider's contract shall be deemed to provide for payments aggregating $1,000 or more and shall be deemed to permit an assignment of all amounts payable under the contract until a fixed date at least 90 days after the date of assignment or until a fixed number of days (at least 90) after notice to the payor of intention to terminate the assignment."

(c) Section 1902(a)(32) of such Act is amended—

(1) by inserting "(A)" immediately after "provide that",

(2) by redesignating clauses (A) and (B) as clauses (i) and (ii), respectively, and

(3) by adding immediately before the semicolon at the end thereof the following, ", and (B) any payment for a service, which under the provisions of subparagraph (A) may be made directly to the physician or other person furnishing such service, may be made to a person claiming such payment under an assignment, including a power of attorney, if (but only if): the assignment is established by or pursuant to the order of a court of competent jurisdiction from such physician or other person furnishing such service; *or* the assignment is in favor of an agent of the physician or other person furnishing such service (who is not related to such provider), is pursuant to an agency agreement under which compensation is paid to the agent for his services for or in connection with the billing and/or collection of any such payment, and complies in all respects with applicable State law relating to the assignment of claims against the State; *or* the assignment is in favor of a bank, trust company, or other financing institution (within the meaning of the Assignment of Claims Act, 31 U.S.C. § 203 and 41 U.S.C. § 15, as amended) and complies in all respects with applicable State law relating to the assignment of claims against the State, but the assignment may provide for a portion of the discount to be attributable to services of an agent who provides billing and/or collection services.".

(d) The amendments made by this section shall take effect on the first day of the first calendar month which begins not less than sixty days after the date of enactment.

SIDNEY KORETZ,
Falls Church, Va., August 4, 1976.

HON. HERMAN TALMADGE,
Chairman, Subcommittee on Health, Finance Committee, U.S. Senate, Washington, D.C.

DEAR SENATOR TALMADGE: Your Subcommittee on Health has held hearings to aid in the "process of developing effective and equitable means of bringing the runaway costs of Medicare and Medicaid under control." I first became involved when I was assigned in the Social Security Administration to study a University of Michigan Report on hospital and medical economics, led by Prof. Walter McNerney, who later became head of the national Blue Cross organization. I was asked to "prepare a summary analysis of those findings which might pertain to a Medicare statistical program."

The Governor of Michigan had included "cost reduction" without loss of quality as part of what should be studied but the phrase "cost reduction" appears not even once in the whole study. Because of too much concentration on what

President Roosevelt called the "foolish old dollar sign," rather than on the real economic resources, costs and benefits which matter more, this omission has by now become almost universal. The Social Security law on Medicare refers to something called "actual costs" (measured in money) but the economist is interested primarily in something called "real costs" and is distrustful of unadjusted monetary figures, speaking of the "money veil," which conceals the true picture. Isn't it strange that health economics is the area where this distinction is most neglected? Here where it really hurts should be of most interest.

My study showed that the advice given to Congress by the Social Security Administration failed to include for Medicare anything that can qualify as sound economic analysis. They looked only for "actuarial soundness" and this does not necessarily bring with it an interest in the economic problem of getting the most for Medicare money. A report to the Finance Committee by the Comptroller General, in the Appendix of that Committee's Hearings of May 25, 1966 on "Reimbursement Guidelines for Medicare," made certain distinctions between the "accounting" and the "economic" approaches of which many hospital people are not aware. Concerning the reimbursement guidelines, Senator Paul H. Douglas, who was a professional economist before he became a Senator, said "there should be a public discussion of half a dozen points involved" and the Finance Committee should "express its point of view, so as to be guideline for revision." (Finance Committee Hearings, "Reimbursement Guidelines for Medicare," May 25, 1966, page 122.) I am not aware that this has ever been done.

The Chief Actuary of the Social Security Administration wrote me that "the subject of whether medical care can be furnished more economically and efficiently than at present is not one of actuarial science or economics, but is rather one of medicine and medical administration." (Letter from Robert J. Myers to me, May 25, 1964). He also said I made too much fuss over the difference between the "actuarial" and "economic" approaches. This can, also be seen, in his lumping together "actuarial science & economics." In this connection, see the speech of Senator Russell B. Long on July 9, 1965, where he says that Medicare "can better be judged by an economist than an actuary, better by a social worker than an accountant, and even better by those of us here today who have the opportunity to go among our folks back home and see the needs that are met, the fears that are dissolved, the wants that are satisfied by what we have wrought." (*Congressional Record*, July 9, 1965, page 15582).

My letter to Senator Harry F. Byrd, Sr., then Chairman of the Finance Committee (Hearings on H.R. 6675, "Social Security," 89th Congress, First Session, May, 1965, pages 1123–5), included criticism of the Report of the Advisory Council on Social Security of 1965, because of its failure to recognize a new dimension in Medicare. Until then the Social Security system was concerned only with transfer payments to beneficiaries who themselves chose how to spend the money they received. With Medicare, a new responsibility came to the Social Security Administration, namely, spending the beneficiary's money for him for medical and hospital services. (This difference is still concealed in the way these government expenditures are classified, erroneously, in the Commerce Department national income accounts.) Operationally, the Medicare program differs entirely from the cash benefit program. This difference was still not acknowledged in the 1971 Report of the Advisory Council on Social Security, which included an actuarial study (the so-called Milliman report) signed by two actuaries and three economists, which neglected the economic dimension. Although it discusses "economic assumptions," it assumes the main purpose to be "crystal-ball gazing," often referred to as "actuarial soundness." The only book I have found attempting to define this is Dorrance Bronson's *Concepts of Actuarial Soundness in Pension Plans* (1957). According to Prof. Bronson, there is no agreement on the very meaning of "actuarial soundness." An actuarial statement about the future is a probability statement based upon assumptions, a hypothetical statement, not a prediction. The assumptions *always* have to be changed, so that the actuarial statement can never be shown to be either true or false. Normally, economic feasibility does not require actuarial "science," why should health be an exception?

According to the July 30, 1976 *Washington Star*, Representative Charles A. Vanik, on the House Ways and Means Committee, says that Congress should not give the Social Security Administration any more new social programs. An interesting historical question is why did Congress, without adequate economic study, give the Medicare program to that agency?

I got no acknowledgement, or criticism, of my report on the University of Michigan study, and only a rhetorical question from the Chief of the Division of Disability Operations, then slated to administer the new baby Medicare on the way, why should he be interested in material of mine printed in the Hearings (1964) on "Medical Care for the Aged," H.R. 3920.

Instead, I was instructed in writing, that it was "inconsistent with acceptable conduct for an employee of the Social Security Administration to write to members of Congress, officials in the Executive Branch, or newspapers, criticizing specific program policies of the SSA or challenging the professional competence of officials of the SSA." I was told of "the policy governing attendance of Department employees at Congressional hearings on matters affecting programs of the Department. Employees should not attend such hearings, even on annual leave, without supervisory approval." (Memorandum to me, August 20, 1964).

On February 17, 1967, Senator Abraham Ribicoff, formerly Secretary of H.E.W., in a Senate speech, upbraided Congress for "abdication of responsibility" because it relied exclusively on the H.E.W. in formulating the Medicare program. He said this made "independent judgment" impossible. On June 28, 1967, before the National Conference of Medical Costs, H.E.W. Secretary John Gardner (whose name never appeared on any Medicare Report to Congress, although he was Secretary when this was first instituted), called for a "radical shift of emphasis" from the "financing mechanism" to the examination of "the efficiency, the productivity, and the logic of the system by which (health) care is delivered." Before the same conference, called under instruction by President Johnson, to help implement, the "cost-benefit" approach of his August, 1965 Executive Order (which, incidentally, I tried to pass along to my superiors in the SSA), Social Security Commissioner Robert M. Ball, in his address, "Problems of Cost—As Experienced in Medicare," showed no interest in cost reduction, as conceived by the economist, but only in how to "correctly reflect the cost," which is an accounting problem for the past, and an actuarial problem for the future, but not a "how to do it" problem which we must solve to make Medicare, Medicaid and other competing and complementary programs work with reasonable success with limited resources.

On November 15, 1967, Senator Ribicoff said that "there is much more that we have to do as a Finance Committee in the field of oversight. If we do not do this as a committee, I have great fears that the burdens will continue to multiply and we may be faced with tremendous costs." Senator Russell B. Long agreed with him, and added that "just as soon as we can find time to do it and assign Senators to that task, we should take a greater look in depth at the Medicare problem." (*Congressional Record*, Nov. 15, 1967, p. S16499). At that time, H.E.W. Secretary Wilbur J. Cohen was denying that the Social Security Administration had authority to engage in economic studies of Medicare without further Congressional action.

As I understand it, your proposed legislation sets up a new agency in the H.E.W. Dept. "into a single Administration for Health Care Financing." I believe this is a step in the right direction, questioning, as I do, the original appropriateness of assigning health care provision, for any group, or for all groups, to the Social Security Administration. But are you going to repeat the mistakes of the SSA, in thinking you can make revolutionary changes without revolutionary effects? Social Security Commissioner Robert M. Ball (before the Group Health Institute, Group Health Association, Washington, D.C. June 2, 1971) said that "when Medicare was passed in August 1965 the general concern was that it not make basic changes in the health system. The basic concern in Congress and elsewhere was that this Government-operated program not interfere with the way the going system of medical care is organized and operated. The public emphasis was almost entirely on keeping the economic burden of illness from overwhelming old people and their sons and daughters. Its object was to prevent economic disaster and to do so without interfering in any major way with the traditional organization of the medical care system." Apparently, that was the justification for absence of planning about "program evaluation" and "cost reduction", both emphasized by Budget Directors, who later became Chairmen of the Health Insurance Benefits Advisory Council, Kermit Gordon and Charles Schultze. It is hard to believe that their reports as Budget Director and as Chairman of the HIBAC came from the same person in each case.

I observe the proposed termination of the Health Insurance Benefits Advisory Council. I was told that all would be well as far as Medicare economic analysis was concerned because this Council was headed by such good economists as Messrs. Gordon and Schultze. Did they do as good a job in a health economics area, in which they were not specialists, as they did in the area of their real expertise, or were they just figure-heads? What good did the Health Insurance Benefits Advisory Council do?

I asked Dr. Kermit Gordon why actuaries were being allowed to usurp the role of economists. (The former deal with how much, the latter with how well, money is spent.) My question and his answer, from the Joint Economic Committee Hearing, "Twentieth Anniversary of the Employment Act of 1946" (Feb. 23, 1966, pages 101–2) are submitted for your Hearing Record, as well as letters to two Presidents, with newspaper clippings. I do this, in the interest of helping to avoid the mistakes and omissions, when Medicare was introduced. Don't think you can have "Health Care Financing" without involvement in "the efficiency, the productivity and the logic" of health care. Especially, the logic.

Yours sincerely,

SIDNEY KORETZ.

DIALOG WITH KERMIT GORDON

Who has the next question? Will you identify yourself?

Mr. KORETZ. My name is Sidney Koretz. I am a dues-paying member of the American Economic Association.

My question follows up the question of Dr. Tobin to Dr. Gordon. As a matter of fact, I asked some people here whether I should ask this question and they said "No," since this was a session on macroeconomics, not microeconomics. My question has to do with a new program that is coming into effect next July; namely, the medicare program.

Now, just before this program was passed, Senator Russell B. Long said on the Senate floor that this "comprehensive, far-reaching, and imaginative program will be better judged by an economist than by an actuary" (p. 15582, Congressional Record, July 9, 1965).

The question that Dr. Tobin raised was about guidelines to Government programs, as well as what Government tells private business to do.

In the discussion of the medicare program, if you look through the records of the House Ways and Means Committee and the Senate Finance Committee, you will find that whenever there was consideration whether a certain measure involving costs should be adopted, a question was asked of the actuaries of the Social Security Administration, and they came up with some answer about a certain percentage of payroll or something like that. This was used as a basis for choice between adoption and rejection of any measure. Presumably, the main consideration was "actuarial soundness." According to the only book I have been able to find on the subject, Prof. Dorrance C. Bronson's *Concepts of Actuarial Soundness in Pension Plans* (1957), there is no agreement what the term "actuarial soundness" (or related terms) means (see ch. 2, "Concepts of Actuarial Soundness—Various Viewpoints"). It is true that "economic feasibility" hasn't been defined clearly either. Nevertheless, it is recognized that "economic feasibility" has an element in it of human activity rather than being limited to actuarial passivity.

This shouldn't be a speech, but a question. The question is for Dr. Kermit Gordon since he has been appointed Chairman of the Health Insurance Benefits Advisory Council. The question is whether up to now the economist hasn't been completely crowded out? I want to present one bit of evidence and then I will sit down. The Budget Bureau informs me that they intend to classify medicare payments for hospital and other medical services as transfer payments, not as purchases of goods and services. It seems to me that if you were only concerned with costs to funds, but not to people, this would be OK. But when you consider, as an economist, real costs to real people, you have to consider that now for the first time social security money is going to be spent for the beneficiaries and not by them. Don't we delay coming to grips with the economic problem of getting the most from limited resources by classifying this as "transfer payment" rather than a purchase of goods and services?

Dr. ENSLEY. I will toss the ball to Dr. Gordon.

Dr. GORDON. I will be very brief. I think to pursue this question very far would be a little outside the bounds of our discussion today, although I would be

happy to discuss the administration of the medicare program with the gentleman who asked the question.

I judge that the central question is whether the actuaries have elbowed the economists out. I don't think this is the real issue here. I think there are some very important actuarial issues involved in planning the medicare program, and actuaries are pretty good at analyzing actuarial issues.

If the gentleman is willing to stretch a point and accept the proposition that I am an economist, I would point out that I am chairman of the committee that advises the Secretary of HEW on the administration of the program, and I did testify on the program when it was under consideration, I think the economists have at least a foot in the door.

Dr. ENSLEY. Thank you, Dr. Gordon.

AUGUST 19, 1963.

PRESIDENT JOHN F. KENNEDY,
Washington, D.C.

DEAR MR. PRESIDENT: In July, 1957 you had an article in the Scripps-Howard newspapers, including the Washington Daily News, advocating better control by Congress of Government spending.

Congress still doesn't have it, as indicated in my Star letter, reproduced here.

It seems nobody has it, not even you. It's bad enough that I shouldn't be able to get information about how much is spent for what, but it is even worse when you can't.

Yours sincerely,

SIDNEY KORETZ.

[From the Washington Star, Aug. 16, 1963]

(By Sidney Koretz)

VAGARIES OF BUDGET

Senator William Proxmire recently defied anyone to tell from the Federal budget how much we are spending in total assistance to foreign countries. He said: "It is literally impossible to determine from the budget or any other published source how much our Government is spending overseas. . . . No single figure in the budget indicates the total expenditures of the Federal budget for education. . . . Similar examples can be given for the health activities of the Federal Government, for research and development programs, and so on."

How can Congress possibly make intelligent decisions about the appropriateness of and appropriations for Government activities when nobody knows what's up in the Government, not even the Government itself?

Senator Proxmire asks: "Do the agencies know what they are doing? If agencies are aware of the nature of the products and services that they are producing, then they should be able to associate costs with those activities. If they do not know the nature of their own output then it is certainly time for the Bureau of the Budget to force them to discover what they are doing. . . . No one else, including the Congress, can learn about these activities unless the agencies present them in an understandable manner."

The first principle of economy in Government, business, or anywhere else is that you must know what good you are doing and how much it costs to do it. An attempt is being made to apply this principle in the Defense Department, where it is said to be helpful in improving efficiency and producing economy without detriment to national defense.

If it can work in the production of such an ill-defined article as "national defense" surely we can use "cost benefit" comparisons in the civilian sector, too, including social services, such as education and health.

AUGUST 19, 1963.

President LYNDON B. JOHNSON,
Washington, D.C.

DEAR MR. PRESIDENT: President Kennedy threw the ball I sent him (a letter, I wrote) exactly three years ago today, to his Budget Bureau, according to the Director Kermit Gordon's reply to it a month later.

On August 25, 1965 you sent a memorandum to all Federal department heads calling for the universal introduction of a new planning-programming budgeting system.

By coincidence, Mr. Kermit Gordon is Chairman now of the Health Insurance Benefits Advisory Council. The Medicare area needs the benefit of the cost-benefit

comparisons you called for. I proposed it in the Social Security Administration when I wrote my letter to President Kennedy.

The Commerce Department now plans a classification of Medicare payments in the national income accounts, in which the "new dimension," noted by Senator Russell B. Long, described in my Washington Post letter shown here, will be completely ignored.

This deserves more public discussion than it is getting. Therefore, I am writing you about it.

Yours sincerely,

SIDNEY KORETZ.

[From the Washington Post, May 16, 1966]

(By Sidney Koretz)

MEDICARE BOOKKEEPING

In his May 10 column, "This Imprudent Democracy," Walter Lippman, in effect, tells us that we are not applying to the coming Medicare program the prudence we have learned in our defense program. As Defense Secretary McNamara once put it, "we have to do our thinking before we start to bend metal."

The Budget Bureau negleted this when they classified Medicare payments in the Federal budget.

The Medicare program will be a bundle of goods and services paid for from Social Security and other Government funds. The American people have a right to demand an accounting of how well this money is spent, just as much as in the case of other Government expenditure on goods and services. They do not have the same right for any accounting of how Social Security beneficiaries spend the money they have received as transfer payments in accordance with the law.

Now the Government is going to spend money for them in a program in whose operation they will play no part. They will be the beneficiaries of the program without themselves making the purchases of the benefits. Surely the Budget Bureau does not wish to minimize the new dimension in a program where, as Senator Russell B. Long, noted just before the Senate passed it, the "worth cannot be measured in terms of dollars. It can be better judged by an economist than an actuary." Money spent on military weapons is seen as productive of general good. Money spent on medical weapons should not become a mere bookkeeping detail registering only money-flows.

The Commerce Department is now reconsidering this question. I expect them to find the Budget Bureau made an error. It should be called a purchase of goods and services from the start.

AMBULANCE AND MEDICAL SERVICES ASSOCIATION OF AMERICA,
Hartford, Conn., July 29, 1976.

Mr. MICHAEL STERN,
Staff Director, Committee on Finance,
Dirksen Senate Office Building, Washington, D.C.

DEAR MR. STERN: Thank you for your prompt response to our request to testify on S. 3205 before the Committee on Finance. As time will not permit us to present oral testimony, please see that the following written statement beomes part of record.

From the standpoint of ambulance providers nationally, who we are representing here, the Medicare Act is basically good and sound. The administration of the act on a local level is the basis of most of our current problems—and they are not solely our problems, because our problems have a direct effect on every individual in this country who may need emergency medical care tomorrow and in the future. The service rendered is a direct reflection not only on the provider of the service, but on the government (both state and federal) because the government regulates ambulance service and determines the administration of third party payment for services.

The majority of the problems with medicare are within its administration procedures, several of which are noted below to give you actual examples of the inconsistencies. As you digest them, please bear in mind that the ambulance service provides service without asking (1) is it medically necessary (2) can the patient sign his name (3) will supplies which are not covered by medicare

be needed. Ambulance service is provided, then paperwork is submitted for payment, with a national average of 37 percent of the claims refused.

(1) Medicare payments are usually prompt, but there are many processing errors which are costly to both the ambulance service and the Medicare carrier.

(2) We must accurately breakdown our claims for services rendered; when we receive payment, it is not itemized and we have no idea whether or not the correct amount has been received.

(3) There is no allowance for most disposable items (bandages, splints, airways, etc.) or for emergency procedures which include paramedic services, vehicle rescue, CPR procedures, etc.

(4) Many stretcher patients require ambulance transportation to a physician's office or clinic. Even though authorized by the physician, it is not covered by Medicare. The patient must be taken to a hospital, resulting in prohibitive costs.

(5) On the other hand, some non-stretcher patients could be transported by wheel chair car at lower cost than the prevailing ambulance rates if wheel chair car transportation were covered by third party pay.

(6) Services which are performed at a hospital are covered. Many of the same emergency services are performed in the ambulance and are NOT covered by Medicare.

The inconsistencies are never-ending. It appears to us, after polling our members, that the majority of the problems we are experiencing are on a local administrative level. Yes, these problems do represent both dollar loss and additional expenditures on our part. At the same time, these same problems are an indication that Medicare and Medicaid are not being accurately handled by the carrier. A clear interpretation of Medicare and accurate administration could provide effective reimbursement for emergency medical care.

Very truly yours,

(Mrs.) LYNNE MAHAN,
Executive Secretary.

PREPARED STATEMENT OF THE CATHOLIC HOSPITAL ASSOCIATION

STATEMENT ON REIMBURSEMENT PRINCIPLES IN THE HEALTH CARE INDUSTRY

The Catholic Hospital Association is the national association of Catholic-owned and sponsored health facilities in the United States. Our nearly 900 institutional members have more than 160,000 acute care beds, making us the largest single system of voluntary hospitals in the country. For more than a century our members have served in all areas of the country—urban and rural, inner city and suburbia. Our dedication to the sick and the poor needs no reiteration. Our commitment to continue as a part of the pluralistic health system is as strong as ever. With the growing cooperation and partnership of the government we hope to be able to serve in an even greater capacity in the years to come, especially in the developing health-gap areas, such as among the aging, in the inner city and the rural setting.

One of our greatest concerns, however, is maximizing the quality of health care delivered to all components of our society within reasonable and effective cost restraints. We recognize the national concern which has been focused on the rising cost of health care. Our members have taken active and leadership roles in addressing the problem areas which are within our scope of control. We also recognize, and take this opportunity to state once again, that many, if not most, of the root causes of inflation in the health care sector are caused by conditions entirely outside of the system and outside the control of individual providers and institutions.

MEDICARE AND MEDICAID

One of the principal contributors to today's economic crisis in health care delivery has been the tremendous increase in demand for services which was precipitated originally by the introduction of Medicare and Medicaid in 1966–67. Medicare has extended health services to a whole segment of our society, but not without a cost to the system. The capability of the delivery system has been stretched to its limit. Utilization of health services exceeded all expectations. Medicaid has had more difficulty. Faulty administration, eligibility controversies and even some fraud and abuse have driven costs beyond even the most liberal estimates. We have learned many lessons from ten years under

Medicare/Medicaid; it is time to apply these to the system so that the same mistakes will not be made under any system of National Health Insurance.

FEDERAL ADMINISTRATION AND REGULATION

Time and experience have shown that, for the system to operate at a maximum effectiveness, reasonable rules and regulations effectuating a concise and consistent national policy must be adopted. Rules are changed so often and with such apparent disregard for precedent that it has become virtually impossible for a provider (yet alone, the government official charged with enforcement) to know at any one time where the program stands.

The Catholic Hospital Association is concerned that there are efforts to fractionalize the administration of health care in this country and to separate the issues of delivery and quality of care from financing and the cost of care. *We believe that issues of quality of care and delivery cannot be separated from those of cost and financial reimbursement and, therefore, programs at the federal level should be coordinated through a single mechanism and not function in isolation.* The nation's health is a priority issue today and will continue to be in the future. It should be given the centralized coordination it deserves.

Health policy must be better coordinated. We cannot speak of cost effectiveness and financing as if they were separate and distinct issues from quality, distribution and availability. Under the current system, advocates of expansion of health care services (and, thereby, resulting cost increases) are speaking out from one agency, while others are promulgating arbitrary cost ceilings and restraints which tend to result in service cutbacks and to stifle the expansion before it can be started.

The hard decisions of quality care, delivered on an optimum basis, but at a fixed price, can only be made when all factors are concurrently reviewed. Isolated, departmentalized government decision-making is not compatible with quality of care, delivery and cost containment.

FEDERAL REGULATIONS—COMMENTARY PERIOD

We support proposals to increase the length of time in which the public can receive and respond to proposed federal regulations on health care. In the past, the 30-day comment period has proven to be extremely burdensome, especially when data must be gathered from health care facilities all across the country. We recognize that particular circumstances may require more expeditious handling, but, as a general rule, *we strongly support provisions which would extend the public comment period on proposed federal regulations to sixty days. We also encourage the practice of filing "Notices of Intent to File Rules and Regulations" even further in advance of actual rule-making.*

STATE AND PRIVATE ADMINISTRATION

We continue to endorse the administration of Medicare and Medicaid on a private intermediary, state-coordinated basis. The federal government has a role in establishing and monitoring uniform standards and in evaluating the performance of state plans vis-a-vis national objectives. However, state governments must be in a position to assure the availability, the access, quality and viability of needed health services. Private intermediaries have proven that, when given adequate utilization controls, they can provide the fastest and most economical claims processing service. We encourage the continued use of these private agencies in the administration of the programs.

We support the creation of standards for claims processing and the development of incentives to encourage even further reductions in administrative overhead. It is our opinion that the private administration of these programs will result in the maximum benefit/overhead cost ratio.

COST OF SERVICE REIMBURSEMENT

Perhaps one of the most maligned systems of health care reimbursement in this country has been the heretofore nearly universally applied system of retrospective "cost" reimbursement. Such payments are difficult to defend as not having a highly inflationary impact on the cost of health care delivery. To recognise this point is the first step in bringing about required change. *The Catho-*

lic Hospital Association endorses the principle of prospective reimbursement, adequate to meet the financial requirements of the individual health care institution. What must be avoided, however, are arbitrary and inflexible caps which do nothing to curb cost increases, but simply impose the burden of such inflation on those institutions and health care recipients least able to bear up under it. Such arbitrary caps unfairly penalize institutions serving the high users of health care—the chronically ill, the disabled and the elderly—where cutbacks in the availability of services can achieve the most "cost-effective" result.

Frequently, it is the older, least efficient health facility, most in need of renovation, which is the primary source of service to the sick-poor and the elderly. It is in this facility, in the inner-city or changing neighborhood environment, which is most hindered by such arbitrary caps which provide no exception for unusual case-load mixtures and which rule out capital accumulation which would permit expansion and improvement of services. Catholic hospitals have served our large cities for years and continue an active presence in the decaying center city. In many of our older cities Catholic hospitals, to a large extent, represent the last voluntary health presence to large parts of these communities. Some of these institutions have a patient population which 80% or more Medicare and Medicaid. It is on these institutions, particularly, that the burden falls—a burden which, unfortunately, can be met only by cut-backs in service or by the eventual deterioration of the institution and its ability to serve. Such a system of arbitrary caps by one governmental agency may achieve a goal of cost containment, but, at the same time, makes a goal of quality care with reasonable access more difficult, if not impossible, to achieve.

PROSPECTIVE REIMBURSEMENT

The Catholic Hospital Association suggests that there has not yet been enough experimentation with various systems of prospective reimbursement to designate any single system as a standard for the nation as a whole. Systems based on prospective rate setting offer some advantages, but they may be outweighed by prospective systems of cost reimbursement. In addition, there are many variables in the types, intensity and breakdown of service loads and occupancy patterns. Demographic and geographic variances cannot be comparably aligned under any one single system. *We, therefore, advocate that several alternative systems of prospective reimbursement be established and that individual hospitals be allowed the option of choosing a system which recognizes its particular local and patient needs.* Health facilities should be allowed to switch systems, but only after giving reasonable notice of their change in accounting practice. After a period of experimentation, the number of alternative reimbursement systems could be narrowed to a more workable number which would then become standardized for the nation.

INCENTIVE REIMBURSEMENT

The past pattern of retrospective cost reimbursement offered no incentive to curb unnecessary increases in costs. Even under prospective reimbursement, this pressure, while abated, will continue. Increases in productivity may be achieved through the use of incentives, including a sharing of cost savings between the institution and the third-party payor for services. *We encourage the adoption of incentive-based reimbursement programs wherein savings can be shared by the provider in order to encourage even greater improvement in the future.* Proposals such as those contained in S. 3205, providing for a 50% sharing of cost savings (up to 5%) are to be encouraged.

PRESERVATION OF THE VOLUNTARY SYSTEM

The Catholic Hospital Association believes that the voluntary system of health care delivery must be preserved as an integral part of any program of National Health Insurance and governmentally-financed health care delivery. *We, therefore, encourage Congress to structure such programs to specifically identify and preserve the voluntary health care facility.* Specifically, *we recommend that at least the current ratio of voluntary health care facilities be allocated to the voluntary component and that a guarantee of this share be written into the law.* Unless such an allocation is guaranteed, The Catholic Hospital Association believes that the voluntary system will be forced out of existence as we have seen similar occurrences in some European countries and, to a certain extent, in Canada.

UNCONTROLLABLE COSTS

Many of the costs incurred by a health care facility are beyond the management and control of the facility's administration. Since we are a service industry, we are subject to the same inflationary presures as all consumers of raw, basic products. As the price of steel and other components goes up, so does the cost of many of the products which we use. Similarly, food costs and the factors of inflation upset the budget equilibrium of the hospital as much as it does the household. *We recommend that, in computing costs or rates to be reimbursed prospectively, that such uncontrollable costs be allowed to pass through as exceptions.* Specifically, we can identify the following as items which should be allowed to so pass through:

(1) technology changes which accelerate the obsolescence of capital equipment;

(2) capital costs generally as they relate to certificated and approved changes in hospital facilities, services, etc.;

(3) education and training costs of health personnel, including physician residents and interns;

(4) energy costs associated with heating or cooling the hospital;

(5) malpractice and liability insurance costs;

(6) inflation adjustments which may be factored in during any one reporting period; and

(7) taxes as they may be applied to hospital property and equipment by state and local governments.

HOSPITAL CONTRACTING

Many proposals have been discussed to limit or reduce the authority of hospitals to contract for services, supplies, equipment and personnel. Most of these take the form of requiring that some bureaucratic official—even to the secretarial level—would make a prior determination as to the reasonableness of all hospital contracts above a certain dollar level. This threshold has been set as low as $10,000. In a modern hospital almost all service contracts, quantity purchase agreements, supplies and materials can reach that level.

We see a major problem in the use of such "prior approval" requirements. Hospital administration is a highly specialized management field. To so dramatically limit the prerogatives and flexibility of the management team can only hinder the operation of the facility and, in the long run, reduce competition and actually increase costs by adding unnecessary layers of bureaucratic red tape.

Such additional "regulation" is duplicative and simply compounds the problem. Assuming reimbursement will be on a prospective basis, contracts entered into by hospital management will already be scrutinized within the general parameters of the prospective determinations. If a contract is excessive, unnecessary or wasteful, the prospective reimbursement system will operate to mitigate, if not completely reduce, its cost impact. Competency is rewarded under the system already outlined. If unreasonable or excessive costs are incurred, they will be caught by the prospective reimbursement system. To provide otherwise removes the very important element of local community involvement and control and reduces management to the level of mere functionaries. *The Catholic Hospital Association strongly opposes the implementation of any such prior approval restraints on hospital contracting.*

PERCENTAGE CONTRACTING

Other proposals in the Medicare/Medicaid cost area have suggested a limitation, if not an outright prohibition against the use of percentage of cost (revenues) contracting. Most frequently, these types of contracts are found in the employment of certain hospital-based physicians (radiologists, anesthesiologists, pathologists, etc.) and in the use of certain management service and shared service concepts.

Again, *The Catholic Hospital Association opposes the implementation of any such arbitrary ban as a harmful infringement on the prerogatives and flexibility of management.* We believe the emphasis should be put on the total effect, the result or the bottom line, so to speak. The question to be asked is, "Is this contract reasonable under the circumstances?" We must assure that an arm's

length transaction has occurred and that competitiveness is guaranteed. This, again, can be accomplished through an effectively operated prospective reimbursement mechanism. The "reasonableness" standard is, of course, a variable, but, nevertheless, is one that is capable of determination and implementation.

QUALITY ASSURANCE

The Catholic Hospital Association believes that, in the drive to control rising health care costs, questions of quality of care and effectiveness of treatment, both preventive and remedial, must not be neglected. The nation's health cannot be measured solely in dollar terms. In measuring the success of any cost control system, dollars and services today cannot be weighed against dollars and services of yesterday. If we can deliver more or better services for the same or even slightly more expense, then we can still consider our effort successful. *We encourage the adoption of quality of care measurements*, including programs for preventive health treatment, physical development and training, recreation, maternal and infant care, as well as specialty programs for the aged and the handicapped, to expand the system of delivery and to improve our nation's health.

CONCLUSION

Rising costs in the health care industry are the joint responsibility of the public, the providers and the government. We at the Catholic Hospital Association are concerned, however, that too much emphasis has been placed on the dollar aspect of the problem. Arbitrary cutbacks hit at quality and availability. And, the first to suffer are the sick, the poor and the elderly. We urge Congress to fully analyze the problem, seeking to preserve the best aspects of our current system, its pluralism, its voluntary character, its creativity and its service commitment, while, at the same time, remedying its deficiencies. We hope our remarks have identified some of these areas. We hope to be able to work together to resolve these problems in the future.

Thank you.

SUMMARY OF RECOMMENDATIONS

(1) The Catholic Hospital Association believes that issues of quality and delivery of care cannot be separated from those of cost and financial reimbursement and, therefore, programs at the federal level should be coordinated through a single mechanism and not function in isolation.

(2) We strongly support the extension of the public comment period on proposed federal regulations from the current thirty to sixty days.

(3) CHA encourages the continued use of the "Notice of Intent to File Regulations" even further in advance of the actual rule-making.

(4) We continue to endorse the administration of Medicare and Medicaid on a private intermediary basis, subject to state coordination and federal standards.

(5) The Catholic Hospital Association endorses the principle of prospective reimbursement adequate to meet the financial requirements of the individual health care institution.

(6) We advocate, however, the trial use of several alternative systems of prospective reimbursement and that individual hospitals be allowed maximum flexibility in adopting a system which reflects their local and patient needs.

(7) We encourage the adoption of incentives and shared savings in any reimbursement system.

(8) CHA insists on the continuation of the voluntary health care delivery system and that protection for such systems be structured into the law.

(9) We recommend that, in computing costs to be reimbursed prospectively, costs outside the management and control of the hospital be permitted to "pass through" as cost exceptions for reimbursement.

(10) The Catholic Hospital Association strongly opposes the implementation of any system of prior approval or restraint on hospital contracting.

(11) We also oppose arbitrary bans on the use of percentage payment contracts and urge the development of, and the adoption of a standard of reasonableness by which such contracts should be measured.

(12) CHA advocates the development of a system for recognizing quality of care in relation to costs, including the expansion of service.

BOSTON UNIVERSITY-MEDICAL CENTER,
UNIVERSITY HOSPITAL,
Boston, Mass., July 28, 1976.

MR. MICHAEL STERN,
Staff Director, Senate Finance Committee, Dirksen Senate Office Building, Washington, D.C.

DEAR MR. STERN. It is my understanding that the Subcommittee on Health of the Senate Finance Committee is holding hearings this week on the "Medicare and Medicaid Administrative and Reimbursement Reform Act" (S. 3205) introduced by Senator Talmadge. I would very much appreciate it if the following comments relating to Section 10 of S. 3205 were forwarded to members of the Subcommittee for their consideration during these hearings.

Speaking on behalf of one hospital that has been seriously affected by the Medicare routine cost ceilings imposed pursuant to Section 223 of P.L. 92-603, it is particularly gratifying that Section 10 of S. 3205 includes so many improvements over the comparable statutory provisions of Section 223 and its accompanying regulations. Section 10 of S. 3205 provides for the exclusion of several particularly variable cost elements from routine service costs, ensures that area wage differences are reflected in hospitals' target rates, and modifies the hospital classification system now used for purposes of Section 223 cost limits to better ensure that comparable types of hospitals are grouped together. Further, the bill calls for the reimbursement mechanism described in Section 10 to be phased in over a period of three years. This feature not only will allow hospitals to better prepare for the impact of the routine cost reimbursement ceilings, but also will allow the Congress to incorporate "state-of-the-art" modifications in Section 10's methodology, in the event that modifications are deemed appropriate, before the section becomes fully operational.

Without elaborating further on the many positive features of Section 10, I would like to make two suggestions that I hope would lead to improvements in the bill: the first relates to the continuance of Section 223 of P.L. 92-603 in the light of the many modifications of Section 223 that have been incorporated in Section 10 of S. 3205; the second relates to a specific element of the hospital classification system calling for the separate classification (without regard to bed size) of the hospitals which are primary affiliates of accredited medical schools.

In my opinion, in view of the stated rationale for phasing in the provisions of Section 10 of S. 3205 over a period of years, it is both inconsistent and illogical that current regulations stemming from Section 223 of P.L. 92-603 will not be deferred or abrogated in the event that S. 3205 is enacted. Section 10 of S. 3205 was designed, in part, to overcome the deficiencies inherent in Section 223 of P.L. 92-603; further, by the degree of specificity of Section 10's provisions, the section was also designed, in part, to ensure that the Social Security Administration, responsible for administering the law, would implement the statute, and enact regulations governing its implementation, in a manner that was consistent with the intent of Congress. Not to abrogate Section 223 and its accompanying regulations at a time when better and more equitable hospital reimbursement provisions are in the process of being phased in will guarantee that many hospitals will be seriously penalized before they are able to gain any relief in the form of the more reasonable treatment to be accorded them by Section 10 of S. 3205.

In regard to the hospital classification system envisioned in Section 10, it is noteworthy that many of the nation's teaching hospitals will be separately grouped for purposes of establishing these hospitals' target rates. In part, this should tend to ensure that such hospitals are not severely penalized because of the necessary and proper costs associated with their characteristically atypical patient mix and scope of services. However, the logic of allowing each accredited medical school to nominate only one hospital to be included in this separate grouping is unclear. In many areas of the country, medical schools in effect direct all of the teaching programs in more than one hospital—that is, medical school faculty select the housestaff, medical school clinical department chairmen or co-chairmen supervise the training programs, and medical school faculty provide the teaching. If medical schools are unable to nominate each of their primary hospital affiliates (in the event that they have more than one) to be included in this separate grouping, it is inevitable that many key teaching hospitals typically providing specialized tertiary medical care will be grouped with non-teaching,

non-tertiary community hospitals and suffer the consequences of target rates reflecting the typically lower costs of providing care in such hospitals. While I recognize the extremely difficult task of developing appropriate definitions for teaching hospitals given the many different types and organizational models of teaching programs, I believe it is terribly important for the Subcommittee on Health to give additional consideration to the development of appropriate groups for teaching hospitals, in an effort, particularly, to accommodate those hospitals that are members of a group of two or more hospitals serving as a medical school's primary affiliates in an integrated program.

Thanks very much for your consideration of these comments and for distributing them to members of the Subcommittee on Health. My apologies for not getting this letter to you prior to the start of the Subcommittee's hearings.

Sincerely,

JAMES L. DORSEY, *Administrator for Fiscal Affairs.*

STATEMENT OF THE NATIONAL COUNCIL OF STATE PUBLIC WELFARE ADMINISTRATORS OF THE AMERICAN PUBLIC WELFARE ASSOCIATION

(By R. Archie Ellis, Commissioner, South Carolina Department of Social Services and William Stewart, M.D., Commissioner, Louisiana Health and Human Resources Administration)

The National Council of State Public Welfare Administrators is composed of state welfare directors who, for the most part, are responsible for administering state Medicaid programs. We are acutely aware of the many shortcomings of this state/Federal program; and, thus, we welcome proposed legislation designed to improve its management and administration. Given the active role of Council in all aspects of Medicaid, its members are particularly well qualified to appraise the provisions of S. 3205. The Council conducted a survey in which administrators were asked to evaluate the Medicaid sections of S. 3205. Some 41 states responded. Our statement is based on the content of these responses and additional discusions held by the Council's Committee on Health Care.

The Council believes strongly in the need for a national health policy which adequately reflects the interests of its citizens objectives of state and Federal government. Our present health system is fraught with difficulties and problems. Our resources are misdirected towards the treatment of illness rather than the prevention of disease. As a country, we need to reassess the role of medical care and spur increased emphasis on the promotion of health.

Medicaid and the problem of rising costs

Perhaps the greatest symptom of this lack of clear national objectives is the continuous disproportionate rise in the cost of health services. Federal and state expenditures alone for health care have been rising at an annual rate of 15%. Increasingly, states have been forced to cut back on the Medicaid program to reduce expenditures. Most states have managed to maintain benefits and eligibility levels—thus, not directly affecting service beneficiaries. For some, however, the time for short term solutions is running out; these states will need some form of assistance and reform that will allow them to maintain existing services. However, cutbacks and changes in Medicaid will not curb the unabated growth in the cost of health services. For the underlying causes of this long term health cost inflation—increased costs of labor, supplies and technology—will no doubt continue to plague Medicare, Medicaid and all consumers of health care until definitive national strategies directly targeted to these sources are implemented.

The possible solutions

Despite the enormity of these problems, there appear to be few options available to Congress likely to have a substantial impact. To a great extent, the Congress must work through those programs funded either in whole or in part by the Federal government—Medicare and Medicaid. Options under these programs include the following:

Adoption of specific incremental program reform;

State assumption of Medicaid management exclusive of Federal controls—the block grant approach;

Federalization of Medicaid with little or no involvement of state government; and

Enactment of national health insurance, ending distinctions between state and Federal programs.

While the latter three options have obvious appeal to certain parties, only incremental program reform is feasible at this time. The others call for a greater commitment of funds and energy not likely to be forthcoming in our present economy. It is the incremental approach that is adopted by S. 3205 and which is under discussion today. Through reforms in Medicaid and Medicare designed to improve administration, foster efficient management, encourage coordinated policy development and curb fraud and abuse, the legislation ultimately seeks to reduce program costs.

The National Council supports these objectives. Moreover, we fully support several of the bill's provisions designed to satisfy these objectives. In some instances we believe alternate strategies would better serve the intent of the legislation. Again, our testimony is largely based on a survey conducted of Council membership.

Summary of general positions: Consolidation

The bill would consolidate Medicaid and Medicare into a single administrative entity.

The National Council of State Public Welfare Administrators supports this effort. The need for coordinated policy development has been evident for some time. We do urge, however, that states have an active role in the development of policy. Medicaid agencies have no wish to become "mini-Medicare's"; the tremendous variability among states has already demonstrated the inadvisability of forcing identical administration upon them. We also urge that related programs such as Title V be included in the consolidated effort.

Summary of general positions: Medicaid administrative reform

The legislation seeks to adopt minimum, uniform standards of performance for the administration of Medicaid.

Again, the states recognize the necessity of improving Medicaid administration. Their comments reflected the following concerns.

Specificity.—The Medicaid requirements are extremely detailed and specific. The states questioned the advisability of locking such regulatory language into legislation.

Flexibility.—Related to the above concern was the lack of flexibility that the legislation would allow. Granted, some of the requirements are necessary to sound program administration. We do, however, question the reliance on process oriented criteria rather than outcomes. For example, collecting information on a quarterly basis does not assure that it will be utilized in an effective manner.

Cost of compliance.—While there are some states already performing the bill's required procedures a number of states have indicated that compliance is not feasible without significant expenditure of state funds. Additional personnel would be necessary in several instances; claims processing systems would require substantial modifications. Therefore, initial compliance efforts would be costly to some states.

The validity of penalties.—The bill includes both positive and negative incentives to encourage compliance. Both are targeted to administrative costs. The rationale is to penalize—at least to some extent—those states found with deficiencies and to reward those demonstrating superior effort. In the case of penalties, the objective is to encourage action without harm to program recipients (administrative costs average 5% of Medicaid expenditures). Virtually all states are opposed to the use of penalties to spur compliance efforts. In particular, they questioned the effectiveness of such sanctions. The loss of Federal revenue, no matter how small, may generate additional program cutbacks which ultimately harm recipients. In addition, state legislatures generally do not differentiate between the cost of program benefits and administrative expenditures; a single budget allocation is made. The states recommended that instead of penalties, additional Federal funds be made available to assist states in compliance efforts.

Applicability.—The legislation calls for consolidated and coordinated policy development for Medicare and Medicaid. Yet, as the states point out, the legislation adopts requirements for Medicaid alone. We urge that any requirement adopted for Medicaid administration be applied to relevant counterparts of Federal administration. For example, time limits on eligibility determination should

apply equally to the Social Security Administration. Claims processing and report requirements should apply equally to Medicare and its fiscal intermediaries. (The legislation is predicated on the assumption that administration of Medicaid is inefficient and not uniform.) Regardless of the validity of this assumption, it is clearly the case that Medicare intermediaries do not hold an unblemished record. We further urge that coordination between Titles XVIII and XIX be assured at the local levels as well.

The means of evaluation.—There is widespread agreement that DHEW has not monitored state compliance efficiently and consistently over time. The bill would seek to remedy this situation by involving another government agency, GAO, in program evaluation, removing considerable discretion in program monitoring from DHEW. Presumably (although not specified) this partnership would function on the regional level as well. The implications of such a development are enormous since GAO, an independent investigatory agency of Congress—the legislative branch—would be directly associated with DHEW—the executive branch—in program evaluation. We are opposed to this monitoring strategy.

Medicaid administrative reform: Specific comments

(1) *Eligibility.*—The legislation would place time limits on determinations of Medicaid eligibility.

The states questioned the need to adopt a 30 day processing standard for Medicaid when a 45 day standard exists for AFDC. It must be remembered that the determination process is identical for cash assistance and medical assistance.

We recommend that redeterminations for the aged, blind and disabled be required once annually. This population is generally stable; our attention should be directed to the medically needy under AFDC. In addition, we recommend that states have 90—rather than 60—days to process medically needy disabled applications, since verification in this program is often lengthy and detailed.

(2) *Claims processing.*—The bill would require Medicaid claims be processed within specific time limits.

Most states indicated that this requirement would present few difficulties upon implementation of the Medicaid Management Information System. We do recommend that given the variation in MMIS implementation schedules, that the requirements allow more lead time before requirements become effective.

(3) *Quality control.*—The bill would target maximum allowable errors to results of the first survey (October 1975 to March 1975).

We believe that this first survey of error rates is an arbitrary and likely inaccurate standard to utilize as a target for compliance. As a result, we recommend that no absolute maximum be adopted, but rather target rates on an individual state-by-state basis. Each state should then work toward this individual rate which gradually changes over time to reflect improvement. Too much emphasis on the accuracy of determinations will no doubt force some states to adopt policies which encourage denial of eligibility—even to those who satisfy the criteria—in the name of quality control.

(4) *Publication of State error rates.*—The bill would require publication of state error rates in eligibility determination.

Publication of state error rates is essentially a political tool. On the one hand, it may encourage corrective action by reluctant state agencies and legislatures unwilling to appropriate necessary funds. On the other, it may generate widespread public displeasure, but with little substantive response by the state.

Most states indicated that a fair presentation of state performance in all areas would be far more effective. In addition, they recommended corresponding publication of Federal government performance in Medicare.

(5) *Reports.*—The bill would require preparation and submission of numerous Medicaid reports to the Federal government on a periodic basis.

Again, most states indicated that they could satisfy requirements upon implementation of MMIS, presuming state formats were acceptable as reporting techniques.

A note on MMIS: the requirements were clearly drafted in light of the capabilities of the MMIS—a program originated and advocated by the Federal government. Many states indicated that while they were implementing the system, they questioned its ultimate worth. S. 3205 mandates a number of processes be performed and material generated that are largely products of this program. It is not clear, in the states' opinion, that such processes will contribute to improved program management or ultimately, containment of costs. Some key areas, such as collection of third party liability, are not included in MMIS.

Therefore, we recommend 100% Federal matching payments for implementation of MMIS. In addition, we recommend that the bill contain provisions to assure the compatibility of MMIS with Medicare.

(6) *Technical assistance.*—The bill includes several provisions for increased technical assistance.

The Council actively supports the emphasis on technical assistance. We do, however, urge that appropriate training and funding be made to assure the effectiveness of this effort.

Medicaid administrative reforms: Summary

In general, the National Council supports the objectives of the S. 3205 Medicaid provisions. The states are well aware of the need to improve program management and administration. We do, however, question the extent to which the proposed requirements satisfy these broad objectives. We, therefore, recommend a thorough review of their likely impact and effectiveness and support efforts to such performance objectives related to outcomes—not process.

Hospital reimbursement

The bill would adopt an incentive reimbursement system for hospitals under Medicare. Since most states rely on Medicare rates for Medicaid hospital reimbursement, these proposed requirements have great implications for state Medicaid expenditures (about one third of which are consumed by hospitals).

The scope of the Talmadge provisions is limited. The three year phase-in period, the focus on only a relatively small number of hospital costs and the generous provisions for extenuating circumstances all point a somewhat incremental approach to the control of hospital costs. The assumption underlying the proposal is that any more comprehensve or restrictive strategy is politically infeasible at this time and thus stands little chance of being adopted.

The bill does address one major problem: the adoption of a uniform accounting system for hospitals. Clearly as the data base by which hospitals are compared and reimbursed improves, the ability to monitor and control costs is enhanced. In its present form, however, the Talmadge proposal falls heir to many of the problems of incentive reimbursement systems; the reliance on existing costs as a base measure (assumes all hospitals operating efficiently at present), the ability of a relatively small incentive payment to encourage cost savings and efficiency and the assumption that all hospitals can be compared through a classification system. Hospitals within the 20% margin would have no incentive to improve. The proposal goes several steps further by allowing retroactive adjustments for inflation, a relatively large (20%) margin for allowable reimbursement rates (presumably without question) and by permitting consideration of numerous exceptions (such as case mix) to the basic formula on a hospital by hospital basis. In short, the proposal would affect only those institutions whose relevant costs exceed the target rate in excess of 20% and who are not able to satisfactorily demonstrate the reason why those excessive costs occur. There are few hospitals who are likely to fall into this category, particularly given their recognized ability to shift costs into those sectors not covered by the reimbursement formula. In this case a number of key cost areas are excluded from the prospective system (e.g. education) and could easily serve as the repository for unapproved costs. In addition, and this is a far more serious problem, even if Medicaid and Medicare hospital costs were constrained there are no safeguards to disallow the reallocation of these costs to other third parties (the so-called "balloon effect"). Therefore, the bill may create a substantial differential between rates under third party payors, such as Blue Cross, and those under title XVIII and XIX. Thus, the discrimination on the basis of acceptance payment and patients—a phenomenon already experienced by Medicaid—may spread to Medicare—discrediting it as well. Thus, it appears that the S. 3205, while establishing a necessary data base, would do very little to constrain the growth in costs without the use of independent criteria to evaluate costs, and without substantial safeguards or other contributers to high hospital costs.

Presuming, however, that at least some marginal effort is necessary we make the following recommendations:

(1) That state with demonstrating successful programs in hospital reimbursement be allowed to utilize their system—for both Medicaid and Medicare—in lieu of the rule specified in S. 3205.

(2) The retroactive adjustments not be allowed. This presents a particularly acute problem for states who must project program costs in advance. A retroactive increase in hospital rates would find most states unable to make payments.

(3) That the section referring to wage differentials be clarified.

(4) That definitions for hospital services be extremely clear and straightforward.

(5) That allowable cost increases be tied not to industry figures, but to the appropriate price index.

(6) That there be more than one primary affiliate for a medical school allowed since many states are experimenting with innovative programs such as community based schools without walls (area health education centers).

(7) That, while we approve of the proposal to reimburse for closure or conversion of facilities, that such efforts involve the input of local and state health planning authorities.

Physician reimbursement

The bill would require Medicaid reimbursement be at least 80% of Medicare's. Even those states using Medicare levels were firmly opposed to this requirement (in the survey cited earlier). Several indicated that this would generate significant additional costs. Therefore, we urge that this provision be eliminated.

Fraud and abuse

The proposal contains several provisions designed to curb fraud and abuse in Medicaid and Medicare.

We wish to go on record supporting these provisions. However, even the broadest estimates of program fraud place the proportion at around 5% of program costs. We, therefore, urge that these activities being pursued in the context of their impact on program costs. Even the most effective fraud and abuse is not likely to have a major impact on health care costs. Moreover, the bill contains few real incentives to eliminate provider fraud and abuse. One provision would require all contracts for services in excess of $10,000 be subject to review and advance approval. While we do believe that service contracts are a source of abuse, the overall level of $10,000 is too low. Should that figure survive, both Medicare and Medicaid would be inundated by proposed contracts. We, therefore, recommend that the amount be raised to $50,000.

Certification of skilled nursing facilities

The bill includes a provision that the Secretary may delegate authority to states to certify skilled nursing home facilities to participate in Title XIX. Such would remove exclusive state authority to certify facilities.

The Council opposes this provision because it would transfer state and local authority to the Federal government in cases where state expertise likely exceeds that of the Secretary. We do recommend, however, that skilled nursing facilities be required to obtain Medicare certification before seeking Title XIX approval.

MISCELLANEOUS PROVISIONS

Issuance of regulations

We support the so-called "savings provisions" which place time limits on the issuance of final regulations. States have long been plagued with complying with requirements which become effective before final regulations are published and under which their compliance will ultimately be evaluated. We do urge, however, that the speed with which the regulations are prepared does not infringe on their overall quality.

Medicaid EOMB

We support the change in the Medicaid Explanation of Benefits requirement which would allow such forms to be mailed on a sample basis.

Medicaid/HMO contracts

The bill includes several requirements concerning Title XX contracts with health maintenance organizations.

We urge that such contracts not be subject to approval by the Secretary since such arrangements are made solely on the state's discretion.

SUMMARY

In summary, the Council welcomes the introduction of the Talmadge amendments as a first step in Medicare and Medicaid reform. Clearly, many of the provisions will no doubt help to prepare the Federal government for national health insurance. We must emphasize, however, that as it is presently formulated,

S. 3205 will have a limited and marginal impact on health costs. Working through Medicare and Medicaid alone is insufficient. It is a holding action which may come too late for some states. As a result, it is likely that state legislatures will act in more dramatic fashion to control health costs and probably to the detriment to our present beneficiaries. We, therefore, urge the adoption of more potent provisions to curtail the increase in health care costs.

RESULTS OF THE MEDICAID SURVEY: THE TALMADGE AMENDMENTS (S. 3205)

To assist in the preparation of testimony on the Talmadge Medicaid/Medicare amendments, APWA surveyed state welfare agencies to determine their opinion of the bill's key provisions. Forty states responded.[1] A summary of their major reactions follows.

The Survey Instrument

The questionnaire asked states to analyze seven major areas addressed in the Talmadge bill: eligibility, claims processing, reports, quality control, publication of error rates, payment levels, and fiscal penalties. Each state was asked to indicate what present capabilities were and if the relevant Talmadge requirement would present any difficulties.

Results

Eligibility.—Ten out of the 39 respondents stated that the requirements would present no difficulties. The rest indicated that eligibility staff would have to be expanded to meet the proposed deadlines which would, of course, result in increased administrative costs. Several states indicated that Medicaid determinations should conform to the present 45-day requirement under AFDC. Further, most indicated that disability determinations required more time than the proposed 60-day limitations.

Claims processing.—Thirty-one of the states responding indicated the requirements would present few difficulties once the MMIS program became operational. Most are presently implementing the system and expect to have it operational within two years. Areas of difficulties included determining third party liability, utilization pattern and fraud and abuse screens. A few states indicated their present claims processing systems could not meet proposed deadlines.

Reports.—Again, most states (28) indicated these requirements were feasible to meet once MMIS became operational. Some did note, however, that it would take a major effort to make their system comply. Some also felt the requirements were too process-oriented and questioned the use to which such reports would be used. Some indicated the 60-day quarterly deadline was not feasible and further requested elimination of the quarterly requirement.

Quality control.—The suggested tolerance levels ranged from 3 percent to 20 percent; some states would utilize SSI error levels. Several indicated there should be no absolute target level. Twenty states indicated publication of rates would present few difficulties as long as information was fairly presented. Conversely, those who disapproved of publication did so because presentation has been biased in the past.

Payment levels.—Many states (19) indicated this requirement would infringe upon the state's right to determine payment levels even when their present rates equaled Medicare's. Fourteen indicated they met 80 percent of Medicare levels at this time. Several states indicated the requirement would raise program costs substantially.

Penalties.—The large majority of respondents disapproved of penalties in any form (37/39). Among their comments: "too severe", "clients ultimately suffer", "result in program cutbacks", "totally self defeating". Two states supported the use of positive incentives. Several suggested that the penalty should be reduced to five or ten percent of administrative costs and allow time for corrective action (the bill allows six months).

[1] Arizona's response was not included.

States responding

Alaska	Minnesota	Oregon
Arizona	Mississippi	Pennsylvania
Arkansas	Missouri	Puerto Rico
California	Montana	South Carolina
Colorado	Nebraska	South Dakota
District of Columbia	Nevada	Utah
Florida	New Hampshire	Vermont
Idaho	New Jersey	Virgin Islands
Iowa	New Mexico	Virginia
Kansas	New York	Washington
Kentucky	North Dakota	West Virginia
Louisiana	North Carolina	Wisconsin
Maine	Ohio	
Michigan	Oklahoma	

TESTIMONY OF PEYTON E. WEARY, M.D., ON BEHALF OF THE AMERICAN ACADEMY OF DERMATOLOGY

The American Academy of Dermatology is pleased to have the opportunity to present written testimony relating to the proposed legislation referred to as the Medicare-Medicaid Administrative and Reimbursement Reform Act (S. 3205). The American Academy of Dermatology is the representative organization for the majority of the approximately 4500 dermatologists currently practicing in the United States.

Our testimony can be summarized by the following two proposed amendments:

(1) That Sec. 2. Section 1862(a)(13)(c) of the Social Security Act (P.L. 89-97) be amended by striking out the word, "warts".

(2) That Section 22(a)(3) of S. 3205 be altered to read: "Pathology services shall be considered 'physicians' services' only where the physician performing such services personally performs acts or makes decisions with respect to a patient's diagnosis or treatment which require the exercise of medical judgment".

The reasons why we request these two changes are presented below:

(1) *Elimination of the word "warts".*—The present Medicare Law (Title XVIII of the Social Security Act P.L. 89-97, July 30, 1965) contains in Sec. 2, Section 1862(a)(13)(c) an exclusion of reimbursement for "routine foot care (including the cutting or removal of corns, warts or calluses, trimming of nails and other routine hygienic care)." As dermatologists we are requested by our patients to remove troublesome warts from the feet (often called plantar warts because they may occur on the plantar surface of the foot). Warts on the feet, just as warts elsewhere on the body, are tumors caused by infective viral agents and differ only by virtue of the fact that because of their location on weight-bearing surfaces *they are often more painful than warts located elsewhere.*

We believe it is inconsistent that removal of warts located elsewhere on the body is a reimbursable service, while warts on the feet are excluded. The inconsistency is further emphasized by the fact that no private insurance plans to our knowledge discriminate in the coverage of treatment for warts on the feet and those located elsewhere on the body nor does the Federal Employees Group Plan deny coverage for treatment of warts on the feet.

We are aware of no other infectious disease which is so discriminated against in the Social Security Act and we are concerned that it is precisely the most painful and disabling form of this infectious disease (plantar warts) which is excluded, while the same infectious process occurring elsewhere on the body is adequately covered. A bill (H.R. 14515) has recently been introduced in the House by Mr. Duncan and Mrs. Keys to correct this inequity. For the reasons noted above we would request that the Senate likewise move to amend Sec. 2, Section 1862(a)(13)(c) of the Social Security Act by striking out the word "warts".

(2) *Alteration in definition of pathology services.*--Our second recommendation is related to the language which appears in the proposed legislation S. 3205 in Section 22(a)(3), Page 59 as follows: "Pathology services shall be considered 'physicians' services' only where the pathologist personally performs acts or makes decisions with respect to a patient's diagnosis or treatment which require the exercise of medical judgment." We are concerned that the word, "pathologist," used in this context could be construed to refer only to physicians who are designated as pathologists, individuals who specialize solely in Pathology by virtue of specialized residency training in the field of Pathology.

We would direct your attention to the fact that a substantial number of dermatologists are highly skilled in interpretation of pathological specimens derived from the skin of patients with skin disease and that all dermatologists receive training in Dermatopathology during their residency and are examined for proficiency in Dermatopathology in the course of their board certification examination. Furthermore, a number of dermatologists and pathologists now hold certificates of special competence in Dermatopathology. In fact, some dermatologists limit their practice to providing dermatopathologic services for institutions and their colleagues.

We would furthermore cite instances in which non-pathologist physicians, such as hematologists, are highly skilled in interpretation of bone marrow specimens and routinely perform such interpretive services for their patients, their institutions or their colleagues in other disciplines.

In order to avoid future misinterpretation between the broad generic use of the word "pathologist" as we are sure it is intended in the proposed legislation, and the narrow restrictive use of the word "pathologist" as it has come to be accepted in common parlance as a specialist who deals solely with Pathology, we would propose that the wording in Section 22 (a) (3) of S. 3205 be changed to read as follows:

"Pathology services shall be considered 'physicians' services' only where the physician performing such services personally performs acts or makes decisions with respect to a patient's diagnosis or treatment which require the exercise of medical judgment."

PREPARED STATEMENT OF THE AMERICAN OSTEOPATHIC HOSPITAL ASSOCIATION

This statement presented by Michael F. Doody, President of the American Osteopathic Hospital Association, 930 Busse Highway, Park Ridge, Illinois 60068.

The AOHA maintains its Headquarters in Park Ridge, Illinois, with an office in Washington, D.C., and represents the osteopathic hospitals throughout the country. Osteopathic hospitals, which number 204 in total, are located in 28 states. These institutions serve as the primary institutional care facilities for those patients (individual consumers) who choose to receive their health care from one of the approximately 15,000 practicing osteopathic physicians in the country.

Osteopathic physicians represent a second school of medicine. The osteopathic profession is a politically and philosophically separate and administratively independent school of medical practice. Osteopathic physicians represent approximately 5 percent of all physicians in the United States; but it has been estimated they care for as much as 10 percent of the United States citizenship.

The 204 osteopathic hospitals represent more than 23,000 inpatient beds and employ 60,185 people. In 1975 osteopathic hospitals had more than $900 million in total expenses while providing health care services for more than 800,000 inpatient admissions and 2.8 million outpatient visits.

Osteopathic institutions and physicians are interested in the delivery of quality health care and for the most part are providers who concentrate in the areas of general practice and family medicine. Approximately 70 percent of all practicing osteopathic physicians are general practitioners or specialize in primary-care areas (internal medicine, family practice, pediatrics, obstetrics-gynecology, general surgery). Osteopathic hospitals are cost-conscious institutions whose primary objective is the delivery of quality health care.

Osteopathic hospitals represent an important community health resource. Many of our hospitals are located in rural or semi-rural areas and provide a very necessary community health service. In some instances the osteopathic hospital is the only hospital present within the community.

INTRODUCTION

This Association agrees completely with the basic premises which prompted the distinguished Chairman of this Subcommittee to introduce S. 3205—we cannot continue with a program which increases in costs faster than the rate of rise in federal revenues; we must make Medicare and Medicaid more efficient and economical or benefits will have to be ultimately reduced; we must avoid arbitrary controls on payments to hospitals; we must provide incentive payments to encourage efficiency; and finally, such changes must be made prior to any expansion of the federal role in providing more health insurance to more people since without such changes any expansion would be an open invitation to fiscal disaster.

The American Osteopathic Hospital Association and its member hospitals have long supported efforts to overhaul the present hospital reimbursement system. We believe that the present practice of grouping hospitals according to bed size and geographic area should be altered to include such other factors as patient mix, level and scope of services, labor costs, and the extent of teaching programs. In addition we have often advocated the undertaking of a positive program to develop incentives for hospitals to participate in programs which have proved themselves to be effective in containing hospital costs, including prospective payment systems.

Under the present system, if two hospitals of similar bed size in the same geographic area have a variation in costs, at least one is assumed to be inefficient and have poor management and unreasonable costs. This is a premise which we cannot accept. Variation in costs between hospitals is not indicative of poor management or inefficiency. Other factors, recognized in S. 3205, contribute to and affect the efficient delivery and cost of hospital and health services. This Association supports government efforts to reduce reimbursement to institutions where it can be shown that costs are unreasonable and the result of marked inefficiencies in operation or conditions of excessive services. We are in sympathy with the concern expressed by the Senate Finance Committee in its report on the Social Security amendments of 1972: ". . . when the high costs (from hospitals) flow from inefficiency in the delivery of needed health services the institution should not be shielded from the economic consequences of its inefficiency." The determination of what is "reasonably prudent and cost-conscious management" is the issue at controversy. It is this issue which S. 3205 attempts to address, and it is this issue which will encompass the majority of our testimony today. It must be remembered that the remarks we shall set forth are directed at achieving one common goal: that of providing the best possible health care and a cost-effective well-organized system for the American people. For purposes of organization our thoughts will be set forth on a section-by-section basis, concurrent with the numbering system in S. 3205.

Section 2. Establishment of Health Care Financing Administration

This section would establish a single administration for health care financing headed by an Assistant Secretary. This provision would result in two Assistant Secretaries in the health area of the Department, leaving the current Assistant Secretary of Health to deal with other health matters. We support this concept if there is adequate provision for the close working relationship between the two Assistant Secretaries.

Such diverse areas as health planning, peer and utilization review, manpower planning, etc., are interrelated and therefore the stated intention of Section 2—to perform uniform policy making and enhance accountability—calls for close communication between these two offices. Creation of a new Assistant Secretary position, without the establishment of a specific and appropriate mechanism to assure coordination of all policy and program implementation, will exacerbate existing problems of fragmentation, bureaucratic red tape, and a slow decision-making process.

This Association also supports the establishment of the proposed position of Inspector General (under Section 3 of the Bill), who would direct the Central Fraud and Abuse Unit established in Section 2. Given the recently disclosed program abuses, a sincere and effective attempt at monitoring the program on a coordinated basis is necessary.

Section 4. State Medicaid Administration

From the point of view of the delivery of health care, and to the extent that the language improves the Medicaid program and saves money, this Association

supports Section 4. We are particularly supportive of the incentive approach, both here and in the Medicare program, which rewards hospital efficiency. We have long advocated that the Medicaid program should be federalized and contracted to private insurers for administration. The unevenness of Medicaid benefits and reimbursements among the states can only be leveled through the intervention of the federal government. The present situation does not consider the critical problems in state financing, and decreases the viability of the existing program and its scope and levels of coverage.

Section 7. Regulation of the Secretary; Savings Provision

We strongly support the requirement of a minimum period of 60 days for comment on proposed HEW regulations with respect to the Social Security Act. As we have stated in testimony before committees of both the House and Senate, we strongly believe that a formal mechanism for Congressional review of administrative rulemaking is necessary and an overdue reform of current procedures. Extension of the comment period to a minimum of 60 days is one of several recommendations we feel would be a step toward this needed reform.

Section 10. Improved Methods for Determining Reasonable Cost of Services Provided by Hospitals

This section of the legislation is indeed far-reaching and the most significant for hospitals. We applaud the Chairman for his insight and his attempts to develop an effective hospital reimbursement system. While any classification system for hospitals is by its very nature arbitrary, the proposed new method of reimbursement for routine operating costs for hospitals embodied in S. 3205 seems to us to be a major step forward in the development of an equitable system. Of all of the proposals made to date, this appears to this Association to be one of the fairest yet devised, and it is certainly vastly better than the classification system presently in place. We are particularly pleased to see the exclusive of variable cost elements such as educational and training costs, and energy costs.

We would also urge that this committee consider including other variable cost elements such as malpractice insurance premiums; the cost impact of government-mandated programs such as health planning, PSRO's, and utilization review; and charity care losses. Each of these areas contributes heavily to hospital costs and does so more heavily in some areas than others. Adjustment of routine operating costs to take into account the effect of area wage differences is also an important factor. We would also urge that the cost of an employee benefits package be included when calculating the effect of area wage difference. This Committee is most aware of the fact that these packages vary widely in scope and cost and that they can have a significant impact on cost.

We are not convinced, however, that any classification system is appropriate for the purpose of identifying institutions whose costs are "unreasonable". A more appropriate use of the classification system might be to identify those hospitals whose costs need more careful review to determine the reason for the "high costs" and to evaluate whether or not, given the hospital's individual circumstances (i.e., size, location, patient mix, services offered, etc.), the costs are excessive or unreasonable.

The amounts hospitals must pay to meet operating expenses has risen steadily over the past several years. The major components of the rising costs include such things as energy, food, premiums for malpractice insurance, and labor costs. The hospital market basket is becoming increasingly more expensive. And that market basket is a considerably higher priced one than the Consumer Price Index (CPI) market basket. Hospitals buy an extraordinary amount of utilities and petroleum-related or petroleum-based products. At the same time hospitals are not producing a uniform product, such as the steel industry or the meat-packing or other industries produce.

The hospital product, a patient-day of quality health care, is an extremely complex item to produce and it is a product that is constantly changing and improving. Improvements in care have contributed to the change and improvement of the product but have also contributed to increased per-unit costs. Finally a highly trained very specialized labor force requires considerably higher rates of compensation.

As stated above, malpractice premiums are a major contributing factor to rising hospital costs. Therefore, we recommend that provision be made to accept the hospital's general and professional liability (malpractice) insurance premium

as an allowable cost or as an adjustment in the routine operating costs similar to that allowed for the effect of area wages and benefits.

Routine operating costs in S. 3205 does not include "energy costs associated with heating or cooling the hospital plant." This Association questions the limitation of this provision to just heating and cooling. Hospitals use enormous amounts of energy, particularly electricity, over and above those amounts used for heating and cooling. While we commend the Chairman for taking the first step in this area, we would strongly recommend consideration of a hospital's true, overall energy consumption, not just that portion devoted to heating and cooling.

This Association supports the application of this Section to Medicaid as well as Medicare as a welcome step toward federalizing Medicaid. We are concerned, however, that the actual language of the legislation is not specific enough to assure state acceptance of and participation in the proposed classification and reimbursement systems. We believe it is essential that the legislation mandate full compliance with the proposed new systems as a condition of state participation in the Medicaid program.

As mentioned previously, this Association favors the incentive approach—rewarding hospitals whose comparable routine operating costs are less than the mean and penalizing those whose costs are substantially above the mean. The three-year phase-in approach will certainly give hospitals time to adjust and we commend the Chairman for his foresight in establishing this concept.

We are somewhat concerned about the system of classification of small hospitals, those in the 5- to 24-bed category, and those in the 25- to 49-bed classification category. Many hospitals in these categories are located in rural or semi-rural areas and compliance with federal regulations is often very difficult for these institutions. Attempts to comply with HEW regulations in order to get the federal funds, which many of these rural health facilities find necessary to remain solvent, have resulted in great expense and in some cases closure of the facility altogether. Despite some HEW attempts in certification of access hospitals, it became apparent in the early 1970's that some rural hospitals were having difficulty complying with nursing staff requirements and other regulations.

HEW is not eager to make provision for the problems of these small rural hospitals and therefore such guidance will probably come only through an amendment to the Medicare regulations. Such amendments would have to create a new classification for rural hospitals. One attempt to do this is House Bill H.R. 13267 and we are sure others have addressed the issue as well. We recommend that this Subcommittee consider this problem, and attempt to make some provision in the categories of classification which would recognize the inherent problems faced in rural areas.

We believe the appeals mechanism provided to those hospitals penalized as a result of the hospital falling outside the parameters of the classification system is unrealistic, inequitable, and designed to prevent the hospital being able to effectively defend itself. It is virtually impossible for a single institution to identify all the hospitals in its classification cell, and then to undertake a proper study to compare and contrast its patient mix, utilization, and cost statistics with all the other hospitals in that cell.

One of our member hospitals, which is owned by a college of osteopathic medicine and which is located in rural Missouri, has been trying to appeal such a decision for the past 6–8 months, at great expense to the institution. The futility of the hospital's effort was evident from the beginning and points up the enormous inequity and unreasonableness of the proposed appeals process.

Finally, in our reading of Section 10, we detected an apparent drafting error in Section 1861(a)(3)(D)(ii). As presently worded, a portion of this section reads ". . . as determined by the Joint Commission an Accreditation of Hospitals, state agency certification procedures, or any other finding or information available to the Secretary."

As the members of this Subcommittee are aware, the osteopathic profession is a second school of medicine, recognized as such and supported by every major federal health care program. The Medicare program recognizes the American Osteopathic Association as the accrediting agency for osteopathic hospitals. We therefore recommend that this section S. 3205 be amended by inserting after the words "Joint Commission on Accreditation of Hospitals," the words "the American Osteopathic Association,".

Section 11. Inclusion in Reasonable Cost of Hospital Services in Allowance for Retirement or Conversion of Underutilized Facilities

This Section provides an incentive to close down or convert to approved use underutilized bed capacity or services. Safeguards are to be provided to forestall abuse or speculation, and during the first two years no more than 50 hospitals would be paid these transitional allowances in order to permit full development of these procedures and safeguards. We endorse this proposal, but we take exception to Section 1132(4)(A), the last sentence of which says "any such final determination of the Secretary shall not be subject to judicial review." In spite of the fact that this Section is essentially a grant provision, we continue to believe that the recourse of administrative and judicial appeal must be made available.

Section 12 Return on Equity

This Section increases the rate of return on net equity of investor-owner (for-profit) hospitals and skilled nursing homes from one-and-one-half to two times the average rate of return on Social Security investment. It is our recommendation that this rate be set annually by the Secretary after consideration of the rates of return in industries of comparable risk. This rate is approximately 14 percent at the present time and the increase to two times the average rate of return on Social Security investment represents a return of approximately one-half of this rate. We would like to suggest that the Committee consider an increase to three times the average rate of return, which would be approximately 10 or 11 percent.

Section 20. Criteria for Determining Reasonable Charge for Physicians' Services

We strongly endorse the amendment to Section 1842(b)(3)(3A)(F)(i) which regards any charge for any particular service or procedure performed by a Doctor of Osteopathy or Medicine as a reasonable charge if such service or procedure is performed in a physician-shortage area. We regard such an incentive as an important step toward encouraging physicians to practice in shortage areas and commend the Chairman for his foresight in including such a provision.

Section 30. Reimbursement Rates under Medicaid for Skilled Nursing and Intermediate Care Facilities

We find the current three-day hospitalization requirement in Section 1861(i) to be unnecessary and unfair to the patient, and it requires, in some instances, unnecessary utilization of the acute care facilities of the hospital when re-admission to an extended care facility would be in the better interests of the patient.

Under present law, a patient can only be admitted to a skilled nursing facility or intermediate care facility, and be covered under Medicare, if he or she has been admitted to a hospital as an inpatient and stays for a period of at least three (3) consecutive days. In addition, if after the patient is admitted to an extended care facility, is treated, and released and it is later determined that re-admission to the facility is warranted, the patient must again be admitted as an inpatient in a hospital for three additional days.

We recommend inclusion in this Section of an amendment to Title XVIII of the Social Security Act, Part C, Section 1861(i), which would strike the words "in which he was an inpatient for not less than three consecutive days before his discharge from the hospital in connection with such transfer". The first sentence of Section 1861(i) would then read as follows: "The term 'post-hospital extended care services' means extended care services furnished an individual after transfer from a hospital."

We also recommend that this Committee consider the possibility of drafting a change in the statute which would provide for direct admission to an extended care facility upon proper certification by a physician. Of course we recognize the need for safeguards to prevent abuse, but we feel the best interests of the patient and the hospital would be served by such an amendment.

Section 40. Procedures for Determining Reasonable Cost and Reasonable Charge; Disclosure of Ownership and Financial Information

It is the understanding of this Association that this Section is designed to prevent abuses in management or other service contracts or provision of services by collateral suppliers such as pharmacies, laboratories, and similar organizations. To this extent, we support the desire to control abuses, but we are concerned over the impact and scope of the provisions. Our evaluation of this provision

leaves unclear the limit of the percentage prohibition. If the intent was to control abuse in clinical laboratories and pharmacies, then we recommend modification of this Section to reflect the provisions of the Clinical Laboratories Improvement Act of 1976, enactment of which is highly likely in the near future. This legislation deals with the regulation of clinical laboratories, and has a number of provisions which would rectify the abuses addressed in Section 40.

If the intention of this Section was to go beyond laboratories and pharmacies, we recommend re-evaluation of the concept, particularly the section dealing with the review and prior approval of consulting, management, and service contracts where any contract involved amounts to $10,000 or greater. Such an approach would create severe hardships on hospitals, since contracts for laundry services, security forces, dietary, housekeeping, data processing, purchasing, etc., would fall under the provision and bring about a situation which we feel would be an unwarranted incursion into the management of hospitals by the federal government.

This provision would also result in an administrative nightmare for HEW and hospitals. The number of contracts of $10,000 or more which hospitals are currently party to is very high. If all of these had to have prior approval of the Secretary of HEW, it would result in an incredible amount of paperwork—the efficacy of which we have serious doubts about.

Section 42. Ambulance Service

We commend the Chairman for recognizing the need to cover ambulance service to more distant hospitals where the nearer hospitals do not have a staff member qualified to undertake the care required. This provision rectifies what we feel has been a long-standing problem in which Medicare has been allowed to pay only for ambulance service to the nearest participating institution with adequate facilities.

SUMMARY

A number of proposals have been offered which impose a percentage limitation on the reimbursement of hospital costs. Such alternatives are by their very nature arbitrary and result in unequal and inequitable consequences. The inefficient institution is rewarded, and the efficient, cost-conscious institution is penalized. The reward system is reversed, incentives for economy are lost, and oftentimes it is the patient who suffers. The hospital reimbursement proposal embodied in S.3205 avoids this pitfall, and while any classification system for hospitals is by its very nature arbitrary, the one set forth in this legislative proposal is one of the fairest we have seen to date, and could be improved with the changes we have recommended.

There is a need to devise new financial mechanisms that will encourage efficient management of our resources and contain rising costs without, at the same time, impairing the capacity of the health care system to meet our patients' needs. By and large most current proposals fail substantially to address this issue. S.3205 is a major effort in the right direction, but we urge this Committee and the Congress to take more definitive action to move away from cost-based reimbursement and into programs utilizing state-level prospective rating systems.

The hospital industry has provided several recommendations and suggestions for bold and innovative prospective financing systems which move away from reasonable cost reimbursement but which take into account hospitals' full financial requirements. We urge your consideration of these proposals.

The American Osteopathic Hospital Association generally supports S.3205, with appropriate amendments as indicated, and we applaud the many months of work and effort that went into drafting what we feel is one of the more equitable reforms of the Medicare and Medicaid programs.

TESTIMONY BY NICHOLAS A. CUMMINGS, PH. D., ASSOCIATION FOR THE ADVANCEMENT OF PSYCHOLOGY

Mr. Chairman, members of the Health Subcommittee of the Senate Committee on Finance, I am Nicholas A. Cummings, Ph. D. I am President of the California School of Professional Psychology and a member of the Board of Directors of the American Psychological Association. I am presenting this testimony under the auspices of the Association for the Advancement of Psychology.

I would like, Mr. Chairman, to address myself to several items which I hope go to specific concerns of this Committee, the interest of the public and the potential contribution of American psychology to the health delivery system in the United States.

The Committee must be concerned not only with the need for a service but with the cost. Health benefits must be paid for and we must all be concerned with cost both as taxpayers and as responsible citizens.

There is ample reason to urge that mental health be a major concern of Medicare and NHI programming. The psychological aspects of disability, injury, illness, chronic disease, death, and dying—quite apart from mental disorder are widely recognized by the medical practitioner. In fact, Alex Kelley M.D., when he testified on National Health Insurance last November before the Subcommittee on Health, Houes Committee on Ways and Means, took special note of the Kaiser Health Plan data, namely, ". . . that 68% of its doctor visits made by 36% of its 1.3 million members, were for complaints for which no organic cause could be found." (The data is reported in the *New England Journal of Medicine.*)

The Kaiser Health Plan to which Dr. Kelley refers is the Kaiser-Permanente Health Plan which I serve as Chief Clinical Psychologist, Kaiser-Permanente Center (Northern California) San Francisco. With my colleague William T. Follette, M.D., Chief of Psychiatry at the same institution, I have co-authored a number of studies which I believe will be of value to this Committee.

THE AVAILABILITY AND PROVISION OF MENTAL HEALTH SERVICES HAVE BEEN SHOWN THROUGH RESEARCH TO REDUCE DRAMATICALLY THE EXTENT OF SUBSEQUENT USE OF SURGICAL, IN-HOSPITAL AND DIAGNOSTIC LABORATORY SERVICES

The Kaiser-Permanente Health Plan on the West Coast flourished in the post-World War II era because it provided comprehensive treatment at low subscriber rates for all ills without the exclusions, limitations, co-insurance and other troublesome features common to health plans at that time. Kaiser-Permanente, as the forerunner to the modern Health Maintenance Organization (HMO), soon found to its dismay that once a health system makes it simple and free for the patient to see a physician, an alarming inundation of medical clinics by seemingly physically healthy persons occurred. The opposite has always been relatively true in private practice where the doctor's fee is somewhat of a deterrent to over-utilization of services. Furthermore, since the financial base at Kaiser-Permanente is one of capitation (subscription), and neither the physician nor the Health Plan derive an additional fee for seeing the patient, rather than becoming wealthy from imagined physical ills, Kaiser recognized early that the system could be bankrupted by what was regarded as abuse by the hypochondriac. Early in its history, Kaiser-Permanente added psychotherapy to its list of services; first on a courtesy reduced fee of five dollars per visit and eventually as a prepaid benefit. This additional service was motivated not so much by an initial conviction of the efficacy of psychotherapy, but by the urgent need to get the so-called hypochondriac out of the doctor's office. Out of this initial perception began sixteen years of extensive research, leading to the conclusion that no comprehensive prepaid health system can survive without providing a psychotherapy benefit.

The conclusion from these studies is that in an HMO-type of health plan, patients in emotional distress, finding an unsympathetic or uncomprehending ear when they attempt to discuss their distress with their physician, quickly begin to translate their problems into physical symptoms for which they receive a great deal of attention in the form of X-rays, laboratory tests, prescriptions and return visits to the physician. The question then remained whether these patients would demonstrate a subsequently different utilization of health plan services, given psychotherapy as the treatment of choice for their emotional ills.

In the first of a series of investigations into the relationship between psychological services and medical utilization in a prepaid health plan setting, we (Follette and Cummings, 1967) compared the number and type of medical services sought before and after the intervention of psychotherapy in a large group of randomly selected patients. The outpatient and the inpatient medical utilization for the year prior to the initial interview in the Department of psychotherapy as well as for the five years following were studied for three groups of psychotherapy patients (*one* interview only; brief therapy and *long-term* therapy) and a control group of matched patients demonstrating similar cri-

teria of distress but not, in the six years under study, seen in psychotherapy. Their findings indicated that:

(1) Persons in emotional distress were significantly higher users of both inpatient and outpatient medical facilities as compared to the Health Plan average;

(2) There were significant declines in medical utilization in those emotionally distressed individuals who received psychotherapy as compared to a control group of matched emotionally distressed Health Plan members who were not accorded psychotherapy;

(3) Declines in medical utilization remained constant during the five years following the termination of psychotherapy;

(4) The most significant declines occurred in the second year after the initial interview, and those patients receiving one session only or brief psychotherapy (two to eight sessions) did not require additional psychotherapy to maintain the lower level of utilization for five years;

(5) Patients seen two years or more in regular psychotherapy demonstrated no overall decline in total outpatient utilization inasmuch as psychotherapy visits tended to supplant medical visits. However, there was significant decline in inpatient utilization in this long-term therapy group from an initial hospitalization rate several times that of Health Plan average, to a level comparable to that of general adult Health Plan population.

In a subsequent study we (Cummings and Follette, 1968) found that intensive efforts to increase the number of referrals to psychotherapy, by computerized psychological screening with early detection and alerting of the attending physicians, did not increase significantly the number of patients seeking psychotherapy.

The authors concluded that in a prepaid health plan setting already maximally employing educative techniques to both patients and physicians, and already providing a range of prepaid psychological services, the number of Health Plan subscribers seeking psychotherapy reached an optimal level and remained fairly constant thereafter.

In summarizing sixteen years of prepayment experience we (Cummings and Follette, 1975) *demonstrate that there is no basis for the fear that an increased demand for psychotherapy will financially endanger the system*, for it is not the number of referrals received that will drive costs up, but the manner in which psychotherapy services are delivered that determines optimal cost-therapeutic effectiveness. The finding that one session only, with no repeat psychological visits, could reduce medical utilization by 60% over the following five years, was surprising and totally unexpected. Equally surprising was the 75% reduction in medical utilization over a five year period in those patients initially receiving two to eight psychotherapy sessions (brief therapy).

The data offers no conclusive reason as to how and why this early, brief psychotherapeutic intervention resulted in a persistent reduction in medical utilization throughout the following half decade. We have speculated that the results obtained demonstrate a psychotherapeutic effect, inasmuch as the clinical procedure was to offer early and incisive intervention into the patient's crisis problem, get beneath the manifest symptoms to his/her real concerns, and offer a understanding and therapy within the very first session itself. Such a hypothesis would suggest that a patient's understanding or appreciation of the problem and its relationship to his/her symptoms would result in a diminution of the somaticizing of emotions, and a consequent reduction in medical visits. This is in keeping with the experiences of providing psychotherapy under national health care in Great Britain (Balint, 1957). Perhaps a less satisfactory, but an equally plausible hypothesis would hold that the patient attained no mastery over his/her problems and that subsequent to the psychological visit s/he found ways other than visiting the doctor to express emotional distress.

In a further present study we sought (in an eighth year telephone follow-up), to determine whether the results described previously were a therapeutic effect, or the consequence of extraneous factors, or a deleterious effect. It was hypothesized that if better understanding of the problem had occurred in the psychotherapeutic sessions, the patient would recall the actual problem rather than the presenting symptom, and would have both lost the presenting symptom and coped more effectively with the real problem.

The results suggest the reduction in medical utilization was the consequence of resolving the emotional distress that was being reflected in symptoms and

doctor's visits. The model patient in this eighth year follow-up may be described as follows: "s/he denies ever having consulted a physician for the symptoms for which s/he had been originally referred. Rather, the actual problem discussed with the psychotherapist is recalled as the reason for the 'psychiatric' visit, and although the problem is resolved, this resolution is attributed to the patient's own efforts and no credit is given the psychotherapist". This reaffirms the contention that the reduction in medical utilization reflected the diminution in the emotional distress which had been expressed in symptoms which were presented to the doctor.

The findings suggest that the expectations of the therapist influence the outcome of psychotherapy, for if the first interview is merely "evaluation" or "intake", not much of therapeutic value is likely to occur in the first interview. If the therapist's attitude is that no real help is forthcoming from less than prolonged "intensive" psychotherapy, s/he may be right (for his/her own patients). Malan (1963), in his classic study of brief psychotherapy, was able to honestly examine the prejudices of his group of psychiatrists about brief therapy: the kinds of benefit possible, the kinds of patients who could utilize it, the permanency of the results, and so forth. He concluded that traditional attitudes about very brief therapy were mostly in the nature of unjustified prejudices. It would appear that therapeutic effects of brief therapy which can be labelled "transference cure", "flight into health", "intellectualization", and other derogatory terms can often be long-lasting and result in a major change in the person's symptoms, relationships and even life style. Many of the patients in this study would undoubtedly be called "poorly motivated for treatment" or "drop-outs from therapy" in many psychotherapy clinics.

The Kaiser-Permanente studies have been replicated in a variety of prepaid settings with similar findings. Recently Karon and VandenBos (1975) reported in a study of hospitalized schizophrenic patients that despite the expense of psychotherapy, there were savings of 22% to 36% in total treatment costs because of the shorter hospitalization of patients receiving psychotherapy as compared to patients who received medication and no psychotherapy.

The growing body of evidence reflects the rightful place of psychotherapy in any health delivery system, and suggests that the health model is the present entree for the psychologist into the the health delivery system. Inclusion of psychologists as health service providers in medicare as well as national health care will conclude a difficult decade-and-a-half struggle for recognition on the part of the dedicated professional leadership of psychology. But this will occur not only because there is a need for psychotherapy within any comprehensive health delivery system, but also because psychologists are beginning to recognize the contribution of psychotherapy in the health setting.

No one at this moment knows what an ideal health system will look like. We can probably reach a consensus, however, on what that ideal system should achieve. It should achieve a long productive life, minimal illness and disability, effective treatment of unavoidable trauma and disease, rapid restoration of optimal functioning following disability, humane treatment, equitable access to quality care: *and* at a cost that permits the realization individually and governmentally of other desirable social and personal goals.

SUMMARY

It is my contention, Mr. Chairman, a contention supported by substantial research data, that an efficient and economical health delivery system whether it be under Medicare or National Health Insurance can only be developed by making available a psychotherapy benefit similar to that provided under the Kaiser Plan.

We can, as a nation, invest more monies on direct mental health services and, at the same time, obtain significant savings in tax monies, prevent loss of money to employers and employees alike while promoting human welfare. Diagnosis and treatment can be made available to all citizens for a reasonably low cost, and the costs of treatment will be offset by substantial reductions in the costs of other health services.

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COMMUNITY SERVICE SOCIETY,
New York, N.Y., July 26, 1976.

MR. MICHAEL STERN,
Staff Director, Committee on Finance, U.S. Senate,
Dirksen Senate Office Building, Washington, D.C.

DEAR MR. STERN: Thank you for the opportunity to submit written testimony on S. 3205, "The Medicare and Medicaid Administrative and Reimbursement Reform Act." As the nation's largest social service organization, the Society supports many of S. 3205's proposals designed to make Federal health programs more efficient and responsive to the public need.

We must, however, express our opposition to the section concerning hospital reimbursement. We believe the incentive reimbursement scheme will fail in practice to contain costs and encourage hospital efficiency.

As part of our efforts over the years to restrain increases in health costs, the Society has undertaken an economic research project to critically analyze hospital prospective reimbursement. This project will culminate in a report to be issued this fall which recommends a model system to be applied nationally. We would like to share this study with the members and staff of the Finance Committee.

At this time we would also like to submit a copy of our earlier letter to Senator Talmadge in which we offered a detailed critique of S. 3205.

Please be assured of our continued support of your efforts to improve the U.S. health care delivery system.

Sincerely yours,

CHARLES B. DORF,
Chairman, Committee on Health.

COMMUNITY SERVICE SOCIETY,
New York, N.Y., April 12, 1976.

Hon. HERMAN E. TALMADGE,
Chairman, Subcommittee on Health, Senate Committee on Finance, Dirksen Senate Office Building, Washington, D.C.

Attention: Mr. Jay Constantine.

DEAR SENATOR TALMADGE: We would like to comment on S. 3205, "The Medicare and Medicaid Administrative and Reimbursement Reform Act." As we have indicated in the past, we generally support the measure and will share our conclusions with organizations and individuals responsible for health policy.

It would be time consuming to list all of the bill's provisions which we believe will serve to make Medicare and Medicaid more efficient and economical. The consolidation of the relevant parts of the Federal health bureaucracy into an Administration for Health Care Financing is essential to the sound and responsive execution of governmental authority. The sections dealing with the prevention of fraud and abuse are well developed and certainly welcome. Your proposal to allow reimbursement on an experimental basis for costs associated with the closing or conversion of underutilized bed capacity or hospital services represents an important innovation.

We would also like to focus your attention on a few areas where we believe S. 3205 should be strengthened. One such area concerns your intention to elimi-

nate current cost-plus reimbursement in favor of a system which would reward hospitals whose comparable routine operating costs are less than the average, and penalize hospitals whose routine operating costs are substantially above average. While we agree with you that such a reform should dampen inflation in hospital costs, the proposed legislation leaves enough questions unanswered that we doubt the program can be successfully implemented as is.

At the outset it should be recognized that the scope of the proposed reforms in hospital reimbursement is clearly limited. The incentive reimbursement system would exclude hospital costs related to capital, medical personnel (excluding nursing), education and training, and energy. Further, for those hospitals whose operating costs are significantly above average there would be no incentive to do anything except get down to the maximum reimbursement allowed, 20 percent above the mean or target rate. There is nothing wrong with achieving limited goals such as these. However, the bill's merit must be judged on whether its incentives encourage the majority of hospitals to do better than this—namely, to spend at or below the target rate.

We question whether S. 3205 can make hospitals more efficient because the retroactive adjustments for inflation appear to be too flexible. Is it your intention to limit inflationary increases to the price rise in the mix of goods and services as determined by the Secretary of HEW, *regardless* of the actual cost increase incurred by a hospital? If so, we would support such a move because it is generally the least inflationary alternative. Specifically, where would responsibility lie for the designation of the inflation ceiling and what methodology would be used, e.g. how would you define "prudent buying"?

Our greatest concern is that if reimbursement rates under S. 3205 are too loosely applied, there will be no incentive for a hospital to beat inflation. We are fearful lest the bill produce an incentive for a hospital to spend right up to the allowable rate level on a basis consistent with other hospitals in the same group. This has been the case in New York State where our so-called prospective reimbursement system has in practice resembled a system of deficit financing; each hospital can incur the maximum cost knowing that the future rate will be adjusted to reflect whatever was spent. The lesson is clear: a hospital reimbursement system will fail to promote efficiency unless it is truly prospective and bases inflationary increases on cost criteria which are not set by providers.

Other observations on your proposed hospital payment scheme follow. With one exception, S. 3205 bases reimbursement rates on historical costs, making the dubious assumption that all institutions are running efficiently at the outset of the program. The exception in question refers to the provision that where general wage levels in an area are significantly lower than the wage level for hospitals, they be the ones used in calculating payment rates. This is a bold initiative to make hospitals more cost conscious. We need to know more about how this would operate before we could extend our support. Who would determine what the general wage levels were? Would this be done on an industry basis or an occupational basis? What deflator mechanism would you use to equalize variations in salary levels within a geographical area? Would this apply to administrative salaries as well as skilled and non-skilled personnel? What would be the role of the unions? Our initial reaction is that this idea while technically very challenging may be feasible; we hope it would not be inequitable also.

Two final points on the hospital reimbursement section: (1) If you authorize a hospital classification system which fails to differentiate between hospitals on the basis of ownership, the effect will be to reward voluntary institutions at the expense of public ones because the voluntaries tend to skim off the paying patients, resulting in lower average costs and higher incentive payments; and (2) Three years seems to be an overly long time to operationalize a reimbursement program which is based on historical costs and is limited to routine operating expenses.

Turning to S. 3205's incentives to encourage acceptance of "assignments" of Medicare reasonable charges by physicians, we offer the following comments. While it is fine to reduce red tape involved in filing claims, it is not realistic to think physician reimbursement within five working days is generally possible. The administrative cost-savings allowance strikes us as a bit bizarre because it lends itself to mountains of paper work and new opportunities for abuse. If your goal is to encourage physician participation, why not simply raise Medicare fee levels by this amount?

The fact is that despite its intentions the bill does not make basic changes in the way Medicare pays for physician services. This seems the time to eliminate from the program any physician who will not accept the Medicare rate as payment-in-full—yet S. 3205 does not. This also seems a propitious time to experiment with different methods of reimbursement such as capitation—yet S. 3205 does not.

Are we correct in assuming that your bill does *not* mandate an objective, competitive selection process under which the most qualified intermediary in terms of efficiency and accountability would receive the Medicare contract? We had hoped this would be the case because it is the best way to encourage competitive bidding on the fixed fee per claim which you would require.

Further, we are disappointed that you have apparently backed away from your expressed intention to promote the consolidation of responsibility for administering Medicare Part A and Part B under a single agent, instead of the present dual arrangement which is uneconomical. Also, we urge you to restore the provision whereby carrier and intermediary areas would be expanded or consolidated wherever necessary to promote efficient operation. Finally, we seriously question the inclusion of "productivity incentives" whereby a carrier whose actual costs were less than the negotiated fixed fee could realize increased avenues. This is carrying incentive reimbursement techniques too far. It should be assumed that the job as negotiated and contracted for will be done efficiently; if it is not done well, then that contract should be terminated come the annual renegotiations with the carrier.

As we stated earlier, your proposal to allow reimbursement for costs associated with the closing or conversion of underutilized hospital facilities and services is excellent. We hope this program would include sufficient safeguards against abuse. For example are the 50 hospitals to be selected on a first-come, first-served basis or would those in greatest financial stress be given priority? There is a possibility that every hospital with or without a financing problem could devise a plan to qualify so that the trial period you envision might serve to demonstrate little.

One last point here: it would be unwise to create a Hospital Transitional Allowance Board to act upon applications by hospitals in accordance with this section. The correct place to make decisions concerning the allocation of scarce public monies to health facilities is the appropriate health systems planning agency. The planning agencies have the technical expertise and detachment to adequately oversee such a program, and these agencies are clearly accountable to the public.

In closing, we would like to offer our reactions to your proposed reform of state Medicaid administration. We have gone on record in support of your plan to establish specific Federal performance criteria for state Medicaid programs, and the tying of these standards to Federal matching for administrative costs. We will support any attempt to raise Medicaid standards and to increase efficiency in operation of the program. In judging S. 3205 against these goals we believe that: (1) Greater care should be taken to ensure that uniform performance standards are broad enough and deadlines flexible enough to accept reasonable differences among the states; (2) Federal Medicaid regulations should not promote compliance with the letter of the law at the expense of the broader goal of improving programs; and (3) Fiscal sanctions should be graduated and targeted to deficiencies as past experience shows that too severe a threat fails to offer a real alternative.

We congratulate you on your efforts to make significant improvements in the way Medicare and Medicaid operate because such reforms are vital to the success of these programs, as well as any future national health insurance program.

Thank you for your consideration.

Sincerely yours,

SUSAN S. LAUDICINA,
Staff Assistant for Health.

PREPARED STATEMENT OF THE AMERICAN PROTESTANT HOSPITAL ASSOCIATION

Mr. Chairman, I am Charles D. Phillips, President of the American Protestant Hospital Association, representing some 300 hospitals, homes for the aging and other health care agencies throughout the country, as well as some 2000 personal

members who are engaged in the delivery of health care services. With me is Kenneth E. Williamson, the Washington Representative of the Association.

We greatly appreciate the opportunity to present the position of APHA on S. 3205. Mr. Chairman, let me say at the outset that the members of APHA appreciate your concern about the rising costs of the Medicare and Medicaid programs to the taxpayers of this nation. We are grateful for your commitment to the development of reforms which will prevent the cutting and slashing of payments to hospitals and physicians indiscriminately and inequitably and the imposing of arbitrary controls and indiscriminate limits on payments to hospitals such as the administration's proposed ceilings on hospital cost increases.

We are concerned, however, that the reforms which are proposed as solutions to the problem of escalating costs of hospital services under Medicare and Medicaid be based on an awareness of the factors which are responsible for such increases, and that the reforms address those factors rather than taking a simplistic approach of limiting reimbursement. We believe that this bill demonstrates your awareness of the enormity of the problems faced both by the federal government and the health care institutions of this nation and that it is a step in the direction of addressing needed reform.

Mr. Chairman, we will comment on only certain sections of this bill which we feel are of more crucial significance to our members.

Section 2. Establishment of Health Care Financing Administration

The bill addresses the current fragmentation of health programs by proposing to merge four existing programs under one administration. We favor efforts to bring about the increased coordination of federal programs. However, we feel that fragmentation and a lack of uniformity in federally financed health programs is likely to be perpetuated if the proposal for two assistant secretaries is enacted. The separation of the administrations for financing and for delivering health care is not in the best interest of the health care services of this nation. Therefore, we support the creation of a cabinet-level Department of Health rather than as a mechanism for the most effective coordination of the setting of national health policies and administration of federal health programs.

Section 4. State Medicaid Administration

This section reflects the awareness of the Chairman of the problems besetting hospitals because of the performance of states in administering Medicaid. We support the proposal to establish specific performance criteria for state administration of Medicaid which will result in more prompt payment of claims and vastly improved administration of the program.

Section 8. Termination of Health Insurance Benefits Advisory Council

APHA believes that the use of expert non-governmental advisors through HIBAC has been the source of significant contribution to the development and implementation of federal programs. Such advisory group appears to be of potentially great importance to such major programs as Medicare and Medicaid, especially during a period of transition. APHA recommends the continuation of HIBAC and a greater utilization of this resource by government, or, in the case of its dissolution, the formation of a new policy advisory council with added authority and responsibility in advising the Secretary of HEW on health programs.

Section 10. Improved Methods for Determining Reasonable Costs of Services Provided by Hospitals

The APHA is concerned with the proposal for the classification of institutions for the purposes of reimbursement on a comparative basis. We can understand the attractiveness of such a methodology to the federal government. However, we feel that great difficulty will be experienced in the technical aspects of devising such a methodology for classifying institutions for purposes of reimbursement. The fact that S. 3205 deletes from the comparison procedure for routine per diem hospital costs some of the elements over which an institution has little or no control is a vast improvement over Section 223 of P.L. 92-603.

APHA is on record as supporting a reimbursement system which includes prospective reimbursement administered on a state level under federal guidelines. We strongly urge that this proposed legislation be amended to permit a state administered rate review option for the determination of institutional reimburse-

ment based upon prospective payment methodology under federal guidelines. State level rate review on a prospective basis will assure that the variables among institutions, which are often very local, are taken into account and that the full financial requirements of institutions are provided. Therefore, we urge that you consider amending the proposed legislation by permitting as an option to a classification system of hospitals a state prospective rate review system involving all payers.

Although APHA supports an amendment which provides for a state level prospective rate review option, we realize that a methodology must be devised for those states not willing or able to exercise the option. For those states a classification system would be appropriate. We are greatly concerned that the classification system be devised with full consultation from the field of health care and government agencies. We therefore recommended that this committee bring together a group of technical experts who have been involved in Medicare-Medicaid reimbursement matters over the years. Representatives should include persons from associations of providers, Social Security Administration, health care institutions, congressional staff, Blue Cross Association, and etc. These experts would discuss in depth the basis for the classification system and the appropriateness and the validity of the components now included in this bill. We believe that the formation of such a panel of experts would be in keeping with the spirit of openmindedness expressed by the chairman when you introduced the bill and that it would prove to be of substantial assistance in forming a workable and equitable method of classification.

Further I want to state that we concur with the addition of an incentive reimbursement system to the Medicare reasonable cost controls which is now in effect. We commend the chairman for his proposal to move from a retrospective costly reimbursement system to one of prospective reimbursement. We also urge that the bill be modified to provide for a new method of reimbursement for Medicaid which would assure that payments are made at a reasonable level so that hospitals will not be forced to provide services for those patients at rates which are below cost.

Section 11. Inclusion in Reasonable Cost of Hospital Services on Allowance for Retirement or Conversion of Underutilized Facilities

We support the demonstration project proposed in Section 11 by which federal financial support would be provided institutions which apply for such support on the basis that their operations would be made more efficient or cost-effective by the closing or conversion of underutilized beds and that they would also become eligible for positive incentives under the provisions of Section 10.

Section 12. Return on Equity to be Included in Determining "Reasonable Cost" of Services Furnished by Proprietary Hospitals

APHA supports the principle implemented in this section—that an adequate return on investment is a reasonable expectation in business. By the same principle, we urge the Committee to amend this section to provide for an adequate operaitng margin on reimbursement by Medicare and Medicaid to not-for-profit institutions, since no institution can continue to operate only on the basis of costs.

Section 22. Hospitals—Associated Physicians

We recognize that the problem which this section attempts to address is not a new one for hospitals or the government. We express grave concern, however, over the proposal that the federal government involve itself with such specificity in determining the types of contractual arrangements between hospitals and physicians We recognize that cases of unreasonable compensation can be documented, but believe that to enact legislation prohibiting a specific type of contract removes decision making from its proper authority—management and the governing boards—and places it in Washington. This eventuality serves neither the best interest of the community or the government.

We are concerned further that the language of the bill will not accomplish the intended result of reducing hospital costs. There are those who have studied this proposal who are convinced that the aggregate costs resulting from categorizing the various services of these physicians and the mandating of a fee-for-service basis of reimbursement for personal patient services will be greater than those now being experienced.

Section 40. Procedures for Determining Reasonable Cost and Reasonable Charges

APHA vigorously opposes this section. The Medicare law already contains adequate provisions to determine reasonable costs. Further, the proposal is a gross infringement on the management prerogative of individual institutions.

SUMMARY OF RECOMMENDATIONS

Mr. Chairman, in conclusion we would like to summarize some of the recommendations that we have made here today.

(1) We support efforts to end the current fragmentation of federal health programs. However, we recommend, consistent with our previous position, the creation of a cabinet-level Department of Health as a mechanism for the coordination of the administration of all federal health programs.

(2) We recommend the continuation of a Health Insurance Benefits Advisory Council, and a greater utilization of the resources by government. However, in the case of its dissolution, we recommend the formation of a new policy advisory council with added authority and responsibility in advising the secretary of HEW.

(3) We recommend that Section 10 be amended to permit as an option to a classification system of institutions for the purposes of reimbursement on a comparative basis a reimbursement system which includes prospective reimbursement administered on a state level under federal guidelines.

(4) We recommend that the committee in devising the classification system to determine reimbursement for institutions in those states not able or not wishing to adopt state administered prospective reimbursement under federal guidelines, consult in depth with a panel of experts drawn from association providers, hospital executives, Social Security Administration, Blue Cross and Other third party payers, congressional staff and etc

(5) We recommend that the bill be modified to include a new method of reimbursement for Medicaid to require that these payments be made at a reasonable level.

(6) We recommend that Section 12 be modified to assure an adequate operating margin on reimbursement for Medicare and Medicaid for not-for-profit institutions in recognition that no facility can continue to operate only the basis of cost.

(7) We recommend that Section 22 be modified so that these specifics of contractual arrangements between hospitals and physicians are left to the management prerogatives and that further studies be conducted to determine more appropriate ways of assuring the accomplishment of the objective of controlling excessive compensation to hospital based physicians.

(8) We recommend the deletion of Section 40 in its entirety.

Mr. Chairman, we thank you and members of this committee for considering these views and for giving us this opportunity to appear before you. Thank you.

NEBRASKA ASSOCIATION OF COUNTY OFFICIALS,
Lincoln, Nebr., July 26, 1976.

Re S. 3205.

Mr. JAY CONSTANTINE,
Staff, Senate Finance Committee, Health Subcommittee, Dirksen Senate Office Building, Washington, D.C.

DEAR MR. CONSTANTINE:

Enclosed you will find copy of letter sent to The Honorable Carl T. Curtis on July 23, 1976, regarding the above listed Medicare and Medicaid Administrative and Reimbursement Reform Act.

Please insert this into the record of the hearings for S. 3205 for July 26, 1976.

Very truly yours,

ARNOLD RUHNKE,
Executive Director.

NEBRASKA ASSOCIATION OF COUNTY OFFICIALS,
Lincoln, Nebr., July 23, 1976.

Hon. CARL T. CURTIS,
U.S. Senate, New Senate Office Building,
Washington, D.C.

DEAR SENATOR CURTIS: We at the Nebraska Association of County Officials have been following efforts for medicaid reform with much interest and concern.

As you may know, Nebraska counties paid 20.3% ($13.2 million) of the state's medicaid program costs for FY '76. It is also our understanding that many counties in other states pay a substantial share of the program and/or administrative costs of their states' medicaid programs. This financial involvement causes a tremendous strain on county budgets. Nebraska counties along with many other counties nationwide are also responsible for eligibility determination in the medicaid program. The complicated regulations now in force contribute to the high error ratio and the large amounts of bureaucratic red tape further disrupting the medicaid system.

Our Washington, D.C., national office, the National Association of Counties, has informed us that they will be testifying before the Health Subcommittee of the Senate Finance Committee on Monday, July 26. We are in agreement with the National Association of Counties position on medicaid reform and feel that this is an excellent time for our association to inform you of our position concerning Senator Talmadge's bill (S. 3205).

We support the Medicare and Medicaid Administrative and Reimbursement Reform Act (S. 3205) and commend Senator Talmadge for his efforts. The Talmadge bill will help eliminate the overlap and red tape now in existence and will also help reduce the high error rates.

Some of the proposals in S. 3205 which we do support are:

(1) Consolidation of the Medical Services Administration (Medicaid), the Bureau of Health Insurance (Medicare), the office of Nursing Home Affairs (Long-Term Care) and the Bureau of Quality Assurance (PSRO's) into a single administrative unit—the Health Care Financing Administration. Coordination under one financing unit can lead to more uniform and consistent policy development.

(2) Creation of a Central Fraud and Abuse Unit charged with the overall monitoring of the various health care programs. The unit would assist federal and state investigative activities as well as provide support to federal and state prosecutors, upon request.

(3) Provision of technical assistance to the states and counties for improving the management, administration and operation of the Medicaid program.

(4) Requirement that regulations pertaining to this act must be issued by HEW Secretary within 13 months of passage.

(5) Requirements for states to comply to standards in eligibility determination, quality control, claims processing and program reports and statistics.

However, we also feel that the October 1977 date for complying is too early for states and counties to meet the requirements.

We strongly urge the Talmadge bill to keep its 30 days processing standard for Medicaid eligibility determination and 60 day processing period for medically needy disabled applications. This ensures the applicant and the local health care facility that fast action will be taken.

The Nebraska Association of county Officials feels that an effective administration, not bureaucracy and red tape, will help reform the Medicaid program. We sincerely hope that you will support S. 3205 and help bring the needed administrative reform to the Medicaid program.

Very truly yours,

ARNOLD RUHNKE,
Executive Director.

STATEMENT OF P. RAPHAEL CAFFREY, M.D., PRESIDENT, PATHOLOGY AND CYTOLOGY LABORATORIES, INC.

I am a physician and pathologist practicing primarily in the Lexington, Kentucky area. I am President of Pathology and Cytology Laboratories, Inc., a corporation which has approximately 60 employees. Pathology and Cytology Laboratories, Inc. operates laboratory facilities principally in Lexington, Kentucky, serving 15 hospitals in Central and Eastern Kentucky, having an aggregate capacity of approximately 1,400 beds. The corporation also provides necessary clinical laboratory services to approximately 300 physicians in the Central and Eastern Kentucky area.

The corporation presently employs seven qualified pathologists, a Ph. D. bacteriologist on its staff. Through its professional employees, the corporation acts as a consultant or director of various hospital laboratories. The aim of the corporation is to provide the highest quality of clinical laboratory services at the lowest fees consistent with maintaining the quality of its services to its patrons in Central and Eastern Kentucky.

In addition to my role as President of Pathology and Cytology Laboratories, Inc., I am engaged in the active practice of pathology, as a physician of pathology, in a corporate professional service group known and designated as Chipps, Caffrey & Dubilier, P.S.C. This group is now, and has been for some years, engaged in the practice of the profession of pathology in the Central and Eastern Kentucky areas.

A pathologist is a physician who has spent at least five years after graduation from medical school in training for his speciality. Most pathologists are board certified in anatomical and clinical pathology.

The role of a pathologist or group of pathologists *who are full time in a hospital* covers the following:

(1) The pathologists perform services of a physician as relates to anatomical pathology including cytology and autopsies.

(2) The pathologist performs the role of a physician in determining what tests can be run on patients, and establishing the methodology by which these tests will be run, and the interpretation of these tests, (this relates to clinical pathology).

(3) The pathologist plays the role of a physician-teacher of students in medical technology (CLA's, MLT's and MT's), a role as a teacher of practicing physicians in the explanation of how certain tests may be helpful in establishing diagnoses, and aid in treatment of certain disease processes.

(4) The pathologist plays a role as an administrator, more of an executive function, but a qualified pathologist is of much more value in that he is able to use his knowledge as a physician and combine this with his administrative capabilities.

The practice of laboratory medicine in a hospital, and the performance of clinical laboratory tests in a hospital, differs from the performance of such clinical laboratory tests in a private office or laboratory. Most testing done in hospitals must be done daily, sometimes two or three times a day, and on definite occasions, with respect to acutely ill patients, tests must be performed on an immediate basis. Tests in general in hospital practice cannot be batched and done in large volume as is and can be done in an outside clinical laboratory (which, by the way, is why commercial laboratories frequently can offer tests at a cheaper price, because of this facility to perform tests at times convenient to the laboratory and in relatively large volume). The costs of conducting tests in a hospital laboratory also are frequently higher than in commercial laboratories because of the fact that time required of technologists and volumes of controlled reagents required for a particular test frequently are the same, whether one test or 100 tests are being conducted at a single time.

A difference in costs exists between commrecial laboratories, and this difference is frequently significant and is the result primarily of the qualifications of those personnel who operate the laboratories. Some laboratories are operated by individuals who are not qualified pathologists and the cost of operation is significantly more than the cost of operation of laboratories that employ qualified pathologists in the supervision of day-to-day testing procedures.

It is difficult to specifically assign an absolute value with respect to the pathologist's role in a hospital operation. His duties include that of an administrator, a teacher, a physician and a clinical pathologist. Certainly, it is to the advantage of both the hospital and patients for all of these functions to be performed by a qualified pathologist. Qualified pathologists are rather hard for some hospitals, because of size and volume, to employ. The number of physicians going into pathology today is greatly reduced, particularly in this country. Coupled with this diminishing number of qualified pathologists entering the field, there is an increasing demand for the services of qualified pathologists in small and medium sized hospitals, particularly as such services relate to infection control comittees and transfusion committees.

Many hospitals have entered into percentage contracts with both pathologists and radiologists. No doubt there are some cases where such contracts have resulted in an abuse, but these are in the small minority. Like abuses can be found in practically any business or profession. Where such abuses exist, and a pathologist or group of pathologists are being paid unreasonably high fees for services rendered, certainly corrective action should be taken. The administration of the laboratories involved and the boards of governors of such hospitals should be able to assess the situation and eliminate unreasonably high charges without a federal mandate, which would affect not only those few unreasonable cases, but would

also serve to unduly restrict the entire profession and make it extremely difficult for small and medium sized hospitals to secure adequate services.

I believe that, as may be pertinent to payments to Medicare and Medicaid patients within hospitals, a set compensation should be established on an annual basis for each test, with the fee being paid to the individual hospital or to the physician who may lease the laboratory. The fees for service should be reviewed annually, whether upgraded or downgraded, whatever is just, in light of cost and economic conditions, including something akin to inflationary factors developed in the various cost of living studies. If this were done, with respect to such fees and with respect to amounts which Medicare and Medicaid would reimburse each hospital for patient days, then arrangements between hospitals and pathologists could be left up to the individual hospitals and pathologists to negotiate. The hospitals and the pathologists are in a better position to know the peculiar circumstances of each, the various types of services being rendered and the value of the service.

I further believe that pathologists should occupy full time positions in hospitals before percentage contracts are permitted. There certainly must be a reasonable figure which could be used for a percentage contract as it relates to clinical pathology, which would encompass teaching and administration and anatomical pathology and the cover of surgical specimens and cytology specimens. Pathologists, through their professional societies (ASCP and CAP), have pioneered continuing medical education in their respective specialties long before the subject was ever discussed by other organizations. They are not completely to blame for the circumstances which now exist and certainly, as a group, are not to blame for abuses of a few that have been highly publicized.

A national scale of fees for tests would be most helpful. For example, Blue Cross may allow one hospital or clinic as much as $15.00 for a specific test, while allowing other hospitals $10.00 or even $8.00 per test for the same identical procedure. If a national scale were established and annually adjusted, such a scale might well serve to eliminate many of the abuses which have historically occurred.

We would respectfully submit that the terms of S-3205 are far too drastic and are not needed to correct the situation which now exists. S-3205 contains the provision that "no percentage, lease, or direct billing arrangements would ordinarily be recognized for Medicare or Medicaid reimbursement purposes." We do not understand what that provision means or how it would be enforced. Regulation of fees, and establishment of a national scale applicable to Medicare and Medicaid would be far better than simply eliminating certain contractual arrangements between hospitals and pathologists, which would have no direct benefit to patients and no particular benefit to Medicare and Medicaid programs.

AMERICAN PODIATRY ASSOCIATION,
Washington, D.C., July 26, 1976.

HON. HERMAN E. TALMADGE,
Chairman, Subcommittee on Health, Senate Finance Committee, Dirksen Senate Office Building, Washington, D.C.

DEAR MR. CHAIRMAN: With regard to S. 3205, the *Medicare and Medicaid Administrative and Reimbursement Reform Act*, about which public hearings are now underway in your Subcommittee, I am pleased to herein submit the American Podiatry Association's position on this most important subject. Furthermore, I would respectfully request that this statement be included in the written record of the hearing.

Initially, I do want to state that the Association strongly supports your concern for the rising costs of both the Medicare and Medicaid programs. We also applaud the solutions S. 3205 advances to bring improved efficiency and quality to these essential programs. Unless we responsibly and expeditiously act, our only remaining recourse might well be a reduction in both the scope and quality of medical care services available to the programs' beneficiaries.

Though S. 3205 does speak to many program deficiencies, there remain other areas which, if corrected, would also result in improved coordination and administration of Titles XVIII and XIX. Your public admission that S. 3205 is not "frozen in concrete" is most encouraging, since the thrust of this statement centers on three specific recommendations which should be embodied in any such reform measure. These suggestions include:

The removal of "warts" from Medicare's excluded benefit list (Section 1862 (13)(c));

The elimination of extraneous language from Medicare's "physician" definition as it relates to podiatrists' services (Section 1861(r)(3)); and

The addition of the doctor of podiatric medicine to Title XIX's definition of physician (Section 1905(a)(5)).

Medicare: Warts

On the subject of "warts," it is incredible but true that the treatment of this particular impairment, when it affects areas other than he foot, is considered a covered Medicare benefit. This inconsistent application of the law is deserving, I feel, of the remedy we have proposed. We are also pleased to note that a few members of the Committee on Finance have already acknowledged this inconsistency and do support an appropriate remedy for it.

Medicare: Physician definition improvement

It is our further recommendation that improvements to Medicare's "physician" definition, Section 1861(r)(3) are both needed and justified. I specifically refer to deleting from this section the following underscored language: *except for the purposes of Section 1814 (a), Section 1835, and subsections (j), (k), (m) and (o) of this section,* a doctor of podiatry of surgical chiropody, but (*unless clause (1) of this section also applies to him*) only with respect to functions which he is legally authorized to perform as such by the state in which he performs them.

Although not underscored in the above definition, the words "or surgical chiropody" could also be removed since their significance is fully embraced by "doctor of podiatry."

Should you find this recommendation acceptable, it is our considered judgment that no substantive change would subsequently result in either Medicare's administration or its projected cost. This is true since the net effect of our recommendation would merely be to authorize the podiatrist as a "physician" under Medicare for the following purposes: certifying or recertifying a patient's need for inpatient hospital, skilled nursing facility or home health care; and serving as a "physician" member of a hospital or skilled nursing facility Utilization Review Committee. Whether a podiatrist can or should serve as a Medicare "physician" for these purposes is a decision which should be made by participating hospitals, skilled nursing facilities and home health agencies. Such a restriction serves no useful purpose in federal law, the primary reason for which I offer this recommendation.

Medicaid: Physician definition improvement

The third and final issue I wish to herein address is one the Association has previously discussed with you. I refer to the limited definition given the term "physician" in Title XIX. Unlike Medicare, whose physician definition includes the podiatrist, Medicaid limits the term to medical doctors and osteopaths. This lack of consistency in defining an important statutory term has unnecessarily produced serious problems over the years for carriers, administrators and program beneficiaries. We are hopeful this obstacle can and will be overcome in the foreseeable future.

A principal reason for limiting Title XIX's physician definition has been, I believe, to help curb program costs. With regard to podiatric medicine, this argument is questionable for at least two reasons:

Nearly 40 state Medicaid plans have opted to include the podiatrist within their Title XIX benefits. So adding the podiatrist to Medicaid's physician definition would not represent a sweeping change in public policy.

More importantly, it should be noted that the medical and surgical care of the foot has always been and remains a required Medicaid benefit in every state plan. So adding the podiatrist to Medicaid's physician definition does not increase the program's benefit structure, but it does make available additional professional manpower to deal with an already covered service.

I would not want to leave the impression that, should the above recommendation be adopted, no additional Medicaid costs would result. Most certainly, there would be some upward trend in this area. But when considering costs, an important analogy should be borne in mind. I refer to podiatry's experience with the various states' Blue Shield Plans, 48 of which, plus the District of Columbia, have, since 1950, been amended to cover podiatrists' services. Interestingly, only

two of these state plans (Illinois and Massachusetts) found it initially necessary to increase their subscribers' premiums for this added benefit. And after brief experiences with this surcharge, each state decided to remove it as an unnecessary assessment. Though not a direct parallel to Medicaid, this experience is a meaningful one, I believe.

I do appreciate the consideration you will give this letter and its recommendations. And if I can provide any additional detail whatsoever, please do not hesitate to inquire. In the meantime, the Association looks forward to working with your Subcommittee in every needed and appropriate way as S. 3205 is being evaluated.

Sincerely yours,

JOHN R. GRAHAM, D.P.M., *President.*

STATEMENT OF KENNETH T. WESSNER, PRESIDENT AND CHIEF EXECUTIVE OFFICER, SERVICEMASTER INDUSTRIES, INC.

My name is Kenneth T. Wessner, and I am President and Chief Executive Officer of ServiceMaster Industries Inc., a company managing more than 25,000 men and women which provides hospital management services to over 500 hospitals from coast to coast. I appreciate this opportunity to present ServiceMaster's views on a provision contained in S. 3205 which could have a significant—although apparently unintended—impact on our operations.

Specifically, Section 40 of the bill is designed to close certain "reimbursement loopholes" whereunder doctors or groups of doctors, for example, may be compensated for services provided to hospitals according to percentage reimbursement arrangements. In his introductory statement on the Senate floor when S. 3205 was introduced, Chairman Talmadge made the following statement:

> The bill would prohibit medicare and medicaid from recognizing percentage arrangements in which a pathologist gets a specified percentage of the revenues or income from all laboratory work, regardless of his direct personal service or involvement. This type of arrangement is highly inflationary in that it gears income to hospital charge levels which have been rising more rapidly than other costs. The percentage arrangement is not much different from the contingency fee arrangement in malpractice suits which so many doctors contend stimulates unreasonable and excessive malpractice awards unrelated to effort on the part of the attorneys involved.

Our company shares the Chairman's interest in this matter; however, for the following reasons, ServiceMaster's activities do not fall within the ambit of concerns described.

First, ServiceMaster does not render the type of services to hospitals with which Chairman Talmadge is concerned. We provide hospital management services in the field of housekeeping, laundry, plant operations and maintenance, materials management, and clinical engineering. Our services are subject to careful scrutiny by individual hospital administrators; and, in most cases, we are able to provide such services at lower costs and at higher standards of quality than the hospitals can provide for themselves. Moreover, it is our understanding and belief that S. 3205 was never drafted with the intent of looking over the shoulders of hospital administrators with respect to service contracts for routine operating and maintenance services, such as those provided by our company.

Second, we do not receive a percentage of the charges or costs attributable to any health service, nor do we receive a percentage of any hospital's revenue. We are paid for the services which we perform, in an honest and legitimate fashion, and for nothing more. In this respect, we would be pleased to provide the Subcommittee with a summary of our performance and accomplishments over the years which can be corroborated by the individual hospitals and hospital administrators with which we deal.

Nevertheless, while we are not concerned about the central thrust of Section 40, another portion of that section would appear to have the unintended result of reaching the type of activities in which we engage. Specifically, Section 40 also would amend the Social Security Act to require the Secretary of HEW to establish procedures whereby there would be review and advance approval of any contract which, among other things, "is a consulting, management, or service contract". While we recognize that this language may have been drafted

more broadly than necessary to cover real or potential abuses, there is the clear implication that it reaches the type of service contracts entered into by ServiceMaster with individual hospitals.

We have been pleased to learn, however, that Chairman Talmadge will be offering an amendment during the hearings on S. 3205 which would exclude "service contracts for routine operating, maintenance, security or accounting functions" from the review and advance approval procedures specified in the bill. We would understand that the amendment covers housekeeping, laundry, plant operations and maintenance, materials management, and clinical engineering. Thus, Section 1133(b)(1)(B) would be amended to require review and advance approval of any contract which, among other things, "is a consulting, management, or service contract (excluding, in the case of a hospital, service contracts for routine operating, maintenance, security or accounting functions)".

We commend the Chairman for this necessary amendment to S. 3205. It is our belief that any unintended effects created by the original draft bill have been remedied by the amendment; and the integrity and basic thrust of the original section have been preserved at the same time.

STATEMENT OF THE AMERICAN PSYCHIATRIC ASSOCIATION

The American Psychiatric Association, which represents 23,000 psychiatrists in the United States, is pleased to submit its views and comments on some of the provisions of S. 3205.

This association wishes to commend the efforts of the Chairman and members of this Committee in their attempts to construct a more effective and efficient system to administer Medicare and Medicaid, and to prevent fraud and abuse. We are supportive of these objectives, although it is extremely difficult to predict with any degree of certainty either the efficacy or any possible deleterious effects of this type of reorganization proposed in this legislation. We believe this reorganization should be studied in great depth considering the successes and failure of some past re-organization plans.

In particular, we are concerned that any wide separation of function between health care financing and health care delivery in proposed administrative reform might create a situation where quality of care could be pre-empted by fiscal considerations. We believe that any new administrative apparatus that is implemented to achieve the committee's objectives should not be constructed in such a way that the elements of cost and service are not working in tandem. We believe that any chasm created between these two vital functions through administrative re-organization would be counterproductive to the delivery of quality health care services.

In regard to fraud and abuse impacting on the Medicare and Medicaid Programs, we believe that a strong administrative structure should exist to control this problem area, and that the essential element of physician-patient confidentiality must be safeguarded in the process. Again, the prevention and control of fraud and abuse in these programs must not adversely affect our existing delivery systems or those patients being treated through these systems.

This association, therefore, is supportive of procedures for improved administration if the plan will be productive in the delivery of better services and save funds for the programs to administer more equitable benefits.

For example, serious inequities presently existing in the treatment of the mentally and emotionally ill in the Medicare and Medicaid Programs. These inequities result in inadequate treatment for the mentally ill, and the present reimbursement cost-sharing mechanisms in Medicare act, in many cases, as a deterrant to patients seeking treatment.

We have expressed our grave concern over this matter before the Senate Committee on Finance, and it appears to us that S. 3205 is the proper instrument for dealing with these inequities since we are talking about the reform of the present system.

To be specific, the present limit of coverage for outpatient treatment for mental illness in Medicare is a maximum payment of $250 or 50% of reasonable charges, whichever is less, after a $50 deductible is met. There also exists a 190 day lifetime limitation for the treatment of mental illness in psychiatric hospitals under Medicare. These discriminatory benefits under Medicare exist despite the fact that the over 65 subscriber population is the lowest utilizer of

mental health services nationally. The consultation rate for HIP's Medicare population was 5.8 per 1,000 in 1975, compared with a consultation rate of 14.3 per 1,000 for those below the age of 65. The rate of services the Medicare population receives is also low: 83 per 1,000 population, compared to 221 services per 1,000 for the under 65 population. The low utilization of mental health services by the aged contrasts strikingly with their high utilizaiton of other medical services.

Remedying this inequitable situation would serve to promote better physical health among the elderly, and lower utilization and costs for the entire Medicare Program. To cite an example, many elderly people suffer from depression as a result of many factors, emotional and organic. As a result, they fail to take proper care of themselves and neglect good health habits. This, in turn, creates many physical problems which are reversible with the proper attention paid to their mental and emotional disturbances. We believe, as do many other agencies and groups in our society, that the mental and emotional attitudes of our elderly play a significant role in their physical health.

The 190-day lifetime limitation for treatment in psychiatric hospitals under Medicare is another aspect requiring remedy, since it makes no sense to force a patient to shift from one institution to another, and it is possible that by placing patients into more expensive general hospital beds for psychiatric treatment that this 190-day limitation is actually augmenting the cost of the program.

Moreover, the very restricted outpatient psychiatric benefits will tend to place medicare patients into inpatient treatment. This is not only much more expensive, but runs counter to the present philosophy of successful outpatient treatment within the community and the prevention of hospitalization whenever practicable. Our recommendation, incidentally, is consistent with the report of the Committee on Ways and Means on H.R. 17550 in 1970 "to create incentives to encourage outpatient services and disincentives for long stays in institutional settings."

As has been stated time and time again by experts in the field, older persons are most amenable to effective psychiatric treatment through an entire range of services, from psychotherapy, group therapy, behavior modification, family counseling, and the like. In many instances, psychotherapy performed by a psychiatrist at fairly frequent intervals will maintain an elderly person in good health, and keep him functioning and productive. Robert N. Butler, M.D., psychiatrist and the newly apopinted Director of the National Institute for Aging has made many cogent arguments not to write off the elderly as presenting little hope for the reversal of commonly misperceived "irresversible" conditions of aging. This inequity in mental health benefits in medicare attests to the erroneous attitude our society has constructed in the past, in this regard, and has anachronistically clung to.

Medicaid presents a situation that is so uneven throughout the country in regard to mental health benefits that a more uniform availability of benefits is absolutely necessary. In recent times, we have seen benefits for the mentally ill under medicaid suffer in many of the states, and physician payments drop to the point that participation in the program has diminished.

Physician reimbursement is a very important issue because it will determine the extent to which physicians will be willing to participate in these federal programs, what kinds of physicians will be willing to do so, and, the resultant quality of care that will be provided to program recipients. Many physicians have already made numerous sacrifices in their decisions to remain in the inner city where indigent recipients reside, or to open a practice in the inner city. A realistic physician reimbursement system will allow services through these programs to have real meaning in terms of high quality care and relief to indigent patients. The discretion of state legislative policy in Medicaid Programs has created a situation that lacks equity for populations from one state to another, and one that calls for remedy through administrative reform. This is especially applicable to mental health benefits in the Medicaid Programs. This association proposes that sufficient mental health benefits be made available to the indigent populations of all states in order to eliminate the inequities that presently exist.

In the "Practitioner Reimbursement Reform", S. 3205 states that Medicaid fees paid physicians for outpatient care would not be less than 80% of "reasonable" charges under Medicare. Although this does not appear to be an improvement, it should be noted that in some states Medicaid fees are presently as little as 50% of the Medicare figure. Inequity in reimbursement also rests with the

fact that the base year is not current in many instances and creates a reimbursement inequity in payment rates.

In Medicare, the mechanism to determine reasonable charges for physicians' services should be structured in such a way as to provide usual, customary or reasonable payment. Fee increases should be appropriate, and any administrative mechanism devised for this purpose should provide such appropriate increases and not curtail them. If the Committee, in its wisdom, feels the existing reimbursement system is inadequate, then we would suggest that a separate set of hearings be conducted to examine specifics of the reimbursement system presently utilized in the Medicare-Medicaid Programs.

In summary, the American Psychiatric Association makes the following recommendations:

(1) Lift the restrictions on mental health benefits in the Medicare Program.

(2) Provide more equity in mental health benefits received through Medicaid, state by state, with adequate benefits to provide sufficient and high quality mental health services for indigent populations.

(3) Implement administrative reforms, but not in such a way as to disregard quality of service, and not with the first priority set on cost containment.

(4) Assure the maintenance of physician-patient confidentiality through any administrative reform that is effected.

(5) Enforce more effective methods to prevent fraud and abuse in these programs.

(6) Devise equitable physician reimbursement in these programs to assure sufficient and highly qualified physician participation to treat program recipients with high quality medical services.

Statement of the American Society of Oral Surgeons

The American Society of Oral Surgeons ("ASOS") is the official organization of nearly 3,700 oral surgeons representing all fifty states, the District of Columbia and Puerto Rico. Today all members must complete three or more years in an accredited surgical residency in a hospital following completion of four years of dental school. Members limit their practice to oral surgery in offices and in hospitals as staff members.

ASOS is submitting this statement to bring to the attention of the Committee two important inequities in the reimbursement provisions under present Medicare and Medicaid laws. Correction of the first inequity described below would not expand covered services and thus would not increase the cost of the present program. Accordingly, reform of this matter by amendment to S. 3205 would be consistent with the aim of this bill, and ASOS urges such an amendment. The second inequity herein discussed involves a modest increase in costs and in the judgment of the Committee may be more appropriately dealt with as part of other legislation.

I. ELIMINATE DISCRIMINATION BETWEEN PHYSICIANS AND ORAL SURGEONS AND OTHER DENTISTS IN THE PROVISION OF COVERED SERVICES

Many of the professional services presently provided by both oral surgeons and other dentists and physicians are only reimbursed when they are provided by physicians. The ASOS asks the Committee to include in the bill presently being considered provisions that will eliminate this discrimination. The requested correction will not increase the costs of these programs. This statement will first explain this problem as it exists in Medicare and then as it relates to Medicaid.

Medicare.—The professional practice of oral surgeons overlaps with that of physicians to a significant extent. Both groups, for example, often admit their patients to hospitals and perform complicated maxillofacial procedures. Further, both groups often provide diagnostic care and treatment of oral infections. Medicare, however, will pay all benefits for these services if they are performed by a physician, but the Medicare Intermediary will routinely reject the payment request if the diagnostic care or treatment of oral infection was performed by an oral surgeon.

Under present law, Medicare only covers the services of dentists when they constitute so-called "physicians' services." It is necessary, therefore, to look at the definition of "physician" in deciding whether a specific service is covered. "Physician" is defined to include a doctor of dental or oral surgery licensed by

his state "but only with respect to (1) surgery related to the jaw or any contiguous structure or (2) reduction (that is, the alignment) of fractures of the jaw or any facial bone.

As existing Medicare law is interpreted by the Social Security Administration, a dentist only functions as a "physician," and his services are only covered, when he is involved in the actual performance of surgery or reduction. Thus the law seriously discriminates against oral surgeons by excluding important nonsurgical functions (such as the management of salivary gland infections) which are covered only if performed by a physician. None of these functions involves routine dental care, which is separately excluded under existing law whether performed by an oral surgeon or physician. No logical reason exists to support this unfair treatment Both disciplines are professionally trained and licensed by state law to perform these procedures.

This problem has serious consequences for the patient, and is important to the professional life of the dentist. If the patient is aware of the discrimination, his freedom of choice of provider between a physician and a dentist will be prejudiced. If he is not aware of this legal pitfall when he is treated by an oral surgeon, he will be deprived of reimbursement for what surely must appear to him a completely arbitrary distinction

To put this problem into concrete terms of actual cases as illustrations, the Social Security Administration's interpretation of present Medicare law:

Denied payment to a patient for the services of an oral surgeon who had been called to the emergency room by the patient's physician to locate a bullet in the patient's tongue;

Forced a 73 year old woman to find her own means of paying for an oral surgeon's evaluation of oral and maxillofacial injuries suffered in an automobile accident;

Denied reimbursement to an elderly man who was treated by an oral surgeon for temporomandibular (jaw) joint arthritis;

Denied payment for drug injections administered by an oral surgeon to a facial nerve of a patient suffering from tic douloureux, the most painful and debilitating of all facial pains; and

Denied payment to a patient for treatment by his oral surgeon of an obstruction and swelling of a salivary gland.[1]

These are not isolated examples. The files of our Society contain numerous similar cases. The problem is serious and it needs prompt correction.

The solution we urge will not increase the scope of covered services. The existing exclusion of coverage of routine dental care found in § 1862(a)(12) would not be changed. Those services that fall into this category would still not be covered. The solution of this problem will merely assure that patients will not be denied reimbursement for otherwise covered services solely because of the academic degree of the provider.

Medicaid.—A similar inequity arises in certain circumstances under present Medicaid law. Section 1902 of the Social Security Act mandates that "physicians' services" be included in all State Medicaid plans. "Physicians' services" are defined as only those of doctors of medicine and osteopathy. This section also permits states to cover dental services and many states have opted to include the dental services provided by an oral surgeon.

Some of those states that once covered dental services have recently elected to eliminate this optional coverage in their present Medicaid plans. The result of this decision is an inequity similar to that discussed in the first section of this statement.

When dental services are covered, the overlapping professional services of both physicians and dentists are reimbursable for both groups of providers. These services, when performed by a physician, are considered covered "physicians' services." When they are performed by a dentist they are reimbursed as optional "dental services." When a state decides to eliminate the optional services, patients who continue to have their fully qualified, fully licensed oral surgeon provide otherwise covered services must find their own means of payment. Had the same patient elected to use a physician, the services would continue to be covered. Patients, of course, are often not aware of these restrictive changes in state Medicaid plans.

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[1] The ASOS has compiled a binder of documented examples of cases where this serious inequity has created problems for patients. This binder is available for the review of the Committee and its staff.

To eliminate this inequity the ASOS recommends that a provision be included in S. 3205 which will permit reimbursement for those services provided by both physicians and dentists in cases where a state once covered both services but subsequently decided to discontinue covering dental services. Such a provision will not mandate the inclusion of routine dental services in any state plan. It will only eliminate the inequity created by a state's decision to eliminate coverage of optional dental services. We have attached to this statement draft language to correct this problem in both Medicare and Medicaid.

II. COVER INPATIENT HOSPITAL SERVICE FOR ALL DENTAL PROCEDURES THAT REQUIRE HOSPITALIZATION

The second area of concern in Medicare which the ASOS would like to bring to the attention of the Committee concerns reimbursement for hospitalization required by the severity of a patient's dental condition. To correct this problem will increase benefits and thereby the cost of the program by a relatively modest amount. The Committee, therefore, may want to deal with this matter in other legislation.

Existing Medicare law differentiates between cases in which the dental procedure itself is a covered service (and thus the dentist's fee is reimbursable) and cases involving noncovered procedures. If the procedure is covered, the inpatient hospital expenses are also covered. However, the present Medicare statute as interpreted by the Social Security Administration restricts the payment of inpatient hospital expenses in the case of a noncovered dental procedure to circumstances in which the patient's underlying medical condition, and not solely his dental condition, requires hospitalization. The only example of a medical condition justifying the hospitalization of a patient for a noncovered dental service given in the Social Security Administration's "Intermediary Manual" is "a patient who has a history of repeated heart attacks who must have all of his teeth extracted."

The effect of existing law is to preclude hospitalization coverage where, in the judgment of the patient's dentist, the severity of his dental condition alone requires hospitalization for the safe performance of a noncovered dental procedure. In these cases the patient must find his own means of payment for the hospital expenses. Sample Medicare rejections when contrasted with the example in the S.S.A. manual starkly demonstrate the problem under present law. For example:

An 81 year old woman in Florida who was hospitalized by her oral surgeon for the removal of six maxillary teeth had her claim rejected because the Medicare Intermediary found that she was treated for a purely dental condition;

A 93 year old man in Illinois who was hospitalized by his oral surgeon for the extraction of eleven seriously diseased teeth had his claim denied; and

In Missouri a Medicare patient had to pay his own hospital bill because he was hospitalized by his oral surgeon for preparation of the lower jaw for dentures using a skin graft.

These are only three of the examples regularly received by our Society every year but they graphically illustrate the problem.[2]

ASOS urges that Medicare should cover inpatient hospital expenses if in the judgment of his dentist the severity of a patient's dental condition requires him to be hospitalized for performance of a dental procedure notwithstanding that the procedure itself is not a covered health service. This will not increase the coverage of dental fees. It will only increase hospital coverage and aid the patient. The Social Security Administration in 1973 estimated the additional first-year federal costs of coverage of Medicare patients in such instances to be four million dollars. We have attached draft statutory language that will make the needed correction.

AMERICAN SOCIETY OF ORAL SURGEONS SUGGESTED STATUTORY LANGUAGE

(A) Eliminate discrimination between M.D. and oral surgeon in the provision of covered services.

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[2] As in the case of the first inequity discussed in this statement the ASOS has compiled documented examples of this problem. These also are available for the use of the Committee and its staff.

MEDICARE (TITLE XVIII)

Parity between M.D. and oral surgeon can be achieved in Medicare by amending Section 1861(r)(2) to read as follows:

"(2) a doctor of [dentistry or of] dental [or oral] surgery *or of dental medicine* who is legally authorized to practice dentistry by the State in which he performs such function *and who is acting within the scope of his license when he performs such function* [but only with respect to (A) surgery related to the jaw or any structure contiguous to the jaw or (B) the reduction of any fracture of the jaw or any facial bone, or (C) the certification required by section 1814(a)(2)(E) of this Act],"[1]

The existing exclusion from coverage of routine dental care under Section 1862(a)(12) ("services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth") would continue to apply in order to assure that the inclusion of dentists within the definition of "physician" would not increase the scope of covered services but would function only to allow oral surgeons as well as doctors of medicine to perform covered services.

Alternatively, the definition of "physician" could be drafted to state affirmatively the functions performed by both doctors of medicine and oral surgeons.

"a doctor of dental surgery or of dental medicine who is legally authorized to practice dentistry by the State in which he performs such function but only with respect to the diagnosis, the surgical and/or the adjunctive treatment of the diseases, injuries, and defects of the oral and maxillofacial region."

MEDICAID (TITLE XIX)

Medicaid should be amended as follows:

Section 1903(g)(1)(A) and (g)(1)(B) of the Social Security Act are amended by inserting "or dentist" after "physician."

Section 1905 of the Social Security Act is amended—

(a) by renumbering paragraphs (f) through (k) as paragraphs (g) through (l) respectively; and

(b) by inserting a new paragraph (f) as follows:

"(f) In the case of any state the state plan of which (as approved under this title)—

(1) does not provide for the payment of some services by a dentist; but

(2) at a prior period did provide for the payment of services referred to in paragraph (1),

the term 'physicians' services' (as used in subsection (a)(5)) shall include and reimbursement shall be made for services of the type which a dentist is legally authorized to perform to the same extent as such services are included in the term 'physicians' services' when they are performed by a physician."

(B) Cover inpatient hospital services for all uncovered dental procedures that require hospitalization.

Hospitalization for noncovered dental procedures could be provided in Medicare by amending § 1814(a)(2)(E) of Title XVIII to read as follows:

"in the case of inpatient hospital services in connection with [the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth] *a dental procedure*, the individual, because of his underlying medical condition and clinical status, *or because of the severity of his dental condition*, requires hospitalization in connection with the provision of such dental services;"

§ 1862(a)(12) of Title XVIII could also be amended to read as follows:

"where such expenses are for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, except that payment may be made under Part A in the case of inpatient hospital services in connection with the provision of such *any* dental services if the individual because of his underlying medical condition and clinical status, *or because of the severity of his dental condition*, requires hospitalization in connection with the provision of such services; or"

[1] The changes in the first two lines of this definition are merely to accord with the appropriate professional nomenclature.

MEDICAL ASSOCIATION OF GEORGIA,
Atlanta, Ga., August 9, 1976.

Senator HERMAN E. TALMADGE,
Russell Building,
Washington, D.C.

DEAR SENATOR TALMADGE: Thank you for the opportunity offered the Medical Association of Georgia to present written comments on your bill, S. 3205.

Let me begin by saying that we are in general agreement with and are in support of the statement presented by the AMA in its testimony before your subcommittee. I would particularly like to bring to your attention three areas which the MAG feels are of special concern to our members.

First, in Section 20, we are quite concerned with the proposed criteria for determining reasonable charges for physicians' services. We cannot understand how physicians can be expected to react favorably to this change which imposes on them a reduction in the current reimbursement level of Medicare. This change would adversely affect not only the physician but the Medicare patient. Additionally, in this section there is an expressed concern for obtaining more physicians in shortage areas; however, we cannot accept the provision which is suggested to achieve this end. Under this provision physicians already practicing in shortage areas would be discriminated against while new physicians attracted to the area would benefit from special consideration. We reject any contention that new physicians coming into an area are greater community assets than those physicians who without the benefit of governmental inducement had already selected a "shortage area" and established their practice. This is not to criticize inducements as a valid means by which to improve physician availability in "shortage areas" but rather we submit that such inducements should be used on a non-discriminatory basis as a means to retain those practicing in "shortage areas" as well as attract new practitioners to these communities.

It may be of interest to you to know that an MAG committee, the Committee on Third Party Relations, has been involved in investigation of the use of UCR (usual, customary and reasonable), as a basis for reimbursement. As this committee develops its recommendations, we would be pleased to make them available to you and your subcommittee.

Second, in Section 21, a drastic change is made in the basis for participation by physicians in Medicare. Rather than increase the number of physicians accepting assignment, the MAG feels that this section would have the opposite effect. We can understand your subcommittee's concern for reducing the costs and burden placed on Medicare patients by having a greater number of physicians accepting assignment. However, this change undermines the basic principles under which the Medicare Program was established. The physician has always had the choice of accepting or rejecting Medicare reimbursement on an individual patient basis. This freedom of choice is destroyed under this new procedure.

We see no necessity for physicians entering into this kind of agreement suggested in this section. Under the current assignment method, the physician may choose to accept some patients under Medicare assignment because of their financial situation or other reasons. On the other hand, he may not accept assignment from some patients recognizing their capability to pay fully for their services and then await Medicare reimbursement.

As far as the inducement offered to the physicians in becoming a provider, we would earnestly suggest that Medicare consider implementing procedures, such as multiple listing billing immediately in the interest of improving the administration of the program.

As you well know, fewer and fewer physicians are currently accepting assignment from Medicare because of the unrealistic rate of reimbursement. If it were possible to compensate those participating in the program on a current basis rather than using two year old data and if it were possible to improve the administration of the program by providing reimbursement in a timely manner and by making the processing of claims more efficient, it might very well be possible to increase the number of assignments accepted in Medicare without the enactment of this section.

Third, a most important change is provided for in Section 22 entitled "Hospital Associated Physicians". While we recognize that there have been some abuses in the Medicare Program, we fail to see why the vast majority of hospital based physicians must be punished and their practice habits limited by this provision. In addition to the concern we have for the imposition of these limita-

tions on certain physicians inherent in the bill there seems to be an opportunity for bureaucrats to expand its meaning to all physicians. The use of the terms "physician's services", "personally performed", "personally directed" and "of such a nature that its performance by a physician is customary and appropriate" would wreck havoc in a physician's practice as we know it today and as it will develop in the future. As you well know, medical practice depends a great deal on utilization of ancillary personnel (nurses, physicians assistants, medical assistants, etc.). The use of these individuals is essential to a physician who is striving to provide quality care to increasing numbers of patients. We believe that this section of the bill threatens the use of physician extenders by physicians not only in hospital based practice but in private office practice as well.

I hope that you will find these comments of benefit to you and your subcommittee. If I can offer any further assistance, please feel free to contact me.

Sincerely,

FLEMING L. JOINER, M.D.,
President, Medical Association of Georgia.

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, D.C., August 11, 1976.

Hon. RUSSELL B. LONG,
Chairman, Senate Finance Committee,
Dirksen Building, Washington, D.C.

DEAR RUSSELL: I have been requested by a Mr. Sandford Brandt of the National Association for Mental Health, Incorporated, to insert my introductory remarks to S. 3708 into the official record of the S. 3205 hearings.

I would appreciate it if you would make the enclosed statement on S. 3708 a part of the official hearing record.

Thank you very much for your cooperation.

Very truly yours,

BILL BROCK.

Enclosure.

[From the Congressional Record, July 29, 1976]

SENATE

(By Mr. Brock)

S. 3708. A bill to amend title XVIII of the Social Security Act to include community mental health centers among the entities which may be qualified providers of services for medicare purpose, to redefine terms used in such title so as to reflect such inclusion. Referred to the Committee on Finance.

LEFT HAND, RIGHT HAND AND MENTAL HEALTH

Mr. BROCK. Mr. President, time and time again we see two congressional committees or two administrative agencies come out with conflicting regulations. Some of these are understandable, for example an agency concerned with productivity is bound to have conflicting ideas with one concerned with environmental problems. These are problems that must be worked out and I can understand and appreciate that kind of problem.

What I do not understand, however, is how one committee and agency of HEW can encourage the establishment of something as important as community mental health centers, with Federal funds, while another agency and committee say that service cannot be reimbursed with Federal funds.

Congressional and administrative support for community mental health centers goes back to at least 1963 when Congress passed the Mental Retardation Facilities and Community Mental Health Centers Construction Act (P.L. 88–164). Throughout the years, congressional support has been strong. Two years later, the act was amended by Public Law 89–105 to provide for matching funds for staffing of these centers. The law was further amended to extend the length of staffing grants support (P.L. 90–31), then to give special consideration to programs serving poverty areas (P.L. 91–211) and then to all centers in meeting the special needs of alcoholics, drug abusers and children (P.L. 90–574). Finally and most germane to the problem, Congress mandated in Public Law 94–63 that community mental health centers serve the elderly.

What is the problem? The problem is that although both Congress and the administration agree that the Community centers should serve the community and then collect as much money as possible from third party providers, another agency has restricted the flow of third party funds from one of the largest programs—medicare. This is particularly sad since most of our elderly Americans only have medicare coverage.

The administration has promulgated regulations and policies that severely restrict center reimbursement under medicare, but the fault is not all with the administration. Another problem is that four different House and Senate committees have jurisdiction over CMHC legislation and medicare programs and they have also failed to correct this injustice.

The bill I am introducing today is to correct this obvious discrepancy of having the Federal left hand aiding the community mental health centers while the Federal right hand says that they cannot be reimbursed with Federal funds. My bill simply states that qualified community mental health centers with qualified persons would be allowed to be reimbursed for their services from medicare. It is time that the Federal left and right hands got together in this vital area of concern—mental health.

STATEMENT OF EDWARD J. WILSMANN, PRESIDENT, HOMEMAKERS HOME AND HEALTH CARE SERVICES/DIVISION OF THE UPJOHN CO.

I'm sure the Committee is interested in both management and reimbursement reform in the Medicare and Medicaid programs. Therefore, why has it ignored new developments in the field?

Medicare expenditures for home health have tripled in the past two years. There are eight and one-half million disabled people in America who are not now institutionalized. Our elderly population of twenty-two million is increasing at the rate of one thousand daily. We now have study after study proving the medical desirability of home health care and the benefits of its cost effectiveness.

A home health care delivery system has tremendous potential for immediate cost savings. Yet, as you know, the program, as currently defined under Medicare, is stifled by a lack of providers and by restrictive definitions which tie the service to acute care and the so-called non-profit agencies.

We now have a home health scandal among the non-profit providers—a history of abuses unearthed by Senator Chiles and now being followed up by the House Ways & Means Committee. Congress waited until clinical laboratories became deeply embroiled in fraud and abuse before it attempted to pass federal licensure standards. Is the Congress going to wait until there is a major scandal in home health before it mandates state licensure standards?

Mr. Chairman, we all know of the hysterical overreaction and objection to the Social & Rehabilitation Service's proposed regulations that attempted to correct these problems. Yet, Mr. Chairman, you propose no legislative changes to correct them.

It seems to us that it's high time Congress listened to the facts. For several years, we have been calling for preventive care as the key to maintenance of the health of the aged. It's time that Medicare took a look at what some of the States are doing with home health care in their Medicaid programs.

If the Committee considers home health care when it revises S. 3205, I am sure it will find that a few simple administrative changes would have far-reaching, healthy effects on institutional overutilization and costs. Our suggested legislative changes are enumerated elsewhere in this testimony.

Homemakers Home and Health Care Services is submitting testimony for the record on S. 3205 because we also believe the Committee ought to know about the ramifications of current institutional problems with Medicare and Medicaid which affect non-institutional providers.

Homemakers Home and Health Care Services is a wholly-owned subsidiary of The Upjohn Company, headquartered in Kalamazoo, Michigan. Homemakers-Upjohn is the largest single supplier of home health care in the nation, presently operating 217 home health agencies located across the country. With over 53,000 employees nationally, Homemakers-Upjohn rendered in excess of twenty million hours of necessary services to people at home in 1975. All of the 2,209 Medicare-certified home health agencies combined employ fewer than 30,000

people. Homemakers-Upjohn can be certified for Medicare participation only in those states which license home health agencies. This is so by statute, solely on account of the company's tax-paying status. Only sixteen states currently license home health agencies. *Consequently, Homemakers-Upjohn operates primarily in the private sector and provides health care without a license.*

Homemakers-Upjohn has, of necessity, established its own standards of performance and quality since *both the federal government and the individual state governments have abrogated their responsibilities in this area.*

Homemakers-Upjohn operates a health care delivery system which provides supportive services to the home and to health care institutions at the lowest possible cost commensurate with quality. It is in the vanguard of organizations seeking to relieve the critical lack of qualified personnel which confront most hospitals and nursing homes, while also restoring personal dignity and care to the patient in his own home when appropriate. Over the long range, home health delivery can lower hospital and nursing home utilization by allowing for early release from the institution, or even preventing and delaying entry to it.

Your concerns about the incredible upward push in hospital costs must not blind you to the fact that the other segments of the health care industry are also experiencing extreme cost problems. In the home health industry there is a wide disparity in cost-per-unit of home health services among agencies—$15.00 to $45.00 for a physical therapy visit, for example, in Florida. In fact, we are concerned that S. 3205 does not recognize long term care costs, especially with a rapidly increasing elderly population (currently at twenty-two million and going up by one thousand per day), bearing in mind that over one-third of Medicare and Medicaid expenditures go for nursing homes. Perhaps we ought to consider pulling long term care out of Medicare, Medicaid, and Title XX and build a separate program with its own legislation, funding, and regulations.

The reforms outlined in S. 3205 attack the effects of the problems, not the causes. In reacting to current fraud and abuse problems, S. 3205 does not delineate reforms aimed at preventing future abuse and it ignores the structural reasons for the current fraud and abuse.

It is time that Congress recognized that the real culprit in the Medicare and Medicaid programs is the reimbursement system created by the health industry's insurance structure.

Certainly if S. 3205 recognized that and dealt with it, while mandating a significant expansion in home health preparatory to building a rational national health insurance structure, Senator Talmadge's bill could become landmark legislation.

I. THE FUNDING MECHANISM

Here's where the problem starts: the Webster definition of "insurance" is "a system of protecting against the risks of individual loss, by distributing according to the law of averages the burden of losses over a large number of individuals."

Robert M. Ball, former Commissioner of the Social Security Administration, said, "*When some form of universal coverage is enacted—and sooner or later it will be—we'll certainly draw on our experience in covering people over 65. If we don't use the time between now and then to correct what we've been doing wrong, we'll risk enlarging Medicare's mistakes.*

"*Time's running out to correct its (Medicare's) flaws before they solidify in a comprehensive national health insurance plan.*"

Commissioner Ball's admonition *must be heeded much more urgently today than when first made in 1974*, this being an election year when anything could happen on the national health insurance scene.

Since hospital costs have risen more rapidly than any other segment of total medical costs, it is only natural that the Committee's primary attention should be focused here in an attempt to uncover the flaws in the nation's health care delivery system's payment mechanism.

The first clues to unravelling this tangle come from the very people who performed on an out-patient basis. That means it can be done in a doctor's office or in a clinical lab—not just solely in the hospital. This experimental coverage is being offered to two-thirds of the Blue's eighty million subscribers.[1] It is

[1] April 19, 1976 *Medical Economics*, page 14.

coupled with coverage for another "patient benefit" (not a "provider benefit")—second and third consultations when surgery is indicated. This represents another potential saving of hospital days and unnecessary surgery.

If we can save four days of hospitalization because of one small change in coverage, *imagine what could be done if we got rid of barriers to "coverage by location" entirely.* The coverage should read that the insurance will pay for whatever care is needed in the most economical location that can deliver it. There should be no restrictions on where a service can be delivered; that's a provider benefit. Let's make health insurance real insurance. Let's go beyond pre-admission testing and go for the most economical modality that fits the situation. Let's get out from under the shackles of institutionalization.

Three or four years ago it was estimated that if we could save one day of hospitalization for every patient we could save the health economy $100 million a year. It is estimated today that if we could save one day of hospitalization for every patient we would save the health economy $300 million. *Artificial barriers to delivery are not just artificial but also expensive!* What we need is a comprehensive benefit package covering human ailment. We must remind you that we have been talking all this time about acute care. Again, this is what the Blues pay for—it's what the private insurance companies pay for—and it's what Medicare and Medicaid pay for. In that sense, the demand for services has been created by the supply of funding. We will discuss long term care later in this testimony.

2. THE REIMBURSEMENT STRUCTURE

From page 21 of the Council on Wage and Price Stability report, "Most advanced medical technological change is centered in the hospitals—where ninety-two percent of expenses are paid by third parties, who usually pay on a cost reimbursement basis. *Decisions as to the purchase and utilization of advanced technology thus need not turn on considerations of cost and efficiency.*" (Emphasis added.) With third party payors covering 67.4% of personal health care expenditures, 92.0% of hospital expenditures, and 65.5% of doctors' charges, it is fair to say that "decisions as to the purchase and utilization of *services* thus need not turn on considerations of cost and efficiency." The Council's report questions incentives for efficiency. Here's the nub of it. *THE COST-PLUS METHOD OF REIMBURSEMENT IS THE GREATEST INCENTIVE TO INEFFICIENCY EVER PERPETRATED ON ANY INDUSTRY!* It is the single most important reason for the high costs of health care.

The cost-plus method is based upon the "bricks and mortar" philosophy of institutional care. Again, the institutional bias has inappropriately influenced all of the health field. A lot is being said these days about prospective reimbursement methodologies. We don't believe that it makes any difference other than in the cash flow of the institution which method you use—retrospective or prospective. The central issue is still going to be what you factor in as reimbursable items; in other words, costs. A prospective reimbursement system might save dollars for a couple of years until the institutions learn to play the "budget game," and then we'll be right back where we started.

For example, in 1954 the IRS, in response to several court decisions, determined that contributed assets to a profit-making institution were non-tax deductible. Here's what this means. *If $10 million is donated to a proprietary facility:*

1. The donor may not deduct the contribution from his taxable income;
2. The facility may depreciate the $10 million asset as a cost factor that would be reimbursable for services delivered under the Medicare program;[1]
3. The facility may not deduct this depreciation from its taxable income; and
4. As a result of the income generated by the depreciation cost factor rendered, the facility would pay the United States government approximately $4.8 million in corporate taxation over the life of the asset.

If $10 million is donated to a non-profit facility.

1. The individual donor can take a tax deduction. On a $10 million donation, it is more than fair to say that approximately 50% would be deductible (that is a mean between the 70% tax bracket donors and the 0–20% individual donors with corporate contributions in the middle at 48%). In other words, the government, right off the top, is losing $5 million in taxes or, in effect, is contributing $5 million of the original $10 million donation.

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[1] The Bureau of Health Insurance's cost reimbursement formula allows depreciation expense to be included for both not-for-profit and for-profit institutions regardless of how the asset was acquired.

2. The facility gets the same cost factor depreciation that the proprietary facility does, so that over the life of the asset, the facility is paid by the government another $10 million in the form of payment for services.[2]

3. The non-profit facility pays no federal income tax.

Consequently, a $10 million donation to a proprietary facility costs the government $5.2 million over the life of the asset, while a $10 million donation to a non-profit facility costs the government $15 million over the life of the asset. Conclusion: ***Contributed assets should not be included in cost reimbursement formulas. Why should we reimburse an institution for a piece of equipment or a building that was given to it in the first place?***

The Committee should also look at Medicare's practice of allowable adjustments to "current market value" for assets written off under an accelerated rate prior to entering the program.

In our field of home health, the idiocy of cost reimbursement stands out in bold relief. By a fluke in 1965 (probably because they didn't know anything about home health and they didn't know where to fit it into the scheme), home health agencies were designated as health facilities and therefore subject to all of the reimbursement mechanisms set up for hospitals. "For hospital-based home health care agencies, costs or charges are relatively high as the result of allocation of hospital overhead to direct home care visit costs." [3]

On the assumption the Committee has had an opportunity to examine BHI's method of factoring into "allowable cost" and "home office" costs of a multiple facility provider, we submit the following:

"Because such "facilities" were not anticipated in 1965, these costs must be prorated down to the individual provider units for cost justification at the individual provider unit level.

COST REIMBURSEMENT HAS NO PLACE IN HEALTH CARE DELIVERY AND CERTAINLY NONE IN THE "PEOPLES BUSINESS" OF HOME HEALTH CARE!

As we have previously mentioned, proprietary home health agencies may become Medicare-certified only if they are licensed by the state. Since less than one-third of the states now have home health licensure laws, tax paying agencies have been locked out. We have known for eleven years that we could "go non-profit" in order to beat the system, but can you imagine a state Medicaid agency recommending to us how to get around this provision? "Your firm may wish to consider a method commonly used in the *insurance industry* as a method of solving the non-profit corporation requirement for home health participation in the program.

"This is the use of a management services contract. A non-profit corporation could be formed specifically to serve Medicaid (or Medicare). A contract to provide management services, personnel, facilities, furniture, etc., could then be given to the Homemakers Upjohn in consideration of a fixed percentage of the gross income. As long as the percentage charged was in line with the services provided and similar to management charges elsewhere, it should represent no problems."

This kind of back door entry into the system is now being used extensively in the home health business.[4]

The game plan is to set up an agency which serves *Medicare patients only* since that's where the cost reimbursement is. While start up costs are in the vicinity of $12,000, you then pick a salary for yourself as the Executive Director at $50,000, put your wife on the payroll as Director of Administrative Affairs for $45,000, put your son on board at $35,000 as the Associate Director of Administrative Affairs, etc., etc.[5] Since the Medicare guidelines say that reasonable costs will be reimbursed and since reasonable is not defined and since there are no parameters for things such as administrative salaries, this game plan can fly. Basically, all you have to do is register as a non-profit corporation and get certified by a state agency for Medicare participation. You don't even need a license. ***But you must remember to turn away non-Medicare patients to make sure that all your costs are covered.***

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[2] See footnote 2 on p. 572.

[3] The Report of the New York State Moreland Act Commission, *Assessment and Placement: Anything Goes*, page 48.

[4] We also called this to the attention of the House Ways and Means Committee on November 11, 1971.

[5] From statement of Douglass M. Richard, Regional Representative for the Bureau of Health Insurance, Atlanta, Georgia, before the Senate Subcommittee on Federal Spending, Practices, Efficiency and Open Government—May 12, 1976.

Another practice encouraged by the cost reimbursement schedule is the creation of "one lunger" home health agencies consisting of an administrator, public health nurse, and maybe a home health aide or a bookkeeper. In fact, half of the Medicare-certified 2,209 home health agencies have three or fewer employees and their overhead costs are comparable to the larger agencies. There is no economic justification for them to be in business. In order to make their administrative costs look better on paper, some home health agencies will arbitrarily increase their field costs by sending out more home health aides. This leads to over utilization, adding to administrative costs and service costs. However, the increased utilization of home health aides means that these agencies are probably providing a more appropriate level of skill for their patients than do the visiting nurse associations who largely rely on registered nurses.

3. LACK OF COMPETITION

Part A—Lack of competition among providers

The competition that is the hallmark of efficiency in the private sector has been closed out by arbitrary government intrusion.

An unsigned issue paper being circulated within the Health Resources Administration recommends that home health agencies be included in certificate of need requirements under the health planning law (P.L. 93-641). Just before making this recommendation that paper states, "As previously discussed, the open-market concept does not apply very well to the to the health care system".

That statement, more correctly stated, should read: "Congress and HEW have done everything possible to prevent the open-market concept from applying to the health care system". This latter statement is particularly true of home health where restrictive legislation and regulations have prevented the delivery of quality care economically based on the application of sound business principles, i.e., central processing of payroll, invoicing and accounts receivable—the bookkeeping—for a large number of agencies, rather than the most costly bookkeeping department in each separate agency, to mention only one of many such economies that could be effected.

The public sector of the home health business today is not accountable, costs a lot of money, and is extremely inefficient. If the proprietary home health agencies were allowed in the program, we think you would see a dramatic change in the home health benefit for the better.

Part B—Lack of competition among fiscal intermediaries

One of the big problems in the home health field is the same lack of accountability among the fiscal intermediaries which administer the Medicare program for the Bureau of Health Insurance. Intermediary contracts are let without competitive bidding, leading to the same old lack of incentive to be efficient. In addition, instructions to home health intermediaries are not uniform and, therefore, reimbursement for certain services varies widely in different parts of the country. This lack of competition holds for other parts of the Medicare program, not just home health.

Part C—Lack of alternatives to institutionalization

Medicare does not fund preventive care. It is, by statute, an acute care model. Consequently, alternatives to institutionalization are not highly funded. The home health care that is funded by Medicare, and thus by inference, by Medicaid, is tied to hospitalization, tied to registered nurses providing the hands-on delivery generally, and extremely limited in scope and services covered.

Figures range anywhere from 10% to 60% of currently institutionalized elderly people as being unnecessarily in the institutions. The generally accepted industry figure is about one-third of those people are receiving care excessive to their needs.

It is time this country recognized its responsibility in the long term care field by enacting legislation that will fund it and that will take into account the peculiar-to-the-elderly need for social services to be funded equally with medical care services. We believe that social services are a part of health care.

4. ANCILLARY FACTORS

(1) If we are going to stick to "reasonable cost reimbursement," the Social Security Administration must come up with a definition of what is "reasonable" in terms of figures and they must be allowed to enforce those determinations.

(2) Tax status as a definition of who may be a provider is arbitrary. As long as there are standards that apply equally to both proprietary providers and non-profit providers, and as long as these *standards are enforced*, then tax status will not determine the quality of the provider's care. Commitment, responsibility and accountability will.

(3) Coupled with the uneven instructions to intermediaries, there is a truly incredible amount of paperwork involved in the cost reimbursement process as administered by the Bureau of Health Insurance for Medicare. Several state Medicaid programs follow the same procedures. This paperwork adds immeasurably to administrative costs and wastes good time and talent which could better be spent on hands-on delivery.

5. THE HOME HEALTH FIELD

The Social Security Act should be the vehicle to prepare the country for an all-encompassing health program in the future. Amendments to the existing titles of the Act must be made in order to erase what are now recognized at inequities and shortcomings. Titles XVIII and XIX over the last ten years have built sufficiently comprehensive hospital and nursing home programs to create a good data and experience base from which to incorporate viable national health insurance provisions. However, the home health provisions in those two titles are neither equitable nor comprehensive. Even though Public Law 92-603 mandated home health demonstration projects, to date fewer than ten have been awarded, much less implemented, proving nothing. Statistics drawn from these projects are by definition too narrowly-based to be effective tools of measurement of the program.

It has long been recognized that America's Medicare and Medicaid health care delivery system is marked by poor utilization of manpower and resources, an over-dependence on costly institutionally-based modes of care, and a tendency to perpetuate the system by adding more dollars to it, rather than attempting to redistribute the manpower and resources through designing new systems of health care delivery. The development of home health care in recent years represents an attempt to redirect the nation's health resources and provide a broad continuum of care for America's increasingly large elderly population.

It is generally agreed by health experts that home health care delivery encourages more efficient utilization of institutional beds through earlier discharge of the patient from the institution to home care where available. Conversely, home health care is a potential mode of preventive care which can delay or prevent institutionalization of the patient. A home health program can relieve pressures to expand institutional facilities.

PROVIDER ELIGIBILITY

Restrictive definitions of provider eligibility have limited the availability of home health services. Section 1861(o) of the Social Security Act defines a home health agency as "a public agency or private organization . . . except that such term shall not include a private organization which is not a non-profit organization . . . unless it is licensed pursuant to state law. . . ." Only sixteen states have licensing laws (and one of these is anti-proprietary).

It is vital that all home health agencies be licensed, regardless of tax status. The home health field—and it's the only one in all of health care to which this applies—has been restricted to the not-for-profit home health agencies since the inception of Medicare. Times change, and now, eleven years down the road, a new assessment must be made.

Soaring federal spending on health since the enactment of Medicare/Medicaid mandates the involvement of the private sector with its manpower, resources and management expertise to help produce a more effective health care delivery system. *It will take the combined and cooperative efforts of all the tax-supported as well as the tax-paying home health agencies to provide a comprehensive and workable home health program.*

Should any state not adopt a licensing procedure for home health agencies, the Secretary of the Department of Health, Education and Welfare should be empowered to issue a license directly to the agency according to federal standards set by the Secretary.

In a speech presented to the National Association of Home Health Agencies in 1973, Dr. Charles Weller of the AMA stated,

"The key to successful co-existence between proprietary and non-profit providers is a set of adequate but non-restrictive controls on standards, accountability, organization, and incentives for efficiency.

"*Whereas an eligibility determination based on the provider's profit or non-profit structure is discriminatory and wasteful, a determination based on the service's quality, availability, and reasonableness of cost would encourage healthy competition for the delivery of services.* Indeed, with adequate standards applied equally to all providers, competition would stimulate quality, availability, economy, and efficiency."

PAYMENT FOR SERVICES

A cost-plus method of reimbursement is inappropriate for home health services and destroys the cost-effectiveness of delivery. The addition of auditing costs is never included in the overall cost of the care. We propose that the charge be based on: *the level of care delivered.*

The cost-plus method is based upon the "brick and mortar" philosophy of institutional care, and is inappropriate for the "people business" of home health agencies. In order to protect the not-for-profit home health agencies with their smaller base for overhead absorption, we would suggest preserving their current method of reimbursement to assure them of recovering their costs, which are proved through the auditing process. In the case of for-profit home health agencies, whose normal billing rates for comparable services are less than those of the not-for-profit agencies in comparable markets, we propose that those agencies be allowed to bill at the usual and customary rate, so long as those charges are no more than the not-for-profit agency charges for comparable services in the identical market. Our premise here is that proprietary home health charges are less than non-profits, and we are attaching for your information a survey we did last year of hourly rates for home health aid services in 73 cities. Example: Venice Home Health Services in Hyattsville, Maryland, a non-profit Maryland-certified home health agency, puts out a flyer which offers registered nurse services at $19.00 for the first hour and $9 for each additional half-hour. Homemakers Upjohn charges for a registered nurse are $7.65 an hour. A Venice Home Health Services home health aide is $19 for the first two hours, and $9 for each additional hour. A Homemaker, Upjohn home health aide is $4.80 an hour. Our Washington, D.C. office has a contract with the District of Columbia Department of Human Resources which pays $5.15 an hour, no matter what the service delivered. We should add that we work holidays, weekends, and evenings, in addition to the regular weekly schedule. Check your local VNA for their hours of operation. Probably 9 to 5 with no weekends or holidays.

6. RECOMMENDATIONS

All of the recommended and enacted changes in the last few years to our current health insurance programs have been aimed at the effects of a poor mechanism; they have not been aimed at the cause which is basically the current insurance structure. We believe that there is a certain amount of urgency in dealing with this problem because, as we all know, national health insurance is looming closer and closer. If we could avoid copying, yet again, the mistakes made forty years ago and compounded over the years when we come to enacting national health insurance, we could avoid wholesale slaughter of our health economy. Consequently, our recommendations to you imply sweeping legislative and regulatory changes because of the severely disabled finance mechanism for health care.

(1) *Insurance benefits must be expanded to cover the risk the patient faces rather than the risk the provider faces.* Insurance should cover whatever care is necessary at an appropriate level of care utilizing an appropriate level of skill in the appropriate setting for the individual patient situation at the lowest possible cost commensurate with quality. Where the care is received should have nothing to do with whether or not it is covered. The point of insurance ought to be to cover individual risk, not specific procedures. This current barrier to appropriate health care delivery must be broken if the industry is to become responsive to need and economy.

(2) *Delete non-cost justifiable contributed assets* from the cost reimbursement structure and clarify the kinds of overhead costs that will be allowed.

(3) Since home health agencies do not have capital assets, they are misplaced in the definition of facility. They should be allowed to charge and be reim-

bursed on a fee for service basis, based on level of skill at an hourly rate. Our strong belief is that you *should not be allowed to charge the government more than you charge the private customer*, and this is exactly what's happening in home health today.

(4) *All providers must be treated equally.* If the federal government cannot mandate state licensure for providers, then there should be federal standards.

(5) *Encourage the development and expansion of home health* with its potential to be a real cost reducer. There are currently movements in this direction—first of all in recommendations made by the White House on Aging in 1971, recommendations made by the General Accounting Office in July, 1974, and in February, 1976, and proposed regulations that were promulgated by HEW's Medicaid Bureau a year ago—although all of these efforts are now stalled.

(6) *Certificate of need should apply to not-for-profit organizations* only with Section 1122, review of capital expenditures, which will probably help to avoid over acquisition of new equipment and supplies. For instance, there needs to be only one coronary care unit in a given community, not one in every hospital.

(7) *Hospital staffing should be based on patient census.* To lower their labor costs, we recommend that hospitals permanently staff at a level near the lowest patient census in the year, and above that level, they would save a lot of money by hiring temporary personnel as patient census increases occasionally arise. This hospital staffing practice is another element of our analogy that is becoming well known in the health industry. The idea is that current practice authorizes the use of too high a level of skill in the provision of services. Current practice also means that you are paying your personnel full time when you probably don't need them full time to deliver care. Why pay them when they're not delivering care and why use the Queen Mary when a tugboat will do the job?

(8) *Reduce administrative costs by cutting down on duplication of management equipment* such as sophisticated computers—you only need one computer *for several hospitals, you don't need an underutilized computer for each* facility.

(9) During the transition period required to turn the industry around in terms of risk coverage, let's *pay the doctor an incentive for writing a plan of care that utilizes the most economic approach to delivery.* All of the data needed to determine the most economical approach does exist and is stored in SSA's computers across the country that have files on each patient, histories by diagnosis, age and geographic area, etc. This information does not need to be restricted just for the use of Professional Standards Review organizations. We all need it.

(10) *Let the health provider provide the care and pay him for it.* If fiscal intermediaries are to be used, let them make 100% payment to the provider and themselves be responsible for collecting co-insurance and co-payments and deductibles from the patient. As it operates now, the 20% co-pay under Part B of Medicare is generally "foregiven" because the providers generally don't have time to deal with that kind of paperwork. As a consequence the 80% payment from the fiscal intermediary is often equal to the original 100%. This procedure would also save on paperwork and allow the provider to concentrate on health delivery rather than attempting to become efficient as a collection agency.

In health care there is a barrier in funding between the social service component of health care and medical service component of health care. A line between the medical/social aspects has been bureaucratically built, isolating these two components from one another and causing immeasurable harm to patients, especially the chronically ill, disabled, long term care patients.

This is Homemakers-Upjohn's grand plan for comprehensive administrative and reimbursement reform for Medicare and Medicaid. S. 3205 is a good start on controlling fraud and abuse in the institutional sector of the health industry.

We belief, however, that the time for patching the program has ended and the time for comprehensive reform is now.

COMPARISON OF 1973 MEDICARE PER VISIT[1] COST VERSUS HOMEMAKER—UPJOHN 1975 HOURLY RATES BY RANGE OF NURSING SERVICES

State	Homemakers Upjohn rate			Average medicare cost
	RN range	LPN/LVN range	Homemaker home health range	
Alabama	5.60	4.55	3.40–3.55	13.50
Arizona	6.50–7.25	3.80	3.80	14.69
Arkansas	6.75	5.83	3.59	14.78
California	7.50–9.50	4.50–7.50	3.50–6.50	19.30
Colorado	6.29–7.20	4.75–7.50	3.80–4.29	15.47
Connecticut	7.50–7.90	6.25–6.70	4.10–5.00	12.98
District of Columbia	7.65–8.45	6.40–7.20	4.80–7.00	19.00
Florida	5.70–8.80	4.60–9.50	3.10–6.25	14.67
Illinois	7.97	6.29	3.97–5.50	14.78
Kansas	6.85–7.80	5.28–6.52	3.80–4.15	9.40
Kentucky				14.60
Louisiana	6.19–6.98	5.27–5.81	3.61–5.81	15.67
Maryland	7.65–8.05	6.35–8.00	4.15–7.00	15.30
Massachusetts	6.80–8.90	5.60–7.55	4.00–4.99	12.41
Michigan	5.48–8.70	4.65–6.89	3.88–5.00	17.22
Minnesota	6.25–7.25	4.80–5.85	4.00–4.20	12.24
Missouri	7.25–7.66	5.65–6.27	3.80–4.30	15.17
Nebraska	6.39–7.29	4.97–5.53	3.69–3.87	11.13
Nevada	6.85–8.65	5.35–6.78	5.18–5.40	11.13
New Jersey	7.25	6.15	3.75	13.66
New York	6.70–7.95	5.00–6.75	3.60–5.85	17.59
North Carolina	6.00–6.25	4.50–5.00	3.35–3.65	10.49
Ohio	6.29–7.78	4.80–5.95	3.25–4.05	13.46
Oklahoma	6.50–7.23	5.44–6.22	3.85–4.48	15.90
Oregon	7.25–8.25	5.85–7.20	4.15–4.35	16.80
Pennsylvania	5.63–7.30	4.24–5.65	2.55–4.30	13.50
Rhode Island	7.45	5.84	3.95–4.46	13.03
Texas	6.75–7.88	4.90–8.03	3.53–4.00	17.23
Utah	6.75	5.35	3.75	10.43
Virginia	7.65–8.45	6.40–8.00	4.80–7.00	11.63
Washington	7.10–8.80	4.90–6.15	3.95–4.25	16.61
Wisconsin	7.40–8.90	6.20–6.75	4.00–4.80	10.59

[1] A "visit" has been defined as generally consisting of 1 hr or less of service.

HOMEMAKERS VERSUS VOLUNTARY AGENCIES, FOR HOME HEALTH AIDE SERVICES

City	Voluntary rate per hour	Homemakers rate per hour	City	Voluntary rate per hour	Homemakers rate per hour
Albany	6.50	4.12	Stamford	5.00	4.28
Ann Arbor	6.50	4.46	Syracuse		3.35
Atlanta		3.75	Temple City	8.00	4.25
Baton Rouge		3.28	Topeka		3.40
Billings		3.20	Utica		3.35
Binghamton		3.35	Van Nuys	8.50	4.40
Bridgeport	4.80	4.10	West Springfield	4.35	3.63
Canton		3.40	West Hartford	4.75	4.00
Cincinnati	3.94	3.29	Albuquerque	7.00	3.55
Columbus		3.29	Austin		3.50
Corpus Christi		3.60	Hauppague	4.00	3.75
Dayton		3.59	Long Beach	9.00	3.50
Denver	3.56	3.15	Tulsa	18.00	3.50
Doylestown	4.25	3.48	San Antonio	6.00	3.20
Erlanger	3.94	3.29	Oklahoma City	3.32	3.20
Erie		3.35	Fort Worth	10.00	3.20
Fresno	6.00	3.50	Dallas	14.00	3.78
Greensboro		3.10	Concord	9.00	4.00
Harrisburg	3.50	3.25	Sacramento	5.50	3.85
Jackson, Miss	5.00	3.30	Stockton	4.80	3.75
Jacksonville	4.20	3.00	Oakland	4.92	3.85
Lafayette		3.28	Lakeland	7.50	3.25
Lansing	4.00	3.85	Louisville	3.60	3.20
New York	4.25	4.15	Minneapolis	5.90	3.58
Niagara Falls		3.35	Tampa		3.20
Oshkosh	6.75	3.45	Seattle	6.25	3.65
Pensacola		2.80	Salem	5.25	3.95
Omaha	10.00	3.52	Spokane	6.17	4.00
Philadelphia	4.50	3.65	Tacoma	5.95	3.80
Pittsburgh	5.00	3.29	Portland	6.25	4.25
Racine	3.73	3.50	Eugene	5.25	3.55
Raleigh		3.00	Washington, D.C	7.00	3.95
Rochester, Minn	6.66	3.96	Indianapolis	4.00	3.20
Saginaw	4.25	3.40	South Bend		3.20
St. Paul	4.75	4.00	Rockford	3.75	3.20
San Diego	7.50	3.80			
Santa Barbara	6.00	3.50			
Scranton	5.00	3.45			

Statement of Center on Social Welfare Policy & Law

The following statement on S. 3205 is submitted by the Center on Social Welfare Policy and Law, the only national law office devoted to problems of social welfare law. The Center has eleven years of experience in representing poor persons affected by public benefit programs, and is currently representing clients with many problems addressed by S. 3205. This statement addresses those points the Center has been able to consider in the time available: delays in determining eligibility, deficiencies in current quality control procedures, inadequacies in current procedures for developing agency policy, and consideration of property transferred to relatives without fair compensation. No position is taken on other portions of the bill at this time.

Section 4

APPLICATION PROCESSING TIME LIMITATIONS

Section 4(a) of S. 3205 would add to the Act a maximum time period of 30 days (60 days in disability cases) for the determination of eligibility for medical assistance benefits under Title XIX. We agree that speedy determination of eligibility is a matter of vital importance to all needy persons requiring medical care, since there is no manner in which a person can be compensated subsequently for denial of medical care at a time when it is most needed. Since delays are now commonplace, we support legislative action such as that reflected in § 4(a). There are certain problems arising from the language of § 4(a), or current agency practices, however, which we believe the Committee should address if it wishes to accomplish its benevolent purposes.

Before turning to those problems, we should first note that time standards of 30 and 60 days are entirely realistic. A 30 day standard was applied by HEW in the AFDC program from 1951 to 1973; the sixty day standard in disability cases was introduced in 1968. HEW defended its 30 day requirement before the United States Supreme Court in *Rodriguez v. Swank*, 403 U.S. 901 (1971), stating in its amicus brief that the mandatory 30 day standard "was drawn on the experience of more than seventeen years in administering the statute, as well as the experience and comments of various states and recipients." A number of states who were out of compliance with the 30 day requirement in the early 1970's were brought into compliance by court orders. Even when HEW extended the time period to 45 days in 1973, it recognized that 30 days was the *reasonable* period, and required that benefits be paid as of the 30th day.

HEW has not set any standard for promptness of determination of eligibility for SSI in its regulations, and has been under serious criticism for its delays. In an October 21, 1975 Report to the Subcommittee on Public Assistance of the House Committee on Ways and Means, SSA stated that by March 1976 it hoped to determine the average case in approximately 30 days (60 days for disability cases). A March 1976 Report states that those goals were exceeded, that is, that the average case took *less* time. Of course many cases took longer. Nonetheless, it is apparent that the time standards contained in S. 3205 are certainly attainable and should be retained in the bill.[1] This brings us to the problems raised by the bill in its present form.

1. We are concerned that S. 3205, as currently drafted, may not have the desired impact in assuring that eligibility determinations will be made within the time limits desired by the sponsors. Thus, S. 3205 could be read to apply the 30 and 60 day time limits for the making of eligibility determinations on "applications for coverage" under the medicaid program only to *medicaid* applications of persons *already receiving AFDC or SSI benefits*. §4(a) now says:

"(37) provide—

"(A) for the making of eligibility determinations under the plan, on the basis of applications for coverage, within thirty days of the date of such application for all individuals: (i) *receiving aid or assistance* (or who except for income and resources would be eligible for aid or assistance) under any plan of the State approved under title I, X, XVI (for the aged and the blind) or part A of title IV, or (ii) with respect to whom supplemental security income benefits *are being paid* (or who would except for income and resources be eligible to have paid with

[1] In this respect, it should be noted that S. 3205 need not be changed to allow for a few hard cases, for the bill allows for cases in which it is alleged that a determination of eligibility simply cannot be made within the 30 or 60 day time limits by providing that the sanction under the Act applies only if timely determinations are made in fewer than 95 percent of all medical assistance eligibility determinations. Section 4(b) of S. 3205.

respect to them supplemental security income benefits) under title XVI on the basis of age or blindness." (Emphasis supplied.)

Yet persons "receiving" AFDC benefits, and most persons to whom SSI benefits "are being paid," are automatically eligible for medicaid benefits, and *no* further delay is warranted.[3] In addition, persons applying for AFDC benefits are determined ineligible solely on the basis of income or resources should also have had eligibility for medicaid determined in the process of making that determination. In sum, the group of "applicants" for medicaid coverage described by § 4(a) includes those persons who should not be applicants, but recipients, since they are already eligible for benefits.

We therefore assume § 4(a) was designed to reach persons applying for medicaid and cash assistance simultaneously, as well as all other persons seeking medicaid benefits, whenever it is the state agency that is determining eligibility. (Those applicants for medicaid for whom eligibility is determined by SSA pursuant to a contract with the state agency would not be protected by a state plan requirement.)

"We therefore recommend that the bill be amended so that the new § 1902(a)(37)(A) read something like the following:

"(37) provide—

"(A) for the making of eligibility determinations under the plan on the basis of application for coverage under such plan (except on the basis of disability), including simultaneous application for benefits under Title I, IV-A, X, and XVI (if eligibility for benefits under such Title XVI is based upon age or blindness, and eligibility is determined by the state agency pursuant to Section 1616), within thirty days of the date of such application.

Subdivision B could be revised smilarly.

A new subdivision should then be added to require immediate determination of eligibility when SSA determines that a person is eligible for SSI benefits, under the state's Title XIX plan the individual is therefore automatically eligible for medicaid, and the state has not contracted with SSA for the determination of medicaid eligibility.

2. We believe it most important that the "date of application" be defined, both to assure that poor persons will receive the protection intended by S. 3205 and so that the Secretary and the Comptroller General can measure compliance. HEW measures the date differently in the AFDC and SSI programs. Under recent AFDC regulations the time period for processing applications begins to run only when a "completed application form" has been submitted. 45 C.F.R. § 206.10(a)(6). Since states now require many documents and other verification, substantial time often passes before the application form is "completed." At that point there should be little need for additional time, since the documentation will be so complete. Nonetheless state agencies begin to measure their 45 and 60 day periods from that late date. Prior regulations required the state agency to measure the time period for determining eligibility from the first time the agency was advised of the applicant's interest in receiving benefits. [45 C.F.R. § 206.10(a)(1), repealed effective August 15, 1973]. In the SSI program the application is considered effective on the date that any written statement of a desire to receive benefits is filed with the agency, provided that a complete application form is filed thereafter. 20 C.F.R. § 416.335

We believe the best approach would be to add a section to S. 3205 which combines these prior and current HEW regulations, and modifies them to conform to other portions of § 1902(a)(37), to read along the following lines:

"An application may be made by an individual seeking coverage, his designated representative, or someone acting responsibly for him, and may be made in person, by mail, or by telephone, provided that the application form prescribed by the agency is thereafter completed and filed within an amount of time designated by the Secretary."

3. A determination of eligibility does not assure that a person actually receives benefits. Thus, even though the Act currently requires that medicaid benefits "be furnished with reasonable promptness," Section 1902(a)(8), and federal regulations require that "medical care . . . shall be furnished promptly to eligible individuals without any delay attributable to the agency's administrative process," 45 C.F.R. § 206.10(a)(5), there are often delays between the determination made by the agency and the issuance of documentation (the "medicaid card") establishing eligibility so that a person may receive medical care.

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[3] Thus, under current regulations, persons applying for AFDC benefits and many applicants for SSI benefits dot not make a separate application for medical assistance, 45 C.F.R. § 206.10(a)(1)(iv)(A), (B).

We therefore suggest that the bill include specific language requiring the agency to provide documentation of eligibility immediately upon the determination of eligibility and, in addition, that the current federal regulation implementing § 1902(a)(8), set out at 45 C.F.R. § 206.10(a)(3), be added to the Act:

"The agency's standards of promptness for acting on applications or redetermining eligibility shall not be used as a waiting period before granting aid, or as a basis for denial of an application or for termination assistance."

Such provisions will help assure that in each case medicaid benefits will be furnished to needy sick persons as soon as possible. If this can be accomplished, this legislation will have succeeded in improving the lives of untold numbers of needy, sick persons throughout the country.

QUALITY CONTROL

We applaud the Subcommittee's efforts to ensure that state determinations of eligibility in the medicaid program will be as accurate as efficient administration can make possible. While much of the support for a rigorous quality control program with specific federal requirements for the systematic reduction of state error rates will most likely come from those concerned primarily with the enormous cost of the medicaid program, and with the impact of waste from the taxpayer's perspective, the individuals and families who depend on the medicaid program for their basic health care have an equal interest in efficient and non-wasteful administration. This is so for two obvious reasons.

First, inefficiency and improper expenditures necessarily reduce the amount of funds available to provide the health services vitally needed. The reduction or elimination of improper expenditures will free local, state and federal funds for expansion, or at least retention, of the amount, scope and duration of health services available to the poor under the medicaid program. The second reason, one which is particularly relevant to our view of this aspect of S. 3205 as presently drafted, is that inefficient, incompetent and careless administration not only causes improper payments to be made to providers of services, and ineligible persons to receive medical assistance benefits, but such lax administration frequently results in individuals and families *eligible* for medicaid assistance being denied such aid despite being entitled to it under state and federal law. It is hard to imagine a greater tragedy than the improper denial of critical medical care to the nation's medically needy.

Despite what we perceive to be the Subcommittee's even-handed concern over inefficient state administration, S. 3205 as presently drafted would have little, if any, impact on reducing state errors that keep *eligible* persons *off* the medicaid rolls. S. 3205 would add to Title XIX a new requirement for federal funding, § 1902(a)(38), which would require state medicaid plans to

"provide for methods and procedures to assure accuracy in the determinations of eligibility for medical assistance and provide that the error rate for eligibility determinations made on or after October 1, 1977, may not exceed the error rate specified in section 1911(b). . . ."

Section 1911(b), the section defining the maximum rate of error that would be acceptable (and also to be added by S. 3205), sets as the maximum allowable error rate that rate which equals the 50th percentile of the error rates reported by the state medicaid agencies during the period October 1, 1975 through March 31, 1976. As § 1911(a) indicates, those state error rates (which are to be published by the Secretary by September 1, 1976) are the error rates reported under the medicaid quality control program specified in HEW regulations "prior to March 1, 1976."

The problem with § 1911 is that under HEW quality control regulations in effect immediately prior to March 1, 1976, and currently in effect, state medicaid agencies were *not* required to review cases in which individuals were found *ineligible* for medicaid, and, as a result, error rates reported during the specified base period do *not* include errors made in denying medicaid.[3] It seems likely

[3] On April 6, 1973, HEW discontinued, without public notice in the Federal Register, its long standing practice of requiring state quality control programs to review not only positive actions (i.e. cases on the assistance rolls) but also *negative case actions* (denials or terminations). On that date it eliminated negative case actions from AFDC quality control and suspended in its entirety the Medicaid Quality Control program. In July 1975 HEW reinstated the requirement for a medicaid quality control program, but consistent with its April 6, 1973 decision, negative case action reviews are *not* included. The elimination of negative case action reviews from AFDC and medicaid quality control was challenged in a lawsuit filed in the District of Columbia Federal Court by NWRO and local affiliate groups, *WROAC* v. *Mathews*. HEW has advised the District Court in *WROAC* that it intends to restore negative case action reviews to the AFDC and medicaid quality control programs, but it has taken no action to date.

that the drafters of S. 3205 did not intend to exclude from the mandatory requirements of § 1902(a)(38) the requirement that state eligibility determinations achieve at least an average standard of accuracy in those determinations *adverse* to applicants. Thus, for example, S. 3205 specifically, and wisely, requires periodic state reports with respect to "statistics on those declared ineligible who are found upon reexamination to be eligible" [proposed amendment to § 1902(a)(16)]. Unless the base period used by S. 3205 as a standard for measuring state performance is changed, or unless S. 3205 is amended to provide an alternative standard for errors with regard to decisions on *in*eligibility, the intended even-handed requirement to "assure accuracy in the determinations of eligibility" will not be fulfilled.[4]

Assuming that S. 3205 *is* intended to apply even-handedly to both kinds of eligibility errors, and that the necessary redrafting is done, we believe that the normative standard of acceptable error adopted by Congress should not be a static one, as is the standard in § 1911, but should be revised periodically to take into account improvements in state determinations expected as a result of the rigorous provisions of S. 3205. Lax federal supervision to date by HEW has undoubtedly resulted in very high error rates.[5] Rather than require the states to attain only a level of efficiency that is represented by an average of unnecessarily high 1975–76 error rates, Congress ought to require the states to achieve a new average level of efficiency each year, as such efficiency improves to more tolerable levels.

Proposed § 1911(a) should be amended to require an annual publication by HEW of state error rates for the preceeding year, and § 1911(b) and § 1902(a)(38) should require the states to achieve the 50th percentile of the "improved" error rate. At some point, of course, it is conceivable that state improvement will be so dramatic that the majority of states will have reduced their error rates to an unreducable minimum. To account for this possibility S. 3205 could be amended to provide that if the Secretary, by regulation and after empirical analysis and study, should establish a minimally acceptable error rate below which improvement cannot be reasonably expected, any state meeting *that* rate would be deemed to be in compliance with § 1902(a)(38).

Section 7

Regulations of the Secretary

Section 7(b) of S. 3205 would amend the provision of the Social Security Act (§ 1102) pertaining to the Secretary of HEW's general rulemaking authority. That provision would require that HEW regulations not become effective until 60 days following the publication of a notice of proposed rulemaking (except where prompt promulgation is indicated by HEW to be "urgent".) While the purpose attached to this provision is to provide a minimum 60 day period for public comment on proposed rulemaking, Cong. Rec., March 25, 1976, p. S4206, a purpose we enthusiastically endorse, the provision as currently drafted might not accomplish this result, and in any case might have consequences unintended by the sponsors.

Before discussing our concerns with this amendment to § 1102, as a preliminary matter we believe that the preferable course of action with respect to HEW rulemaking, deficient as it has been in recent years, is to await the outcome of pending legislative action with respect to agency rulemaking applicable to *all* agencies, not just HEW. For example, H.R. 12048 was reported to the floor by the House Judiciary Committee on April 6, 1976 and is now pending in the House. That bill, if enacted, would substantially revise the informal rulemaking provisions of the Administrative Procedure Act (5 U.S.C. § 553) to accomplish, *inter alia*, the following objectives relevant to this subcommittee's concerns as expressed in S. 3205:

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[4] As indicated in footnote 1, HEW eliminated negative case action reviews without a rulemaking notice in the Federal Register, and we thus assume the drafters of S. 3205 were not on notice of this action and did not intend the anomolous result created by the reference in § 1911 to error rates reported in 1975–76. If, however, the result *was* intended by the drafters, we request the opportunity to provide more detailed testimony as to the serious implications of such an omission.

[5] HEW was unable to provide us with any figures for the October 1, 1975 to March 31, 1976 base period.

1. It would subject HEW's medicaid rulemaking to the requirements of the APA by virtue of the repeal of the statutory exemption for "public property, loans, grants, benefits, or contracts." [(H.R. 12048, § 3(a)(3)]

2. It would require more rigorous agency efforts to inform members of the public likely to be affected by regulations that they have been proposed. [H.R. 12048, § 3(b)(1)(A)]

3. It would require that agencies use § 553 notice and comment procedures in adopting "general statements of policy." [H.R. 12048, § 3(b)(3)]. Such rulemaking is currently exempt from the notice and comment requirements of § 553.

4. It would provide a minimum 45 days for public comment. [H.R. 12048, § 3(c)]. While this is shorter than the 60 day period purportedly required by S. 3205 (but see discussion *infra*), the 45 day requirement would be most effective when coupled with other provisions of the bill requiring greater specificity in the notice of proposed rulemaking as to the agency's "purpose" in rulemaking, and with stricter requirements for responding to public comments in the final publication.

5. Finally, H.R. 12048 would establish an elaborate procedure for Congressional review of all agency rules, with the power to veto rules which are unsatisfactory. [H.R. 12048, § 4]

While we do not necessarily agree with each of the provisions of H.R. 12048, we do believe that Congress should consider the broader questions raised by agency rulemaking before this committee tackles the issues in a particularized context of a single agency, and in connection with a bill targeted on a specific program. In any case, if special attention to HEW rulemaking by this Committee is believed to be necessary, we would strongly urge that such consideration be given separate from the substantial medicaid-medicare reform proposals in S. 3205. The problems with HEW rulemaking in the public assistance area pertains not only to medicaid, but also to AFDC and SSI, and the entire range of issues should be explored by the Finance Committee and the public undiluted by the equally important health issues addressed by S. 3205.

If amendments to § 1102 are considered, however, we would note the following problems with § 7 of S. 3205:

1. Section 7(b) applies to proposed regulations published "in compliance with applicable requirements imposed by law." As indicated above, HEW is not presently bound by the requirements for proposed rulemaking in § 553 of the APA when it establishes rules in the public assistance programs. HEW publishes proposed regulations in the Federal Register because of a voluntary adoption of the recommendation of the Administrative Conference that they and other exempt agencies do so. Since "law" as used in § 7(b) might be construed as applying only to federal statutes, and since HEW could in any case rescind its voluntary utilization of § 553 procedures, § 7(b) should specifically require HEW to utilize § 553 despite the exemption afforded for regulations governing grants and contracts.

2. Section 7(b), referring to the notice of *proposed* rulemaking, provides that "such rule *shall become effective* not less than sixty days after publication of *such notice*. . . ." (emphasis added). The problem with this is that to become effective, the proposed rule would first have to be published in the Federal Register in *final* form, 5 U.S.C. § 552(b), § 553(c). Such final publication must consider the comments submitted, provide the agency's statement of basis and purpose, and include the text of the *final* rule (which may well have been modified from the proposed rule). 5 U.S.C. § 553(c). Under § 553(d) of the APA, the *final* rule cannot be made effective until at least 30 days following *final* publication (with certain exceptions for emergency cases) in order to give the public time to adjust to the new rule.

If § 7(b) is not amended, it may well be construed as authorizing the effectiveness of a *final* rule 60 days from publication of the *proposed* rule. If so, the actual comment period will necessarily be substantially shorter than 60 days so as to afford receipt of and consideration of public comment, and indeed, if the 30 day delayed effective date rule of § 553(d) is still applicable (and it appears to be), the comment period would almost certainly be less than the present practice of affording 30 days. We suggest that § 7(b) simply provide that the period for public comment afforded by the APA in § 553(b) shall not be less than 60 days absent an "urgent" need for more prompt issuance.

• HEW presently utilizes APA rulemaking procedures on a voluntary basis.

Of course, if the intent of § 7(b) is to eliminate the provision for a 30 day delayed effectiveness of a *final* rule then it should be struck from the bill. The immediate implementation of a *final* rule without advance warning of its specific terms and certainty of its adoption is as injurious to those regulated and the ultimate program beneficiaries as the promulgation of a *proposed* rule without affording sufficient time for public comment.

3. Section 7(c) provides that in issuing "major policy guidelines" under the Act, the Secretary shall use procedures which will afford the public the opportunity to express their comments to the Secretary before the policy becomes final. We assume that the intent of this provision is to provide the public with an opportunity to be heard with respect to medicare and medicaid policymaking not otherwise subject to the public participation provisions of the Administrative Procedure Act and § 7(b) of this Bill. The Administrative Procedure Act, for example, presently exempts "interpretative rules [and] general statements of policy" from the § 553 notice and comment requirements "except when notice or hearing is required by statute." 5 U.S.C. § 553(b). While we support this goal, we believe that if § 7(c) is to be assured of accomplishing its purpose, it should do so by specific language which makes clear that the procedures to be used are those provided in § 553, and which describes precisely the types of policymaking which are to be covered, i.e., "general statements of policy" and "interpretive rules."

If changes are not made, the vagueness of § 7(c) will permit the Secretary to devise procedures which are different from the time-tested procedures of § 553, and which may not be adequate to the task. Such new procedures would unnecessarily create separate mechanisms for obtaining and reviewing public comment, a result which would confuse the public and burden the internal administrative process of the agency. In addition, absent such a reference to § 553 in § 7(c) of the Bill, public comments may not prove worthwhile, since § 7(c) would not require the Secretary to take into consideration and respond to public comment when he promulgates a final policy. Such an obligation is specifically imposed by § 553, which requires a statement of basis and purpose to accompany the promulgation of a final regulation. Finally, the use of the term "major policy guidelines" may lead to considerable confusion since substantive rules are already covered by § 553 and it is not clear to what extent normally exempt "statements of policy" or "interpretive rules" are intended to be covered by this term. The bill should clearly specify.

4. Section 7(c) should also be amended to delete the parenthetical phrase "(other than those issued through regulations)." While, as noted, the purpose of § 7(c) seems to be to require notice and comment rulemaking even in those cases where it is not presently required, the language used in § 7(c) suggests that the Secretary has discretion as to whether "major policy guidelines" shall take the form of published rules, since the term "regulations" normally refers to such published policy. The deletion is needed to make clear that policy guidelines otherwise required to be published in the Federal Register as final rules will still be required to be so published.

General policy statements, or "major policy guidelines," are clearly "rules" within the meaning of the APA, 5 U.S.C. § 551(4), and must therefore be published in the Federal Register. 5 U.S.C. § 552(a)(1)(D). This publication requirement is independent of the notice and comment requirements of § 553 used in connection with *proposed* policy, and does not contain the exceptions of that statute. Even with the law as clear as it is at the present time, HEW frequently does not comply with this publication requirement, and makes major policy in unpublished documents distributed only to a select group of outsiders. The Administrative Conference has criticized the federal agencies for failing to observe this requirement of § 552. See 41 Fed. Reg. 7895, (Feb. 23, 1976).

Therefore, § 7(c) should be amended to remove any suggestion that the Secretary has any discretion to issue general statements of policy without notice to the public through publication of the final rule in the Federal Register. Such an amendment would eliminate a potential conflict with § 552. In order to require notice and comment procedures to be used where they are not already required by law to be used, which is really the purpose of § 7(c), the bill should simply be revised as we suggested in paragraph 3, *supra*, to eliminate those few specific exemptions from the notice and comment provisions.

SECTION 44

TRANSFER OF PROPERTY

This section provides that an applicant's or recipient's resources will be considered to include the current market value of property transferred to a relative within the past year for less than fair market value. We assume that this provision is intended to prevent persons from transferring substantial assets to family members in order to qualify for medicaid benefits. We have several comments.

1. We do not believe there is any evidence that such transfers of property are at all common. HEW has indicated in correspondence provided to us that it does not have information as to frequency of such transfers. Surely the eligibility determination process should not be encumbered by unnecessary additional criteria.

2. If the provision is to remain in the bill, it should be revised to apply only where the transfer was made for the purpose of establishing eligibility for medicaid benefits. The bill as written would deny medicaid to persons making gifts to members of their family even if such gifts were made at a point in time when application for medicaid benefits had not even been contemplated or when the transfer was made for other reasons unrelated to medicaid eligibility.

3. Only a person's equity in property may be counted as a resource to determine eligibility for medicaid benefits, since that is the amount of money the person could obtain to meet the cost of medical care by selling the property. Nonetheless the bill would require that full market value be counted as a resource even if a person had only a small equity in the property. Surely more value should not be attributed to a resource than a person could have received.

By the same token, the provision should not provide for an attribution of the value of the transferred resource to the person so long as the person received fair compensation for the value of his or her equity in the property. As currently drafted, a person who sells encumbered property to a relative for an amount in excess of his or her equity, but less than full market value, would have current market value attributed to him or her as a resource.

In sum, if the transfer of property provision is to be retained, it should (1) call for an attribution of resources which have been transferred only when the transfer was made solely for the purpose of qualifying for medicaid benefits, (2) the value of the resource so attributed should be the person's equity in the property, less the amount of compensation received for the property, and (3) the provision should apply only if the person received less than the amount of his or her equity in the property.

Submitted by Steven J. Cole, Henry A. Freedman, and Mary R. Mannix.

AMERICAN OSTEOPATHIC COLLEGE OF PATHOLOGISTS, INC.,
Kansas City, Mo., July 28, 1976.

Hon. HERMAN TALMADGE,
Chairman, Senate Finance Health Subcommittee, c/o Michael Stern, Staff Director, Senate Committee on Finance, 2227 Dirksen Senate Office Building, Washington, D.C.

DEAR MR. CHAIRMAN: As President of the American Osteopathic College of Pathologists, I am writing to submit our views on S. 3205, the Medicare-Medicaid Administrative and Reimbursement Reform Act, introduced earlier this year by the distinguished Chairman of the Subcommittee, Senator Herman Talmadge.

Our College is composed of osteopathic physicians who by their post-doctoral training have achieved the status of "specialist". Specifically, the osteopathic pathologist is a physician who possesses a learned expertise in the laboratory phases of medical practice, and who integrates this special expertise with patient care, either directly by himself, or through the physician who is directly attending the patient.

While the osteopathic specialty of pathology is comparable, in degree of training and certification to other specialties, in other respects it is a very unique specialty.

In the osteopathic profession, virtually all pathologists are "General Pathologists", and are "Hospital-Associated". The few exceptions practice in one of the subspecialties of pathology, for example, research pathology, industrial pathology, forensic pathology, etc. Thus, we are first unique in the restriction of our practice setting.

Next, the specialty of osteopathic pathology is unique in that, while it is at the hub of nearly all hospital services, it involves the least direct patient contact of all specialties. The professional services of the "Hospital-Associated" pathologist vary with the size of the hospital, the extent of its pathology service and the scope of his services, in providing health care to the patient. These services may include, but are not limited to, the following:

1. Direct operating room and bed-floor medical patient consultation.
2. Diagnosis and interpretation of all materials derived or expressed from the human body.
3. Interpretation of clinical findings, and laboratory data whether performed by himself or other technical personnel, in order to establish a diagnosis for the patient's ailment, and a therapeutic program to be conducted by the attending physician.
4. Performance of autopsies and interpretation of the findings to constantly improve the professional confidence in medical practice and knowledgeability in all disciplines of medical practice.
5. Maintaining the proper quality control programs necessary to insure accurate and reproducible results of all laboratory examinations.
6. Responsibility for organizing and maintaining a proper technical staff in the laboratory. This function requires ongoing teaching and training of paramedical staff, the instituting and monitoring of all new procedures, medico-legal responsibilities of work performed by himself or others under his jurisdiction, etc.
7. Fiscal management of the laboratory to control the cost and expenditures at a reasonable level, as required by third-parties.
8. The execution of other duties, beyond the customary activities of general staff members, which are required, either by law or directive. These duties may include the maintainance of a tumor registry, the statistical documentation of surgical tissue analysis, and program teaching of resident and visiting staff, etc.

Because of the uniqueness of our specialty several unique patterns of service and methods of compensation therefore have evolved, as working agreements between osteopathic hospitals and their "Associated Pathologists".

All of the foregoing brings us to our concern over the provisions of S. 3205 which relate to "Hospital-Associated" physicians.

We, in the American Osteopathic College of Pathologists, are not blind to the acceleration in hospital care costs during the past several years and are fully aware of the impact of these increases on the administration of the Medicare and Medicaid programs. We are also aware that increases in laboratory services have contributed to the overall problem of increasing hospitals costs. We must respectfully submit, however, that neither the increase in laboratory costs nor the overall cost in patient care have been significantly affected by the level of compensation of "Hospital-Associated" pathologists.

We do not contend that there have not been isolated instances where hospital-associated pathologists have obtained excessive compensation, nor do we condone such practice. We do affirmatively assert, however that the varying contract forms presently employed, most hospital-associated pathologists are now fairly and *reasonably compensated* for their highly specialized and unique services. I would add, that the American Osteopathic College of Pathologists does not, and has not at any time, endorsed the use of any particular method of compensation, but rather accepts the premise that a pluralistic approach is most reasonable, since circumstances affecting reimbursement policy may differ from hospital to hospital.

While we fully sympathize with the Congress' feeling of obligation to curtail rising hospital costs in order to concommitantly curtail Medicare and Medicaid costs, we do not feel that the provisions of Section 22 of the bill as they relate to pathology services are either reasonable or fair. As we have said above, pathology services are unique in their remoteness from direct patient contact. We feel it is most unfair and frankly, just plain wrong, to limit reimbursement to pathologists to instances "only where the pathologist personally performs, acts or makes decisions with respect to a patient's diagnosis or treatment which required exercise of medical judgment". As we have said above, the scope and function of our professional services is for more pervasive and far less easy to categorize, in reality. We strongly maintain that compensation to the "Hospital-Associated"

pathologist must, in all cases, reflect the true extent of the *total* activities and services rendered by him, since, ultimately, his total effort enures to the benefit of the patient.

It is our belief that the adoption of Section 22 of S. 3205, as presently drawn, would not only be an injustice to those now practicing as "Hospital-Associated" pathologists, but, in the long run, would precipitate a drastic decline in the number of qualified physicians entering the specialty. The specialty requires an expertise acquired only after years of training and study. If an immutable and inequitable level of compensation is established and perpetuated by Federal Act, then prospective candidates for residencies in pathology are likely to pursue more lucrative specialties requiring no more training. Any depletion in the number of osteopathic pathologists now, or in the foreseeable future, would jeopardize the high quality of health care being delivered in osteopathic hospitals.

Recently, the American Osteopathic College of Pathologists queried 75 Pathology Department Chairmen about the type of compensation arrangement between the hospital and the pathologist being used by the institution involved. Of those responding, 52 percent are salaried employees of the hospital. The remaining three categories are as follows:

(a) Pathologists being compensated by percentage contract are 21.4 percent.

(b) Pathologists being compensated by a fee-for-service basis are 8 percent.

(c) Pathologists being compensated by a combination of the above methods are 18.6 percent.

The total average compensation received by a D.O. pathologist is approximately $78,000 per year.

For all the reasons we have recited, we respectfully request that this Committee consider an alternative approach to the language of Section 22 which will insure truly equitable reimbursement.

Your serious consideration of the issues we have raised herein will be most appreciated.

Very truly yours,

JOHN A. KLINE, D.O., *President.*

STATEMENT OF JOHN F. HORTY, PRESIDENT OF THE COUNCIL OF COMMUNITY HOSPITALS

This statement is made on behalf of the Council of Community Hospitals and is addressed solely to a discussion of Section 10 of S. 3205. We do not believe it necessary to burden the subcommittee with a personal appearance, and request that in lieu of such appearance, this statement be included in the printed record of the hearing.

The Council of Community Hospitals is an organization composed of large and small hospitals from all parts of the country. Our member hospitals are community hospitals. They provide hospital care to the communities in which they are located. To ensure that community hospitals are able to continue providing quality care to their patients, CCH assesses major Federal regulatory and legislative proposals that affect its members and expresses its independent views on such proposals.

I would like at the outset to commend Senator Talmadge and the other sponsors of S. 3205, as well as the staff of this subcommittee, for their willingness to tackle some of the most vexatious problems that have arisen in the Medicare and Medicaid programs. Congress has not addressed these problems in a comprehensive manner since 1972, when it enacted P.L. 92-603, and that Act left many of the most difficult questions open for subsequent solution. It is high time that the problem of Governmental payment for Medicare and Medicaid services provided by hospitals be readdressed. We welcome the opportunity to offer our thoughts on Section 10 of S. 3205.

Section 10 of S. 3205 would result in a major revision of the Medicare system for payments to hospitals. Yet, notwithstanding the broad scope of the proposed change, this revision would continue the central theme of the current system—that hospitals will be paid their "reasonable costs" for providing covered services. Before we take a further, and possibly irrevocable step down the reasonable cost road, I believe that it is time for a reexamination of the basic system. All too often once a basic system is adopted, we fail to reexamine the underlying premises upon which it is based. Instead, we tend to tinker with and build upon the preexisting system to patch up perceived shortcomings. However, in the case

of the Medicare and Medicaid reimbursement system, I believe that the problems are too fundamental and serious for a patch up job. Instead, I believe that we must reconsider the basic philosophy underlying the system. And, it is my view that such a reexamination must result in the conclusion that hospital payments by the Government for caring for Medicare and Medicaid patients no longer can be soundly based upon "reasonable costs".

The "reasonable cost" concept has proven to be unsatisfactory both to the Government and to hospitals. It has been tried and found wanting. It should be eliminated.

The Government seems to believe (erroneously, I must emphasize) that "reasonable cost" gives hospitals a blank check to spend whatever they want and provides no incentive for them to save money. At the same time, hospitals believe that "reasonable cost" prevents them from being fairly compensated for care to Medicare and Medicaid patients. It enables the Government to question each minute item of expenditure on the basis of standards unilaterally set by the Government long after the rendering of the service.

"Reasonable cost" carries with it an army of Federally employed and Federally activated accountants whose sole mandate is to save the Federal dollar without consideration of the effect on quality care or provision of service.

"Reasonable cost" contains no recognition of hospitals' need for discretionary funds and working capital and even the smallest expenditures are subject to retroactive review.

We conclude that the reasonable cost reimbursement system is resulting in the destruction of the managerial initiative that is essential if hospitals are to provide better and more sensitive core. It will result in a marked decline in the quality of care provided. We do not imply fault—Government and hospitals got into this fix together and they must get out together. But the system must be replaced—now.

I think it might be useful to set forth in some detail how hospitals have been affected by a system of compensation denominated "reasonable cost" but which is actually much less than reasonable and holds hospitals in a straight-jacket of financial instability.

1. What constitutes "reasonable" cost is not capable of definition. It is—like beauty—entirely in the eyes of the beholder. Consequently the concept of "reasonable cost" enables the administrative agency, HEW, in its own discretion and without effective legislative check or judicial review, to define what is reasonable and to vary that definition as it desires merely by publishing new or changed regulations.

This power has been abused by HEW, particularly in recent years under the pressure of its own economic difficulties. HEW has on numerous occasions restricted what is "reasonable," not because the service was unreasonable or unnecessary or because the cost of the service actually was unreasonable as a financial matter but only because the Government sought ways to reduce Federal expenditures for health care. The Government has transformed a system that was designed and intended to prevent hospitals from overcharging the Government into a mechanism for under-reimbursing them.

An effective health-care system cannot be operated under the gun of self-serving reimbursement decisions by HEW. A purchaser of hospital services (as the Government is on behalf of Medicare and Medicaid patients) cannot be permitted to "purchase" hospital services and unilaterally determine, after it has received the services, what it deigns to pay for them. It is "Alice in Wonderland" and it doesn't work.

2. The concept of "reasonable cost" requires review and audit of each of the many thousands of expenditures incurred by each of the thousands of participating hospitals. Hospitals are subject to burdensome, time-consuming, and expensive audits, which are expensive to both the hospital and the Government. Worse still, reimbursement decisions on these multitude of items are made by accountants and their bureaucratic superiors who have no expertise in hospital management and who consider their mandate to be only cost-cutting. This process has a deadly effect on patient care and on good management—the reverse of what is intended. It is no wonder that hospitals feel, as the Government reduces reimbursement on a multitude of services, that they are not so slowly being nibbled to death.

3. The effort of the Government to avoid these vast numbers of audits by classifying hospitals and pegging reimbursement (for routine services) to the

cost of the hospital at an arbitrarily selected percentile within the classification completely ignores the vast—and beneficial—diversity among hospitals and the services they provide, and erroneously assumes that a hospital whose costs are above the selected percentile is somehow inefficient. Further, the unilateral determination of the operative percentile confers upon the Government yet another tool to reduce reimbursement levels when it feels constrained.

Hospitals must have incentive, not "classification" and audit.

Classification is essentially an illogical process. It is fruitless to attempt to regiment all aspects of human behaviour. It is equally futile to try to categorize and regiment hospitals—which are made up of thousands of people interacting with each other and with numerous different extrinsic forces. The effort to keep up with the inevitable changes in each hospital will only lead to further classification in a vicious cycle of a never-ending search for conformity and fixedness that does not exist and would not be beneficial if it did.

4. The "reasonable cost" concept subjects hospitals to a process of review and second-guessing years after the services have been performed, and after the reimbursement has been approved and paid by the Government itself. The Government can demand that amounts paid in reimbursement be refunded by hospitals which acted entirely in good faith, on the theory that the services were unnecessary or the costs unreasonable. This is unfair.

5. The reasonable cost concept makes no allowance for the fact that even not-for-profit hospitals need a "profit" to provide them with working capital and discretionary funds. Even if such hospitals were fully reimbursed for the reasonable cost of caring for Federal beneficiaries, they would not have the money necessary to purchase even replacement equipment if they did not have other, non-Governmental sources of revenue. The problems created by the absence of provisions for a "profit" are exacerbated by the serious time lag between the time services are performed and hospitals are reimbursed for them by the Government—a time lag that increases (particularly with respect to state Medicaid payments) during periods of economic difficulty.

The reasonable cost concept has trapped hospitals on a treadmill of minutiae that the Government is turning ever more rapidly. Hospitals can never catch up. Under "reasonable cost," they can never obtain the financial stability necessary to provide effective and sensitive hospital care over the long term.

The Government is also dissatisfied with the reasonable cost system. Its main complaint is that the system encourages unbridled spending by hospitals. Regardless of the validity or invalidity of the Government's fear, its generally accepted belief is that the "reasonable cost" system somehow adds to cost.

Despite this apparent agreement on the part both of hospitals and the Government that reasonable cost is a barren approach, we continue to discuss payments to hospitals for care given beneficiaries of Federal programs as if reasonable cost reimbursement were the only possible system. We seek to cure the deficiencies of reasonable cost by tinkering with the system, when we should replace it. Adjustments to an unworkable system can only create an even more unworkable system. Concentrating energy and thought on making those adjustments, moreover, distracts us from considering the development of wholly new mechanisms.

The most recent effort to cure the problems caused by the reasonable cost system is the bill introduced by Senator Talmadge. This bill (S. 3205) is a comprehensive effort to resolve numerous problems in the administration of Medicare and Medicaid. As I have stressed previously, CCH commends and welcomes this attempted reform. But the reforms proposed by the bill are shaped and limited by being constructed on the reasonable cost system. They will not work, because the underlying system does not work. Despite the extensive effort and care that were expended in drafting it, the bill demonstrates the sterility of the reasonable cost system and the futility of seeking to cure it by adding further complexities to the system.

The bill does not resolve the problems of reasonable cost. The Government would still retain the power to determine unilaterally what is the reasonable cost. It would entail the same army of accountants to gauge the "reasonableness" of each item. Indeed, even more accountants, regulations and barren, stifling bureaucracy would be necessary under the bill because reimbursement would depend on complex indexing factors applied to the costs both of the classification and to each hospital within it.

We cannot fashion an acceptable system for compensating hospitals for services—one that is equitable to hospitals and satisfactory to the Government—if

we continue to focus only on reasonable cost. We must recognize that this system will not work. We must cease trying to fix it up. Government and hospitals must together develop a new mechanism.

The creative thinkers in Government and outside of it must work together to develop a new reimbursement system. In the present direction lies ruin. For all we are trying to do is tinker with a system the philosophical premise of which is no longer valid. And we must not institute a national health system without a workable system of payment.

S. 3205 presents a valuable opportunity to stimulate this effort. It can serve as a catalyst for a wide-ranging discussion of entirely new payment methods. If we do not seize the opportunity, consideration of the bill will result in a dreary debate of fringe details and if enacted the resulting regulation will only increase the frustrations of the Government, the field, and the public.

In danger there is also opportunity. We must search for and develop a system for compensating hospitals for care that (1) emphasizes local control and interest, (2) enhances management motivation and discretion and permits management to concentrate on the real problems they confront rather than being forced constantly to react to Governmentally created strictures on how hospital care should be provided, and (3) recognizes the right of not-for-profit (as well as profit-making) hospitals to earn a "profit" that can be ploughed unrestrictively back into the endeavor to provide innovative and better services for the community the hospital serves.

We must *develop* health care institutions, not just "control" them!

STATEMENT OF PHILIP L. TOIA, COMMISSIONER, NEW YORK STATE DEPARTMENT OF SOCIAL SERVICES

The need to reform the administration of the Medicare and Medicaid programs is obvious, unquestioned by most, and strongly supported by the State of New York. This bill displaces much evidence of a thoughtful design to provide this urgently needed reform. However, analysis of the bill, with all of its positives, leaves several overriding and pervasive concerns which transcend other issues.

First we are concerned with the loss of State administrative and cost control of the Medicaid program. In our Federal system, such control is essential as long as the State and its localities are expected to fund half the cost of the program, and are legally responsible for its operation.

Second, and of paramount concern, is the fact that enactment and implementation of the provisions of this bill would result in substantially increased costs to the State and its localities. This comes a a time when we are making significant efforts to contain costs. This year, State legislation was passed (Chapter 76 of the Laws of 1976) to control the ever rising Medicaid expenditures without reducing eligibility standards and without denying vital health services to those people in need of them.

The point is that States, as well as local communities, have reached the limits of their resources, even for well-intentioned programs which promise to eventually save money.

Therefore, while we strongly support the intent of this bill, we cannot support it in its entirety as written. The following are our reactions to those sections of the bill of specific concern to us:

SECTION 2—ESTABLISHMENT OF HEALTH CARE FINANCING ADMINISTRATION

The consolidation of the Medical Services Administration, Bureau of Health Insurance, Office of Nursing Home Affairs, and Bureau of Quality Assurance into a single administrative unit offers the promise of improving coordination of policy development and simplifying Federal directives to the states.

SECTION 3—INSPECTOR GENERAL FOR HEALTH ADMINISTRATION

The overall effectiveness of the office of Inspector General is limited by the heavy emphasis on program review and by the lack of authority to carry findings and allegations through criminal and civil prosecution.

We believe this section would be strengthened by the adoption of the following amendments:

(1) Amend to place responsibility in the Inspector General for the complete fraud and abuse investigation and prosecution process and to delete the responsibilities for program review and evaluation described in Section 1124, (c), (1), and (2).

(2) Amend Section 1903(a) by adding sub-section (7) to allow 100 percent federal matching for professional medical fraud and abuse Medicaid staff employed by the State to implement the provisions of Section 1909 of the Act.

(3) Delete Section 1124(c)(2) which *requires* the Inspector General to conduct investigative studies for, and/or to provide information to, certain Congressional committees.

SECTION 4—STATE MEDICAID ADMINISTRATION

The performance criteria, reporting requirements, and penalties specified in this section in relation to eligibility determination and redetermination, claims processing, and specific data required are unrealistic and inequitabe for states with large urban population centers. We, in New York State, are currently in the process of implementing a Medicaid Management Information System (MMIS) and Welfare Management System (WMS) which, when fully operational in 1980, would meet these specifications. However, without extremely costly (if not impossible) interim changes, we would not meet the implementation deadline of October 1977. Thus, New York could be subject to the loss of all Federal reimbursement for administrative costs—approximately $104 million in fiscal year 1977–78 and a similar amount in the next fiscal year. We therefore, oppose this section in its entirety and respectfully recommend:

1. Maintaining current time frames for determining eligibility (i.e., 45 days) and redetermination of eligibility (i.e., annually).
2. Establishing a normative standard error rate based on a weighted average, rather than that rate which equals the 50th percentile of the rates reported by all states.
3. The bill be modified to accommodate those states which do not have an MMIS by providing different effective dates related to where the states are in the development of such a system at the time legislation is passed.
4. Adding a provision for 100% federal funding for both the development and implementation of an MMIS.

SECTION 6—CLAIMS PROCESSING AND INFORMATION RETRIEVAL SYSTEMS FOR MEDICAL PROGRAMS

The implications of this provision on New York State's MMIS effort are significant.

In order to receive 90% FFP for design and development, the State would have to assure that its system could be integrated with those used by the Medicare intermediaries. Since current Title XVIII systems are not compatible among the various Medicare carriers, it would be impossible to meet this requirement. Thus, the 90% FFP would be jeopardized and the MMIS implementation delayed.

SECTION 10—IMPROVED METHODS FOR DETERMINING REASONABLE COSTS OF SERVICES PROVIDED BY HOSPITALS

The classification of hospitals into nationwide groups presupposes a transfer of responsibilities in the reimbursement area from the states to the Federal government with no allowance for input by states in the process. States could not handle the number of appeals from their hospitals under such a national grouping system, and no provision is made for grouping by type of ownership (public, nonprofit, proprietary).

As proposed, it is expected that all proprietary facilities would receive incentives based exclusively on a cost comparison. The 120% ceiling over a target rate is not productive but will be necessary because of the broad classifications and scope of activity included. The target rate will underpay about half the hospitals in a rate year with full cost reimbursement following at the end of the year. Appeals should be expected from 50% of the hospitals nationwide.

We do not support this provision since we do not think it can be administered and supervised nationally, and is several years behind the current State system

SECTION 12—RETURN ON EQUITY TO BE INCLUDED IN DETERMINING "REASONABLE COST" OF SERVICES FURNISHED BY PROPRIETARY HOSPITALS

The basis underlying an increase in return on equity for proprietary facilities is not clear. If the increase is designed to encourage investment of private capital in certain areas of the country, it will not be needed in states where expansion of proprietary facilities is not needed. If the increase is exclusively related to economic factors and elements of risk, the concept might be appropriate. Reviews by the New York State Moreland Act Commission have determined the current rate of return for proprietary facilities in this State to be adequate under its capital cost reimbursement system.

Further clarification of the need for this provision is needed.

SECTION 20—CRITERIA FOR DETERMINING REASONABLE CHARGE FOR PHYSICIANS' SERVICES

The Medicare method for determination of reasonable charges allows physicians to inflate their fees to serve as justification for a subsequent increase in the prevailing charges. The economic index is applicable only to the 75th percentile maximum allowable charge. Any physician below that could receive, in the subsequent year, the current 75th percentile plus any increase due to the economic index (affected by voluntary raising of fees). This system is highly inflationary.

Limitation on reimbursement for medical services, supplies, and equipment is applicable only to physicians and should be extended to institutional providers where the dollar impact would be significant.

Reimbursement for new doctors in physician shortage areas will be allowed at the 75th percentile (up from the 50th percentile). We believe this will not be sufficient incentive to solve the problem in areas where factors such as lack of cultural and social facilities, minimal professional contacts, and poor economic environment apply. The 75th percentile in a remote rural area may not be any greater than the 50th percentile in an over-supplied non-inner city urban area.

SECTION 22—HOSPITAL ASSOCIATED PHYSICIANS

We support this section as writtten. It would eliminate lucrative arrangements bordering on abuse where some scarce hospital-based physicians (e.g. radiologists, pathologists, anesthesiologists) have taken economic advantage of the hospital's need for their services as a specialist in short supply.

SECTION 23—PAYMENT FOR PHYSICIANS' SERVICES UNDER MEDICAID

This section, which requires Medicaid to pay not less than 80% of the Medicare reasonable charge for non-surgical care provided by physicians outside of a hospital, effective July 1, 1977, would limit the State's flexibility in rate setting and result in an estimated additional State/local expenditure of $28 million annually.

SECTION 30—REIMBURSEMENT RATES UNDER MEDICAID FOR SKILLED NURSING AND INTERMEDIATE CARE FACILITIES

Since this section allows states at their option, to include a "reasonable profit" for skilled nursing homes and intermediate care facilities under the Medicaid Program, we support its enactment.

SECTION 31—MEDICAID CERTIFICATION AND APPROVAL OF SKILLED NURSING FACILITIES

The procedure provided for in this section is already in practice. The State's authority for certifying Medicaid-only skilled nursing facilities rests with the Secretary's approval. Medicaid waiver authority is vested in the Secretary now, and time limits for agreements have always been predicated on compliance with standards or acceptable plans of correction. This is the same process which holds for Medicare certification.

As this section affects compatible procedures for both Titles XVIII and XIX, especially for decertification actions, we support it as writtten.

SECTION 32—CRITERIA UNDER MEDICAID PROGRAM FOR DETERMINING REASONABLE VALUE OF CERTAIN TRANSFERRED FACILITIES

This section would require conformity between Medicare and Medicaid with respect to sales or transfers. Each state has different problems, and various solutions are needed within general Federal legal or regulatory parameters.

States should be given the option to develop their own methodology in this area as long as the State method conforms to the general "reasonable cost" requirement.

SECTION 33—VISITS AWAY FROM INSTITUTIONS BY PATIENTS OF SKILLED NURSING OR INTERMEDIATE CARE FACILITIES

Visits away from Skilled Nursing Facilities and Intermediate Care Facilities should not be used as indicators that patients are not in need of services since some institutions (particularly mental retardation facilities), promote such visits as a key factor in the "normalization" process.

We support this section as long as a patient's medical record is the determining factor in establishing eligibility for Medicaid.

SECTION 40—PROCEDURES FOR DETERMINING REASONABLE COST AND REASONABLE CHARGE, DISCLOSURE OF OWNERSHIP AND FINANCIAL INFORMATION

We support the procedure which would be established by this section for determining reasonable cost and reasonable charge, disclosure of ownership and financial information. In those instances where state monitoring of contracts is Federally supported under a state agreement with the Secretary, such activity should be limited to the manpower capability of the state agency.

SECTION 41—STANDARDS FOR PAYMENTS UNDER MEDICAID TO HEALTH MAINTENANCE ORGANIZATIONS

While this section is designed to alleviate the problems of inflated premiums which have occurred in the past, tying Medicaid reimbursement mechanisms to Medicare may not be the most effective means of achieving this goal. HMO's may enter into a reasonable cost reimbursement contract in which payments made to the HMO would be subject to suitable retroactive corrective adjustments at the end of each contract year so as to assure that the organization is paid for reasonable cost actually incurred. This provision is not appropriate as HMO's exercising this option would not have the opportunity to profit or be at risk, thereby reducing the incentive to reduce expenditures.

We oppose this section and recommend Federal guidelines for Medicare and Medicaid providing flexible standards which allow for capitation rates subject to negotiations to provide an incentive to the HMO for containing costs. Such rates would, of course, have to be equal to or less than the cost of providing comparable services under a fee for service arrangement.

SECTION 42—AMBULANCE SERVICE

We cannot support this section since it does little to solve ambulance emergency care problems. There is no distinction made between emergency and non-emergency ambulance use. There are no provisions for a responsible authority to determine the adequacy of a hospital's equipment and staff to service a patient, merely the hospital's self-assessment and geographic proximity to the patient.

Where state hospital certification of appropriate emergency care is available, by condition, these certifications should be provided to ambulance companies and be included as another factor in the choice of nearest hospital for an emergency care patient. Where ambulance service is for non-emergency transport to a hospital, the patient's choice, if any, should also receive consideration.

SECTION 44—RESOURCES OF MEDICAID APPLICANT TO INCLUDE CERTAIN PROPERTY PREVIOUSLY DISPOSED OF TO APPLICANTS RELATIVE FOR LESS THAN MARKET VALUE

We support the amendment to mandate that the market value of a Medicaid applicant's property be counted as a resource if the property was disposed of within a year to a relative for less than market value.

SECTION 45—PENALTY FOR DEFRAUDING MEDICAID PROGRAMS

We support the amendment to change the charge for defrauding Medicare and Medicaid to a felony and increase the penalty to include the possibility of imprisonment up to two years.

CONCLUDING STATEMENT

In conclusion, I would like to reiterate New York's support for constructive reform of the Medicare and Medicaid programs. We believe this reform is necessary and capable of being achieved in an equitable manner.

In specific reference to this bill or any related reform measures, we respectfully recommend that Congress make provision for 100% Federal funding for the development, implementation and maintenance of:

State Medicaid Management Information Systems.

Fraud and Abuse Units with investigatory staff and legal staff for prosecution.

Both efforts have the potential for expeditiously achieving several of the major objectives of the Medicare-Medicaid Administrative and Reimbursement Reform Act.

Thank you for the opportunity of commenting on this bill and be assured of our interest in any revisions and the course of the bill in Congress. We will be glad to provide any additional information which you think may be helpful.

STATEMENT OF THE AMERICAN SPEECH AND HEARING ASSOCIATION

The 24,000 members of the American Speech and Hearing Association—speech pathologists and audiologists—serve the nation's more than 20 million communicatively handicapped.

The Association fully endorses S. 3205, the Medicare and Medicaid Administrative and Reimbursement Reform Act and its objective: to stem the tide of federally supported health care costs by eliminating administrative waste and abuse rather than by curtailing coverage of essential services.

Because the twenty million Americans with either hearing deficits or speech impairments cannot afford any retraction in the federal government's commitment to them, this Association commends Senator Talmadge on his efforts evidenced in S. 3205, and the manifestation of support which the Subcommittee has lent the legislation in holding a full week of hearings.

This statement will address two points which we feel are worthy of consideration in connection with S. 3205.

One of the most pervasive cases of overutilization in the health care delivery system has been programmatic overreliance on the physician as overseer of all aspects of health care. While this is certainly necessary and justified in the lesser skilled "aide" categories, such as paramedics and physicians' assistants, there can be no justification in the case of master's level trained, nationally certified and state licensed professionals [cf the Medicare definition of speech pathologist or audiologist, section 405.1101(t)], such as audiologists and speech pathologists.

In fact, requiring physician prescription and patient plan formulation and review for speech pathology services under Medicare came about by accident. Congress, most appropriately, extended Medicare coverage for speech pathology services rendered in outpatient settings such as freestanding speech and hearing clinics, rehabilitation centers and public health agencies in 1972. But, in end-of-the-session haste to achieve its passage, conference committee drafters merely analogized the provision of speech services to physical therapy services [Section 1861(p) of the Social Security]. The unfortunate—and unintended—result is that the law requires a great deal more than what in reality is necessary: a physician must prescribe a plan of treatment, detailing amount, duration and scope and must recertify the need for treatment and the plan every thirty days. Not only does this requirement for federal reimbursement ignore the traditional physician-speech pathologist relationship, long accepted by both professions, but it costs the communicatively handicapped, Medicare, and, ultimately, the American taxpayer needless millions in physicians' charges.

The Senate has already recognized this as an oversight:

The provision in Public Law 92-603 unintentionally penalized the speech pathologist. By incorporating through reference certain requirements applicable

to physical therapy, the provision seemed to require that there must be not only a physician's referral but also a specific physician's plan detailing the amount, duration and scope of services to be provided by the speech pathologist. Since speech pathology involves highly specialized knowledge and training, physicians generally do not go into this type of detail when referring a patient for these services. [S. Rept. 93–553, page 66, referring to H.R. 3153.] and amended the House bill to eliminate the physician-prescription requirement. The House, however, did not accept the Senate amendments, and the amendments died in conference.

Far from increasing the costs of the Medicare program, such a clarification would reduce the costs of the program by eliminating unnecessary physician billings. Requiring physician prescription and certification escalates the costs to Medicare in much the same way that Medicare requirements for hospitalization trigger a benefit period increase in costs where such care is not necessary. Ending the physician prescription requirement for speech pathology services is truly a measure which addresses "overutilization" at a basic conceptual level.

Reform of the Medicaid-Medicare system should be just that: putting an end to programmatic weaknesses which give rise to provider abuses. The American Speech and Hearing Association can do and has done more than merely applaud federal efforts in this regard; it has one of the most active and highly effective professional ethics programs of any association. In the last ten years, the Association's Ethical Practice Board has formally handled and resolved 941 cases—the overwhelming majority of which were requests for guidance from conscientious members in interpreting the widely disseminated and enforced Code of Ethics. The Association is extremely proud that its members seek the advice of the Ethical Practice Board, since this evidences the high degree of professionalism and voluntary compliance with the Code, regarded as a model by other professions. The Association firmly believes that licensure by the states of health professions—where such laws establish high educational and examination standards and hold licensees accountable for ethical violation—also furthers the objective of professional responsibility.

Through complaints by its members, ASHA is becoming increasingly alarmed at institutional overcharges to Medicare for speech and hearing services provided on a part-time or intermittent basis. Institutional middlemen are not only skimming the cream off the top but taking most of the milk, too. Under current regulations, institutional providers may bill Medicare for therapists' services provided on a part-time basis at the per-hour rate that it would pay for a full-time employee, plus overhead. For part-time services less than 15 hours per week, the institution may bill Medicare the reasonable going rate. The result is that Medicare is paying the same unit charge for therapy services whether or not the institution employs a therapist full-time or part-time. But the therapist working part-time is in many cases getting only a usurious fraction of the amount Medicare is being billed. One case reported to our office was of a hospital billing Medicare $20 per hour, while paying the speech pathologist $3 per hour. In this situation, everyone—except the institution—loses: Medicare is paying for institutional costs unrelated to the provision of services for which it is being billed; providers are being paid no more than minimum wage with no recourse but to go on the unemployment rolls; and, worst of all, Medicare recipients are receiving services from providers least abie to succeed in a competitive job market, while their billings reflect the highest level of care. While this situation could be addressed by yet another technical rule-making, the proliferations of which are themselves adding to the crippling costs of health care, there is a more direct and more effective way: allowing audiologists and speech pathologists to receive direct reimbursement for their services by recognizing those in private practice as qualified Medicare providers, commensurate with their level of training and expertise.

National Health Insurance is just around the corner. Members of this Subcommittee, especially, and Senator Talmadge, preeminently, recognize that we must put our house in order for its coming. We must correct past mistakes before they are concretized into a federal commitment for all time. For this reason, it is essential at this time to correct existing programs' oversights and to tighten up past laxity in their drafting and administration.

Therefore, the American Speech and Hearing Association, in addition to hailing Senator Talmadge, his cosponsors and members of the Subcommittee for their foresight in drafting and considering S. 3205, respectfully request consideration of these three points:

1. Recognition of speech pathologists and audiologists in private practice as qualified Medicare providers whose services are directly reimbursable.
2. Clarification of section 1861(p) to eliminate the need for physician prescription and patient-plan monitoring for speech pathology services.
3. Supporting state licensure of allied health professions as the most expeditious and constitutional means of assuring quality and accountability in the provision of health care services.

While the American Speech and Hearing Association could request much more in the way of expanded coverage of speech and hearing services: coverage of hearing aids and related habilitation under Medicare, mandating inclusion of speech and hearing services under Medicaid, it has made its comments in line with the tone the Subcommittee has set—realism. These three propositions are purely technical. Implementation of them would not only not add a penny to the costs of the programs, but would enhance the bill's aim of eliminating provider abuse.

Thank you for the opportunity you have provided the Association to comment on a fine piece of legislation.

STATEMENT OF THE AMERICAN PHYSICAL THERAPY ASSOCIATION

The American Physical Therapy Association ("APTA") is an association composed of approximately 21,000 physical therapists who are licensed to practice physical therapy in their respective states and as such is the largest association of physical therapists in the United States. APTA has long had a deep and active interest in the development and maintenance of fair and efficient administrative and reimbursement practices in the Medicare program. Its experience with Medicare causes APTA to fully endorse Senator Talmadge's conclusion that Medicare must be made "more efficient and economical." APTA applauds the Senator's decision to do more than restate the normal cost control methods such as curbing abuses and minimizing waste by incorporating in S. 3205 incentives which will encourage better use of available resources by rewarding health care institutions which improve their efficiency in the delivery of services to Medicare beneficiaries. APTA believes that administrative and reimbursement reforms of this genre are necessary to preserve the viability of the health care industry as a whole and to ensure continued efficient delivery of quality health care services.

In addition to these general concerns, APTA is, of course, particularly interested in the method of reimbursement for physical therapists under Medicare. The purpose of this statement, therefore, is twofold. First, APTA seeks to make known its position that the current method of making payments to providers for the reasonable cost of physical therapy services should be supplemented by a method of recognizing and encouraging improved productivity and efficiency in the delivery of physical therapy services in contract settings. This approach would ensure a more economical use of Medicare resources and minimize waste while at the same time guaranteeing equitable compensation for independent practioners of physical therapy. Second, APTA wants to express its deep-seated opposition to § 40 of S. 3205 which requires advance approval by the Secretary of Health, Education, and Welfare of most service contracts including agreements to furnish physical therapy services. This provision is unnecessary, represents a totally unjustified intervention into the administration and operation of providers, and subjects both independent contractors of physical therapy and providers to conflicting and confusing cost control mechanisms.

I. THE NEED TO RECOGNIZE THE PRODUCTIVITY OF INDEPENDENT PRACTITIONERS OF PHYSICAL THERAPY

The prevailing mechanism for reimbursing providers for the reasonable cost of physical therapy services furnished under arrangement is the salary equivalence standard which was established by Congress in 1972 when it passed Pub. L. No. 92-603. The salary equivalence standard limits payment for physical therapy services furnished under arrangement to Medicare bneficiaries to an amount which does not "exceed an amount equal to the salary which would reasonably have been paid for such services" if they had been performed in an employment relationship with the provider. The Bureau of Health Insurance's regulation which implements this provision includes a Schedule of Guidelines for Physical Therapy Services Furnished Under Arrangement which sets out hourly "salary equivalence amounts" for each state.

APTA is well-acquainted with salary equivalency because over the last four years it has worked extensively with BHI to ensure that reimbursement based on that standard is both fair and efficient. More importantly, many of its members who are independent physical therapists have been subject to the salary equivalence standard for over a year. It should be noted that although the 1972 statute requires that the reasonable cost of all types of therapy services be evaluated on the basis of salary equivalency, physical therapists are the only health practitioner group for whom the standard has been fully implemented.

APTA's experience with the salary equivalence standard has not shown that it is generally ineffective or unworkable. It has indicated, however, that there is substantial room for further reducing waste and improving efficiency in the delivery of physical therapy services to Medicare beneficiaries. Specifically, the salary equivalence standard does not encourage the optimum use of scarce health care resources because it is not able to recognize or compensate physical therapists for improved productivity and efficiency in the delivery of their services in contract settings. The principal deficiency in the salary equivalence standard is that because it is predicated on inflexible hourly salary rates all physical therapists in a given state are reimbursed at the same basic rate regardless of how efficient or productive they may be in furnishing their services. Where then, is the incentive to work harder, to be more efficient, and to optimally utilize available resources? The fact is that salary equivalency provides none. At a time when Medicare costs are escalating so rapidly, APTA sees no reason why this situation should persist.

What is vitally needed is a means of recognizing and compensating improved productivity and efficiency in the delivery of physical therapy services under the Medicare program. A reasonable approach and one that is fully supported by APTA, is contained in S. 3611 which was introduced by Senator Robert Dole on June 23, 1976 and which is now pending before the Senate Finance Committee. This proposal provides an alternative to the salary equivalence standard by permitting physical therapy services furnished under arrangement to be made on the basis of the professional personnel cost per patient visit for physical therapy services furnished in a comparable employment setting. As Senator Dole explained in his introductory remarks, the " 'professional personnel cost' per patient visit is simply the cost to the provider for the salary of physical therapists and physical therapists' assistants over a particular period of time, divided by the number of patient visits or the same period." Under his proposal, such cost "would represent the maximum amount that could be paid to physical therapists or each patient visit performed under arrangement in comparable employment settings."

The uniqueness and simplicity of S. 3611 is that it avoids the strict use of hourly salary rates and predicates reimbursement on the cost of physical therapy services per patient visit—a criteria which allows productivity and efficiency to be taken into account. Thus, under the proposed alternative, an independent physical therapists who works harder and performs more authorized patient visits—*i.e.*, is more productive—would be eligible for greater reimbursement than a physical therapist who was less efficient.

S. 3611 also strikes a delicate balance between creating a much-needed incentive for more efficient service and opening the door for abuse of the Medicare program. Senator Dole curbs the potential for abuse of his proposal by limiting the use of the professional personnel cost alternative to only those situations where the physical therapist treats patients individually. Further, he expects ongoing reviews of physical therapists to be conducted by Professional Standards Review Organizations, or where they are not fully implemented and operative, by physical therapy auditors or utilization review committees. He also made it clear that HEW is to implement the proposal in such a manner that will "insure that each patient visit is necessary and is performed in accordance with the highest professional standards."

In sum, Senator Dole's proposal is an important step toward improving the efficiency with which health care services are delivered to Medicare beneficiaries. For this reason, APTA believes that S. 3611 is a valuable and wholly compatible adjunct to S. 3205.

II. APTA'S OBJECTIONS TO § 40 OF S. 3205

Althodgh APTA generally supports S. 4205, it vigorously opposes §40 of the proposal. Section 40(a) provides that reimbursement to contractors, presum-

ably including independent contractors of physical therapy, would not be recognized where compensation or payments are based upon percentage arrangements. The percentage prohibition would operate in both directions—either from the contractor to the provider or from the provider to the contractor.

Section 40(b) provides that the Secretary of Health, Education and Welfare must review and give prior approval to any service contract which constitutes an element of cost of any health service for which payment is authorized under Medicare and which involves payments "with respect to any consecutive period of twelve months which aggregate $10,000 or more." Thus under the terms of this provision, each time an independent practitioner of physical therapy seeks to enter into a contractual arrangement with a provider to furnish physical therapy services the value of which exceeds $10,000 (as it often does), prior review and approval must be given by the Secretary. For the reasons set out below, APTA recommends that §40 be deleted from S. 3205 or, in the alternative, tailored to exclude physical therapy services furnished pursuant to arrangement with providers.

First, §40 is unnecessary and, if adopted, would subject independent contractors of physical therapy services and contracting hospitals to several duplicative and conflicting cost-control requirements. Such a situation could only result in additional unjustified administrative costs for the independent contractor and provider alike, frustrate efficient and long-range planning for physical therapy departments and inject deleterious uncertainty into the entire reimbursement process.

As described in detail above, the reasonable and hence reimbursable cost of physical therapy services furnished under arrangement is limited to amounts determined pursuant to the salary equivalence standard. Salary-equivalency is now in full force and effect and is the primary basis for evaluating the reasonableness of reimbursement amounts under contracts for physical therapy services. Despite the rigid limitations imposed by the salary equivalence standard, § 40 seeks to impose what APTA considers to be a wholly unnecessary requirement that the Secretary give prior approval to physical therapy service contracts.

The need for § 40 of the bill is also obviated by § 10 of S. 3205—a provision which predicates a hospital's reimbursement amount on its total operating cost. Section 10 sets a per diem target rate for hospitals for routine operating costs. Hospitals are encouraged to maintain their actual per diem routine operating costs below their respective target levels because they receive as an incentive one-half of the difference between their actual cost and their assigned target rates up to 5% of the target levels. Hospitals whose actual costs do not exceed their target rates by more than 20% are paid their actual costs. Hospitals whose actual costs are greater than 120% of their target rates are reimbursed only to the extent of 120% of the target rate. Thus, by its system of bonus payments to those facilities who successfully control their operating costs, hospitals are compelled to negotiate contracts which are as cost-conscious as possible. APTA submits that this pressure in itself is sufficient to insure that physical therapy service contracts are reasonable and that therefore there is no need for the type of line-by-line budget review called for in § 40.

Second, § 40 represents an unjustified governmental intrusion into the management, administration and operation of hospitals. Congress recognized the necessity of preserving the ability of providers of service to manage their own businesses when it enacted § 1395 of the Medicare Act which provides that:

"Nothing in this subchapter shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any institution, agency or person." 42 U.S.C. § 1395.

Section 40, by denying reimbursement for all percentage-based contracts and requiring advance approval of most other service contracts, is certainly an exercise of "supervision or control over the administration or operation" of hospitals. As previously explained, there is no countervailing justification for such intervention because § 40 is not needed as a cost or abuse control measure.

Finally, § 40 contravenes the express purpose of S. 3205 to promote greater efficiency and economy in the delivery of quality patient care. The ultimate effect of

the contract review process proposed in that section will be to precipitate costly delays in the provision of needed services, preclude efficient and orderly hospital administration and planning, and to necessitate the expenditure of scarce health dollars to comply with diverse and duplicative review requirements. APTA suggests that the spectre of a hospital's entire administration collapsing while the inherently cumbersome bureaucracy of HEW reviews the numerous types of service contracts into which all hospitals must enter is not illusory.

It is also APTA's belief that the criteria specified in § 40(b)(2) which the Secretary is required to utilize in determining whether to grant approval of a service contract are particularly inappropriate for such a task and require intrusions into the administration and operation of a provider which can only be considered to be completely unjustified. For instance, the Secretary may give advance approval to a service contract "only if . . . the services to be furnished thereunder are found to be services which may appropriately be furnished on a contract basis." Since the bill provides absolutely no guidelines as to what types of services would be considered to be appropriately furnished pursuant to contract, § 40 leaves the door open for the Secretary to make completely arbitrary decisions with respect to whole types of services. There has been some evidence over the past few years that HEW has been actively encouraging providers of services to refrain from contracting with independent practitioners of physical therapy and instead to hire physical therapists as members of their staff. APTA submits that the unbounded flexibility which this criteria vests in the Secretary will provide HEW with exactly the vehicle which it needs to eradicate the furnishing of physical therapy services by independent contractors.

With the exception of § 40 of the proposal which APTA strenuously urges to be deleted, APTA believes that Senator Talmadge's proposal is a decisive and significant approach to controlling runaway Medicare and Medicaid costs. Further, APTA commends Senator Dole for his proposal and draws it to the attention of this Subcommittee as a measure eminently compatible with S. 3205 and which would aid that proposal in initiating much needed efficiency in the delivery of health care services under the Medicare program.

Statement of the American Society of Internal Medicine

Section 2. Establishment of Health Care Financing Administration

The American Society of Internal Medicine (ASIM) supports the establishment of a Health Care Financing Administration as an interim step in reorganization of the administrative agencies for federal health programs. Such reorganization should result in greater administrative efficiency and better enable the public, physicians and the Congress to identify the accountable unit.

The major deficiency of this proposal is that responsibilities for financing and health services will still be divided. In the past many administrative decisions based on financial considerations have compromised the quality of health services. We strongly recommend that the bill be amended to specify that the Assistant Secretary for Health Care Financing be a physician. This should ensure that decisions due to financial considerations are not made in a vacuum without regard for quality.

ASIM believes the optimal administrative structure should be designated to consolidate all federal health programs to allow better coordination such as the establishment of a separate cabinet-level department of health.

Section 3. Inspector General for Health Administration

ASIM concurs that fraud and abuse must be eliminated from federal and other health programs. However, the authority proposed for the Inspector General seems dangerously broad and we suggest three minor modifications which should not restrict the ability of the Inspector General to carry out his assignments.

First, the apparent blanket access afforded to the Inspector General to all DHEW reports, audits, documents, etc., necessary to discharge his responsibilities should be modified to assure confidentiality and to require adherence to the confidentiality requirements of the affected federal programs.

Second, the subparagraph providing the Inspector General with $100,000 "bag money" should be deleted. It should not be necessary for the Inspector General to engage in clandestine activities.

Lastly, because one of the apparent purposes of the Inspector General and the Office of Central Fraud and Abuse is to control program costs, the Inspector General should be required annually to report the cost effectiveness of his activities.

SECTION 7. REGULATIONS OF THE SECRETARY; SAVINGS PROVISIONS

ASIM supports this provision which would prevent a proposed rule or regulation from becoming affective in less than 60 days following publication in the *Federal Register* unless it states that prompt promulgation is urgent. However, any stated need for prompt promulgation should be supported by fact.

SECTION 8. TERMINATION OF THE HEALTH INSURANCE BENEFITS ADVISORY COUNCIL

The stated reason for discontinuing the Health Insurance Benefits Advisory Council (HIBAC) is that it is no longer significant in policy development for Medicare and Medicaid. What has not been stated is that the reason HIBAC has not recently played a significant role is that it has been denied the opportunity to do so. Initially HIBAC served as a value advisory group. But as the programs evolved, bureaucratic policy direction appears to have replaced outside advisement. Non-governmental input into federal policy making is an integral part of our democratic process and we strongly recommend that HIBAC be continued and assigned a meaningful advisory function.

SECTION 20. CRITERIA FOR DETERMINING REASONABLE CHARGE FOR PHYSICIANS SERVICES

Because much of this section is a restatement of existing legislation governing the determination of prevailing charge levels, we believe it is appropriate to again express ASIM's opposition to the inadequate reimbursement to patients for physicians' services. The intent of the original Medicare legislation was to reimburse beneficiaries based on the usual, customary and reasonable (UCR) concept. Subsequent amendments and regulations eroded and distorted the original UCR concept and have caused a widening disparity between program reimbursement and physician charges. This accounts for most of the increased out-of-pocket expenditures by beneficiaries and the declining rate of assignment acceptance by physicians.

Imposition of the state-wide prevailing charge levels called for in this section may further increase this disparity. While ASIM concurs with the goal of attracting more physicians into rural areas, it does not believe restricting reimbursement differentials between patients of urban and rural physicians in this manner will accomplish the intended goal. A more obvious effect is likely to be a curtailment of patient reimbursement for the services of urban physicians rather than a positive economic incentive for rural physicians. ASIM recommends that this provision be deleted or at least amended to include authorization for exceptions in instances where large differentials appear warranted because of high overhead expenses in urban areas.

SECTION 21. AGREEMENT OF PHYSICIANS TO ACCEPT ASSIGNMENT OF CLAIMS

ASIM strongly supports the retention of the individual patient assignment option. We are *adamantly opposed* to the creation of two classes of physicians under Medicare—"participating physicians" (those agreeing to accept assignment on all Medicare patients) and "non-participating physicians" (those not permitted to accept assignment on any Medicare patients).

It has been a tradition of medicine to treat patients individually, and to seek reimbursement according to their ability to pay. The individual patient assignment option has allowed continuation of this tradition for Medicare patients. Because of the increasing disparity between program reimbursement and the actual charges, the majority of primary care physicians would be forced to assume a non-participating status, thereby denying them the opportunity of assisting poorer patients by accepting assignments. This would make access to care more difficult for poorer patients.

The proposed provision would allow participating physicians to bill on a multiple-listing basis, would pay 50% of those bills within five days and would

provide a $1-per-patient "administrative cost-savings allowance." ASIM believes these would not be sufficient incentives to override concern with low program reimbursement or to induce physicians to forfeit their freedom to bill directly. While the ideas of multiple-listing billing and more rapid payment are commendable, they should be accomplished without requiring physicians to accept assignment on all patients. The $1 cost-savings allowance is arbitrary and its effect would vary from physician to physician. For example, physicians who see fewer patients will find the $1 less of an incentive. And, for physicians providing more comprehensive services, this amount is insignificant when compared with the differential in reimbursement between accepting and not accepting assignment. What adoption of this provision will probably do is encourage low quality, frequent return type practices specializing in Medicare patients in order to capitalize on the $1-per-patient incentive. Although a very small minority of physicians are likely to be involved in such practices, the result could be inferior care to a significant number of Medicare patients.

SECTION 22. HOSPITAL-ASSOCIATED PHYSICIANS

This section, although titled "Hospital-Associated Physicians" would establish a new legislative criteria for defining all reimbursable physician services under the Medicare program. The new definition of "physician services" would exclude services performed as an educator, an executive or a researcher, and would exclude any patient care service unless such service was (1) personally performed or personally directed by a physician for the benefit of such patient and (2) is of such a nature that the performance by a physician is customary and appropriate.

ASIM objects to this definition of what constitutes physician services. Physicians should be reimbursed under Medicare for services which are recognized as appropriate medical practice within their state. The proposed definition is vague and could be subjected to varying regulatory interpretation. Because of its vagueness, it could be interpreted in ways that would further limit services reimbursable under Medicare.

SECTION 25. PAYMENT UNDER MEDICARE OF CERTAIN PHYSICIANS' FEES ON ACCOUNT OF SERVICES FURNISHED TO A DECEASED INDIVIDUAL

ASIM supports this provision to provide greater flexibility for survivors of *deceased beneficiaries in obtaining payment for services rendered to the* beneficiary.

SECTION 26. PROHIBITION AGAINST ASSIGNMENT BY PHYSICIANS AND OTHERS

This section would limit the circumstances under which payment for services could be assigned to a third party (agent). Such assignments could only occur pursuant to an agreement with an agent under which the compensation to be paid to the agent was not dependent either upon the amount of billing in payment, or upon the actual collection of any such payment. ASIM recommends that this section be deleted since it interferes with the contractual rights of individuals.

SECTION 33. VISITS AWAY FROM INSTITUTIONS BY PATIENTS OF SKILLED NURSING OR INTERMEDIATE CARE FACILITIES

This section allows a Medicare patient in a skilled nursing facility or in an intermediate care facility to make visits outside the institution without such visits being conclusively regarded as indicating that the patient is not in need of the facility's services. This is highly commendable. If more regulations which affect patient care were similarly flexible to allow application on an individual patient basis, physicians would find federal health programs much less objectionable.

SECTION 42. AMBULANCE SERVICE

This section extends Medicare coverage to provide ambulance service to the nearest hospital only if it is adequately equipped and staffed to provide the necessary treatment. This addresses only part of the identified problem. While it fills the obvious need for adequate facilities, it ignores the desirability of having the patient treated by his personal physician. The proposed wording of this sec-

tion perpetuates this problem in many cases. It is recognized that there are instances which preclude taking a patient to the hospital where his physician has privileges (i.e. when there is an unreasonable distance to travel or when there is an emergency requiring prompt treatment). However, it is often unreasonable to deny a patient treatment by his personal physician in the absence of such conditions. When treatment is provided by another physician unnecessary repetition of tests and longer hospital stays often result adversely affecting the cost of medical care.

POSITION OF THE CALIFORNIA STATE DEPARTMENT OF HEALTH REGARDING S. 3205

The California State Department of Health opposes S. 3205, Medicare and Medicaid Administrative and Reimbursement Reform for the following reasons:

(1) The Administrative Reform components of this proposal would consolidate the federal administration of the Medicare and Medicaid programs. Although there might be some cost savings due to this consolidation, there is no reason to think that there would be any greater coordination of these programs. In fact, the consolidation would most likely cause confusion between the two programs and make it more difficult for the individual states to obtain decisions on their Medicaid programs. For example, it appears that the newly formed Inspector General for Health Administration is a duplication of the United States General Accounting Office assignments. This means that the states' Medicaid programs have two auditing factions to deal with instead of just one.

(2) The Hospital Reimbursement Reform portion of the proposal would be costly to the federal government, costly to Medi-Cal (California's version of Medicaid), and would do little to restrain inflation in hospital costs.

Actually, it increases the acute hospital costs for Medicare by allowing additional costs not currently allowed. Although the proposal to encourage the closing of underutilized facilities appears to be a good one, it is only a small part of this reform package.

(3) The Practitioner Reimbursement Reforms would be damaging to the Medi-Cal program. It is important for California and other states to maintain fiscal and programmatic flexibility. The portion of this report which requires the Medicaid programs to pay not less than 80% of the Medicare allowable charge for non-surgical care provided by physicians outside of a hospital would undermine flexibility in both of these areas. In the short run, this change would be costly to California and it would greatly inflate the current allowable charges under the Medi-Cal program. In the long run it would tie Medi-Cal's fee structure to whatever policies Medicare adopts in the future.

STATEMENT OF THE CHAMBER OF COMMERCE OF THE UNITED STATES BY ROSE P. WOODEN[1]

The National Chamber, on behalf of over 60,000 members, welcomes this opportunity to comment on the "Medicare and Medicaid Administrative and Reimbursement Reform Act." (S. 3205).

We commend this committee's effort to design legislation to contain the burgeoning expense of these programs, which are expected to cost $38 billion in fiscal 1977, up $7 billion from fiscal 1976.

We agree with Senator Talmadge's remarks when introducing this bill. He said.

"We just cannot go on this way. The increasing cost of these programs consistently outstrips the rate of rise in Federal revenues. The choice is a simple one—either we make Medicare and Medicaid more efficient and economical or we reduce benefits. We have just too many worthwhile demands on the limited Federal dollar to be able to allocate increasingly disproportionate amounts to Medicare and Medicaid."

The National Chamber supports access to medical care for all Americans at reasonable costs, but is concerned with the runaway inflation in health care costs. We support the intent of S. 3205 to contain costs but we oppose the bill due to the questionable effectiveness of certain concepts in it. We believe the methods chosen in S. 3205, to seek economies in federal health programs, will

[1] Associate Director, Economic Security, Education and Manpower Section, Chamber of Commerce of the United States.

shift health care costs to the private health insurance system when providers fall short of expected reimbursement from Medicaid and Medicare programs. Business already pays, by virtue of employee health benefit plans, for 80% of the estimated $27 billion to $33 billion of private health insurance purchased in the United States. If these proposed reforms to contain or reduce costs in the government health programs for the elderly and poor cause increased and unfair cost shifts to the private sector, we must oppose them.

In general, S. 3205 attempts to increase health care regulation, even though it is unclear what impact other recently enacted laws are having in holding the cost of health care down. Laws governing health planning, professional standard review organizations, and health maintenance organizations were designed to contain health care costs. These laws have not been fully implemented so their full impact cannot yet be assessed.

Government planners and policymakers are presently developing ideas on reducing regulation of other industries because regulation disrupts the free market and contributes to inefficiency and excess costs. S. 3205, despite all its good intentions, is just one more regulatory scheme.

The paradox is that government policymakers have steadily tried to reduce the flow of federal health care dollars through increased regulation of the health industry, rather than through establishing workable rules that will foster cost containment in the marketplace.

MAJOR PROPOSED REFORMS AND CHAMBER RECOMMENDATION

Administrative reforms

The bill would combine the Medicare and Medicaid agencies, the Office of Nursing Home Affairs, and the Bureau of Quality Assurance into a single Administration for Health Care Financing headed by a newly created Assistant Secretary for Health Care Financing.

Also, the bill would create an Office of Central Fraud and Abuse Control in the Department of Health, Education and Welfare (HEW) to monitor certain health programs administered under the Social Security Act.

An Inspector General for Health Administration would be created with responsibility for reviewing, inspecting, and auditing all federal health care programs under the Social Security Act.

There is a real need for better coordination and administration of the various programs within HEW, but streamlining the program operations does not require new legislation or the creation of new levels of bureaucracy. The creation of an Office of Inspector General for Health Administration appears to duplicate the jurisdiction of both HEW's Office of Investigation and the Justice Department.

In other sections of the bill, new criteria for quality controls and performance review would be established for the states in administering Medicare and Medicaid. Also, the bill contains procedures for claims processing by carriers administering Medicare.

The Chamber agrees that improvements can be made in the administration and claims processing of the Medicaid and Medicare programs. However, flexibility and experimentation are needed to determine which methods would best achieve the desired performance standards.

The bill, in addition, would terminate the Health Insurance Benefits Advisory Council (HIBAC)—a serious mistake. If the Congress decides to terminate HIBAC, a suitable replacement should be created so the private sector can continue to convey to the Administration its views on the Medicare and Medicaid programs.

Hospital reimbursement reforms

The Chamber supports the general concept, outlined in S. 3205, of incentive prospective rate reimbursement methods to improve hospital efficiency. Classifying hospitals to measure routine operating costs is sound. However, before federal uniform accounting procedures and prospective rate reimbursement systems for hospitals are established, we need more information to determine methods for distinguishing between efficient and inefficient institutions and which prospective rate system will work best.

Practitioner reimbursement reforms

Criteria for determining reasonable charges for physician's services and methods to encourage physicians to accept Medicare assignments must recognize eco-

nomic realities. Current physician reimbursement levels are such that the elderly must pay a large share of their physician fee or forgo care. An improved reimbursement system will insure physician participation in the Medicare program.

Much attention has been given to the costs of services of hospital-based medical specialists. Since numerous variables affect these costs, an objective answer as to the relative value and desirability of these services is hard to determine. We question whether controlling the contractual arrangements between hospitals and physicians as outlined in this bill will accomplish the desired result without unduly interfering with management prerogatives.

SUMMARY

To summarize, we support the intent of S. 3205 but oppose the bill as introduced. We recognize the difficulty in designing federal legislation to control the costs of Medicare and Medicaid. Reforms are necessary but health care cost control is not a simple matter of reducing fraud and inefficiencies. Utilization of hospital services, new technology, and total hospital expenditures must be taken into account when searching for economies. Rate reimbursement systems alone will not eliminate improper, or insure proper, use of hospital services. Competition, well-designed incentives, and disincentives are needed to make the nation's health industry operate at its optimum.

We urge this Committee to consider further the net effect of more regulation of the health industry before any final version of this bill is reported.

Experience suggests that government imposition of detailed controls, fee schedules and limits on hospital charges will do little to prevent rising health care costs. Such controls limit the clinical freedom of physicians and could create unnecessary conflict among health care providers, institutions and government. Controls could be counterproductive to the efficient use of expensive health care resources. We urge flexibility to allow for innovation to take place so the health industry can better serve the American people.

The Chamber's Special Committee on the Nation's Health Care Needs has a number of members who are highly qualified experts on health care issues. We stand ready to assist the Subcommittee and its staff to refine this bill.

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