CUTBACKS IN MEDICARE AND MEDICAID COVERAGE

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH OF THE ELDERLY

OF THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

NINETY-SECOND CONGRESS

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Part 1. Los Angeles, Calif., May 10, 1971
Part 2. Woonsocket, R.I., June 14, 1971
Part 3. Providence, R.I., Sept. 20, 1971

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[1] Senator Winston Prouty, Vermont, served as ranking minority member of the committee from September 1969 until his death, September 10, 1971. Senator Robert T. Stafford, Vermont, was appointed to fill the vacancy on September 17, 1971.

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CUTBACKS IN MEDICARE AND MEDICAID COVERAGE

MONDAY, SEPTEMBER 20, 1971

U.S. SENATE,
SUBCOMMITTEE ON HEALTH OF THE ELDERLY,
SPECIAL COMMITTEE ON AGING,
Providence, R.I.

The subcommittee met at 10 a.m., pursuant to call, in the Diocesan Auditorium, Saints Peter and Paul Cathedral, Cathedral Square, Providence, R.I., Senator Claiborne Pell, presiding.

Present: Senator Pell.

Also present: Keven McKenna, legislative aide to Senator Pell; Kenneth Dameron, Jr., professional staff member; Carol Ann De Vaudreuil, secretary; and Janet Neigh, assistant chief clerk.

OPENING STATEMENT OF SENATOR CLAIBORNE PELL, PRESIDING

Senator PELL. This hearing of the Subcommittee of the Special Committee on Aging of the U.S. Senate will come to order.

I am very pleased to say I am grateful to the Catholic Diocese for the use of this auditorium. I thought we would start punctually because we have quite a long list of witnesses.

Nearly 7 years ago the Congress acted to pass a law to care for the health needs of our senior citizens. Today we are here to review the operation of the Medicare and the Medicaid programs over the past years in Rhode Island. The Senate is presently considering a bill, H.R. 1, to change the scope of the Medicare and Medicaid programs. Today we are here to examine the ramifications of that bill on the senior citizens of Rhode Island. Today we are also here to take a comprehensive overview of the Medicare and Medicaid programs in Rhode Island.

Following our discussion of the problems of access to health care, we will hear senior citizen consumer representatives as to the adequacy of the Medicare and Medicaid programs in Rhode Island. Following our discussion of consumer viewpoints, we will hear directly from those persons who have the responsibility for providing health care services to senior citizens, the doctors, the hospitals, the nursing homes, and the visiting nurses.

The Department of Health, Education, and Welfare recently predicted, in a cost study required by an amendment of mine enacted into law last year, that health costs will rise by 50 percent in the next 2 years. One question I plan to pose for the providers of health care services in Rhode Island is how they plan to control this expected 50 percent rise in health costs. If this rise cannot be controlled, the senior citizens will unfortunately have to pay the bill.

Following up on our panel discussion we will look at a new means of health delivery which offers much hope for senior citizens in the future. Ed Brown of the Rhode Island AFL–CIO will discuss with us at that time the program of the Rhode Island Group Health Association.

One of the purposes of our hearing is to hear directly from the senior citizens. At the close of our panel discussion, there will be a town meeting in which members of the audience will be invited to offer their comments for the hearing record. In this regard, I am informed, one group feels they have been muffled and not been able to make their viewpoint known. If there is any group that feels muffled, please let me know and we will be more than glad to hear from them.

The only pressures are those of time, and I would urge all witnesses to be as brief as they can in their presentation.

Now, I am particularly honored that we are up here also under the auspices of the city of Providence; and its chief executive, my old and good friend, Joseph Doorley, is here to help open our proceedings and grace them. Mayor Doorley. [Applause.]

STATEMENT OF JOSEPH DOORLEY, MAYOR, PROVIDENCE, R.I.

Mayor DOORLEY. I think it would be somewhat presumptuous of me to welcome Senator Pell to Providence, R.I., for as long as I have been mayor, whenever I have had a problem I have never hesitated to call upon him. He has always been accessible and he has always been of great assistance to me.

But in his capacity as a member of the Committee on Aging, and particularly in his capacity representing the U.S. Senate, I would like to formally welcome this panel discussion and this hearing, because I think it is fair to say that to the best of my knowledge no other group in this Nation has been as severely affected by inflation as our senior citizens.

Their incomes are limited in 95 percent of the cases. And one of the gravest concerns, and I speak now from personal experience, of our senior citizens is the dreaded fear of becoming ill. What is going to happen to them when they become ill? When they become sick, what is going to happen to whatever limited resources they have?

We ought to be concerned about medicare and medicaid. I have had the personal experience of a man 67 years old, the father of a close friend of mine, with a rare blood disease, and without medicare his personal medical expenses in 2 months would have been over $26,000. Now, without the programs that have been promulgated through the help of men like Senator Pell, that man would be without a home today, without an automobile, and without any resources.

Another problem area that has been directly brought to my attention are those people in what I would call the twilight zone. They are in their early sixties and they are not 65, and they have some resources, and the cost of medical care is drastically affecting them, the outright cost, and what will happen after the Medicare has been used up. What do they do then?

And this is an area which I think merits your concern. Another factor that I am personally aware of is the cost of pharmaceuticals, pharmaceutical supplies and drugs, which is greatly needed by our

aging. I think, Senator, we are going to have to find some way of providing a pharmaceutical center where our people, particularly our senior citizens, know they are getting a fair deal on their pharmaceutical supplies.

Now, I know, for example, from the personal experience we have had with the operation of the Rhode Island Group Health Association facility, that the savings for pharmaceutical supplies runs anywhere from 30 to 70 percent. And I am hopeful there is some way we are going to be able to provide these drugs and pharmaceutical materials at a discounted price for our senior citizens.

And finally, one last word, Senator, we can provide a tremendous amount of services, health carewise, recreationwise, and educationwise, when we have our senior citizens where they can gather together or where they are naturally gathered together. I think of the facility such as Bradford House. There is not a week that goes by that I do not receive at least 10 letters requesting some type of assistance in having people admitted there.

I think if we can assure a better share of housing for the elderly and we have these people in these facilities, we can provide the health care using the home or the facility, of course, as the center. And I do hope, Senator, that the Congress of the United States will look very, very carefully at what the administration requests in this particular area and, naturally, increase it.

With that, I thank you for the opportunity of making a brief presentation.

Senator PELL. Thank you very much. Mayor Doorley. I would add that we from the northeastern part of the country are very conscious of these problems of the elderly and the importance of rearranging some of our priorities and the importance, Mayor Doorley, of having more units for the elderly. Actually, our own Congressman, Congressman St Germain, in his district has gotten more units than any other Congressman in the country, but we need far more because the pile of citizens is 6 years, and he has more pressure in his area than any other area, I think, in our State in this regard.

I would also like to mention that this hearing is not just a unique occurrence, but is one of a series. The first hearing in the series was held in May, in Los Angeles, and we had one in Woonsocket, R.I., in June. Next week there is going to be one in St. Louis, and then one in Florida and in Maine.

These hearings of this subcommittee, which is chaired by Senator Muskie of Maine, have been called at his request and we hope to do a fairly good job covering the whole United States so as to find out how H.R. 1 can be improved, what are the needs of the elderly, and to try and marshal public opinion behind a reordering of the priorities, so you don't have a situation that presently exists where better than 95 percent of the moneys that are authorized for defense and space are spent, while an average of 50 percent of the funds that are authorized for the human sector of the economy, health and education, housing for the elderly, things of that sort, are spent.

And one of the purposes of these hearings is to marshal public opinion to try to rearrange these priorities. Now we come to our first panel, which is the Panel on Access to Health Care. And I would hope that the first panel, which is Mrs. Ann Hill, director of the St.

Martin dePorres Center for Senior Citizens; and Miss Hannah Marshall, can come up and sit with us here. And Miss Ruth Lamoreux with Mrs. Sadie Gildea, Mrs. Connie Carter, field aide for Project SECAP, which is senior citizens action program. Mrs. Eleanor Slater, an old friend and coordinator of the Rhode Island State Division of Aging. And most important of all, our Col. Walter McQueeny, chief of the Providence Police Department, who has done such a fine job in opening communications in our city here.

If they would all come up and sit in the panel on the left, I'd be very grateful. Maybe I started so promptly, which is unusual for a politician, we haven't got all of our panel here. I think I still want to keep on schedule, so we will start with the witnesses that we have and just move ahead.

Medicare could provide all the health benefits possible and still be meaningless to our older citizens if those health benefits were not accessible to our senior citizens. Actually, census figures today indicate that Providence is becoming increasingly a city of citizens of grayhairs, longhairs, and Afros; that is to say, middle-class, middle-aged citizens have moved out of the city and left it to their elderly mothers and fathers and the youth and the poor of the city.

Our first panel will discuss the relationship of our poverty, youth, and our elderly citizens in our city of Providence and see how this relationship is sometimes rooted in brutal crime. Our first panel will discuss how terror has immobilized our senior citizens and inhibited them from obtaining the health care they need. And I see our panel is increasing in size. Colonel McQueeny has many, many responsibilities; he may be a little bit late.

So I think we will open up, if I may, with Mrs. Ann Hill and Miss Hannah Marshall. And I would ask Mrs. Hill, director of the St. Martin dePorres Center for Senior Citizens, sponsored by the Catholic Church, to begin. She is a member of the Rhode Island Crime Commission and the Rhode Island Drug Commission. And Miss Marshall, who is with her, 76 years of age, has been robbed twice and can speak specifically.

Mrs. Hill is at the far end. Mrs. Hill, would you start out?

STATEMENT OF ANN HILL, DIRECTOR OF THE ST. MARTIN dePORRES CENTER FOR SENIOR CITIZENS

Mrs. HILL. Thank you, Senator Pell. I think that a part of this discussion in transportation and crime are very interrelated with many other problems that go along with it. Miss Marshall, at my right, is one of our senior citizens who has had the personal experience of being robbed, purse snatching in the street.

LACK OF IMMEDIATE FACILITIES CONTRIBUTE TO CRIME

We could very easily attribute these things to many circumstances. It is my opinion that the lack of transportation and immediate facilities in certain neighborhoods contribute a great deal to crime. For example, in our own West End neighborhood, we do not have a super-

market; so it means that our seniors travel 2 to 3 miles for grocery shopping. The same thing holds true in other areas.

There are certain days in the week, certain hours in the day transportation is very, very slow on our streets. Most of our senior citizens don't drive. Most of them are on fixed incomes, which means an impossibility to take taxicabs. So, therefore, they are prey to the person who wishes to snatch a bag.

In discussing this the other day, I related our high drug problem with our crime wave of purse snatching and robbery of our elderly. I also attributed the fact that many of our seniors have a hearing problem. Because of the high cost of hearing aids, for example, many persons cannot afford this kind of health service; therefore, they do not hear an intruder approaching them.

Senator Pell talked about our community becoming a white-haired Afroed, and long-haired community. I thought this was rather unique in that most of us attribute the white youth with long hair as being a hippie, and we are afraid of them; and we attribute the black youth with the Afro being a Panther, and we are afraid of them. Actually, it isn't judging a book by its cover; it isn't always these kinds of persons that are robbing us.

I don't know how long Senator Pell wishes me to go on with this, but I could go on a little more maybe after Miss Marshall has given her experience personally and then wrap up from my end.

Senator PELL. We want to run right down the panel. First Miss Marshall and then we will move on from there.

STATEMENT OF HANNAH MARSHALL, PROVIDENCE, R.I.

Miss MARSHALL. I was going to the market to cash my check, and I didn't have very much money in my pocketbook, all I had actually was $28.30. So then after I cashed my check I had some money in my pocketbook saved to pay my rent, and my rent was $50. So then, before I got home, I had some groceries and a few things.

MONEY AND GROCERIES STOLEN ON STREET

So then a little boy in the store, he was in the candy department, so the grocery man said he has some candy; and then two more boys were standing outside the door. I didn't see those two boys. And when I come out and walking home, I got almost home to Sunset Village, and then three boys sneaked up behind me, my bag was gone, all my money and my groceries and everything was in there and I couldn't pay my rent.

And 2 weeks later three more boys were trying to break in my house. So I was getting ready to go to bed and I got on the phone and I called up my daughter. She said, "Well, ma, this is a bad thing, that's all this is." So, then I go to the phone and call the police. The police was so long in coming, and so then my daughter got in touch with my daughter-in-law and she said, "Well, ma, you have to have someone at your house." And she got dressed and came. And still the cops didn't come.

So I come downstairs and I was scared to death. And so then the boys came back again and they said, "I will cut the door, I will cut the screen on the door." And so finally, in the meantime, my daughter-in-

law came and I rushed out the door and three boys came right straight back again and watched me get in the car, my daughter-in-law's car. And so then she drove up the street and the cop was up there, still he didn't come.

Then the cop came and so he said, "What can we do?" So I said to him, I said, "I am not going to go back and let the three boys come in with a knife." So then I rushed out the door and I went to my daughter-in-law and stayed overnight. And then she come over and spent a couple of nights with me. Then I got scared. I am not living there anymore. I am living at 97 Superior Street.

Senator PELL. Thank you very much indeed, Miss Marshall. I think now if we can move on to Miss Ruth Lamoreux and Mrs. Sadie Gildea. Miss Lamoreux is the director of the Providence Senior Citizens Center at 51 Empire Street, and she is accompanied by one of the Providence senior citizens. Miss Lamoreux.

STATEMENT OF RUTH LAMOREUX, DIRECTOR OF THE PROVIDENCE SENIOR CITIZENS CENTER

Miss LAMOREUX. Thank you, Senator Pell. I am here just to give a few instances of some of the things that I know have happened to the senior citizens. Even though we take precautions and our program is based on trying to take the fears away from the senior citizens, we still continue to have problems.

For instance, we had a 2-day trip to New York City. We planned that trip so the seniors would be back before dark. As we got off the bus, it was just dusk. Two of our senior citizens were crossing the street when two fellows grabbed their bags. One of the seniors was just lagging a little behind and she hollered.

Now, there were people around, but the question is people do not like to get involved in anything, so they just sat there watching, or stood there watching these fellows run off with the bag. Now, I know it is a problem, I know we all hate to get involved in things that might end up wrong for us, but still our senior citizens need protection.

Another incident is Margaret Caldwell, 89-year-old, who is one of the oldest members of our center, and I think we are all very familiar with this case as it was well publicized. Her home had been broken into a number of times in the Chad Brown Housing Area. Even with heavy screening in the windows and double locks on the doors her home was broken into, I think, either three or four times.

We have seniors that come to the center and while they are in the center, their houses are broken into. And this is because they live alone. Evidently, their homes are watched to see what the person's pattern is, and when they see a person go out on Tuesday at 1 o'clock and they don't come back until 4 o'clock, they will say, "Well, no one's going to be home in this house; we can go in and take what we want."

ELDERLY AFFECTED MENTALLY AND PHYSICALLY BY ROBBERIES

People have got to realize these instances, not only the material things they lose, but what it does to the individual mentally and physically. We also had another lady who lived at Roger Williams Housing and she was knocked down and her pocketbook taken on

three different occasions. After the last one she was missing from the center and she was one who never missed, she was always there. We checked to find out she was ill. People attribute her death to being knocked down for her pocketbook, and on one incident she only had 18 cents in her bag.

Now, I think Mrs. Gildea can tell of the things that have happened to her and she's avoided some of this by speaking out to individuals. I know it takes an awful lot of courage, but even to the senior citizen we have got to help one another. You know, our program is geared because of fear. We are only open at our center from 9 o'clock to 4 o'clock, and if you visited us you would note that between 3 and 4 o'clock, people pick up their things and get ready to go home, because they do not want to be out after the sun sets.

I think it is a shame that we can't have a few evening programs without the senior citizen having these fears. Thank you very, very much, indeed.

Mrs. Gildea will now cite a few instances.

STATEMENT OF SADIE GILDEA, PROVIDENCE, R.I.

Mrs. GILDEA. Mine are very minor compared to what Miss Lamoreux had to offer, but I come to the center of Providence quite often and I have had several experiences which other people wouldn't think too much about. I, at Tilden and Thurber's, on the Mathewson Street side, met two girls holding up a lady for money, which people have told me I was foolish to do, I got in between and asked the girls, "What are you doing to this woman? Are you asking her for money?"

And this younger one said, "Yes." And I said to the woman, "Don't give them any money. I will go right around the corner and get the policeman." I didn't know where the policeman was, but I said, "What are you going to do with the money?" They said they were going to the show, but that's the start.

The other day I came to Mathewson Street, three boys had rocks stoning an elderly man, and I went to the boys and said, "How would you like somebody to do that to your father?" I was with another lady and she left me because she was afraid. And I found the boys and the man stood there and I went around the corner of Grace Church and on the steps there was a young man sitting, and he said to me, "What is the matter?" And I said, "Those three boys there are stoning an elderly man on Mathewson Street, and he is coming through, you will see him in a minute."

He said to me, "Please go along and don't bother, I will take over." And he followed those boys and chased them and they went down Westminster Street through the Mall and went between Shepard's and Cherry's because I stood on the steps of Grace Church to see where they went. So when I was coming home the other day, I have another complaint, bicycles on the Mall. They won't let you by. You get up against the window, and this day they had a war at the corner of Shepard's on one of those big planters that they have in the center, and wouldn't let us go by.

They said, "Go ahead, you are old enough to walk around the middle of the road." And finally, I got the younger one at the end, I

thought I could maybe get by him, and I pushed the bicycle and got by, but he closed it up after I left.

So those are the minor things that grow into big things and that's why I am telling you.

Senator PELL. Thank you very much.

Miss LAMOREUX. We have run into a number of people who have had instances happen to them of either their pocketbook being snatched or their homes being broken into, and they have a fear to call the police because they are afraid there will be reprisals, and I think that's terrible. For instance, when I was checking out my list of people, I contacted individuals, and some of them did not want it mentioned because they were afraid if this got publicized, that the same thing would happen all over again.

Senator. PELL. Thank you. Now Mrs. Connie Carter will be the next witness, and she is accompanied by Mr. Arthur Conroy. Mrs. Carter is field aide for Project SECAP, and Mr. Conroy is one of her citizen-clients and has been robbed twice himself. I will ask Mrs. Carter to speak first.

STATEMENT OF CONNIE CARTER, FIELD AIDE FOR PROJECT SECAP

Mrs. CARTER. Thank you, Senator Pell. My name is Connie Carter. I am a field aide for Project SECAP. SECAP has a staff of nine: six aides, one director, and one assistant director, and one clerk-typist, which serve the senior citizens of the model cities Martel neighborhood. At present, we are providing direct services to 406 persons. We have contact with over 200 persons that presently do not need our services, but know that we are on call if they should need us.

All of the following instances are fully documented and can be checked at any time. In providing health care to senior citizens, we have discovered many of the problems and problem areas. A most serious one is the victim of senior citizens being alone on the streets because of the crime atmosphere in the neighborhood. Upon request, within 5 minutes I can list 17 people who were attacked, robbed, and beaten. One of these situations concerns a lady who was attacked by four females as she was waiting for us to pick her up.

One of the victims became fed up with the situation, moved out of the neighborhood. When she moved out, she found out the neighborhood in which she moved to, they did not provide the type of services that we provide, so she moved back. Our experience has indicated that the need for transportation is a paramount problem and getting senior citizens to these points that they can get health care.

ROBBED WHILE DELIVERING FOOD STAMPS

Three days a week we have the Red Cross vehicle that we provide transportation to the doctors and the hospital clinics. We even have situations where persons have been fearful of using the rescue squad. A recent situation concerned one of our field aides on Friday who was attacked while she went to get food stamps for individuals, for the senior citizens, and cash their checks. As she was distributing the food stamps and the cashed checks for two of the senior citizens, she

and a volunteer worker were dragged out of the car, robbed, and both handbags were snatched. There is also——

Senator PELL. Excuse me. I'd like to interrupt this to say Mrs. Person, by coincidence, is supposed to be on the next panel, so she is not here, and we understand the reason. If she is here, I congratulate her on her bravery in being here.

Mrs. CARTER. I have something else to say. There is also the problem of the press publishing the names and addresses of the victims, thereby giving the hoodlums an address at which to use the keys inevitiably found in the snatched bag.

To my right I have Mr. Conroy, who would like to tell the audience what happened to him.

STATEMENT OF ARTHUR CONROY, PROVIDENCE, R.I.

Mr. CONROY. Thank you, Senator. The main trouble with us seems to be in the mail boxes. They go down there, if you ain't right there when the mailman comes, you don't get any mail because somebody beats you to it. So I have been attacked down there, once I lost $16 and the next time I had no money; I don't carry any more money down there.

And I think when the checks come the 1st of the month and the 16th of the month, I think we ought to be provided with a guard or something. Not only good for us, but good for the mail carrier, too. And I think when the checks come, there should be somebody there, security guard or someone there to take care of us.

Some time ago, since I lost that money, I have lost a couple of orders of food stamps since then, and it is all in the corridor. It happens right in my own house. I think if we had a guard there, somebody to keep an eye on them, I think we'd eliminate a lot of the stuff that's going on.

I called the police. The police did a good job. They go right after it. The second fellow took me and I didn't have any money, but he took me up the stairs and hit me right in back of the neck and I fell down. And I called the police about it and they had the fellow in 1 hour. He was a training school man that got away.

So I think if we had a little more protection for check day, I think it would be good for us and good for the mailman.

Senator PELL. Thank you very much, Mr. Conroy. So you all understand, you have been robbed twice, as I understand it, and you feel your main problem is through the mails?

Mr. CONROY. Senator, I want to state one little item. This place that Mrs. Carter belongs to is one of the best organizations you can get for the old people. They did—they take wonderful care of us. They get our stamps and they do everything possible to help you out. And I think they sure deserve a little something good for them.

Senator PELL. Right. Thank you very much. I'd like to ask the audience if they would participate a bit here and would all those in the audience who either have been the victims of hooliganism or vandalism or seen instances of hooliganism or vandalism, the crime, violence, would you hold up your hands, all who have been either the victim or witness. Give us a feel of how prevalent it is among the older people. About 1 out of 6, I'd say, something of that sort.

Thank you very much. Now, Mrs. Eleanor Slater, a very old friend.

STATEMENT OF ELEANOR SLATER, COORDINATOR, DIVISION ON AGING

Mrs. SLATER. Thank you, Senator. I have turned in a formal paper for the record. I am just going to shortcut this and take short excerpts from it. And to underscore what I think——

Senator PELL. I'd like to interrupt here and assure all the witnesses if they have longer statements than they say, the full statement will be published in the record.*

Mrs. SLATER. Transportation is the real problem. Transportation may well be the sleeper as the prime issue at the soon to be held White House Conference on Aging. Almost every State had transportation as the top priority in the State White House Conference. This makes sense when one stops to think about services and programs. How do poor elderly get to use services and participate in programs unless they have the means to get where services are available? Transportation is the real problem, is a worry, is a frustration. It is unobtainable to many.

TRANSPORTATION—A REAL PROBLEM

Today, many of you attending had to have transportation to get here. Transportation is a real problem; it is difficult. To be constantly concerned on how to get there, whether it be to a meeting with others or for a hot meal or pleasant socializing or to get to the doctor's office, a hospital, a clinic, or to go marketing for food or any other reasons, older people more than any other age group get worn down and become resigned to being unable to be mobile and thus may become isolated, unless they have the transportation to take care of getting to all these various services.

For instance, older people cannot walk too far for public transportation nor wait too long. Ofttimes they are physically not capable. Many times they are afraid to walk in certain neighborhoods. Violence has made living in some neighborhoods a nightmare. And I won't belabor that particular point because this is what we are hearing.

We believe, we in the Rhode Island Department of Community Affairs, have a good idea. A grant proposal has been written and delivered to the Department of Transportation in Washington for a demand delivery transportation system, a pilot project to be inaugurated in this State. This grant is still alive because we have only been in contact a few days ago in Washington and we hope—we still live in hope that we may be one of the States in the country to have a program of a demand: Delivery kind of transportation.

A study that was made of the elderly in the State, titled "The Aging in the Rhode Island Community, 1970," gives some data on physical conditions which do not necessarily hospitalize people, but identifies those who can get around, however limited. Now, we have a vast number of these people, Senator. Those who are in hospitals get there, but there are—well, I will go on here—for example, arthritis is one of the most prevalent diseases of the aged, and yet only 58 percent of the elderly in Rhode Island who have arthritis indicated having received any medical help for their painful and crippling disease.

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*See appendix 1, p. 310.

Only about 35 percent of those suffering from varicose veins received medical assistance. There are similar examples of hemorrhoids, anemia, constipation, and sinus, such conditions as these, they are conditions for which many people need medical care, and yet they are not ill enough to be in a hospital. I would say that probably 75 percent of our older population find themselves in this kind of group, and these are the people that we want to bring health services to.

But again, so many cannot get to the health services unless there is transportation. I won't go on because my paper here is in the record. All I can say, Senator, that these statistics are in the study, we are aware of them and we know them. The Older Americans Act, my office, the Division on Aging, is financing two transportation programs here in the State. One, the Urban League is the grantee, they share in part of the cost.

But this is down in the model cities area of Providence, a transport and escort service. The escort service is part of this particular service because of the kinds of things that you have heard these elderly people say. The escort service, they go right up to the door of the apartment or the tenement and bring the person down to the vehicle. And also, if it is a marketing kind of trip they have been on, carry the bag into the house.

Also, Senator, this summer, without Federal funds, with State funds and with private funds, I might say that the Grace Episcopal Church made a gift of $2,000, plus $5,000 in just State funds, and we have been running transportation summer programs of taking people who live in Providence on regular marketing trips. We are hopeful of developing this even more, and I see Mr. Max Cohen in the audience here. Max Cohen came to the Governor's office with several others—I would say 30, 35 other senior citizens—and we talked about 10 days ago. Mr. Cohen has some idea about getting together with management, our office, and setting up a transportation marketing program for the elderly. Max, we want to see you.

We are doing all we can to the degree there is personnel, to the degree there is money, we are aware of the programs and are very anxious to do more about them.

Senator PELL. I thank you very much. In that connection, we are following up on this request of yours to the Department of Transportation and we do the best we can. I think another point here is that the vehicles will be electric vehicles, which go slower and also will pollute the air less. In that regard, I think we are very fortunate that the Assistant Secretary of Transportation for Environment is a former Rhode Islander and his good offices also would be of great help in producing more vehicles of this sort.

I must add in my own inspection or visit to various housing for the elderly units, I have noticed this question of transportation is particularly important. Thank you. Now we have, as our final witness on this panel, Col. Walter McQueeny. I would like to add a personal word of thanks to him for coming, because we have just seen the amount of work he has from the statements of the previous witnesses, and also to congratulate him on the way he's opened up communications with all the different elements of our community.

I think the relationships between black and white are better now, thanks to him, as far as the police and the citizens go, and they haven't

been this way in many, many years. I have a high personal regard for Walter McQueeny and am glad he consented to be a witness here. Colonel McQueeny.

[Applause.]

STATEMENT OF COL. WALTER A. McQUEENY, CHIEF OF PROVIDENCE POLICE DEPARTMENT

Colonel McQUEENY. Thank you very much, Senator. The Honorable Senator Pell and staff, members of the panel, Reverend Fathers and Sisters, ladies and gentlemen, I think after the events that I have heard told about here this morning, if I were at all weak I would throw the towel in and walk out the front door and say, "See you later." It would seem that it is an insurmountable problem.

However, let me, if I might, and you might bear with me for just a few moments, give you a little bit of insight, of my insight, of some of the problems that have been brought out this morning. Some of my reference to them may be repetitious. I know most of the people who have spoken. I have the highest regard for them. I know they are telling the truth. In fact, I could multiply many times over the number of events that they have given you in a small way this morning.

SAFETY OF SENIORS—TOP PRIORITY

I can tell you about what most of the people at this table are doing, and I can tell you that I have the very highest regard for you, as senior citizens. Upon my return to the Providence Police Department on January 24, I made a statement to the police department in general on what I called a general rollcall of all policemen gathered together under one roof that my priority, and top priority, was the handbag-snatching and the knocking down of the older and senior citizens and people innocently walking down the streets, getting off buses, and immediately ordered what I call an aggressive patrol.

We have moved ahead with what I did call aggressive patrol. We are not, nor do I sit here this morning under any circumstances wanting to create the impression that we have solved the problem by any means. I can only tell you this, that we have made more arrests in perhaps the last 5 months than have been made in some time, but also crime has gone up.

Now, I have some answers of my own. Everybody will not agree with me, but I think that I would be hypocritical if I did not express my feelings as I feel them, regardless of whether they are taken differently by somebody else or not. I can find no way of being the chief of police of the capital city of this State unless I am sincerely honest in what I think are some of the root causes. I would accept the responsibility for the police, I would tell you that we have faltered in some areas. I would tell you that I would like to be able to have a policeman on every street where a crime occurs. I would tell you that I have ordered all of our cars up and down every side street, when they see buses stop and people get off to ride up and down these streets, whether they are marked police cars with big words, "Police," on them, or whether they are the new innovative approach that I have taken to

deal with this situation by putting men out with beards and leather jackets and motorcycles and trucks and taxicabs and any other vehicles that I can find to fight crime. I will fight crime in whatever way I have to do it to try and eliminate this terrible problem. [Applause.]

Now, I want to say this: I feel, and I'd like to explain to you if I can, I am sure we have a few moments, that I don't believe—first of all, let me say I think that the police are like the top of an iceberg, if I might explain it in that way. They are completely visible, easily observed, but representing only one-eighth of the total iceberg. The remainder of that total iceberg, if you will, is the entire criminal justice system, which I think has a part and should be concerned with the robberies and the crime that is taking place, and not just always be ready to blame the police.

I will accept the blame for the police when we falter and when we do not catch the criminals. But when I think there is another section of an entire picture that should be looked into, then I think it is about time we explained a little bit. I am not against the courts, believe me, but I have some things to say. When I say that the entire criminal justice system moves about obscured from sight, yet represents seven-eighths of the total iceberg, and just as alterations to the top of the iceberg cannot substantially affect the total mass of ice, changes in the efficiency or effectiveness of the police alone did not substantially affect the criminal justice system over a long period of time.

In the State of Rhode Island, for example, 31 percent of the criminal justice dollar is spent for police operations, while 28 percent is spent for prosecution and adjudication of offenders, 8 percent is spent for probation and parole services, and the remaining 33 percent is spent to operate custodial correctional institutions. Consider the import of these figures, ladies and gentlemen, if you will. One-third of the total for prosecution and adjudication of offenders, 8 percent is spent for the care of 400 or so offenders, 75 percent of whom will later be arrested; 28 percent of the local expenditures has been used to determine guilt or innocence, and only 8 percent is used for community-oriented treatment of offenders. And most importantly, over 75 percent of criminal justice expenditures are concerned with costs which occur after crimes have been committed, and 75 percent of the costs occur after offenders have been arrested.

More Emphasis on Crime Prevention

What does this all suggest? It is my belief that it very strongly suggests that we reorient our approach to the criminal justice system. It very strongly suggests that we attempt to prevent crime, that we attempt to prevent young people from becoming involved in crime, and increase the effectiveness of our treatment of those people who do become criminals.

Our strategy in the prevention and reduction of crime must be based on a three-pronged attack, and if you will, I might suggest those three prongs. We must reduce the need and the desire to commit crime. We must increase the difficulty of committing crime. And we must increase the efficiency of all elements of the criminal justice system, and not just the police.

The reduction of the need and desire to commit crime involves far more than the criminal justice system. It involves, if you will, the whole society. It must include the elimination of the ghettoes, the slums that spawn crime, the provision of equal opportunities in education and employment, and the identification of the psychological and sociological roots of criminal behavior. It must include better efforts to assist those who do run afoul of the law despite the best efforts of parents, schools, and youth agencies.

Now, I'd like to make some reference to the courts, if you will, only to make some points to you with regard to some of the cases that have been mentioned here this morning by this honorable panel, and a most respectful panel and a truthful panel. But I say to you this, ladies and gentlemen, we have had handbag snatches, people knocked down, 89-year-old women with their ribs and nose kicked in, which have brought my blood pressure to a point that I have had to go under a doctor's care, believe it or not, because it irks me and it irritates me so much.

And if you don't think that I spent 8, 10, 14, or 15 hours in that police department trying to find some of the answers to these problems, then I respectfully submit to you that you talk to my subordinates to find out whether or not this is true. I spent 1 year and 10 months on a leave of absence involved as the executive director of the Law Enforcement Assistance Administration program dealing with the money that was being filtered into Rhode Island, and I was the appointment of His Excellency, Governor Licht.

During my 1 year and 10 months in that program, which I left voluntarily because I wanted to be the chief of police, and sometimes I wonder whether I should have seen a psychiatrist when I was sitting comfortably in a nice office, but those handbag snatchers and these women that have been assaulted have irritated me to no end. But what are more of the problems than we are confronted with and faced with this morning?

Victims Afraid To Make Identification

No. 1, I put it to you very bluntly, identification. No. 2, repercussions, people being afraid. And I think that probably they have a right to be afraid. But I tell you that there are some people that before long have got to stand up and be counted. They have got to come in and identify these people and give us the opportunity of placing them before the courts.

Now, I want you to know that we have placed a great number of them before the courts; and let me tell you that it is no small number, it is a large number. And I want to repeat something that I heard here this morning made reference to of some of the young fellows with the long hair and mustache and the beards. They are not the worst kids in the world, believe me. There are some very great ones. I am not here to criticize them. Just because I happen to wear my hair short—I wish I had some hair. [Laughter.]

But the point is I say to you that these kids are not all bad. A small percentage of these kids are making every kid in America look bad, the same as a small percentage of the policemen make every cop in America look bad. Now let me say this to you, there is some explanation that I think is deserving of your consideration, and particularly

of the honorable Senator's consideration and the people sitting in the House and the Senate in Washington. While I do not know the answers, I am not a lawyer, I am a cop, frankly; but let me be very honest in my opinion of what's happened since some of the things that's happened on Supreme Court decisions dating back to 1961, and then you can draw your own inferences as to why you are being assaulted and knocked down and robbed. But let me just cite you a few of them.

The *Mapp* v. *Ohio*, *Escobedo* v. *Illinois*, *Miranda* v. *Arizona*, *Wade* v. *The United States*, and *Gault* v. *Arizona*, all are cases which go directly to the exclusionary rule of law which requires that any evidence obtained in the violation of constitutional rights of an individual must be excluded from the weight of evidence in the prosecution of the defendant. Now, let me just explain that perhaps in my own terms as a policeman.

More Consideration to Victim's Rights

I am not against the Constitution of the United States, God bless us, I love this country and we need it and I am for every bit of it, and I am for everybody's rights. But I think it is about time consideration was given to your rights besides the criminal's, and just as much and even weighed more so your rights rather than the little, small, technical errors that are made in a warrant that causes it to become defective and the hardened criminal is released to walk the streets and to prey upon you again.

Recidivism is the cause of most of our crime and this can be proven over and over and over again because I can name to you over and over and over again the same people day in and day out walking into the training school, walking out, coming back into the street, going to the jail, suspended sentences, probation, no bail, low bail, personal recognizance, and if you don't think this has had an effect on your living, then there is something wrong with my thinking. [Applause.]

Let me just go a little bit further and then I will be very happy to cease my testimony. The *Mapp* case in Ohio began the special rule whereby all evidence secured in violation of constitutional rights of an individual is excluded is applicable to all lower courts. Now, I go along with that, that is a reasonable thing; I think the Supreme Court has done some good things. I am not against everything they have done. *Escobedo* case in Illinois was decided, accused persons have the right of assistance of counsel not only at trial, but also at the critical stages of investigation. That is the sixth amendment protection.

Now, the case of Mr. Escobedo, Danny Escobedo in Chicago, Ill., was that he was questioned by the police and that when a lawyer attempted to see him, the police did not allow him to be seen, and as a result the lawyer could see him through the doors and he felt this was a violation of his constitutional rights that the police withheld and would not let him be talked to by his attorney. I am not opposed to this.

But was it necessary to apply this to every one of the other 49 States of America because one police department may have made a mistake? Now we have the rule whereby if we pick up a criminal and the crime has been committed and one of you ladies is laying in the street or you are in the hospital and you are unconscious and you are in no condi-

tion to identify, then if we bring the man in and he says, "My name is Joe Jones and that's all I am going to say and I want my attorney," then that is what we have to do. And when the attorney arrives, you can be sure he tells him, "You don't open your mouth, you say nothing." This is one of the cases.

Now, I could go on citing many, many of these things, but this is probably beyond the scope of my testimony and I apologize if I have done that. But let me say this, there are economic problems in the cities and towns all over the United States of America. We need more police. We have the Law Enforcement Assistance Administration, which has provided up to $4 million for the State of Rhode Island to try and sophisticate law enforcement. When I was its director I was in trouble in Washington because I was directing a good part of this money toward the police system because who needed the police? Who needed the money the most? The police did because they needed education, they were at the low end of the totem pole as far as I was concerned.

Police Need Training

The courts had the judges, who were lawyers; probation and parole had professional people; correctional people needed training; yes, but the police needed training more than anybody else. And they needed that money. But the fact remains that particularly with regard to the lady's testimony of two men robbed them while they were delivering stamps and checks a week ago Friday, this morning I sent a policeman with two women. But the fact remains that I do not have the personnel to provide this type of protection 24 hours a day, and this is the big problem.

I suggest and I resuggest, if I might, because I made the suggestion once before, to the President of the United States at a hearing where I had the pleasure of sitting, and it was last year in the month of August in Colorado Springs, that they make men available for police departments who will be the kind of policemen that we need with the background, with the education, with the sociological, physiological, and every other demand that we need to make a good policeman, that they make them available, that even the President might consider a deferment for a man who might be willing to go into law enforcement and help protect the people in the United States as well as being sent to Vietnam.

The other thing I feel is that LEAA, with all of the money that it is dispensing for purposes of sophistication, could put up some money to provide for us some more men so that we might properly be able to hire more men, provide money so we can properly send more people onto the beat, bring back some of the foot patrolmen, put some of the people back in the area that you need for your protection.

And the day that we reach that goal, ladies and gentlemen, I will be ready to say then, and only then, will we be able to live in a free society. Thank you.

Senator Pell. Thank you, Colonel McQueeny, for very heartfelt, strong, and eloquent testimony. So good, we should let the panel stand really on what you have said. But there is one question I would like to get an answer to before this panel leaves, and I'd like to address this question to Mrs. Hill, if I could. And that is we have discussed the

problems of the elderly going to shopping centers and traveling, moving around the city. Do they have adequate health care? Could you touch that for a minute and is it available to them when needed?

Mrs. HILL. Absolutely not, Senator. I find that here in our city, no. It comes back to transportation again. We do have some very good clinics at Rhode Island Hospital, plus our health centers located in our various neighborhoods, but here again we come back to getting our seniors to and from these facilities to get the necessary care they need.

I spoke briefly on the hearing aid problem. Hearing aids cost anywhere from $52 to $500. Either one of these amounts would be out of the question for a great many of our golden agers when there is barely enough funds for proper nutrition and diet. I have also found in my personal experiences that our senior citizens are treated as second class citizens. They are not really given the kind of care that a middle age or other person might get for the simple reason that it is not demanded by them. Many of our seniors really don't know their rights as individuals, and unless there is someone who speaks very firmly on the rights of a golden ager, they don't have it.

Second, many of our seniors are not aware of where these services can be gotten. We were very fortunate in having the Urban League transportation and many others, but many of our citizens are not aware of the services available to them. I would say within the St. Martin dePorres Center we serve about 160 golden agers. And I would daresay that one-half of my group, I would doubt, have been seen by a doctor in their lifetime, or if so, not more than once. This to me is where an outreach program is absolutely necessary because of our shut-ins, because of lack of telephones in some cases, because of lack of family.

PERSONAL TOUCH NEEDED FOR ELDERLY

Because of that our social welfare rehabilitative services have withdrawn social workers. Forms have to be filled out by senior citizens who cannot see and do not read well enough to understand them. All of these things have come together with progress, and all of these things are progressive, but with progress we always lose something, and this is that personal contact that is absolutely necessary for our elderly in the community.

I would be most happy to see some very up-to-date health facilities within our neighborhoods. Rhode Island Hospital, St. Joseph's Hospital, various hospitals, cannot anywhere near meet the growing needs because here is a conflict. In some cases because of medical care we have people living longer, therefore, our elderly are increasing in numbers. By the same token, they don't get the proper care because the facilities are not that close at hand.

Senator PELL. Thank you very much indeed. I'd like to keep asking questions of this panel, but we have others coming along, so I think we should leave it that we all join in being shocked by the stories of brutality that we have heard today perpetrated by, the only way to describe it, young barbarians on our older citizens.

The question is what can we do about the problem. I think we have heard as eloquent a statement from the chief of police as one could get anywhere showing that his portion of the work is but a portion; it is like the tip of an iceberg, was the phrase he used——

Colonel McQueeny. Senator, may I interrupt at this point, it is important. I feel that you ladies and gentlemen should know, I can't express strong enough my desire to help to protect you and I know of your sometimes fearfulness. I hope that everybody would know the box No. 875 at the post office in Providence, that you can write to me personally, and I assure you I am the only one who opens that letter, and whatever action I take from that letter I dispense to various parts of my department without the name ever being known.

So if you have a problem in your area and in your neighborhood that you want to get to me and yet you are afraid to get to me, then I ask you and I beg you to write to me at box 875, tell me what your problem is. I may not be able to eliminate it overnight, but I will do my best. If you'd like to sign your name, it will give me the opportunity of personally being able to call you up and talk to you. But I promise you upon my honor your name will not be given to anybody else in that police department.

So you remember the number 875. If you'd like to sign your name, I assure you I will be the only one that will have it. And I will, if I have to get in touch with you and see if we can't eliminate such a problem that cause a lot of anguish. Thank you. [Applause.]

Senator Pell. Thank you, Colonel McQueeny. I am very glad you have this policy, which is an excellent one, and I'd like to join with you in it and say that my policy has always been any letter that comes to my office marked personal, this I have done for the past 10 years, is opened by nobody else but me. So on the Federal level if you have a problem and you are concerned about your name being known, just put a personal on the outside of the envelope.

Now, what we have seen here is a demand for action on every level of government and by every concerned citizen, and we have seen the efforts that are being made; we have seen the dimensions of crime. But we see also the necessity for an appeal to the parents of the youth of Providence to make a greater effort to look after their youngsters. Perhaps in some cases more discipline at home would be the necessity. There is no excuse for anybody brutalizing older people as they are.

Poverty Breeds Criminals

I would also make an appeal to sons and daughters of our older citizens of Providence who abandon the city for the luxury or security of suburbia to make an effort to locate safe and secure housing for their elderly parents in Providence. As we all know, there are few crime waves in suburbia. As Colonel McQueeny has said, crime and poverty go hand in hand, and we always blame it on the group in the ghetto, but the reason for it is the poverty and not the color of the skin or the degree of education; it is the poverty that produces the crime.

And I defy you to find crime waves in Barrington or the richer section of Warwick. And this is the essence of the problem and this is the root cause of what we must go after. Those of us in the Congress who are concerned with this problem are looking into introducing legislation to make the theft of Social Security checks and food stamps, and robbery and assault in Federal subsidized housing a Federal offense punishable by severe penalties unless an adequate rehabilitation program for the offenders can be provided.

This is a proposal in which I am interested. I am now considering the advisability of introducing such legislation. [Applause.] I also plan to introduce legislation to provide 100-percent Federal grants for the hiring of additional local police for the sole purpose of protecting senior citizens in federally assisted housing, protecting senior citizens from theft of their Social Security checks and food stamps. I also plan to ask the administration to supply additional funds for the construction of safe elderly housing not mixed up with other housing units.

I must say, too, I like the idea Colonel McQueeny advanced for a draft deferment for those men willing to go into police service, which really is the first line of defense in our country. What good is it to have a wall of steel, and bombs, and missiles surrounding our Nation if the internal heart and core of the country are weak, divisive, or falling apart? And the first line of defense are the police and the inner core, I think, should receive its share of manpower.

So I believe if we all make concerted efforts together, that we can help resolve some of the problems we have heard today. [Applause.] Now, I would like to thank this panel very much for coming here. I'd like to be with them the rest of the morning, but we have more panels coming and we thank them again and we ask the next panel if it would come forward.

The second panel, Panel on Senior Citizens' View of Medicare and Medicaid, consists of Mrs. Mildred A. Dean, president, Rhode Island Association of Senior Citizens and Senior Citizens Clubs, Inc.; Anthony Vittorio, Providence, R.I.; Mrs. Betty Curley, senior vice president of the Rhode Island State Council of Senior Citizens; Mrs. Alice McGrath, member of the Senior Citizens of Rhode Island Action Group, and the senior action group wants another person, Mrs. Eleanor LaPlante; Mrs. Ruth M. Person, field aide for Project SECAP, and Dr. Mary Mulvey, vice president, National Council of Senior Citizens.

At this time I'd like to acknowledge the staff here: Ken Dameron, representating the Democratic majority, and John Guy Miller, the minority staff director, representing the Republican side of the aisle, is also here with us today.

We will now move directly into this panel. I thank Dr. Mulvey for being here, because I know her husband has been quite sick. We will now move on to hear from representatives of the senior citizens groups who are concerned about inadequacies in the Medicare and Medicaid program. And the first witness from whom we will hear is Mrs. Mildred Dean, who is president of the Rhode Island Association of Senior Citizens and Senior Citizens Clubs. Mrs. Dean, would you proceed as you will.

STATEMENT OF MILDRED A. DEAN,* PRESIDENT, RHODE ISLAND ASSOCIATION OF SENIOR CITIZENS AND SENIOR CITIZENS CLUBS

Mrs. DEAN. Thank you, Senator. I would like to say that for those on Medicare, I find that we do not have adequate care. On Medicare we wish to have optical work, dental work, care of feet, and prescriptions, and at least one thorough examination each year. On Medicaid,

*See appendix 3, p. 364.

they receive this care, but we do not, and many only get a few dollars, and if they should be taken to a hospital, 1 week will clear their problems up. And I find that many are afraid to go for any medical treatment.

On Social Security, we also find that the percentage allowed on this, they take out already for Medicare, and you will find many will be in the high expense area, and we feel that the raise in Social Security will not take care of them, because you give with one hand and take away with the other. If you take them out of that percentage for Medicare and go up on rent, what are you going to have on food they are supposed to get the raises for?

Now, transportation also we find is inadequate. Recreation for the institutionalized elderly is far from what it should be. Now, these patients in the medical center, they cannot get out and be in the groups that have good times; so, therefore, we should take recreation to them. Some have no relatives come on a visiting day, and I feel that these are the forgotten few that recreation should be taken to.

I'd like to add something on crime, if I may. I'd like to say that 2 years ago I lost my home because of vandalism. They broke into my home four times in 1 year and for 4 years, while I lived in that housing, I had to go to bed and stay ready to get up and run if something should happen because my life was threatened. And this past year I have been very happy because I have been living in a project where they have adequate guards and so forth.

But I lost my home that I worked hard to get figuring that when I retired I would have my own home, which I don't have.

Senator PELL. Thank you, Mrs. Dean. Our next witness is Mr. Anthony Vittorio, who is a member of the Senior Citizens of Rhode Island Action Group, and first spoke with me right here in this auditorium last April.

STATEMENT OF ANTHONY VITTORIO, MEMBER, SENIOR CITIZENS OF RHODE ISLAND ACTION GROUP

Mr. VITTORIO. Thank you, Senator. I am Anthony Vittorio. I represent the Senior Citizens of Rhode Island Action Group. This is my case. I would like, Senator Pell, to relate the case of a friend of mine who cannot be here today because he passed away last Saturday. This man was speaking with me complaining of a pain in the chest. He was 80 years old.

I suggested to him that he should see a doctor. He said, "A doctor won't take me because I am on Medicare," because a lot of doctors do not accept Medicare. "I already have paid over $100 for glasses. "This man was almost blind. He tried to care for himself as cheap as possible because he couldn't afford anything else. So he gave a dollar to someone to buy him an enema, thinking that he could be relieved from constipation, he would be OK.

So a couple of days later I went to see him to find out how he was feeling. He was no better. Against his wishes, I called his daughter, who contacted her doctor. As soon as the doctor saw him, my friend was immediately brought to the hospital. Seven days later my friend was dead. Senator Pell, this is one case that I have time to speak of.

How many more cases and more tragic ones are still taking place because of Medicare and Medicaid? They are a great problem to senior citizens.

I would ask that all those healthy children be eliminated and full health benefits be given to senior citizens under a national health program. Thank you very much. [Applause.]

Senator PELL. Thank you, Mr. Vittorio. Now, if Mrs. McGrath would care to give her testimony, also a member of the Senior Citizens Action Group, a very active group indeed, and a group with whom we usually find ourselves in agreement. Mrs. McGrath.

STATEMENT OF ALICE McGRATH, MEMBER, SENIOR CITIZENS OF RHODE ISLAND ACTION GROUP

Mrs. MCGRATH. I am Mrs. Alice McGrath and I represent the Senior Citizens of Rhode Island Action Group. There are many services available for the sick and elderly in our State of Rhode Island. Medicare and Medicaid are good programs; however, I know several persons who do not benefit from the services granted by our Government.

COMMUNICATION GAP

In our times when TV and radio do such a good job of communicating information of all kinds, there is for the elderly people of Rhode Island a serious communication gap. We have over 30,000 senior citizens who are below the poverty level. Many of them have neither radio nor television. There are several groups of seniors who cannot read English. Some have spoken French or Polish or Portuguese all their life. Because of this problem and because of this language barrier, Senator Pell, here in the city of Providence there are elderly people who do not get proper health service.

A very dear friend of mine, Senator Pell, I met her coming from the doctor's office one day with a prescription for the druggist. She said, "I don't know how I am going to get through the month." I said, "Why?" She said, "With the high cost of the office visit and the high cost of drugs, I don't know whether I will be able to make it to the end of the month." So I said to her, "Don't you have Medicaid?" She said, "What is Medicaid? I have never heard of it." So I explained it to her, I helped her fill out an application, and now she is receiving Medicaid and she has been very grateful for the help I have given to her.

In the rural area such problems are just as numerous, but less known to the authorities on aging. If not less known, there are less opportunities to solve these problems than there are in the city. Communication is a severe problem throughout the State, Senator Pell. This communication problem is very much related to our health problems, Medicaid and Medicare.

Again, I speak for all the elderly who are poor, who receive insufficient amounts of money, and moreover, I speak for those who do not even know about the facilities that are offered to them. What we need is someone to contact us on a human level. We often do not have rides or phones to get in touch with organizers. We are afraid to burden others. We need someone to help us know what is available to us, someone who is sensitive to the needs of low-income people.

Senator Pell, do you think people should be informed properly about what is available in the lines of health services, and don't you think we should have organizers to have us know what our rights are on Medicaid and medicare? Could you give us someone to care, really care, about our problems of health, pay some organizers to help us? We believe that a very great need would be served if in the allotment of funds for the older Americans provisions were made for the hiring of full-time workers to contact and inform senior citizens not now being helped by the Medicare and Medicaid agencies.

Thank you, Senator. (Applause.)

Senator PELL. Thank you, Mrs. McGrath. Actually, one of the purposes of this hearing today is somewhat along the lines of what you are saying, to try to get across to the community as a whole and the older people particularly, not only what the problems are, but what the present programs are. And I think in general you will find that the question of carrying the message of what the programs are to the citizens is one that is not handled as well as it should be, but it is usually not a question of ill will, but a question of omission.

I think groups like yours can do a great job of it and on a volunteer basis as well.

Mrs. MCGRATH. But, Senator Pell, we cannot always reach the isolated cases, people that are living in one room and no one to come to speak to them on the level of their own language. They don't understand some of the things that are said because they don't understand the language.

Senator PELL. That is very true. As you have pointed out, many citizens have Portuguese or French or Italian heritage, older citizens who don't speak English. And this is one of the areas where we have a particular need in Rhode Island.

Now Mrs. LaPlante is a witness who also has a message for us from the Senior Citizens Action Group.

STATEMENT OF ELEANOR LaPLANTE, MEMBER, SENIOR CITIZENS OF RHODE ISLAND ACTION GROUP

Mrs. LAPLANTE. I am Eleanor LaPlante. I believe we have met before and we did discuss some of the problems concerning Social Security increases, Medicare and Medicaid. We still encounter several problems and they are big problems. We are meeting with you today as we need action now, not in 1973 or 1972, but now, in 1971.

Action, Senator Pell, means, as you know, willingness, choices, and doings. We feel you are willing to help, but we would like to tell you that action is most urgent now. Right now, we senior citizens are paying out of our Social Security checks $5.60 a month, which adds up to $67.20 a year. Do you realize that more than 30,000 of us in the State of Rhode Island are unable to pay for this service?

As a representative of the Senior Citizens of Rhode Island Action Group, I am asking you if you could find a way of getting free Medicare for so many deserving people. I would like to remind you that Canada provides free care for her people. Why can't the United States provide free care for their people?

Several people have already asked us why wouldn't Medicare benefits go back to the original cost. I go further, Senator Pell, knowing

that you are willing to take action for the benefit of the elderly and ask for free Medicare. Senator Pell, I have three more points to make clear with you: No. 1, many doctors will not take care of Medicare patients. Why shouldn't all doctors be obliged to take care of people on Medicare? I believe that if Medicare were better organized, with less paperwork, doctors would not hesitate to care for us.

No. 2, Medicaid takes care of many things that Medicare does not cover, but many people are not eligible for Medicaid. No. 3, the pension for all senior citizens should be lowered to 60 years of age with full benefits.

Tired of Surveys

Senator Pell, we are very tired of surveys and studies on old age, as we know what is best for us. Why waste money on surveys, let's use that money for free medical services for the elderly of the Ocean State. Let's have a pilot program. Senator Pell, please be our action man. We're banking on you. Thank you, Senator Pell. [Applause.]

Senator Pell. I think you will be glad to hear that I have already cosponsored an amendment that would make part B free. But it takes a majority of the Members of Congress to pass a law, not just one or two or three or four or 20 or 30. So your message will be delivered to my colleagues from all over the United States as well as right here in Rhode Island.

As far as the other point you mentioned, the question of the doctors giving the treatment, this will be discussed later on in another panel and we'll see what their reaction is to the point you made. As far as pensions at 60 goes, that is a nice idea, it would be nice to have pensions at 55, too. But it would be the question, really, of the amount of money that it would cost the taxpayers and the government as a whole, and how much more that would add to the tax burden of our citizens.

As to the question of Medicaid coverage: It certainly should be more inclusive. My own view is that dentures and eyeglasses and hearing aids should be included. But this again takes a certain amount of discussion around the country. One of the purposes of these hearings is to have these issues ventilated not only in Rhode Island, but, as I pointed out earlier, in other points of the United States.

Thank you, Mrs. LaPlante, for very specific suggestions. Our next witness is Mrs. Betty Curley, senior vice president of the Rhode Island State Council of Senior Citizens, and a senior aide in Dr. Mary Mulvey's agency.

STATEMENT OF BETTY CURLEY, SENIOR VICE PRESIDENT, RHODE ISLAND STATE COUNCIL OF SENIOR CITIZENS

Mrs. Curley. Senator Pell, members of the panel, ladies and gentlemen, may I say that I heartily agree with Colonel McQueeny. I personally know of three instances of our senior citizens being sent to the hospital after being robbed and assaulted, and two others had their homes burglarized of substantial sums of money and articles impossible to replace.

This leaves us in such a state of apprehension that we are being deprived of the right to live out our lives as free senior citizens, afraid to leave our homes for meetings and classes we wish to attend even

though we are always furnished transportation to and from such meetings. It is about time for us to recognize that the protection of the law is for the innocent and not the guilty. Therefore, there must be some sort of a plan of protection devised to allay our growing fears of assault and robbery on the streets, even in the daylight hours.

Improvements on Medicare and Medicaid

Now, I have several suggestions for improvements on Medicare and Medicaid. (1): Enactment of national health insurance, health security bill. Our immediate goal is early improvement in Medicare and Medicaid. (2) Eliminate the premium charged for Part B, combine parts A and B, and finance through taxes on payrolls and through Federal general internal revenues. (3) Fill prescription drugs. Medicare does not pay the full cost of Medicare drugs prescribed for us on an outpatient basis. It now pays only during hospitalization.

(4) Eyeglasses, dentures, and foot care are three leading ailments of our senior citizens and these definitely should be included in our Medicare program. (5) Limitations on hospital care should be abolished. The benefit period should cover the entire period of the illness or disability, including the first day payment of $60, additional payments beyond 90 days, and limit of 100 visits under Medicare home health services. (6): Eligibility, immediate determination for extended care. Many people enter nursing homes believing they have coverage, only to learn after weeks or months that Medicare officials have ruled against their reimbursement. This is a frightening experience. The U.S. Department of Health, Education, and Welfare should promptly devise some method to insure early decision of eligibility.

I personally know of a terminal cancer case, a very dear friend of mine, she had been hospitalized for about 2 months and the supervisor walked in one day and said, "You have to go down into a different room, $100-a-day." And she panicked and said, "I can't afford that." They said, "The only alternative is to go to a nursing home this afternoon." And they packed up her things and sent her to a nursing home. I saw her a week later, she was very pitiful, and she was a well-educated and intelligent woman, didn't know where she was, didn't know how much she was going to have to pay for the room. And they then found out she wasn't eligible, after she had been in and out of the hospital and nursing homes, and she died 3 weeks later.

(7) Nursing homes. I would recommend sweeping changes in nursing homes nationwide. David Pryor testified in Washington at our Senior Citizens National Conference. At a time when the Nation's attention has been on the young, David Pryor has been concerned with older Americans. He worked as a volunteer janitor and nurse's aide. He gave some shocking testimony on brutality existing in Washington homes right in the shadow of our National Capital. This is a gross miscarriage of justice when we realize that they are being paid by our Government with Federal funds.

Action Needed Now

The time to act is now—this year. We can no longer postpone action in the hope that all problems associated with old age are transitional problems, that given time they will solve themselves. To the contrary,

given sufficient time, given no action, the situation of the people already old will deteriorate still further. Today's young people will face exactly the same problems now facing us when they reach old age.

And last, but not least, always remember that we will be heard if we stand together and speak with one voice. The time is now in letting our Nation know that. Thank you for allowing me to present this testimony. [Applause.]

Senator PELL. Thank you, Mrs. Curley. And now——

Mrs. Dean, do you want to say something?

Mrs. DEAN. I would like to say on nursing homes that I have had reports that the patients are charged for therapy where they think they just have a little visit and a little thing with the legs in the nursing home; and when the month was up their husband got a bill for over $100 for therapy which they did not feel they had received.

Also, other nursing homes do not provide adequate food; rather patients have to go out, if they are able to walk at all, they go out and ask neighbors for a cup of coffee or something for lunch time. Thank you very much, Senator Pell. [Applause.]

Senator PELL. Thank you, Mrs. Dean, for those poignant comments. Now, Mrs. Person, the lady with the arm in the sling, will testify. And maybe she will also mention if she knows what happened to the people who abused her last Friday and where they are at this point.

STATEMENT OF RUTH M. PERSON, FIELD AIDE FOR PROJECT SECAP

Mrs. PERSON. Thank you. I am Mrs. Ruth Person. I am a field aide for Project SECAP of the model cities area. Time won't permit me to tell of the inadequate coverage of medical needs for glasses, hearing aids, and the rest by Medicare, which is another real problem area for our citizens. We have many situations where a person who cannot meet poverty qualifications must go without glasses or a hearing aid because Medicare does not meet payments for such items.

One of our recent cases on September 16, we had a situation which we are still working on where a woman needs two pairs of glasses which will cost approximately $50. She is on Social Security and receives a small veteran's pension and, therefore, does not qualify for welfare and thus has no other help to pay for her glasses, which are sorely needed as she is only able to see shadows.

This lady is despondent to the point of vocally suggesting that she will be better off to end it all by taking an overdose of her available medications. One man was unable to get a necessary hearing aid due to his financial situation. A blind man was referred to us by a district nurse. He was living in a deplorable situation at the Continental Hotel. As of this morning our worker was having trouble trying to secure a cane for this blind person. We are in the process of finding a place for this man to live in view of the conditions in which he is living now.

We are following up an application for housing in a housing project for the elderly, knowing full well that his name will only end up on a list of 100 or more. Another pressing item is medications that have to have prior authorizations. I can pinpoint many, many cases that have to wait as long as 2 to 3 weeks for a prior authorization from the Providence Public Assistance Department.

Too Much Redtape

Once the patient has visited the doctor and receives a prescription, it is necessary for this patient to present the prescription to a pharmacy who has to have a prior authorization. When the authorization comes through, it comes to the druggist, who in turn notifies the client, who in turn notifies our office to pick it up. Some doctors have refused to contact pharmacies by phone to give prescriptions, necessitating a trip by one of our workers to the doctor's office to pick up the prescription and on to the pharmacy to pick up the prescription there. They will not send the prescription through the mail, either.

Prior authorization medications are something that go on special slips, and some doctors do not place these prescriptions on the slips, the proper slips, which then necessitates a return trip by one of our workers to the doctor's office to receive the correct form. The redtape involved in securing ordinary medical services and in maintaining medicines for senior citizens leaves much to be desired. In case of pharmacists, they are not only refusing to transport the necessary medicine, but Medicare and Medicaid paying customers will be treated differently and definitely not as well as cash paying customers.

It is necessary for the Medicare and Medicaid patient to show identification cards or their last check stubs before receiving medications. While searching for her identification card, one lady on public assistance did not receive her card on time and the doctor would not fill the prescription until she had her card. An identification card was stolen from one lady and a request was made for a new one to be issued. It was very difficult to obtain a new card and the lady was, therefore, without a card necessary to obtain her medicine.

The recognition of the need for more adequate food as a basic element of good health where senior citizens are concerned is long overdue. It would seem to me that a correlation of the Medicare, Medicaid, and Food Stamp program to a better advantage of senior citizens is indicated. We have any number of situations where the need for a housekeeper or someone visiting on a daily basis exists to assure that the elderly are making proper and adequate use of medication provided them.

Supervision of Medicines Needed

In one situation we found a senior citizen who was receiving and taking the same medication which was prescribed by three different physicians. The insight of the field aide to recognize the similarity of the prescriptions made it possible to prevent this woman from taking a real overdose of medication. In another instance, the district nurse asked us to go in daily and supervise the case of one person. In one case, a diabetic lady was almost ready to go into a coma. She received a prescription, but because she could not read and write, it was necessary for her to have a box of crayons and color the chart with the color that described her urine so the doctor could prescribe the necessary medication.

The above are only a few of a large number of documented situations in our office regarding the need for some health care and some more active provisions in the immediate areas of senior citizens. Thank you.

Senator PELL. Thank you, Mrs. Person. I would add that when we asked you to speak on this panel on Medicare and Medicaid, we would have also asked you to speak on the panel on crime if we had known the sad event that was going to befall you after we asked you to come. Would you describe the incident to us and what happened to the hoodlums who are responsible?

Mrs. PERSON. Well, as you know, twice a month we do pick up food stamps and cash checks and do shopping trips for the elderly citizens of the Model Cities area. Of course, this Friday happened to be the day for food stamps. Fortunately, I had delivered all of my food stamps except one.

I happened to have a client that lives next door to me. I was delivering her food stamps and I ran into my house next door to make a phone call to the office. At that time, although I didn't make the phone call, I came right out, I had left a young lady, Miss Conway, in the car, who is a volunteer worker, with both of the bags, and I told her that I would be right back. By the time I got back down the stairs, I saw these three gentlemen——

Senator PELL. Hoodlums.

DRAGGED FROM CAR

Mrs. PERSON. Hoodlums, tussling with Miss Conway. They had dragged her out of the car. They had walked up, she said, to the passenger side and dragged her out of the car and, naturally, she held onto the two bags. When I ran and saw what was going on, I rushed to try to help also, and at that time I was pushed to the ground. Fortunately, Miss Conway is a very strong lady. She held onto the man until she actually ripped his shirt off. She also, while we were tussling with him, saw the fellow pitch the bags into the air to the other two guys, and they took off.

I would like to insert here when I saw what was going on, I started to holler. I said, "We are being robbed, help, help, please help us." And no one came to our rescue. One gentleman that was standing across the street on the steps, he said that he thought we were fighting, but we were actually being robbed. As I said, Miss Conway, in her bag she had personal checks in the amount of $400-some-odd, I'd say I had one lady's food stamps and all my other personal papers and what have you.

Senator PELL. What happened to the three hoodlums?

Mrs. PERSON. The three hoodlums ran across the field and one of the fellows was picked up by the police, and I must say that the policemen, well, they really were on the ball in this incident. And they cooperated and we tried to cooperate with them. At present they are holding the fellow downtown, the one of them that robbed us.

Senator PELL. He is being held for trial?

Mrs. PERSON. Yes.

Senator PELL. Presumption is that he will go to jail? How old is he?

Mrs. PERSON. He can't get bail.

Senator PELL. How old is he?

Mrs. PERSON. The paper said 32.

Dared to Press Charges

Mrs. Newsome. Senator Pell, as a supervisor, the problem now is whether or not I will subject my staff to go into court and identify these folks and then having their homes burglarized. We have already received threats in our office this morning, "if you go to court and press charges against that fellow, we will take care of your first." I am a supervisor at Project SECAP. That is the status of affairs, whether or not we will have the courage to go through and dare them to burn down our houses and come and rob us some more.

Senator Pell. Thank you. For the record would you identify yourself?

STATEMENT OF ELIZABETH NEWSOME, DIRECTOR, PROJECT SECAP

Mrs. Newsome. I am Mrs. Elizabeth Newsome, the director of Project SECAP. We have gone as far as to go through the lineup and identify these hoodlums. My girls call him a gentleman. This morning Mrs. Conway did not come in. I couldn't blame her. She is a volunteer worker, free, for nothing, serving senior citizens. I say we will go to court and testify against them. Then I will tell you to read the paper where Mrs. Newsome's home, a senior citizen's life, has been robbed again.

I will tell you to read the paper that Mrs. Person got more than just those slings helping senior citizens. We have got the courage. When you back us up and we go down there and testify against the gentle hoodlums—[applause].

Senator Pell. Mrs. Newsome, I admire your courage. I recall the words of Colonel McQueeny when he said he also needed courage and needed the help of people who would have the guts to take the risk and stand up and be counted and to identify the hoodlums.

Too Risky for $100 a Week

Mrs. Newsome. I was late coming because the police department is out working with the rest of my girls. We did not get all the food stamps picked up Friday because the minute this happened I called in the other five girls. Colonel McQueeny has given us police protection this morning for the rest of the job. I have said to Dick Torshia, "This is going to be your money to pay to protect us. I am not sending any more girls out there without the police protection because I am not going to have people working for measly salaries of $100 a week to end up with that kind of thing happening."

Now, if you want your police money to go that way, that's the only way you are going to get the service. I am not going to have for $100 a week people hurt trying to serve senior citizens.

Senator Pell. Thank you, Mrs. Newsome. And I do hope you will go in with Mrs. Conway and identify them, although I realize it takes very real guts and courage on your part to do that.

Our final witness on this panel is Dr. Mary Mulvey, who has delved deeply into the problems of our elder citizens and who is an

old friend of mine. I can assure you she has a comprehensive statement. It will be put in the record in its entirety, and she will review just the major points for us now.

STATEMENT OF DR. MARY MULVEY, VICE PRESIDENT, NATIONAL COUNCIL OF SENIOR CITIZENS

Dr. MULVEY. Thank you, Senator Pell. I have prepared a statement which I won't read. There are many more people to be heard from this morning. I would like to speak to you on Medicare and its shortcomings.

Senator PELL. Right. And the regular statement will be put in the record as is.*

Dr. MULVEY. Thank you, Senator. The cost of medical care is one of the principal problems that our elderly people face today. In Rhode Island, the over-65 group in the 1967–69 period had a median family income of only $4,347, which is lower than the national median. The national median at that time was $4,802. It is less than half of the median of people under 65. The median of individuals aged 65 and over who live alone was $1,855 in 1969, and $1,951 in 1970. Furthermore, our older people are slipping more and more into the poverty level year by year.

Coupled with the fact that our median for our families in the over 65 group is lower, the cost of living in Rhode Island and the Northeastern urban areas is much higher than in the rest of the country. Total costs of budget can vary from $269 a month in a small southern town to about $400 a month in our New England cities. I have included in my written testimony a chart of what the cost of living is in many urban areas in our country.

Now, medical costs also run way ahead of the national average. The average reimbursement of hospital bills for the aged in Rhode Island under the Federal Medicare program in 1969 was $307, as compared to a national average of $237. The average Medicare reimbursement for medical bills, for out-of-hospital medical bills, was $104 in Rhode Island, as compared with the national average of $87.

Now, the Federal Medicare was a great social advance, but it does not cover 45 percent of our senior citizens' health costs. And the financial outlay by senior citizens for the coverage has been increasing year by year. Plan A deductible rose from $40 to $60—50 percent increase in 4 years. Out-of-pocket premium payments, Part B, increased from $3 a month to $5.60 in 4 years—an 87-percent increase. Older people who can afford to buy Blue Cross Plan 65 have had their premiums increased 65 percent.

REDTAPE CREATES LACK OF UNDERSTANDING

So those enrolled in Part B and Blue Cross pay about $153 a year right now, and this does not give them the coverage of the many kinds of services you have heard here today, prescription drugs, eyeglasses, dentures, and so forth. Now, in addition to the shortcomings of Medi-

*See appendix 1, p. 311.

care coverage, many of our older persons are not getting, are not collecting, their reimbursment costs, largely because they don't understand how to go about it; there is so much redtape.

Others lose out because the information which they receive on statements for medical services under Part B does not explain why they will not receive what they expect under the law. And this misunderstanding arises in part because the information contained on such statements is that part of the bill is not covered by Medicare.

The fact is the Medicare law allows the carrier, which is Blue Cross in Rhode Island, to pay 80 percent of the reasonable charge. Now, if a physician charges an amount beyond what is determined reasonable, the carrier is required by the Social Security Administration to cut the total amount back to what has been determined under the provision of the law to be a reasonable amount. Now, if the physician does charge an amount beyond the reasonable, he should explain that to the older person. However, neither the Social Security Administration nor the doctors nor the carrier—in Rhode Island it is Blue Cross—explain in their notice to the beneficiaries about reasonableness of the charge.

The Social Security Administration should require the carriers to notify the beneficiaries in clear, precise, and unmistakable terms the reason for the reduction in the amount that is reimbursable. Old persons should be instructed thoroughly on all phases of applying for reimbursement under Part B. They should also be aware that it is not always a case of reimbursement; in other words, older persons are not required to pay their medical fees before they receive Part B Medicare coverage. They may present the physician's statement to the Part B carrier, namely Blue Cross, and receive payment due.

Still another problem arises because part B statements are submitted on Blue Cross letterheads. Because of this many people in Rhode Island over 65 assume that they are enrolled in Blue Cross. Again, this fuzziness about the whole program should be eliminated. Training in senior citizens advocacy is in order so that they will learn all of the benefits under Medicare and all methods of collecting their health care costs, meager though they be.

Support National Health Security Bill

We feel, in view of the shortcomings of coverage and payment of costs, that the most direct, the most immediate way to correct the shortcomings will be to get behind the national health security bill now pending in Congress. I want to congratulate you, Senator Pell, for your having introduced a bill of health insurance for all people, including the elderly. You have also cosponsored the national health security bill, S. 3 in the Senate, H.R. 22 in the House. This is the bill which the National Council of Senior Citizens is backing, and I know that many of the provisions of your bill are the same as those in the Kennedy-Griffiths bill—S. 3 and H.R. 22.

Medical care today is a crazy quilt paid for with private and Government funds. Medical bills are paid in part by private citizens' health insurance, in part by health payments, in part by public welfare funds, and in part by Medicaid for the elderly. Now, this particular bill would be financed by taxes on employers, employees, the self-

employed, and on unearned individual income and by Federal general revenue. The work share will be 1 percent of wages and unearned income up to $15,000 a year.

It is not a new tax. Workers are now paying almost that amount for the Medicaid program. S. 3 and H.R. 22 would reduce out of pocket nonreimbursed medical expenses while it will provide a better and more comprehensive health service. The employers' contributions would be just about what many employers now pay for inadequate private health insurance for their workers.

Under this legislation, the Federal General Revenue would pay for approximately half of the total cost of the program, so there would not be a new outlay since Medicare for those aged 65 and over and Medicaid, the Federal-State program for health care for the needy, and other Federal health care expenditures, represent a large and growing portion of the Federal budget. National Health Care Insurance proposed under S. 3 and H.R. 22 will absorb these present heavy outlays. S. 3 and H.R. 22 incorporate built-in financial, professional, and other standards and incentives to encourage preventative medical care, which is not in the present Medicare bill, and early diagnosis as well as better treatment of disease and disability once it has occurred.

Now, this bill, of course, is for all people, all Americans, including the elderly. But for the elderly, it would cover, all the elderly. Eligibility for hospitalization in the program would not depend on past employment status. In other words, they would not have to have been enrolled or be eligible for cash benefits under Social Security or have met the requirement for eligibility for Medicaid. There would be no monthly premium to pay. Included would be prescription drugs, no limitation on hospitalization or home care services.

Incidentally, there would be 120 days of nursing home care, whereas now there are only 20 under Medicaid and there are many restrictions as to nursing home eligibility. There would be no outlay by anybody except that their income would be taxed at 1 percent to cover it.

I hope that I have not imposed on your time, but I want to thank you for the opportunity of giving testimony. [Applause.]

Senator PELL. Your full statement will be put in the record. Thanks very much to this panel on Medicare and Medicaid for being with us. I think they have brought out the fact that present laws are insufficient, because, for example, Medicare does not now cover out-of-hospital prescription drugs, glasses, or dentures. The need for additional help in these and other areas is very real and very vital. I think one of the subjects we are discussing, H.R. 1, goes in the wrong direction because it would increase the amount of the deductible under Part B and it would also make the elderly subject to a $7.50 daily copayment charge for each day in the hospital from the 31st to the 60th day. So I think these are areas where we should go counter to the proposals in H.R. 1. I thank this panel very much.

Now, the next panel, Panel on Health Care Providers, consists of Dr. Richard J. Kraemer, chairman of the Committee on Aging of the Rhode Island Medical Society; Mr. Wade Johnson, executive director of the Hospital Association of Rhode Island; Mr. Gustin L. Buo-

naiuto, president of the Rhode Island Nursing Home Association; Mr. Albert V. Lees, president of the Rhode Island Association of Facilities for Aged; and Miss Shirley Whitcomb, member of the Association of Home Health Agencies.

Elderly Hit Hard by Inflation

I think also as we see the problems of the aged and hear from the older people themselves, we realize how acutely they are hit by inflation. We also realize the extent to which they must go in order to maintain a normal level of diet. Sometimes you will find dog food and cat foot advertised as luxury products on television being used by older people as a staple for food. I think the degree of illness, degree of poverty, degree of misery, is often not available to the general public because misery and poverty and illness cannot move around, it has to be still. And people who are aware of it are not the public as a whole, who don't realize what exists. But those of us who go into these areas are aware.

I think the social workers are aware of these problems, each of them have their load of individuals that they try to help; the clergymen who go around, who are interested in their soul; I guess the politicians who are interested in their votes. But I guess these three categories of people, the social workers, clergymen, and politicians, are probably more aware of the extent of misery and poverty in our community than any other group of citizens.

Now, I thank the Panel on Providers for being with us. I don't want to cut off anybody at all, but I do have questions, so if any of you have rather long statements, I assure you it will be put in the record in full if it is not read. We have representatives of all the different providers of health care services for the elderly. I am very glad to say our first witness is the chairman of the Committee on Aging of the Rhode Island Medical Society, Dr. Richard Kraemer.

STATEMENT OF DR. RICHARD J. KRAEMER,* CHAIRMAN, COMMITTEE ON AGING, RHODE ISLAND MEDICAL SOCIETY

Dr. Kraemer. Good morning, Senator. The stated charge to the November 1971 White House Conference is to propose a plan of national action, and the doctors believe it is incumbent upon organized medicine to insure that proper emphasis is placed on improving and maintaining the health of the aged.

Medicine has adopted a series of 10 concepts which, if implemented, would help meet the stated charges of the conference. No. 1, there are no known diseases specifically attributable to the passage of time, but the diseases and health problems which frequently develop in the elderly render the health care status of the aged not as favorable as that of the younger group. No. 2, since the vast majority of older citizens are not sick, any program on behalf of older citizens should place emphasis on keeping them well. It was stated recently from information taken in Washington that only 7 percent of the aged are hospital-

*See appendix 1, p. 303.

ized or institutionalized. The remaining 93 percent are out in the world just as you and I, 63 percent with their families and 30 percent alone or with nonfamily groups.

Encourage Elderly to Remain Active

No. 3, encouraging older persons to assume functions, valuable roles in the family and community will reduce their emotional problems and improve their general health. No. 4, the health of all people, including those in the older age group, can be significantly improved by adoption of a positive health program, including: (1) periodic health appraisals, planned regular visits to physicians, exercises, planned activities to challenge their thinking, diet planning to avoid obesity and malnutrition, modification of habits that might be detrimental to health such as the overuse of alcohol, drugs, and tobacco, and participation in preventive medical programs.

No. 5, the financing of long-term care continues to present a special problem for elderly people, means to provide protection from catastrophic costs of such care should be explored as well as the development of incentives to communities to make home health services readily available as an alternative to the more costly institutional care. As you heard this morning from Dr. Mulvey, Medicare provides only 45 percent or less of your actual cost, and Medicaid covers an uneven protection which meshes very inefficiently with Medicare.

No. 6, there should be no selective social discrimination against the aged solely on the basis of their age. No. 7, compulsory retirement and artificial barriers to employment based on age can be prime factors in the deterioration of health. Middle age and older workers, therefore, should be afforded equal opportunity with others for gainful employment based on their ability, personal desires, and capabilities.

No. 8, workers who are capable and who personally desire to postpone retirement should be encouraged to do so by implementation of the Work Old Age Insurers Program and by flexible protection policies by both industry and Government. As you know, the middle group is getting proportionately smaller than the young and aged that they support directly or indirectly, and it is certain that the older age group is going to have to be gotten back into the work force and their talents and abilities used in order to take some of this load off the middle-age group.

Pension Portability

No. 9, a voluntary pension system transferable among employers should be devised to encourage the expansion and improvement of private pension coverage. Your pension should be transferable and not lost if you transfer from one job to another. That is called vesting.

No. 10, a formula for fulfillment for the aged should be, should include independence and self-esteem, opportunity for work part- or full-time on a paid or voluntary basis, continued meaningful participation in family and community life, adequate housing, ability to enjoy leisure time and participation in recreational activities, continuing self-appraisal and availability of protective services and medical and nursing care should be made.

A recent survey in a large medical journal reported a survey of doctors and their attitudes toward national health care. Their attitude was that with practical politics and the social consensus of opinion in this country, national health insurance was going to come, and it is just a question of how to keep the system within bounds of reasonableness and practicality.

The survey peculiarly shows that the doctors were much more generous in their attitude on benefits, including care for catastrophic cases, dental care, long term psychiatric ills, nursing home care, and prescriptions which are not included under the present Medicare and Medicaid today. It was felt that in order to keep the plan solvent there had to be a very definite deductible and coinsurance factor to keep down what we call induced costs; in other words, when somebody gets something for nothing, they are apt to take more advantage of it and come more often simply because of it being free.

Free Care for Needy and Indigent

Those people who are so-called solvent, who are able to pay their way; should do so in proportion to their ability. Medical men in general, in this survey, were of the opinion that care should be free to the needy or the indigent or those who are nearly so. It is a very tremendous hardship at the present time to have all these deductibles and coinsurance payments out of small pensions. It is an unfair tax upon you with such limited means.

Dr. Mulvey mentioned unreasonable costs which should be explained in detail for you. Actually, that is why many of the doctors do not wish to participate in this thing because of the statistical inadquacy of the method by which the reasonable and usual customer charges are determined.

In finishing, I would like to say just be reassured that the doctors, as always, want to see that everybody has the care they need. As one doctor at the end of his statement in the recent Medical World News geriatrics article said, give the aged full pocketbooks to take care of their every day living and a physician with a warm heart. [Applause.]

Senator Pell. Thank you very much, Dr. Kraemer. I know that a point that you made about the vast majority of our older citizens not being sick is one about which the Rhode Island Medical Society and I have been jousting for about 8 years. I think there has been an exchange of articles on that point. There was some disagreement whether three-fourths of all senior citizens have at least one chronic condition and 50 percent have two or more chronic conditions. I think the point at issue is chronic disease, whether it means being sick. In my view it does and in your view it does not. I suspect we will continue jousting on this for many years.

The next witness we have here is Mr. Wade Johnson, executive director of the Hospital Association of Rhode Island, who's been closely associated with me and my office and with whom I have been very close in the past few years.

Mr. Johnson. Thank you, Senator Pell.

Senator Pell. I would like to add another thought. I think it would be helpful if all witnesses could limit their statements to a maximum

of 5 or 7 minutes in accordance with, I believe, the staff request to witnesses.

Mr. JOHNSON. Thank you. I might mention that I do have a written statement.

Senator PELL. It will be printed in full in the record.*

STATEMENT OF WADE JOHNSON, EXECUTIVE DIRECTOR, HOSPITAL ASSOCIATION OF RHODE ISLAND

Mr. JOHNSON. I will not completely read it, I will try to stay within the time limit. I will begin by mentioning that I am here as the chief staff person of the Hospital Association of Rhode Island, and that the membership of our Association consists of all of the voluntary nonprofit hospitals and all of the State government hospitals in Rhode Island. And I am going to confine my remarks mainly to the concern shared by the hospitals in Rhode Island about the problems of Medicare and Medicaid and some thoughts about the existing pending legislation that might affect those programs.

At the outset, I'd like to make a couple of general observations. I assume that all of us here are going to not look at certain health programs in themselves, but are concerned for the net effect of all of the programs on the quality of life to people who we call the elderly in this country. As you surely know better than I and as we have been hearing very distinctly this morning, this quality of life is affected by many variables: economic, social, environmental, as well as the important one of health services, which society needs to evaluate both by study and observation and by hearing from the elderly themselves.

MEDICARE ERASES WELFARE LABEL

So having sounded this note of caution, I can now say it is our general impression that Medicare, despite its problems, has made a significant contribution toward improving the quality of life for the elderly in this country. The Medicare program committed the Federal Government to the responsibility of financing most health services for this major segment of the population; in so doing, Medicare relieved the elderly of both the financial roadblock to some extent and of the welfare label as it had become their right to expect.

As you so well know, it is now widely accepted that health care is no longer a privilege for only those who can afford it, but rather it is an inherent legal right of all individuals. Also, we think it can be said without contradiction that Medicare, more than any other single development in the health field in the past 5 years, has served to bring into focus the weaknesses and problems as well as the strengths of the health care delivery system in this country.

In doing so, however, it has exacted a high price, both in terms of the cost to the taxpayer and in terms of additional problems in the health care system generated by the program itself. Now, in my written statement I delved into the severe inflationary effect Medicare itself has had on health care costs; the underestimated cost projections of the program that were given to Congress when it enacted Medicare,

* See appendix 1, p. 315.

and into a few of the many administrative problems for both Medicare and Medicaid or welfare patients, which have resulted from the way the law was written.

In this connection, one specific suggestion we make in our written testimony is that we believe H.R. 1 should contain a precise definition of reasonable costs for providers, specifically in this case, hospitals, and the determination of reasonable costs should be uniform among the Medicare, Medicaid, and other health programs. It is only when the precise agreed upon definition of reasonable costs is stated that we believe progress can be made toward an effective and efficient reimbursement formula.

Proposed Guidelines for Health Care

Now, our written testimony* at this point introduces and discusses at some length a set of principles for financing health care which have been developed by the American Hospital Association, and which we believe are sound and should be reflected in any future legislation. The passage of Medicare and Medicaid underscored the fundamental weaknesses of health care financing. The programs assume the burden for the payment of health care bills of a large segment of the population, but explicitly renounce any obligation to share in the meeting of the total needs of our health care system except as that system meets the need of the particular beneficiary.

So it is out of a deep concern for the broader community interest in the financial stability of the health care system that the American Hospital Association, with which our Rhode Island Hospital Association is affiliated, issued the above mentioned guidelines, called the Statement on the Financial Requirements of Health Care Institutions and Services. These guidelines declare that collectively all purchases of health care, particularly all major third party purchasers, have an obligation to recognize and share in all the financial requirements and needs of institutions providing this care.

The entire list of these financial requirements and their components is appended to our written testimony as an appendix. Now, this statement of financial requirements I have been referring to takes into account such things as the institution's responsibility to the community, the need for systematic financing of all their operating and capital needs, a rationale for proper planning of facilities and services with due regard for variations, and incentives for economy and efficiency of high quality health care.

In our written testimony we develop each of these key points in more detail. Now, on the last of the aforementioned points, incentives for economy, our statement goes into the importance of encouraging new methods of reimbursement and the promising experience to date with prospective rating as one such new method. We are very encouraged to see that section 222 of H.R. 1 would authorize the Secretary of Health, Education, and Welfare to experiment with methods of reimbursement designed to increase efficiency and economy.

Additionally, this same section of H.R. 1 calls for experimentation with the method of payment to providers of health care on the pros-

* See appendix 1, p. 315.

pectively determined basis. The Hospital Association of Rhode Island and its member hospitals wholeheartedly endorse the concept of the prospective rating and strongly encourage the Federal Government to continue to speed up the experimentation with methods of reimbursement.

We would like to point out for the record that the voluntary hospitals of Rhode Island are all presently operating under the prospective reimbursement contract with Blue Cross. Rhode Island was the first statewide group of hospitals since Medicare to come under the prospective rating method where rates are negotiated between the payer and provider. We think it is worth noting that the agreement between the two parties was reached voluntarily. Although the prospective rating method is only partially in effect in this present fiscal year ending October 1, 1971, we already have some indications it is having a favorable effect on costs.

State Made Party to Negotiation

Based on preliminary data recently gathered by the Hospital Association, the hospitals in Rhode Island are presently "under budget" when actual costs are compared with budgeting costs. It appears significant dollars will be saved in this 1 fiscal year alone as a result of the prospective rating method. A recent development in the prospective reimbursement picture here in Rhode Island was the passage of a bill by the Rhode Island General Assembly making State government through the State budget director a party to hospital budget negotiations between all voluntary hospitals in the State and Rhode Island Blue Cross. This will begin for the fiscal year that starts a year from now, October 1, 1972.

In addition to making the State a party to the budget negotiations, the new Rhode Island law paves the way for the State to enter into a contractual agreement with the hospitals to determine prospective rates it would pay as a major purchaser of health care for Medicaid and other patients. Presumably this would come about with the passage of H.R. 1 and section 222.

Medicare and Medicaid principles of reimbursement are inadequate to the extent they do not comply with the AHA statement on financial requirements, specifically in nonreimbursement of their respective share of bad debts and failure to recognize working capital needs of health care institutions.

As a way of concluding our testimony this morning, I would like to address myself to that which I feel is necessary for changing the present health care system to insure the proper and adequate delivery of health care to the aged and indigent as well as to all Americans. We have discovered the hard way through Medicare and Medicaid that to pour additional money into the existing system will not solve our Nation's current health care problems. What is really needed is a basic restructuring of the entire health care delivery system and a realinement of financing mechanisms. Plans, which we feel can bring about these changes, are contained in Ameriplan, the national health care program recommended by a special committee of the American Hospital Association.

Unfortunately, Ameriplan is but one of many national health insurance proposals to be considered by Congress during the coming year. Each of the proposals attempts to provide a minimum level of health care benefits for the entire U.S. population. Where they part company is on the issues of the needed reforms that should be carried out and how they should be financed. Ameriplan offers a proposal to restructure the entire delivery of home-care services as well as financing.

Health Care Is Right of All Individuals

At the very outset of our testimony we said health care is no longer a privilege of the few who can afford it, but is the inherent right of all individuals. It is on this principle that the goals of Ameriplan were founded. The corollaries of this principle, as stated in the AHA health plan, declare that the dignity of the individual and better community life are functions of health care, that government must assure preservation and maintenance of health, that health services must be delivered without regard to the ability to pay or to race, creed, color, sex, or age, and that health services must be accessible to all.

Some of the proposals call for long-range planning and increased national expenditures for health care. Others require little change in the way that health care services are presently delivered. One far reaching goal is that delivery of health services much provide comprehensive health care, the five components of which are health, primary care, specialty care, restorative care, and health-related custodial care. Another goal which reaches into the future is that the system must provide incentives to health care providers for keeping people well.

At the heart of Ameriplan are health care corporations organized to manage and coordinate health care services at the community level. The health care corporation would be responsible for providing the five components of care, either through its own resources or through contracts with providers. It would be approved for operation in providing its services to a defined population group in a specified geographic area by a newly formed independent agency. This agency would be known as the State health commission.

National Health Commission

This commission in turn would be answerable to a National Health Commission having the responsibility at the Federal level for establishing standards of quality and regulations for the scope of benefits and comprehensiveness of services.

Senator Pell. I hate to interrupt. There is no better friend I have than the American Hospital Association, but I am trying to limit the witnesses, if they would, to 5 or 7 minutes. Otherwise this means no questions.

Mr. Johnson. The plan is admittedly difficult of explanation briefly, but it is one we hope certainly Congress will give consideration to. Realistically speaking, I am sure none of the specific programs right now is to be the final proposal enacted. In this connection, I'd like to mention the fact that we are well aware of your own national health plan before Congress at the present time and that it embodies some of the elements that I have been talking about.

We'd like to take this opportunity to publicly applaud you for the outstanding direction and leadership that you have provided in behalf of better health care delivery, not only nationally, but in the State of Rhode Island, particularly in the areas of medical education, health manpower, and neighborhood health centers.

Again, thank you for this opportunity to testify here. [Applause.]

Senator PELL. Thank you very much. One very brief question here. As you know, as a result of an amendment that I put in one of the health bills, an HEW cost study predicted a 50-percent increase in health costs by 1974. Do you see the cost of hospitalization going up by 50 percent by 1974?

Mr. JOHNSON. I think it depends on how we define hospitalization. I would hope and expect that the total expenditures for medical care would not go up 50 percent. I think some of the unit costs could well go up 50 percent.

Senator PELL. I agree with you and I think we both have the same concept that the hospital should be the central unit in providing health services to the people and that we should phase people out to increasingly lower levels of health care as they attain better health.

Mr. Gustin Buonaiuto is the next witness, and I had the pleasure, 2 weeks ago, of being accompanied by him as I went through various nursing homes in Warwick. He does a great job as president of the Rhode Island Nursing Home Association. Although he got out of the job a couple of years ago, he has been drafted and again is president.

STATEMENT OF GUSTIN L. BUONAIUTO, PRESIDENT, RHODE ISLAND NURSING HOME ASSOCIATION

Mr. BUONAIUTO. Thank you very much, Senator Pell, for the opportunity to be here today. As a provider of service for Medicare and Medicaid, I would like to touch briefly on a few basic points that can give some direction to this hearing. While we have made great strides in the field of health care, there needs to be a revamping of the entire health care system.

One of the problems in our present programs is the lack of total patient care.

BENEFITS NEEDED FOR CHRONICALLY ILL

The title XVIII program allows extended care benefits for acutely ill people only. Unfortunately, many of our elderly are also chronically ill. In many cases, benefits have been retroactively denied because the patient does not meet the written definition for being acutely ill, even though he may need extensive nursing care.

The Federal Medicare program also has no provision which would allow posthospital care because of a sociological problem. It seems rather basic that an elderly person might need posthospital care in an extended care facility because there may not be anyone to care for him at home. This program will deny benefits to anyone in this situation. It would seem in the interest of good health care that benefits should be allowed in cases such as this. Under the current program the patient has a tendency to remain in the more costly hospital bed for a longer period of time because he may need some minor nursing care and cannot be sent home to care for himself. If regulations were loosened to allow

extended care benefits for people who cannot be cared for adequately at home, I feel the result would be better total care for the patient and less cost to the Government.

My third point concerns the many inadequacies in the reimbursement from the State Medicaid and Federal Medicare programs. While the Federal Medicare program pays on the basis of reasonable costs, the State Medicaid program in Rhode Island will pay reasonable costs with a maximum of $15 per day, regardless of what the facility's costs may be. Many newer and larger homes have costs in excess of $15 per day which means that if these homes are to accept State patients, they have to operate at a loss. This situation can only limit the quality of services available to all patients. Since Federal standards and requirements for both of these programs are becoming practically the same. I think it should be mandatory that reimbursement be the same. The indirect effect of the current reimbursement program on the patient is such that a patient may not be able to gain admission into an extended care facility because the management of that facility faces the danger of being reimbursed on a less-than-cost basis under the State program. The patient may be admitted as a Federal Medicare patient and after being in the facility for several days, a determination will be made that the patient is not eligible to receive benefits or may receive limited coverage under this program. The facility may then have to accept him for the maximum payment under the State Medicaid program. This gross inadequacy to the facility and the patient can be corrected by guaranteeing that reimbursement will be made until eligibility is determined.

Fiscal Intermediary—Expensive Luxury

I would also like to examine the need for the fiscal intermediary in this program. Extended care facility administrators are burdened with a long siege of onsite audits which consume many man-hours. These audits, performed by highly skilled and highly paid employees of our fiscal intermediary seem to be a tremendous waste of the taxpayer's money. Since most of the regulations and determinations are made by Federal Government authorities, it is an expensive luxury to have a fiscal intermediary. Interpretations of the regulations which are supposedly the function of the fiscal intermediary are being made by BHI. This method leads to confusion and procrastination, and many interpretations are never resolved. Investigation must be made to determine if the cost of the fiscal intermediary is justified—can the same operations be carried out more efficiently by the Government at a lower cost.

In conclusion, I feel that provision must be made for the total care of the patient. That total care includes chronic and acute illnesses and consideration of the sociological factors. Medicaid reimbursement must parallel Medicare reimbursement and that reimbursement must be guaranteed to the patient and the provider. I believe that these recommendations could greatly enhance our present programs by improving the quality of care provided at a lower cost to the Government.

Thank you very much for the opportunity to be here, Senator.

Senator PELL. Thank you for your statement, Mr. Buonaiuto.

Our next witness is Albert Lees, who is president of the Rhode Island Association of Facilities for the Aged, which includes nonprofit nursing homes.

STATEMENT OF ALBERT V. LEES, PRESIDENT, RHODE ISLAND ASSOCIATION OF FACILITIES FOR THE AGED

Mr. LEES. Ladies and gentlemen, the Rhode Island Association of Facilities for Aged is a voluntary organization of not-for-profit extended care facilities, skilled nursing homes, convalescent homes, rest homes, retirement residences and feeding programs for the aged. We are organizations of church, State, and voluntary groups.

As administrators of these not-for-profit facilities we are quite concerned about the present Medicare program.

We would like to refer to our letter of June 17, 1971, addressed to the Honorable Claiborne Pell, wherein we outline our feelings as a professional group.

1. As stated therein we endorse the principles of Medicare as originally set, but fluctuating administrative interpretations as to what is "covered care" have created great confusion on the part of prospective beneficiaries and service providers. Firm guiding rules still do not exist. The program was instituted before it was administratively ready, and failure to provide precise information to eligible beneficiaries has resulted in financial hardship for the aged, because many canceled existing insurance in the belief that all hospital and nursing home care would be covered.

2. We believe the public assistance program needs reevaluation and revision. Presently, reimbursement rates do not cover costs in most if not all of the Rhode Island nursing facilities. The not-for-profit facilities must seek charitable contributions, raise rates for the full-payment patients or use endowment funds to meet the difference between actual costs and reimbursement rates. Providers of services should be reimbursed on governmentally sponsored patients, at cost, by the sponsor.

3. We are opposed at this time to the so-called "universal medical care program," since neither facilities nor personnel are available to make it work.

4. We do, however, endorse the "catastrophic illness" principle, regardless of the age of the beneficiary, if the program specifically defines what care will be covered prior to implementation.

5. Provision for long-term chronic care must, at long last, enter the care for the aged scope of coverage.

6. We do not endorse any one of the 12 or so proposals, now under legislative consideration, to revise or supersede the Medicare and/or the Medicaid programs. Rather, we believe the best elements of the plans will be amalgamated by the appropriate legislative committees. We take no stand on the reimbursement mechanism (governmental versus nongovernmental insurance companies) but feel any program must be geared so that providers of service are assured of cost recovery.

7. We recognize that the area of critical bed shortage, at least in Rhode Island, is in the intermediate care category. Skilled nursing

beds could be vacated if adequate intermediate care beds were available to which some patients could be transferred. We feel that a Federal grant program for construction of intermediate care beds, perhaps an extension of the Hill-Burton program, should be considered, so that this category of critically needed beds, locally, could be made adequate.

8. We recommend that the following be used as evaluation principles for any revisions of present programs or new programs:

a. Are physical facilities and trained personnel available to meet the program needs?

b. Have the specifics of coverage been furnished to prospective beneficiaries and service providers in advance of implementation.

c. Is there assurance that providers will recover the costs of furnishing services.

d. Has sufficient time been allowed to develop administrative details before the scheduled date for program implementation?

The American Association of Homes for the Aging has recommended improvements in health care for the aged in the United States through the program of GERI-CARE and we, as a State organization, also firmly recommend this program. We would like to further state that we believe that national health insurance should be a federalized program, administered the same as Social Security as it is inevitable that one day a great majority of our elderly citizens will be in need of long-term health care. The present program under Medicare of 100 nursing days is far short of the total needed at the present time for long term intermediate care.

As stated in our letter to Senator Pell our interests are objective—our concern is for the aged American in need of help. Thank you.

Senator PELL. Thank you very much. Now we have as our final witness on this panel Miss Shirley Whitcomb, who is a member of the Association of Home Health Agencies. Miss Whitcomb.

STATEMENT OF SHIRLEY WHITCOMB, MEMBER, ASSOCIATION OF HOME HEALTH AGENCIES

Miss WHITCOMB. Thank you. I am here as a representative member of the Association of Home Health Agencies of Rhode Island. We appreciate the opportunity to share our thinking with you regarding health care problems of people over 65 years of age. Rhode Island is fortunate in that there is complete coverage of all areas of our State by certified home health services. You have heard from active, independent, proud, capable people who can speak for themselves, and do.

I am here to speak for the 2 percent of Rhode Island population over 65 served by home health agencies as well as for the countless thousands not well enough to come to a hearing such as this. We are using today the term home health agencies, but our audience will recognize my uniform as that of the district nurse or visiting nurse, which is also what our patients and their families call us.

For generations our role has been to care for the sick in their homes, to promote health, and to prevent illness. We have always known that the patient is happier, the family more content, and that health is restored faster when the patient is home. To the elderly, after a lifetime

of work and struggle, his home becomes a symbol of achievement, pride, and security. To remove him from this setting would mean breaking his spirit.

Some people would deteriorate into senility; others would die. I think we all have seen people who have become confused when hospitalized.

Removing them from this setting also would break their finances. Many older people are living on tightly balanced budgets with only Social Security or perhaps another small pension if they are lucky. No unexpected expenses could be met, including, in many cases, the premium on insurance protection.

Medicare—Boon to Persons Over 65

Thus, Medicare, when it was put into effect in 1966, was a boon to the person over 65. It paid his hospital bill, it paid for certain care in certain nursing homes or extended care facilities, and it paid for certain care at home. In fact, Medicare demanded some services that had not been provided by the traditional agencies previously, such as social services, physical therapy services, and so forth. But Medicare was a boon also to the district nursing agencies.

These agencies had long been aware that the patient in his home needed more services than just nursing. Many with large financial support had attempted to provide limited services such as physical therapy. But most of these agencies did not have financial resources to do this. Now this Medicare law not only paid for these services, but demanded them. It was soon learned, however, that there were some problems.

The 3-day hospitalization as a requirement for plan A out of hospital, or 100-percent coverage, became a hardship. Many people were not sick enough to require hospitalization. To put them in the hospital in order to fulfill this requirement for plan A; it was an expensive unnecessary hardship on the hospitals as well as the patients. Many people were so very sick that moving them in the first place and out of their homes in the second place for the short period of time before death was of no benefit and actually cruel. However, without the 3 days in the hospital, the full coverage of plan A was denied them.

Deductible and coinsurance concepts were also confusing. Very few patients had read all the literature and, therefore, most knew nothing about this. Many patients had been told by well-meaning and trusted people that Medicare paid for everything. Even if the patients knew about some of these charges, few could meet them. Again, the fixed income of only Social Security or of a pension did not allow for these expenses.

Agencies Go Into Debt

Since Medicaid did not meet these charges and United Fund did not meet the deficit, the agencies were plunged into debt. Interpreting custodial care prevented payments to the agencies for preventive health service and care of patients with chronic illnesses. Consideration was made only of the limited restorative potential and a slim prospect for total recovery. Changes in the patient's physical and emotional condi-

tion may alternate between acute and stable change, meaning change of regime and medication.

Intermediary letter No. 395 says patients who are "stabilized" and have "no more potential for rehabilitation" do not meet Medicare requirements. Who is to be the final judge? It might well be for our legislators to look into the total picture of preventive service. Some agencies are providing, currently, visits for the purpose of health teaching and supervision, with the goal being that of preventing illness and the anguish and financial load this brings.

Funds for Group Meetings

Group meetings to provide information providing proper nutrition, early care of some aspects of disease; for example, care of diabetic feet to prevent gangrene, are less costly and still valuable teaching methods. Currently these programs are financed by agencies from funds not related to the Medicare program. Yet, from the point of view of their long-term objectives, would this be a wise use of Medicare funds?

The Association of Home Health Agencies in Rhode Island would like to propose the following: First, in agreement with the Health Insurance Benefits Council to place all home health benefits under plan A with a maximum eligibility of 200 visits per year. Second, to remove the 3-day hospitalization stay requirement for home health benefits. Third, to provide for coinsurance with the second hundred visits per year. Also, a clear statement in the law of the intent to include coverage of home health services necessary to prevent hospitalization. And finally, to clarify the definition, adoption of the Rhode Island State Nurses Association official definition of professional nursing as Medicare's definition of skilled nursing care.

We are most grateful to this committee for the opportunity to present our concerns for the elderly patients who are entitled to quality care in their own homes with the dignity and family comfort they deserve. Thank you, Senator.

Senator Pell. Thank you very much. There are so many questions that I'd like to ask all these panels, but in organizing this morning I think we probably have succumbed to the temptation of covering too much and simply don't have the time to both ask the questions and hear the witnesses. So, if you have any further thoughts you'd like to put in the record, please submit them in writing. The record will be kept open for 7 days for additional statements.

Any other points any of you care to make before our next panel? In which case I thank each one of you very much. There is one particular question I would like to ask the doctor who is here. Does he have any suggestions of how we could make these forms simpler so that there will be less reluctance by physicians to handle Medicare and Medicaid patients?

Dr. Kraemer. Much of this depends on the deductibles, coinsurance receipts and cumbersome bureaucratic regulations. It is a tremendous administrative problem, and I am sure that it would take many hours of mutual conference to make a statement that would be relevant to your question.

Representative James C. Wright, Jr., chairman of a House Public Works Subcommittee, recently offered these observations:

These hearings have demonstrated that redtape can be a sieve through which escape much of the benefit intended by a program and much of the taxpayers' hard-earned money. It is no wonder that, as the testimony indicates, more and more people avoid Federal programs like the plague.

But the overpowering temptation of government administrators has been to add to each of them dimensions of paperwork never envisioned or intended by Congress.

Needed projects are delayed, local interests become confused and frustrated, conscientious administrators lose enthusiasm and the public loses confidence in the government. The credibility of government is involved.

Senator PELL. Well, if you have a specific suggestion or if the Rhode Island Medical Society has a specific suggestion in this regard, I wish you'd send it to me in letter form and we will try to get it cranked into H.R. 1, and I think it could be helpful. What we are trying to do is not make life more complicated, but make it less complicated for you.

Dr. KRAEMER. Of course, true simplification of the matter is to get adequate income into the patients' hands and you will find they will buy their medical care very judiciously.

Senator PELL. Thank you, the panel, very much.

Mr. TIERNEY. Senator, are the senior citizens going to be heard? We are put down at the end. I'd like to have a chance to be heard.

Senator PELL. Mr. Tierney, you will be heard. If you wait your turn like everybody else, you will be heard. We have a series of panels and the programs are in your hands, I believe. So you will have an opportunity to be heard. OK? Or do you want to jump in ahead out of turn?

Mr. TIERNEY. I don't know if anybody can hear. They are going out very fast.

Senator PELL. I think we are all getting hungry, but we have a set schedule and witnesses are doing the best they can. We have certain questions that will be asked. Mr. Tierney, be patient just as the audience and the panels are. I thank this panel very much indeed for being with us and am most appreciative.

The next panel is on fiscal intermediaries, and consists of Mr. Arthur F. Hanley, chief executive officer of Rhode Island Blue Cross and Blue Shield; Dr. Alex M. Burgess, Jr., chief of the Division of Planning and Standards of the Rhode Island Department of Health; and Dr. P. Joseph Pesare, medical care program director, Rhode Island Medical Assistance program.

I apologize if the hearing seems too long, but there is a great deal of material that has to be gone over. We had another hearing in Woonsocket, went over the ground there, and there is just a great deal of vital information that is being presented here, and every witness will have his turn.

Now, the type of health services that can be provided our senior citizens depends to a great extent on who pays their bill. Under the Medicare and Medicaid program, the taxpayer's dollar doesn't directly go from the Federal treasury to the provider of the health services. The money goes to a middleman called the fiscal intermediary. For the Medicare program the chief intermediary in Rhode Island is Blue Cross-Blue Shield. And for the Medicaid program, the chief intermediary is the State government.

This panel will discuss the views of the intermediaries on Medicare and Medicaid. Our first witness is Mr. Arthur Hanley, chief executive officer of Rhode Island Blue Cross and Blue Shield, whose head-

quarters are right near this building and who does an excellent job and provides a great deal of service for the State of Rhode Island. Mr. Hanley.

Mr. HANLEY. Thank you very much, Senator Pell. I am well aware that time is very important, I should just——

Senator PELL. I don't want to hurry you; it is the audience who seem to be hurrying me. I want to get the material from you.

Mr. HANLEY. I will try to cooperate both ways, Senator, first of all by mentioning that we have left with your staff a prepared testimony which we have spent some time on because we appreciate its importance.

Senator PELL. It will be printed in full in the record.*

STATEMENT OF ARTHUR F. HANLEY, CHIEF EXECUTIVE OFFICER, RHODE ISLAND BLUE CROSS AND BLUE SHIELD

Mr. HANLEY. Thank you, sir. So all I shall attempt to do is perhaps summarize and hit some of the things we consider important in our role as both intermediary in part A under contract with the Federal Government, and as carrier part B under contract with the Federal Government. There is obviously so much that can be said, and we have embraced the essence of it in our prepared paper.

I think perhaps the thing that has come through to me and my staff in administering these two programs for the Federal Government in the past 5 years has been misunderstanding on the part of both the beneficiary and the provider. Now, this does not get into benefits, does not get into financing both of which, of course, are of extreme importance. But when the Congress passed the Medicare law over 5 years ago, we didn't know, that a great number of people who are over age 65 really sincerely felt that the provision of their health care needs was not fully met by this wonderful piece of legislation.

Unfortunately, this is not so, and Congress has so many things to contend with in its individual problems, not the least of which is financing, and all financing, as you know, must come essentially and ultimately from the taxpayer. So that certain controls, if you will, to control the expenditures of the program were instituted. They have already been mentioned here directly and indirectly by several of the preceeding members of the various panels: deductibles is one.

DEDUCTIBLES

Deductible is a phrase that I imagine many of our people over age 65 possibly never even heard about until Medicare, although it is a common phrase in the insurance and prepayment industry. There are deductibles on part A. Unfortunately, the way the law necessarily had to be structured, the deductibles have been increased several times since 1966. So that now that part A deductible, which used to be $30 or $40 a day, is now $60 a day. And the co-pay, which started with the 60th day of care, a beneficiary had to pay x-amount of dollars for days spent in the hospital after that time, that is just part A.

Under part B, which is normally doctors' and professional and allied type services, there was a deductible and still is of $50 a day,

* See appendix 1, p. 295.

and then a co-payment, that is the Federal Government under the program would pay 80 percent of reasonable and customary charges, leaving 20 percent to be paid by the beneficiary.

I would like to make reference to the House of Representatives Bill No. 1 which has been passed in the House and is now before the Senate and will be reviewed when the timetable permits. There are several provisions in that bill which we endorse and endorse heartily. There are others that we have certain reservations about. I am making no attempt during these proceedings to tie in the part Blue Cross and Blue Shield has played over these past 5 years in attempting to fill these gaps and voids necessarily structured in the basic Medicare law.

As we have seen it, however, it has been our job. People look to us as the leaders in the prepayment of health care needs, so that we look upon it as just something that had to be done. Whenever you want to take an assignment of this type, naturally again through lack of communications, inability to talk directly to everyone, certain misunderstandings to do arise and, of course, we have been criticized for the fact that the rate had to go up, which it did, after 5 years, last year.

But I am only making this one plea to you ladies and gentlemen, the only reason the rates went up is because under the law as structured the deductibles and copayments have to go up or increased to you as individual beneficiaries, and our two boards of directors did not think it was the thing to do to say let them pay it. We structured the program to help fill those gaps and voids and we continue, we intend to continue to do so.

Now, again it is awful easy to be facetious at times. As a staff with now over 5 years' experience running these two Federal programs for the Government, we think Medicare has done a wonderful job in Rhode Island for people over age 65. We have set up a subscriber service section which will entirely take care and answer the questions, specifics, whether they pertain to their eligibility or the particular claim, and that is our job and we accept it as such.

There are some things, however, that perhaps will cast it in this light. I have one reference here, without reading, if I can just put my finger on it. Again this may sound a little bit wise, and I sincerely hope you will believe me when I say it is not intended that way. The Medicare law, as it was printed by the U.S. Printing Office, was 138 pages long and weighed 6 ounces. Now, since that time, the Department of Health, Education, and Welfare, and in turn, the Social Security Administration, obviously have had to administer this law, interpret it, issue guidelines and things of that nature, that Miss Whitcomb and one or two of the gentlemen who preceded me made reference to.

Must Explain Regulations to Beneficiaries

Since that time the regulations and instructions to carriers, intermediaries, and providers pertinent to the administration of that law now embraces some 37 volumes with more than 8,000 pages weighing nearly 46 pounds. There have been almost 800 revisions and clarifications of the regulations. Here again we are not saying that this is unnecessary. I merely point it out to show you that we as intermediary carrier have to take our instructions and strictly conform to all regula-

tions, guidelines, audits, performance reviews of every description, which in turn is to protect the public interest and, obviously, the taxpayer's dollar. We welcome it, that is part of the job, we sought it and we intend to continue to do it.

But it does point out some of our difficulties, because all of this information has to the best of our ability in turn have to be interpreted, explained to all of the people who are beneficiaries. And our job is to do that as effectively as we can, as efficiently as we can, and at all times as courteously as we can.

I'd like to turn, Senator, directly to some of our comments pertaining to H.R. 1 now before the House——

Senator PELL. Excuse me for interrupting, but there is a time element here.

Mr. HANLEY. Yes, sir, I am just going to refer to the conclusion on H.R. 1. One is we strongly advocate that all deductibles be eliminated, but a copayment across the board for both programs be initiated. We would recommend that part A and part B be combined into one more easily explained mechanism. We would suggest that not only combining part A and part B, but this would involve the financing also, because as we know, part A is entirely the Government's responsibility, whereas part B is one-half, 50 percent paid by those who subscribe to it, with the Government pertaining to the other half.

ENVIRONMENT—A HEALTH FACTOR

We would strongly recommend the inclusion of a disabled clause, provided there is clear evidence they have been disabled for a stated period of time. We strongly endorse the inclusion which is being considered in the bill of prescription drugs and other pharmaceuticals, and perhaps last, we would strongly consider, we know that this is almost an impossible problem for the Congress to wrestle with, but we would strongly recommend they consider the social and environcental contributing factors to health care rather than just benefits and the financing of them, because these are the important things.

If a person comes from an environment which is conducive to illness and goes and receives some type of care, and then has to return to the same environment to either prolong or have again inflicted upon him the same condition, is just ring around the rosy.

So thank you, Senator Pell, we are delighted to have been here.

Senator PELL. Thank you very much. Your full statement will be printed in the record.

STATEMENT OF DR. ALEX M. BURGESS, JR., CHIEF, DIVISION OF PLANNING AND STANDARDS, RHODE ISLAND DEPARTMENT OF HEALTH

Dr. BURGESS. Thank you, Senator Pell. In the interest of brevity, since nearly everyone has voiced points that I might have made, more ably than I could have. I think I will restrict myself to perhaps one

single central point, which is illustrated rather well by the fact that I am sitting here billed as a fiscal intermediary with these two gentlemen, who are, in fact, such. In those terms I am a fraud.

The State Department of Health serves, on the one hand, as a qualitative conscience, and enforces several kinds of standards. We dislike the word "enforces". We think it is a little too much like Colonel McQueeney's police function. On the other hand, we visualize our role as one of a developmental consultant in the system, a group which tries to tie the whole show together somehow. You have all heard that pouring money into this system will not do any good, unless the system itself is modified and made rational.

Medical Care for Everyone

We then are enforcing some overall Federal regulations that are devised to work anywhere, and thus, fail to work perfectly anywhere. We find ourselves in conflicting roles when we try to help the provider achieve high quality care while enforcing standards. What we'd like to see, not only for the elderly, but for all people, is a flow-through system starting with people at home and on their feet, people in various levels of dependent housing, people requiring different levels of nursing and other services, such as acute hospital care, postacute extended care, long-term care—the whole business. We'd like to see this tied together in a working system wherein any person can be located in the one place which best suits his needs and at the appropriate level of cost. This then is a statement of our aim as a planning agency. It sometimes gets lost a bit in our day-to-day pressures to meet our responsibilities to the Federal programs and we sometimes chafe under this situation.

I think we must work out these matters, because nothing is clearer than the fact that the system will become more nationalized as time goes on.

I don't think anyone still doubts this. However, there is no precedent in this country, as far as I know, of this occurring except by development of what we already have. Medicare and Medicaid are at times frightening precedents. I think, for the future form of our one system when we get it. So I think the faults of Medicare are an extremely important issue, and you have heard several comments on that today.

Certainly this matter of the feeling of dissatisfaction on the part of the beneficiaries, has resulted largely from an inferior education at the beginning which made it purport to be many things it wasn't.

But there are a few other problems like the fact Gus Buonaiuto mentioned, that standards produce costs, yet we have to find some way to be sure that we have the quality we want.

The final point I should like to make is the narrowness of the Federal regulations as they get down to the individual State. I'd like to think the model of the Hill-Burton legislation, which is now a quarter of a century old, gives a clue as to what might be done. In this instance the States produce an annual plan with the approval of the Federal agency, but in it are those features and characteristics which minister to their own individual State needs. I hope that as plans develop (and this will be largely a matter of the regulations rather than the law) that they take this pattern into account.

I think on that point, Senator Pell, I will rest my case and thank you very much. [Applause.]

Senator PELL. Thank you very much. Dr. Burgess is the chief of the Division of Planning and Standards of the Rhode Island Department of Health, and also associate professor of preventive medicine at Brown, which I neglected to mention. Actually, on Wednesday we hope we will be holding a House-Senate conference trying to get the acceptance of the House conferees for an amendment to aid the establishment of a medical school at Brown University.

The final witness on this panel is Dr. P. Joseph Pesare, Medical Care program director, Rhode Island medical assistance program, and he's been that for many years, in fact since 1952. He has strongly advanced the view that Rhode Island must be a leader in providing medical services for the poor.

STATEMENT OF DR. P. JOSEPH PESARE,* MEDICAL CARE PROGRAM DIRECTOR, RHODE ISLAND MEDICAL ASSISTANCE PROGRAM

Dr. PESARE. Thank you, Senator Pell. First of all, I want to take this opportunity to express my gratitude to you—the "so-called" elderly citizens of Rhode Island. I think you have effectively proven a point which I made back in the year 1965; namely, that our elderly citizens do have dignity which we must strive to preserve at all costs.

This point was made at a meeting of State senators when they were discussing the future course which Rhode Island should be taking with reference to our Kerr-Mills program—also known as the MAA program— at a time when we were contemplating the development of a new State medical assistance program under the provisions of title XIX.

ELDERLY CITIZENS HAVE DIGNITY

I can vividly recall taking the position that our elderly citizens do have dignity; they would rather belong to a medical care program to which they had made financial contributions; they would not prefer to be totally dependent upon a State medical care program. I strongly opposed doing anything which would destroy that element of dignity which I saw in our elderly citizens.

It is interesting to note that one of the senators who was taking the opposite position was taken to task by an elderly lady who emphatically stated that the elderly would not want to be brought under the umbrella of a State program rather than belong to a medical care program to which they had made contributions and were, therefore, eligible for medical benefits.

In preparing for this meeting I gathered some rather significant and interesting statistics:

1. In the year 1970, there were 103,932 persons 65 years of age and over residing in the State of Rhode Island.
2. Of this total, 102,130 or 98.3 percent were entitled to benefits under the provisions of title XVIII(A).
3. 95.4 percent were entitled to benefits under part B of title XVIII.
4. It should be noted that these 99,170 persons are voluntarily paying premiums at the rate of $5.60 per month in order to qualify for supplementary medical insurance benefits.

*See appendix 1, p. 322.

5. 63,070 persons or 60.7 percent of the total population 65 years of age and over have bought into Blue Cross 65 at an annual cost of $85.80.

This particular figure represents a truly remarkable phenomenon. This, in itself, is a strong substantiation of the position taken by me during the year 1965.

6. In the year 1970, there were 24,328 persons 65 years of age and over who were eligible for our Rhode Island medical assistance program.

7. Of this total number of 24,328 persons, 94 percent voluntarily bought into part B of title XVIII in order to qualify for supplementary medical insurance coverage. In other words, 94 percent of our 24,328 eligible recipients 65 years of age and over are voluntarily paying $5.60 per month for premiums for part B of Federal Medicare.

I say to you that these persons have no compelling reason to buy into part B of Federal Medicare except for the fact that they do want to maintain that dignity of which I speak.

Rhode Island has had a comprehensive Public Assistance Medical Care program since 1952. In the year 1952, Rhode Island was classified as one of five States providing a comprehensive medical care program for its public assistance caseload.

When I was asked to assume the position of Medical Director of the Public Assistance Medical Care program, I envisioned the scope of the program to be developed to include all those essential medical services which I would want for my own parents or members of my own family—regardless of ability to pay.

If you were to review the scope of medical services of the Rhode Island Public Assistance Medical Care program in 1952 and compare them to the scope of services within our State Medicaid program, in 1971, you would find very little difference. The essential medical serv-

MONEY SPENT THROUGH STATE MEDICAL ASSISTANCE PROGRAM

It is true that we have been spending quite a bit of money in the delivery of medical services through our State Medical Assistance program. In the fiscal year 1962–63, Rhode Island spent a total of approximately $5,500,000. Of this total, approximately $2,500,000 was spent for nursing, convalescent and rest home care and the balance of $3 million was spent for all other medical services and supplies.

During this fiscal year 1971–72, the Rhode Island Medical Assistance program will be expending approximately $49 million to deliver comprehensive medical care to a total of approximately 94,000 persons.

The following is a point which I would like to clarify at this time; 78 percent of these total expenditures of $49 million will go for the payment of four categories of medical services; namely:

1. Inpatient hospital services.
2. Hospital outpatient services—the clinics that were referred to earlier in this program.
3. Public hospitals.
4. Skilled nursing homes.

Consider the fact that these four categories of medical services will account for a total expenditure of approximately 78 percent of our total Medicaid budget for the fiscal year 1971–72.

I cite these statistics since there are many rabid critics of Medicaid in Rhode Island and throughout the country who maintain that the program is a very expensive one; that the administrators of the program squander State and Federal money; that we are in a chaotic state and know not what we do.

I take exception to this unwarranted criticism. In Rhode Island, we can account for every dollar that is being spent for the Medicaid program, the channels into which these funds are going and the reasons for why they are being spent. I would ask you to reflect upon the fact that only 22 percent of our budget goes for all the other services included within the comprehensive scope of our Medical Assistance program; namely, physicians' services, pharmacy services, dental services, podiatry services, optometric services, and so forth.

Some Propose the Abolition of Medicare

There are those who maintain that the State Medicaid programs are so poorly organized and administered that they should be abolished. The same criticism has been leveled at Federal Medicare. There are those who maintain that a new system should be developed. I am not so sure that I concur with those who propose the development of a new system of national health services.

I am reminded of a statement made by Senator Abraham Ribicoff immediately after the enactment of Federal Medicare or Public Law 89-97. His statement was essentially as follows: We have obtained so much health legislation out of the last session of Congress that I am afraid we are going to be getting a case of indigestion.

In other words here was indication that we would not be able to implement all of the programs for which provisions had been made through the newly enacted Federal legislation or Public Law 89-97.

In the fall of 1965, immediately after the enactment of Federal Medicare, I heard the late—not the late for he is still very much alive—former Secretary of HEW, Wilbur Cohen, speak at a meeting of State program administrators in Washington, D.C.

Senator Pell. You are right, from the viewpoint of being effective, he is late, but his brain is alive and with us.

Dr. Pesare. At that time he took pride in the fact that we had gathered from the most recent session of Congress much more thay any of us had ever dreamed possible. This observation underlies my conviction that the mechanism or instrument required for the delivery of comprehensive medical services for all of our elderly citizens has been with us since 1965.

I will get off this subject by simply stating that I do not concur with those who maintain that what we need is a complete restructuring of the method of delivering health services in America. I maintain that what is required is to use more effectively the statutory mechanisms which we already have available to us.

I should like to briefly discuss some of the inadequacies in the machinery presently available for the delivery of comprehensive health services to the elderly.

First of all, I should like to raise this question of the drastic increases in premiums which must be paid in order to buy into plan B or SMI of title XVIII. I feel very strongly with you that a very seri-

ous hoax has been perpetrated upon the elderly citizens of our Nation. These premiums were originally $3 per month. They have gone up steadily up to the present premium of $5.60 per month.

ELIMINATE INCREASES IN MONTHLY PREMIUMS

If the Federal Government is sincere in its desire to help the elderly citizens, then I say let them eliminate these increases in monthly premiums. Let them find additional funds from the General Treasury or through some other method of financing, instead of increasing the premiums which are already creating hardships for our elderly citizens.

With reference to the deductible for hospital charges, you will recall that it started as a $40 deductible; now it is up to $60; and there is indication that it will continue to rise. The Rhode Island Medicaid program does pick up the deductible for its eligible recipients. I am concerned about those who are not covered by Medicaid. Once again, I am of the opinion that the Federal Government could employ a more simple maneuver which would permit the utilization of already existent machinery more effectively.

In the beginning of Medicare, the coinsurance to be paid by the patient after the first 60 days of hospitalization was $10 per day; this has now increased to $15 per day. We don't need new and more expansive health insurance programs. We do not need new and larger bureaucracies. We do need the more effective utilization of the medical care programs presently available to our elderly citizens.

We are confronted with a very serious problem in the area of payments by Medicare for visiting nursing and home health services. It has become increasingly difficult to obtain any reasonable assurance that Medicare will assume responsibility for the payment of these services as provided within the provisions of Public Law 89-97. I do not blame the fiscal intermediaries; I know that they are following their instructions as outlined by the Social Security Agency. However, I do blame the Social Security Agency and those Federal authorities who permit the Medicare program to be administered in this fashion. It appears that they have lost sight of the intent for which Medicare was enacted by Congress. I am sure that you will agree that visiting nursing services are essential in order to keep people out of expensive hospital and extended care facilities and when these latter facilities are no longer required—to get the patient home as quickly as possible.

Since 1969, the Social Security Agency through its fiscal intermediaries, has indeed changed the rules as they apply to home health services. Within the last 2 years Medicare has rejected an unreasonably large number of bills for visiting nursing services. The visiting nursing agencies have been passing these bills on to Medicaid for payment for its eligible recipients. It doesn't require much imagination to appreciate the fact that this has added to the financial burdens of Medicaid programs. I consider this a serious injustice to State programs.

Very few persons succeed in qualifying for Medicare benefits in extended care facilities. We should recall the fact that extended care facilities were included within the scope of the Medicare program so that those who were no longer in need of inpatient hospital services

would not tax our inpatient hospital facilities at rates which now range from $80 to $150 per day.

Are you aware of the fact that not more than 5 percent of approximately 340,000 certified extended care facility beds in the Nation are actually being used by persons who are entitled for benefits under Medicare and paid for by Medicare? This is a sad commentary on the performance of Medicare in fulfilling its obligations as they relate to extended care facilities. There is something very wrong with the system that allows this phenomenon.

In Rhode Island, not more than 7.5 percent of our elderly citizens who are eligible for benefits under Medicare and Medicaid manage to obtain medical care in extended care facilities at the expense of the Federal program.

So much for the problems and inequities generated by Medicare—as they relate to its beneficiaries and the State Medicaid program.

I should like to respond to one of the criticisms of the Rhode Island Medicaid program as expressed by one of the panelists during the morning session. She complained about the State requirement of prior authorization as a basis of obtaining certain drugs to be paid for by the State program.

Liberal Medicaid Pharmacy Program

Your attention is called to the fact that Rhode Island provides for one of the most liberal Medicaid pharmacy programs in the Nation. We do not insist that our eligible recipients obtain only the least expensive drugs available without concern for quality. I am sure that you are aware of the fact that some States limit payment for generic prescription drugs which are cheaper than quality brand-name drugs.

I have always maintained that if we were to adopt such a policy of limiting payment to the less expensive generic drugs for eligible recipients of Medicaid then we would, in fact, be supporting a policy of de facto discrimination against our eligible recipients of Medicaid.

With reference to the requirement of prior authorization for certain drugs, it is a fact that this is a requirement. This requirement is intended to assist in protecting the health and welfare of our eligible recipients. You know as well as I do—and I am sure that Senator Pell will concur with me, that the Food and Drug Administration is trying to do a good job in clearing new drugs before they are marketed. However, it is indeed unfortunate that some drugs do get on the market and dispensed to people before they are proven to be safe for human consumption.

Yes, we do have a list of drugs which require prior authorization—especially those drugs which are new, in order to make sure that these drugs are prescribed and dispensed carefully. We are very much concerned about the amphetamines, narcotics, injectables, et cetera. We are concerned about all new drugs until they have been on the market for a period of approximately 2 years, on the average. I am happy to note that the Federal Government is demonstrating real concern about the same problems.

All requests for prior authorization are handled on a priority basis—usually—within the same day on which the request is received.

In conclusion, I should like to reiterate the following:

1. I am not in favor of the total restructuring of the system of delivering health services.

If we were to attempt this total change, I can assure you that another meeting of this type held after a period of years with the new system would find us in much more serious trouble and with many more problems than confront us today.

2. Let us utilize more effectively the system and machinery which we presently have for the delivery of health services to our elderly citizens.

3. If we are genuinely concerned about the problems of medical care for our elderly citizens, then let us make a serious effort to eliminate the hardships and inequities which have been created by the administration of the Medicare program.

I note that Senator Pell has proposed the elimination of payment of premiums for benefits under part B of title XVIII, I commend you for this position.

If the premium for part B is to continue as a personal responsibility, then let us at least put a freeze on these premiums.

Let us put a freeze on the increases in the coinsurance segment for hospital charges.

4. The time is rapidly approaching when Medicare beneficiaries will be priced out of the market in terms of ability to pay deductibles, coinsurance and the premiums for SMI.

5. I continue to seriously question the wisdom and the legality of the Social Security Agency's policies pertinent to transferring patients from in-patient hospital facilities to Extended Care Facilities. The fact that no more than 5 percent of the certified extended care facility beds in the Nation are occupied by eligible beneficiaries of Medicare is lamentable and almost unbelievable.

Physicians are urged and actually pressured to get patients out of expensive hospital facilities—transfer these patients to their homes or less expensive extended care and skilled nursing home facilities; however, the road from a hospital to a certified extended care facility—at Medicare expense—is almost completely obstructed.

I have no doubt that many patients are going without skilled care of the type provided by an extended care facility; in addition, I am confident that many thousands of patients are being kept in expensive hospital facilities longer than necessary; that an even larger number of patients are being readmitted to hospitals many times in the course of each year because of a lack of appropriate posthospitalization care during convalescence from a serious illness.

6. I would make the same plea in behalf of visiting nursing agencies in the provision of home health services. I refuse to accept the need and validity of the subjective judgments that are made by the administrators of Medicare as they relate to the types of services and types of cases for which they will accept responsibility for payment.

Policies Detrimental to Elderly

The policies of the Social Security Agency as they relate to extended care facilities and visiting nursing services are unquestionably serving to destroy a system of delivering medical services to the elderly.

These policies are imposing insurmountable barriers to the availability of essential health services and are also serving to compound the medical problems of the elderly. These policies do not reflect the intent of Public Law 89–97 as most of us have interpreted the purpose and intent of this act of Congress. These policies have also generated an adverse impact on the smooth operation of State Medicaid programs. The State programs have been compelled to assume certain responsibilities which Medicaid planners had considered to be the basic responsibilities of the Medicare program.

Thank you.

Senator PELL. Thank you very much. I thank you for your specific and written statement. I would also add that Mr. Hanley has a great ambassador in Washington in George Kelley, who is the representative of the Blue Cross-Blue Shield and who is so well grounded in health problems. In his service for Congressman Fogarty, he contributed hugely to the cause of bettering health conditions for all our citizens and was particularly concerned with all our older citizens.

I thank this panel very much for being with us today. And now I'll ask to have the discussion of health care delivery for the future. I'll call to the platform Mr. Ed Brown, secretary-treasurer of the AFL–CIO, who is an imaginative, innovative fellow, and who's sponsored a program which I think, if we all knew about it, would immediately result in his having many more applicants going to his program for service.

The problem we face today is that on the fee-for-service basis, doctors receive fees when their patients are sick. They don't receive them when they are dead, they don't receive them when they are well. But fortunately, we hope doctors are not pushed along on that basis, but are motivated more by service. But because this emphasis is only on the patient being sick, what Mr. Brown sought to do with his group health organization is to try to bring the fee-for-service idea in line with the future where the doctor will be reimbursed for keeping the person well.

This reminds me of the old Chinese method where the doctor is paid as long as the patient is well, but then he takes care of you when you are sick. I will turn the program over now to Mr. Brown.

STATEMENT OF EDWIN BROWN, SECRETARY-TREASURER, RHODE ISLAND AFL–CIO

Mr. BROWN. Thank you Senator Pell. We of the Rhode Island AFL–CIO really appreciate you conducting these hearings in Providence and showing your concern for the health care of the elderly. I have a prepared statement and, I would appreciate it if the statement was entered into the record.

Senator PELL. It will be included in full in the record.*

Mr. BROWN. Because of the shortness of time and the concern to hear from the elderly citizens, I will make my remarks very brief. I know Mr. Joseph Tierney has something of importance to say to the committee and I will make my remarks short so that Mr. Tierney can have time for his remarks. However, as you indicated, Senator we in the Rhode Island AFL–CIO have been very much concerned over the

*See appendix 1, p. 306.

delivery of health care to all citizens, including the senior citizens. We believe we are a long way down the road in providing the ideal plan for the health care of the future.

On June 1 of this year the Rhode Island Group Health Association started providing a health care program on a prepaid basis. We are involved in not only collecting the money and dispensing the money for physicians, labs, X-ray, and all the other ancillary services, but we are providing the ambulatory health care directly at the facility. It is on a prepaid basis and I think if such a program was incorporated in the Medicare act, the Government would save a considerable amount of money and render better care. Presently the physicians and all those associated with the health care industry are paid on a piecework basis.

Prepaid System Allows Advance Determination of Costs

The Government has no knowledge of what the cost is going to be. Under a prepaid system similar to the one that is being operated on the grounds of Our Lady of Fatima Hospital, by Rhode Island Group Health Association the Government can determine the costs in advance. There are several other features that I would like to see amended in the Social Security Act, but as I say, in the interest of saving time I have numerated them in the prepared statement.

Senator Pell. I would commend Mr. Brown, and I have worked very closely with him in helping with regard to Federal financing of this project, and I wish there were more projects like it in the State. I think only his and a similar group in Bristol presently exist.

They need support because they are the wave of health care for the future. Presently, how many members have you?

Mr. Brown. Right now it is about 2,300, 2,400 enrollees as of the first of the month.

Senator Pell. And to break even you need how many?

Mr. Brown. Oh, to break even in the operation it will take about 13,000 people.

Senator Pell. Is the monthly fee $44?

Mr. Brown. $43.80 per family.

Senator Pell. It is open to all groups, not just union groups. It is the wave of the future. I think it will be the precursor of other similar group health units throughout our State and the country. It is as imaginative and progressive as any in the United States and really I hope our citizens will join it in order that it can reach the breakeven point quickly.

Mr. Brown. We expect to very shortly. Only recently Mayor Doorley of the city of Providence has made the plan available to city employees on a dual-choice basis. We expect to be expanded to other communities and other areas of public service.

Senator Pell. As a politician who's actually gone through your unit in Bristol, I must say I am very impressed with their method of bringing health care to our people. I speak not only from theoretical knowledge, but from actually having seen and gone through both of these excellent facilities. I thank you very much, Mr. Brown.

Our next witness is Mr. Joseph Tierney, who asked earlier why he couldn't speak then. I said his time would come, but we have to go

through the list of programed witnesses, as you know; and Mr. Tierney is president of the Rhode Island Congress of Senior Citizens. And then Mrs. Annie Butler Cilione wants to be heard. And anybody else in the audience who in any way feel they have been muffled or has a desire to speak, let him or her come forward at this time, I won't say or forever hold your peace, but at least come forward.

Mr. Tierney, you go ahead. Anyone else who wants to speak, come up.

STATEMENT OF JOSEPH TIERNEY, PRESIDENT, RHODE ISLAND CONGRESS OF SENIOR CITIZENS

Mr. TIERNEY. Thank you, Senator Pell. I want to apologize publicly for that interruption.

Senator PELL. Perfectly all right. You are just as hungry as I am.

Mr. TIERNEY. The reason I done it, most of these older people are on diets, they are diabetics, etc. All right, that's why I did it. They were coming over to me and asking me about this. I didn't mean no intent of beligerancy there. No intent. But they were leaving so fast, I thought I would try and I did it the wrong way.

Senator PELL. Why don't you concentrate on the testimony.

Mr. TIERNEY. The thing is I don't think we are getting a fair shake. This morning I picked up a juicy piece out of the paper where $600 million is to be appropriated for a Communist country. It is in the morning press, $600 million, Senator. That is a huge sum of money. I believe in the last 12 weeks there was $800 million went out of the country for public aid. It went to Taipei. I didn't see breadlines. But we do have breadlines in Providence, Senator. And anything I am telling you can be authenticated. I have no reason to lie and I know what I am talking about.

Now, people here, many, many people, large groups with hundreds and hundreds of members in them, have been bypassed by the Division of the Aging, the candidates for the representatives to go to Washington, D.C. We were never consulted, we were never asked, we were never called to a meeting. So I don't think their operation is a good operation, and I resent what they are doing. And I know these people, most of them personally. Mr. Brown is a personal friend of mine and a fine gentleman; otherwise I probably wouldn't be down here. I figured if I did come down, I'd probably get ousted. These are facts.

Senator PELL. I thank you, and the point you raised is very valid. We give lots of money abroad. At the same time we have very real needs at home. I think we are all aware of that and I thank you, Mr. Tierney. Any other specific points?

Mr. TIERNEY. I have always respected you and admired you. I hope it stays that way.

Senator PELL. Mrs. Cilione.

STATEMENT OF ANNIE BUTLER CILIONE, PAWTUCKET, R.I.

Mrs. CILIONE. I'd like to ask you, Mr. Pell, if you could get somebody to visit the nursing homes. The nursing homes, some of them, they are outside clean and they are inside dirty, and our people are not being kept clean. One of our members came into our club last week

and said, not last week, a couple of weeks ago, and I said, "Where have you been?" She says, "I have been to a funeral and looking after my aunt." I says, "Has she died?" She said, "Yes, she died with two black eyes and a broken leg in the nursing home." How about that, Senator Pell. That's in Rhode Island.

I would ask you myself, I go down on my hands and knees if I could think you'd do this, get anybody to put one of these like the act puts on, to get the old people for each town and nursing home where an old man and wife spent all the beautiful years together and they could live together in these nursing homes, such as the old folks home. There's a line a mile long at the old age home for people to get in. There are one or two nursing homes, we have a good one, but it is only one in Pawtucket.

MORE NURSING HOMES NEEDED

I think, Mr. Pell, I know you could because I have so much faith in you, that you could do this for us and get us a nursing home for ourselves where we could be all together in our evening of life. We have had to be separated so many years going without, going out working for our children to bring them up good, and now in the evening of life we are all separated. That's not fair. I don't call it a little bit fair. Get us hospital for ourselves, where a man and wife can live together, they can have a dining room, a living room where they can play cards, where the men can go out and do a little bit of gardening, the women can crochet, and let our own people take our Social Security, not these that are making so much money.

And I would thank you, I never got over thanking you, and I am 82 years of age myself. [Applause.]

Senator PELL. I think your plea is absolutely justified. During the summer recess, I spent a good deal of time going around the State, going through various nursing homes and homes for the elderly. I think more homes for the elderly where couples can live together is one of the answers to the future and we need far more. As of now only 5 percent of our elderly in the State are living in these wonderful homes. And the problem is—either there is just not enough of them or the Government is not appropriating enough funds for it. And they must also meet the Medicaid and Medicare standards.

I thank you very much for your statement.

Mrs. CILIONE. I hope to see that in the paper. I hope and trust all these children that we have given you all look after us. I hope that they will for once look after you.

Senator PELL. I agree with you. I also think——

Mrs. CILIONE. And we get no doctors at night, we cannot get a doctor at night, sir, how you try.

Senator PELL. I think we have a rather cruel society where instead of looking after our older people, the children very often tend to shove them away. That's wrong. Now we come to our next witness. Identify yourself, please.

STATEMENT OF AVLINO MAGLIO, PROVIDENCE, R.I.

Mr. MAGLIO. My name is Avlino Maglio, pharmacist, Providence, R.I. Now in my retirement I am a senior aide with the adult education department, a program, as you know, sponsored by the National

Council of Senior Citizens and funded by the U.S. Department of Labor. Incidentally, we would like to see this senior aide program be made permanent. Nationally known for her work on aging, Dr. Mary Mulvey is our director.

Senator Pell, for me it was a great privilege to meet you only 10 days ago at the Holiday Inn on the occasion of the installation of officers of the Rhode Island Council of Senior Citizens. In shaking your hand, Senator, I indeed felt your sincere friendship and your compassion for the elderly. And my voice is reaching you now in fervent appeal that you and your colleagues in Congress uplift the status of our American seniors from their position of squalid poverty. Much you have done; much more is to be done.

Social Security has to be increased immediately by 25 percent so the elderly can meet the cost increase of such basic foods as eggs, fruit, vegetables, not covered today by the price freeze.

Rent increases also deplete the meager amount of dollars received by Social Security beneficiaries. And our venerable senior citizen fingering his venerable hair in despair, dejected and forlorn, cries out, "America has foresaken me." Foresaken indeed are the elderly in the nursing homes where you notice the people using their working time reading magazines or in a group chatting about the latest fashions, ignoring the calls or the need of a patient. And you notice this human excrement on the patient's bed, human excrement on the curtain around the bed that hasn't been washed or changed for weeks, dirty linen that hasn't been removed for days.

". . . I Am Lonely . . ."

America has foresaken the elderly. An 80-year-old woman in a nursing home sitting in a wheelchair by the window noticed my presence in the room. She turned and pointing to her Bible on the windowsill she said, "I have one eye, it is very dear to me. Will you read the last paragraph on the last page of my Bible." I did. Then I thanked her. "Oh, don't thank me, I haven't done anything for you. I am the one to thank you because I am lonely and through someone like you God spoke and visited me." She reclined her head to one side, closed her eyelid, and quietly I left.

There, right there is a great need in a nursing home, the personal neglect, the personnel neglects this human need by being very impersonal. America has foresaken the elderly. The intent of the Constitution of the United States was and is to promote tranquility on the law. There is no tranquility for the senior citizen unless the law makes it so. And I urge you, Senator, to use the power of your office to improve the plight of our senior citizens whenever the people appear before Congress in their behalf. Now is the time to inculcate the American heart and mind by repeated admonition that the senior citizen will always be on the American scene. Let his declining years be a period lived in dignity, in tranquility, and in health in this God's open world we call America.

Thank you. [Applause.]

Senator Pell. Thank you for a very, very eloquent statement indeed. The gentleman on the end, if he would identify himself.

STATEMENT OF MAX COHEN, PROVIDENCE, R.I.

Mr. COHEN. I am Max Cohen, and I am an individual connected in spirit with the Rhode Island Senior Citizens Action Group.

Senator PELL. With a name that is well and favorably known. Nice to see you this morning.

Mr. COHEN. I was very disturbed, Senator, last Friday, when I read the Evening Bulletin and saw a notice about Senator Pell holding a hearing about the elderly, because many were mentioned, organization-wise in that news release, but the Rhode Island Senior Citizens Action Group was not mentioned, and I assumed that somehow we were asked not to appear and participate because we have demonstrated an aggressive spirit—

Senator PELL. No, I must interrupt here. We will give you a copy of the press release, your name was included in the press release and you have had three witnesses. So your name was in the press release.

Mr. COHEN. I will apologize.

Senator PELL. We can't instruct the newspaper what to publish.

Mr. COHEN. I will certainly apologize.

Senator PELL. It was in the news press release.

Mr. COHEN. I will apologize, sir, I misread it.

Senator PELL. No, it is not in the newspaper, but it was in the press release. The newspapers do not have to print what we put out. I wish the Senate would pass a law to that effect.

Mr. COHEN. Then I thank you very much, Senator, in telling us that you wanted the Rhode Island Senior Citizens Action Group included.

Senator PELL. They are included in the press release. I think that covers that. Thank you. We have had three witnesses from your group, but carry on.

Mr. COHEN. May I continue? Notes I made will be brief, but I made them while I was sitting here. The first thing I want to say, Senator, as an elderly person who is above 70, I want to thank the Senator and all the men who are, and have been, in the Congress of the United States, and all the Presidents back to Franklin Delano Roosevelt, who made it possible for me and the elderly out there, to live in some sort of dignity, so that we are able to hold our heads up high and attend meetings like this and express our points of view. And I say to the Senator give our thanks to Congress. And when you go to church, say a little prayer for those who have gone.

TO THE ELDERLY, TIME IS PRECIOUS

Now, above all things, Senator, I had this one thought while I was sitting out there listening to all the speeches. I wondered if they knew how old 73 years of age was? There was no sense of urgency. One thing is positive—to the elderly—time is precious. We haven't got much of it. Now, what you are going to do to help us in 1972 and 1973 we thank you for it, in the names of those that are going to be around—but we might not be. I ask in the name of those that are 73, 74, 75, time is of the essence, help us this year on some of the things I mentioned. Please try to do it.

So I will come to thank you for suggesting increases in Social Security, whatever year. And particularly I want to thank you, Senator, for

raising your sights to putting $2,700 (instead of $1,600), above what they get for Social Security. The average monthly Social Security check last year, was $99, so it is probably $115 now, so they won't have too much money with the additional earnings. But that's fine, we thank you for it.

The people, on Social Security, who are 72 years of age can earn an unlimited amount. How much money does the average man make when he is 72 years of age? How much does the average lady make when she is 72 years of age? I thank God there may be some, but let them make what they can when they are 70 years old, not when they are ready for the grave. Give them a chance to make a few dollars so they can die with peace of mind if that is possible when you are 72, 73 or older.

Now, then, there is one thing that grieves me. It seems to be a topic that never gets discussed. There was one exception this fall, in the auditorium, about 6 weeks ago it came up. I ask you Senator, to give your attention to those recipients who might now or have, in the past, made over $1,680 and are going to be unexpectedly penalized, and they are told by a form letter that information has come that they made over $1,680 and their Social Security check or checks may be withheld. You heard Miss Whitcomb and Dr. Kreamer say "try to prevent the elderly from getting sick because it is awfully expensive when they get sick."

Well, I say to the Congress don't permit the elderly to get a shock when they are told, "we are going to withhold your check 100 percent for 1 or 2 or 3 months"—and if you starve, that's all right, "we are upholding the law." I plead with you, Senator, if they are going to punish anybody for making $200 or $300 over in a given year, that you give them a time-payment program to pay out what they made over, so they never take over 25 percent out of any one check the Social Security recipient has coming. Or the union that if they are taken off Social Security—instead of letting them starve, they should go on welfare or social rehabilitation and get enough to live on. That is of paramount importance. Maybe it shouldn't be spoken of in public, in the minds of some, but I feel a profound duty to the older Americans.

I feel there is an urgency for it, and I hope that you, Senator, will put your powerful voice to work and say nobody shall starve because they made $300 over $1,680 in any given year. And furthermore, put a stop to warnings such as form letters that are sent out to elderly people stating without signature of any kind, without postmarks of any kind, "We have information you have made over $1,680 and we may hold back a check or checks from you in the near future." No postmark, no signature, no responsibility, and the senior citizens are "scared to death." I ask you, Senator, to stop that sordid diabolical method of worrying the recipient. A "fishing expedition" that may or may not involve him in anything, is a "Sword of Damocles" technique, can cause underserved suffering.

Give the elderly all the peace of mind they can have, they deserve it, and if there is some minor infraction, don't force them into a starvation situation. Just one more thing, Senator, and I will conclude. Con-

gress has passed an increase in Social Security and there is another one coming up in January, a 15 percent package, for which we are grateful. I hope that any national legislation in the future will include the statement that the States shall adjust and keep pace with the increases of Congress so that Medicaid will be permitted at a little higher level of earning comparable with the increase in Social Security. And furthermore, the eligibility of those going into housing projects will be upped accordingly so that an individual making $3,000 will be up to $3,500 to keep pace with the Social Security increases that are made because Congress knows they are necessary. So if they are necessary in Washington, they should be necessary in every State of the Union.

Thank you very much, Senator. [Applause.]

Senator PELL. Thank you, Mr. Cohen.

STATEMENT OF CARL FLIGNER, PROVIDENCE, R.I.

Mr. FLIGNER. I am Carl Fligner, Providence, R.I. I have in mind, Senator Pell, Congressman Fogarty, who is the gentleman that started Social Security.

Senator PELL. The late John Fogarty played a role in it; Rhode Island has done very well.

Mr. FLIGNER. I know the Senator is probably tired of all this talking this morning, and I don't blame him, that is one of those things. In fact, I came here at 10 o'clock this morning.

Senator PELL. That's my job. I'm glad to be here. Do you have any suggestions for us?

Mr. FLIGNER. Yes; I will get to my point immediately. I took a major heart attack on coming back from Germany. I was there 3 days and I had one of the moderate heart attacks. I flew into Boston and I was—give or take—5 minutes out of Logan Airport when I took a major heart attack and was put into Horwood Hospital. I was immediately drugged and put into oxygen. The next day the doctor came in, Dr. Eugene Doherty, young fellow, said, "We have major problems here, you have a complete urinary blockage," which, of course, as you know, if it isn't immediately taken care of, you get uremic poisoning and you are gone in a couple of days.

However, he called in a specialist, Dr. Frank Walters of Boston, he catheterized me through the use of a metal tube, and the bill was $25. I had the same thing done 1 year ago in the Osteopathic Hospital here in Cranston and the doctor charged $200 for the same operation. Now, I will give you his name, Dr. Brodsky. I can back up any of my statements. And I complained to the Blue Cross that this was an excessive charge and they asked me if I would sanction payment of it; I said no. But they did. They paid $200 for which another doctor charged only $25. In fact——

Senator PELL. What is the name of the doctor?

Mr. FLIGNER. Dr. Brodsky. And I have catheterized myself, a complete amateur, three times, and now he charged $200 for that. I went to my own doctor and showed him the sanctioned payment by the Blue Cross and I called the Blue Cross six times, this is 15 months ago, nothing has taken place. Now, on top of that I was overcharged in Hamilton, Ontario, a doctor visited me there on my third heart attack,

he billed for five visits and I only had two visits, and when the Blue Cross called me, I refused sanction of payment.

And what my contention is right now, Senator, is that the Blue Cross is overpaying definitely in great amounts to doctors. They are making from $50,000 to $100,000 a year, and here the Blue Cross is overpaying them and overcharging us.

Senator PELL. I think you have got your point across and I think what you ought to do is perhaps put the specifics in a letter to me and I will try to get a reply from Blue Cross. Could we move on to the next witness.

Mr. FLIGNER. I still want to make my point that Blue Cross is overcharging us much too much and I can't afford it and I deserve to get payment. I have Blue Cross and I have Medicare through the sweat of my brow. Blue Cross is charging too much and certainly through Mr. Hanley there is something wrong there somewhere.

Senator PELL. Send me the specifics.

Mr. FLIGNER. All right, here is more specifics, I have to carry three different kinds of pills which I just took now, I could drop dead walking off here.

Senator PELL. Better stop testifying.

Mr. FLIGNER. But why isn't something done about the prices of the medicine? Here are pills, valuable pills that cost me $5 which I can't afford, but I have to take them in order to live. What is going to be done or what would you suggest doing as a Senator in regard to lowering medical payment for drugs for the elderly?

Senator PELL. We have been listening to testimony, we have said this is one of the things that is needed. Can we go on to the next witness, please?

STATEMENT OF WILLIAM HOUSTON, PROVIDENCE, R.I.

Mr. HOUSTON. All I wanted to know. Senator, is there a freeze on Blue Cross?

Senator PELL. How do you mean a freeze?

Mr. HOUSTON. They are supposed to go up October 1.

Senator PELL. I cannot give you the answer to that. I would think this would apply to Blue Cross rates as anything else. Perhaps Mr. John Anderson of Blue Cross-Blue Shield of Rhode Island, who is in the audience, can help us answer your question.

STATEMENT OF JOHN ANDERSON, PROVIDENCE, R.I.

Mr. ANDERSON. Senator, that is an old folder. Plan 65 rates went before the Director of Business Regulation back about March, and they were increased for the first time in 5 years at that point. I think the folder that he has was dated back then.

Mr. HOUSTON. It was before October 1, but the rates were to go up October 1.

Mr. ANDERSON. The rates were adjusted, sir, starting in July, July and August.

Senator PELL. If they happened before August, they are not included.

Mr. ANDERSON. It is an old folder; it is dated.

Mr. HOUSTON. On this here, it is supposed to go up $3.30.

Senator PELL. Excuse me, maybe you could take up this discussion with Mr. Anderson afterward.

Mr. HOUSTON. That settles that. I told you I am a very short speaker. Now, on another topic I want to know, are these rent controls coming on into effect?

Senator PELL. I think rent controls will stay on as long as the freeze stays on.

Mr. HOUSTON. It is going to end in November.

Senator PELL. That's right. When the freeze ends, however, it is up to the administration to decide whether it will continue.

Mr. HOUSTON. What I am getting at, Mayor Doorley raised it $7 on the thousand, the taxes, which he has a right because they got to run the city, but what I am getting at, suppose the house is worth $15,000 or $20,000, and it is a 15 family, and the landlord raised it $10 each tenant, now there's $30, $360 a year. He is only paying out $105. He is making $255 on this deal. I don't think that's right. Now, that's coming out of these people on Social Security, and even the people that work for a living. I think there ought to be a limit on that thing, how much they could raise.

Senator PELL. It is a good idea to have controls, there should be controls. My own view is we should have had a system of controls 2 years ago. But this will be decided on a national basis. Thank you very much.

Mr. HOUSTON. I think there ought to be something done about that rent there.

Senator PELL. There is one more witness who wants to say something, is that right?

STATEMENT OF FATHER GEORGE DEMERS, PROVIDENCE, R.I.

Father DEMERS. Senator, I have worked with senior citizens quite a while. One of the concerns that we have is that, I'd like to compare what you said, you mentioned poverty and crime go together. I think that it is very criminal in a sense that there are so many grand programs that have been legislated, but that such a great number of people, senior citizens, are not taking advantage of them because they don't know about them or don't know how to go about getting the benefits of them. So my suggestion at this meeting, after 4 hours and 20 minutes, will be to try to consider some way of forming an organizational setup whereby there will be a different agency separate from all the other agencies that exist, whether it is older Americans or anything else, so that there will be positive moneys available for aides that would go out and knock on doors and visiting people and seeing people where they are and how they live.

I think this is a very important crucial part of our coming to the aid of elderly. I'd like to introduce Miss Veronica Murray, who is the vice chairman of the Rhode Island Senior Citizens Action Group. Thank you for listening.

Senator PELL. Thank you for your suggestion.

STATEMENT OF VERONICA MURRAY, VICE-CHAIRMAN, RHODE ISLAND SENIOR CITIZENS ACTION GROUP*

Miss MURRAY. I live here in Providence. I am very concerned about the 30,000 senior citizens here in Rhode Island living below the poverty line. Our pensions are very, very inadequate. Senator Pell, I noticed that you are proposing $120-a-month minimum. That is not sufficient to keep up with inflation. I believe the poverty level is considered $3,300 a year, am I correct?

Senator PELL. That is correct.

Miss MURRAY. Well, your proposal of $120 a month would only be $1,440 a year. Now, how is that ever going to help us? Senator Pell, we have got to do something, at once, about poverty. It is a very important issue. Now, I have been here since 10 o'clock this morning. I have listened to Medicare and Medicaid, and I am very much for it. Senator Pell, but many things must be added, such as foot doctors, eyeglasses, and chiropractors. If people were given better pensions—pensions so they could live like human beings—they would not get sick. Worry causes sickness. Now, what can you do as our representative for us there? Can't you do better than $120-a-month minimum? The minimum should be $300 a month to bring us up from the poverty line.

Senator PELL. I'd like to do a lot better. Presently, the level is about $90 a month, so a $30-a-month raise is already substantial. I'd like to get it up to a figure where all people are above the poverty level. However, this is up to the taxpayer. Moreover, a general Social Security increase will also help those who do not need help. As one of your representatives, I will do what I can to see that people don't live in misery as some people now live.

Miss MURRAY. Senator Pell, it seems awfully funny that they cannot find the money to do things for the deserving elderly, but yet they can always find billions of dollars to send men up to the moon to bring back rocks. I and millions more are sick of billions of dollars being given for foreign aid while we live in poverty. They cannot take care of the people here that built our State and our country. Now, this is something I am asking you, when is something going to be done for us? When our President went into office his salary was doubled. They found the money for that. What is the matter with finding money for the deserving people here? Senator Pell, we have four representatives in Washington from Rhode Island representing us. We have a Democratic Congress there. Why can't more be done for us? Now, we are banking on you. Will you be our action man and speak for us in Washington?

Senator PELL. May I answer?

Miss MURRAY. Yes.

Senator PELL. Thank you very much.

Miss MURRAY. Senator Pell. Will you be our action man? Thank you.

Senator PELL. With regard to sending the men to the moon, I was one of five Senators to vote against the space program.

Miss MURRAY. I know you were, Senator, and I admire you for it.

Senator PELL. I happen to believe very strongly that the whole sense of priorities is wrong, because you will find, as I said earlier—you

* See appendix 3, p. 363.

may have listened to my statement—that more than 95 percent of the moneys that are authorized for space and defense are spent, whereas about 50 percent of the moneys that are authorized for health and education, the human sector of the economy, are spent. I think those priorities are wrong; they should be turned around.

I can only speak for myself and I think I speak for my colleagues from Rhode Island, we all think fairly much alike. You look at our voting record and you will find in general this is the philosophy we advanced. But it takes more than four Representatives to Congress from Rhode Island to turn the Nation around. It involves a question of who is President and it depends on who the Congressmen are from the other 49 States. This is the only answer I can give you. I stand on my record.

I think we have had a long enough meeting. It has now lasted 4 hours and 25 minutes. I must say I am getting a little bit hungry. I have not been able, due to time limitations, to get to all the questions that I wanted to ask the witnesses. I plan to submit some of these questions to certain witnesses by mail, and I will appreciate their responses as soon as possible.* If nobody else wants to speak, I will adjourn this hearing.

(Whereupon the hearing was adjourned at 2:35 p.m. subject to the call of the Chair.)

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*See appendix 2, p. 338.

APPENDIXES

Appendix 1

PREPARED STATEMENTS

ITEM 1. PREPARED STATEMENT OF ARTHUR F. HANLEY,* PRESIDENT RHODE ISLAND BLUE CROSS AND EXECUTIVE DIRECTOR, RHODE ISLAND BLUE SHIELD

Mr. Chairman, my name is Arthur F. Hanley and I reside at 76 St. George Court, Warwick, Rhode Island. I appear before this U.S. Senate Subcommittee hearing in my capacity as President of Rhode Island Blue Cross and Executive Director of Rhode Island Blue Shield.

We certainly appreciate this opportunity to express our views on health care for the elderly. But, first, for the record, here are some brief background facts about the two organizations which I represent.

Approximately 758,000 Rhode Islanders are served by these local Plans, which is about 80 percent of the eligible population of the state. Of these, 703,000 are regular Blue Cross and Blue Shield subscribers. More than 63,000 Rhode Islanders over the age of 65 supplement their Medicare coverage with Plan 65 benefits.

Blue Cross administers Part "A" of Federal Medicare for 102,000 eligible Rhode Islanders in its role as fiscal intermediary for the government, and handles hospital bills for another 16,000 servicemen's dependents under the CHAMPUS program.

Blue Shield has also been chosen by the government as carrier for Part "B" of Medicare in Rhode Island, which has 99,000 enrollees in this state.

To give you some indication of how the overall operations of Blue Cross and Blue Shield impact on health care in Rhode Island, this year the Plans will process one and one-half million claims, totaling nearly $120 million in health care benefits.

For the Subcommittee's consideration, we will review four main points affecting the health of the elderly in this presentation. They are:

1. The accomplishments of the Medicare program in Rhode Island during the first five years of its existence.
2. The problems we have found in the Medicare program, as they affect the beneficiaries and the providers of services.
3. Our views on some of the proposals contained in H.R. 1, the Social Security Amendments of 1971.
4. Suggestions on improving the Medicare program in the future.

I. ACCOMPLISHMENTS

It is very easy, and sometimes convenient, to criticize a program such as Medicare for its shortcomings without recognizing or appreciating the positive effects it has had on the people it serves. Generally, we feel the Medicare program in Rhode Island has been very successful. The elderly population now, more than ever before, are receiving most of the essential health care services they require. This has been made possible by the benefits of Medicare, coupled with the supplementary benefits of Blue Cross and Blue Shield Plan 65 and other financing sources such as Medicaid.

Another important factor contributing to the program's success has been the tremendous cooperation given by doctors, hospitals and other providers of health care services to Blue Cross and Blue Shield, acting as fiscal intermediaries for the government.

*See statement, page 272.

A. Benefits Used

1. The Federal Medicare program observed its fifth anniversary on July 1, 1971. In the five-year period, Rhode Island Blue Cross and Blue Shield processed 1,518,000 claims for the state's elderly. The total bill was more than $153,000,000. (See exhibit #1.) Add to that $4,723,000 in Medicare benefits that was paid directly to the State Department of Mental Health, Retardation and Hospitals for the care elderly patients received at the General Hospital, the Institute of Mental Health, Zambarano Memorial Hospital and Charles V. Chapin Hospital; and $4,975,000 paid through the Travelers Insurance Company, which handles claims for 12 extended care facilities in Rhode Island, and Medicare benefits in five short years amount to almost $162,760,000.

B. Types of Services Provided

1. Part "A".—The great bulk of Medicare expenditures in Rhode Island during the five-year period has been paid through Blue Cross in Part "A" benefits. (See exhibit #2.)

a. $108.6 million for inpatient hospital care.

b. $2.4 million for hospital outpatient care.

c. $3.1 million for home health agency services.

d. $2.1 million for care in the 11 extended care facilities in Rhode Island which have their claims administered by Blue Cross.

2. Part "B".—In the first five years of Medicare, well over one million Part "B" claims were paid for the elderly by Rhode Island Blue Shield. And those claims amounted to nearly $36.9 million in health care benefits. (See exhibit #1.)

3. Blue Cross & Blue Shield Plan 65.—Of the 102,000-plus Rhode Islanders eligible for Medicare, 63,000 are enrolled under the supplementary Blue Cross & Blue Shield Plan 65.

Since the program began five years ago, Plan 65 has helped fill the gaps in more than 764,000 Medicare claims, virtually providing full payment for covered services when coupled with the beneficiaries' Medicare benefits. (Exhibit #3 contains a summary of Plan 65 benefits.)

In dollars, the gap-filler coverage amounted to $12.8 million, of which $9.5 million was spent to cover the $50 deductible and 20 percent coinsurance provisions of Medicare Part "B". (See exhibit #4.)

C. Cooperation of Providers

An essential factor in the success of Medicare has been the continued cooperation of doctors, hospitals and other providers of health services in making the program work for the benefit of beneficiaries.

1. Understanding.—In the few short months between the passing of the Medicare law and its implementation date, doctors, their medical assistants and countless categories of hospital personnel devoted many, many hours of their working and leisure time to participate in training sessions with Blue Cross and Blue Shield personnel to learn the intricacies of Medicare. The providers' cooperation was instantaneous and it has been continuous, staying abreast of the many changes in, and interpretations of, the Medicare law.

2. Concern For Patients.—Probably the best indicator of provider cooperation in making Medicare work for the benefit of the beneficiary is the ratio of assignment claims accepted by Rhode Island physicians. Doctors can collect for Medicare services directly from patients and not be bound by the "reasonable and customary" payment provisions of the law. However, 82.8 percent of Part "B" claims in Rhode Island have been paid under the assignment method since the program began in 1966. (See exhibit # 5.)

D. Plans' Performance

As was true of most carriers and intermediaries, we experienced some administrative problems in the developmental stages of Medicare. Currently, however, our systems are functioning smoothly. Doctors' claims are being processed in four to five days, and hospital claims for inpatient care are processed within two days of date of receipt.

We are also proud of our record of cost efficiency in processing claims for the government. Our current administrative costs, reflected as a percentage of dollars paid, are:

Part "A", 1.55%.
Part "B", 7.83%.

Rhode Island Blue Cross and Blue Shield administrative cost figures under Medicare, as has been the case under our basic business, have consistently been among the lowest in the nation.

Behind the stark realism of these cost and production figures stands an extremely complex program. Some reference to this complexity will be made later. For the moment, we would like to dwell on just one facet of the program—beneficiary eligibility. Beneficiary records are maintained in the Baltimore Office of Social Security—the Bureau of Data Processing Accounts (BDPA).

Each time we receive a claim, our data processing system creates a magnetic tape eligibility query which is wire transmitted to BDPA. Within 20 to 48 hours the transmittal is reversed with an eligibility query response from BDPA to our computer. The claim is then processed toward final settlement. What is most impressive is that R. I. Blue Cross and Blue Shield processes an average of 1,500 Medicare claims each working day.

II. PROGRAM PROBLEMS

While the program has been an overall success, Medicare has had its share of problems.

A. Complexity

1. For illustrative purposes only, we weighed and measured the original Public Law 87-97 (Medicare) as printed by the U.S. Printing Office—it consists of 138 pages and weighs less than six ounces.

The regulations and instructions to carriers, intermediaries and providers pertinent to the administration of that law now embrace some 37 volumes, with more than 8,000 pages, weighing nearly 46 pounds. There have been almost 800 revisions or clarifications of the regulations. (See exhibit #6.)

2. We are not denigrating this paper proliferation. We recognize the necessity of keeping carriers, intermediaries and providers currently informed of mandated changes or revised interpretations of the original Congressional action and intent. We applaud the communications efforts of the Bureau of Health Insurance.

We do submit, however, that the administration of so complex a law, as evidenced and underscored by this paper deluge, inevitably leads to some confusion and considerable misunderstanding on the part of both providers of care and recipients of care. It is particularly troublesome to the beneficiary of advanced age limited education and foreign background.

In our dual role as this state's primary intermediary (Part "A") and carrier (Part "B"), we have developed written and verbal communications with providers to keep them abreast of all new developments in order to ensure prompt claims processing and reimbursement, within, of course, the framework of reasonable control.

We have exerted a particular effort in communicating with our beneficiaries—efforts that range from the design of our office facilities to the creation of a subscriber service department whose function is to ensure that when a beneficiary has a question about his benefits or a specific claim, he is served quickly, efficiently and courteously.

B. Growing Gaps in Medicare Coverage

One of the biggest problems in Medicare at the beginning was that the elderly thought all of their health care bills were going to be covered in full. This singular problem is being compounded by the increasing gaps in the deductibles and coinsurances in the program.

Rhode Island Blue Cross and Blue Shield developed Plan 65 to complement Medicare. By having the deductible and coinsurance amounts covered, subscribers were better able to understand the benefits they were entitled to under Medicare.

Our initial program covered the inpatient hospital deductibles and coinsurances in full on the Part "A" side, with a Major Medical approach in providing

benefits for doctors' services not covered by Part "B". It was soon evident that our subscribers preferred "first-dollar" coverage, and our present program evolved. Impacting heavily on this evolvement were the changes in the law. Exhibit #8 details the changes that were necessary each year to continue to provide Plan 65 subscribers with the "first-dollar" coverage they wanted.

III. REACTION TO PROPOSALS IN H.R. 1, SOCIAL SECURITY AMENDMENTS OF 1971

A. Deductibles and Coinsurance.—We are greatly concerned about further reductions in Medicare benefits for the elderly. Present deductibles and coinsurance provisions under Part "A", such as the $60 deductible for hospital care, are already 50 percent higher than they were when the program began. And the cost of supplementary medical benefits under Part "B", which the beneficiary must pay, has increased from $3.00 a month to $5.60 a month, which is an increase of 86.7 percent.

Just two of the many proposals in H.R. #1 would cost our 63,000 Plan 65 subscribers $834,000 next year, assuming the legislation took effect on January 1, 1972. (See exhibits 7 and 7A.) Those proposals are to increase the Part "B" deductible from $50 to $60 a year and to add to a coinsurance provision for each day in the hospital from the 31st through the 60th day. If plan 65 adds coverage of the deductible and coinsurance increases, membership rates will have to be increased by 16 percent. We estimate the total impact of those provisions on all Medicare beneficiaries in Rhode Island to be $1,316,000 (See exhibit #7B.)

In other words, Congress would be taking $1.3 million in buying power away from the people in Rhode Island over age 65, many of them living on limited and fixed incomes.

B. Increasing Lifetime Reserve.—It has also been proposed to increase the lifetime reserve, under which the patient presently pays $30 per day, from 60 to 120 days. We support this proposal because it adds that much more peace of mind to the elderly person suffering from severe, long-term illness. The Blue Cross and Blue Shield Plan 65 program covers the $30 deductible for the present 60-day lifetime reserve.

We estimate that it would cost $66,000 next year to increase the Plan 65 benefit to 120 days of lifetime reserve.

C. Extending Medicare To Disabled—We also support the provision that Medicare be broadened to include disabled beneficaries under age 65, provided they have been receiving disability benefits for at least two years. Using national ratios, we estimate that inclusion of the disabled under Medicare would benefit approximately 7,000 Rhode Islanders. And there is hardly any doubt about the need of the disabled for health care coverage. Studies have shown the disabled use three times as much hospital care as the average person under age 65 and utilize the services of physicians at a ratio of seven to one.

D. Prospective Reimbursement.—The final provision in H.R. 1 we wish to comment on deals with provider reimbursement. It provides for incentives that will stimulate providers to use their facilities and personnel more efficiently. The purpose is to contain or reduce the total cost of the health programs involved without adversely affecting the quality of services.

We wholeheartedly endorse this provision. The Prospective Reimbursement Contract between Rhode Island Blue Cross and its 16 member hospitals falls into this category. Budget negotiations for the next fiscal year are presently underway for reimbursement under basic Blue Cross programs. We are hopeful that our Prospective Reimbursement Contract will qualify under the provision in H.R. 1, and that an experiment will be underway for Medicare reimbursement in Rhode Island next year.

Briefly, Prospective Reimbursement works like this:

Each hospital submits its approved budget, with related statistics and revenue projections to the Hospital Association of Rhode Island for peer review and then to Blue Cross for review and negotiations in advance of the beginning of the fiscal year.

Prospective payment rates for the full fiscal year will be calculated based on the resulting approved budget.

The rates hold firm for the duration of the year, provided that utilization of hospital services does not exceed or fall below certain percentage parameters built into the contract.

At year-end, a savings or loss calculation is made. If the hospital's actual costs exceed the approved budget, the hospital absorbs the loss; if a hospital is able to operate for less than the agreed-upon budgeted costs as reflected in the prospective payment rates, the hospital keeps a portion of the "savings" or profit as an incentive. During the first year of the program, not yet completed, the savings will be split between Blue Cross and hospitals on a 50/50 basis.

IV. SUGGESTIONS AS TO THE FUTURE OF MEDICARE

A. While we realize that Congress must balance the health care needs of the elderly with the taxpayers' ability to pay the increased cost of broader Medicare coverage, the following are some unmet needs, as we see them:

1. We would advocate the inclusion of prescription drugs in the Medicare program. There has been a tendency to dismiss the importance of this area of coverage by citing the fact that acute episodic illness does not result in prescription drug expenses beyond the economic reach of Medicare recipients. Our concern is directed toward the large number of chronically ill over-age-65 persons whose prescription drug costs may go as high as $500 to $1,000 per year.

2. In the five years of Medicare administration, we have concluded that the health care need most difficult to make provision for is also the most difficult to identify—it embraces that "gray area" between Health Care and Social Care. We, as the intermediaries for Medicare, often find ourselves in the position of demanding "institutional discharge" of a patient due to lack of medical need, while knowing that his "social environment" to which he will be discharged may have been the primary cause of his illness in the first place.

We believe that this unhappy cycle of "cause—to cure—to cause" can only be broken by the provision within Medicare of some medical/social benefits. Among them we would list coverage of homemaker services, mobile meals, day-care for physically and mentally impaired, temporary inpatient care when "family" is itself impaired or in need of respite, foster home care, and institutional custodial care.

3. Closely allied to the need for responsiveness to medical/social care is our recommending removal of the prerequisite of three days' prior hospitalization for coverage of Extended Care Facilities and Part "A" Home Health Agencies. We recognize that the original intent of this requirement was to assure that patients hospitalized in acute-care facilities did not remain longer than medically necessary. In practice, the requirement has proved disruptive to optimum patient care and wasteful of tax dollars by hospitalizing patients unnecessarily and even prolonging stays while arrangements are made for transfer.

4. We endorse the principle of merging of Parts "A" & "B" of Medicare. This would provide for a single entity of the financing and delivery of health care. It would eliminate much of the confusion surrounding Medicare as it now stands and establish the principle of financing all Medicare benefits prior to retirement.

5. Coupled with the merging of Parts "A" & "B", we would recommend the elimination of all deductibles with the application of an "across the board" uniform coinsurance.

The effect of deductibles and coinsurances, originally intended as incentives for appropriate use of facilities and services, is still unclear and controversial. There is a real danger that they may promote underutilization among the aged. If there be a need for program cost-containment, it might better be in the form of coinsurance, but most certainly not a combination of both deductibles and coinsurances.

V. CONCLUSION

In Rhode Island, we believe Medicare has accomplished what Congress intended. But the deductible and coinsurance gaps, mandated under the law, are widening to the point where costs to the individual needing care are now inflicting great hardship. This is occurring whether the beneficiary is paying the deductibles and coinsurance amounts out of his own pocket or paying higher premiums to Blue Cross and Blue Shield, or to a commercial insurer, to fill the gaps.

Now that Medicare is five years old, we feel that it is most appropriate that Congress is taking another look at the program to correct its shortcomings. We cannot see how that can be accomplished by adding other coinsurance factors or increasing present deductibles. We advocate elimination of deductibles; and if cost-containment factors are needed, apply an "across the board" uniform coinsurance: the merging of Parts "A" & "B", establishing the principle of financing all Medicare benefits prior to retirement; inclusion of prescription drugs under Medicare; and, simplifying the law by recognizing the social needs of the elderly as they relate to their health and include some medical/social benefits under Medicare.

Again, Mr. Chairman, thank you for the opportunity to express our views.

EXHIBIT NO. 1

MEDICARE A AND B—NUMBER OF CASES AND DOLLARS PAID

	Medicare A		Medicare B	
	Cases	Amount	Cases	Amount
1966	17,785	$4,033,120	12,379	$816,193
1967	94,042	17,421,563	142,302	5,630,638
1968	82,111	20,061,919	201,591	7,290,218
1969	104,683	27,721,192	275,776	8,731,924
1970	105,404	30,144,581	293,055	9,570,791
Jan. 1-June 30, 1971	50,496	16,812,712	139,833	4,831,335
Total	454,521	116,195,087	1,063,936	36,871,099

EXHIBIT NO. 2

MEDICARE PART A—DOLLARS PAID (BY TYPE OF PROVIDER)

	Hospital inpatient	Hospital outpatient	Home health	ECF's	Total
1966	$3,960,108	$3,447	$69,565		$4,033,120
1967	16,550,702	233,117	438,997	$198,747	17,421,563
1968	18,808,060	412,845	601,154	239,860	20,061,919
1969	25,505,594	632,054	865,397	718,147	27,721,192
1970	28,024,335	745,295	783,370	591,581	30,144,581
Jan. 1-June 30, 1971	15,778,640	345,871	345,549	342,652	16,812,712
Total	108,627,439	2,372,629	3,104,032	2,090,987	116,195,087

EXHIBIT NO. 3

SUMMARY OF PLAN 65 BENEFITS

Type of health care service	Medicare coverage	Plan 65 coverage
1. Care as bed patient in the hospital, semi-private room and board, and general nursing service, X-rays, drugs, supplies, etc.	Medicare pt. A pays 90 days in full during a spell of illness, except 1st $60 and $15 per day for 61st through 90th days. An additional "lifetime reserve" of 60 days, paying all but $30 per day.	Pays 1st $60 and the $15 per day and $30 per day coinsurance amounts.
2. X-ray, other diagnostic tests in hospital outpatient department. 3. Hospital outpatient treatment for accidents and medical emergencies. 4. Surgeon, assistant surgeon, anesthesiologist. 5. Doctor home and office calls or visits to the hospital or extended care facilities. 6. X-rays taken in the doctor's office.	Medicare pt. B pays 80 percent of reasonable charges after the beneficiary pays $50 deductible each year.	Pays $50 deductible and remaining 20 percent of reasonable charges to give full coverage.
7. Hospital and doctor care outside the United States.	No coverage (under normal circumstances).	Pays the hospital and doctor charges in full for services the beneficiary would be entitled to in the United States through medicare and Plan 65.

EXHIBIT NO. 4

PLAN 65—CLAIMS PAYMENTS COMPLEMENTING MEDICARE PARTS A AND B, JULY 1966–JUNE 1971

	Dollars of payment		
	Part A	Part B	Total
1966 (July–December)	$136,110	$18,385	$154,495
1967	479,801	487,540	967,341
1968	665,610	1,214,644	1,880,254
1969	700,103	2,602,270	3,302,373
1970	795,200	3,178,415	3,973,615
1971 (January–June)	564,107	1,996,293	2,560,400
Total, July 1966–June 1971	3,340,931	9,497,547	12,838,478

EXHIBIT NO. 5

MEDICARE PART "B"—CASES AND DOLLARS BY ASSIGNMENT AND NONASSIGNMENT

	Assignments		Nonassignments		Total	
	Cases	Amount	Cases	Amount	Cases	Amount
1966	10,249	$660,075	2,130	$156,118	12,379	$816,193
1967	117,826	3,959,087	24,476	1,671,551	142,302	5,630,638
1968	166,917	5,439,535	34,674	1,850,683	201,591	7,290,218
1969	228,343	7,035,776	47,433	1,696,148	275,776	8,731,924
1970	241,822	8,092,351	50,233	1,478,440	292,055	9,570,791
Jan. 1–June 30, 1971	115,782	4,071,250	24,051	760,085	139,833	4,831,335
Total	880,939	29,258,074	182,997	7,613,025	1,063,936	36,871,099

EXHIBIT NO. 6

MEDICARE VOLUME SURVEY

	Weight (pounds)	Number of pages	Number of revisions (letters, bulletins)
Medicare law	0.6	138	----------
Part A manual	11.2	1,840	220
Part B manual	7.7	1,380	233
Intermediary letters (current)	5.12	690	103
Regional office bulletins	2.1	230	45
HIM manuals (16)	15.3	2,990	166
HIR manuals (17)	4.2	920	16
Comparison:			
Original Medicare law	.6	138	----------
To date	45.62	8,050	----------

DISTRIBUTION

	Internal	External
Intermediary letters (10)	10	Special
Part A manual (14)	14	----------
Part B manual (14)	14	----------
Regional office bulletins (6)	6	----------
Hospital manual (75)	18	57
Extended care facility manual (40)	13	27
Home health agency manual (52)	12	40
Provider reimbursement manual (97)	17	80

Note: Other HIM's are sent—approximately 2 per facility.

EXHIBIT No. 7

PLAN 65—*Estimated effect of providing coverage of Medicare deductible and co-pay changes stipulated in H.R. 1, age 65 and over subscribers*

(Assumed effective January 1, 1972)

Assumed 1972 incurred claims, excluding H.R. 1		$5,410,000
H.R. 1 proposals: 31st–60th day co-pay, at $8.50 per day	500,000	
Part "B" deductible increased from $50 to $60 (20%):		
Deductible increase	418,000	
20 percent co-pay decrease	−84,000	
Total	334,000	834,000
Lifetime reserve increased from 60 to 120 days		66,000
*Assumed 1972 incurred claims—including H.R. 1		6,310,000

EXHIBIT No. 7A

PLAN 65—*Assumptions in the Estimation of H.R. 1 Claims Cost*

(1) 1972 Part A deductible to be $68; therefore, co-pay 31st–60th day will be $8.50, or ⅛ of $68.

(2) An increase in the Part B deductible will have a decreasing effect on the 20 percent co-pay coverage.

(3) The national ratio of Disability Pensioners to Medicare Beneficiaries (.075) is applicable to R. I. Plan 65.

(4) Factors for conversion of *Over Age 65* utilization to that of *Disability Pensioners:*

A. Per capita expenditures for the aged in ratio to the under 65 population: Hospital Care, 3.66:1; Physician Services, 1.94:1.

B. Per capita expenditures for the disabled in ratio to their under age 65 peers: Hospital Care, 3:1; Physician Services, 7:1.

EXHIBIT No. 7B

ESTIMATED H.R. #1 IMPACT ON 104,040 RHODE ISLAND MEDICARE PART "A" BENEFICIARIES, YEAR 1972

R. I. Age 65 & Over Population:
1960, 87,552 (Bureau of the Census—PC (1) 41 C R. I.).
1970, 103,932 (R. I. 1970 Census by Age and Sex—R. I. Dept. of Health).
10-year growth=18.7%.
Average annual growth=1.87%.

Part "A" Medicare Beneficiaries—Year 1972:

(102,130 Beneficiaries as of 7/71×1.0187=104,040 1972 Beneficiaries)

H.R. #1 Impact in R. I. for 104,040 Part "A" Beneficiaries

65,941	1972 Plan 65 members		
104,040	1972 R. I. Part "A" Beneficiaries 1972 HR#1 Impact on Plan 65	= .6338	
$834,000	Over Age 65 Sub. (See Exhibit 7)		
.6338	Ratio 1972 Plan 65 Members to 1972 R. I. Part "A" Beneficiaries	=$1,315,873	H.R. #1 Impact in R. I. for 104,040 Part "A" Beneficiaries.

PLAN 65 PROGRAM CHANGES

1. *July, 1966.*—Plan 65 introduced, covering the Part "A" deductible of $40 . . . the coinsurance of 10 per day . . . and providing Major Medical-type coverage for Part "B" services, paying 80% after the $100 deductible.

*If H.R. 1 proposals become law, this would require an estimated 16.1 percent rate hike—if Plan 65 covers the full additional cost.

2. *July, 1967.*—Change from Major Medical-type plan for doctors' services to straight "gap-filler" on Part "B", covering $50 deductible and 20% coinsurance for doctor bills, excluding home and office visits.

3. *July, 1968.*—Add coverage of 50 Part "B" deductible and 20% coinsurance for doctors' bills for home and office visits.

4. *January, 1969.*—Part "A" deductible increased by Social Security Administration from $40 to $44 . . . coinsurance from 10 to $11 per day . . . lifetime reserve coinsurance from $20 to $22 per day. All picked up by Plan 65.

5. *January, 1970.*—Deductible increased from $44 to $52 . . . coinsurances from $11 to $13 and $22 to $26. Covered by Plan 65.

6. *January, 1971.*—Deductible increased by SSA from $52 to $60 . . . coinsurances from $13 to $15 and $26 to $30 per day. Covered by Plan 65.

ITEM 2. PREPARED STATEMENT OF DR. RICHARD J. KRAEMER* CHAIRMAN, COMMITTEE ON AGING, RHODE ISLAND MEDICAL SOCIETY

STATEMENT OF THE AMERICAN MEDICAL ASSOCIATION FOR THE WHITE HOUSE CONFERENCE ON AGING [1]

IMPROVING AND MAINTAINING THE HEALTH OF THE AGING

The White House Conference on Aging has been called by President Nixon to "help develop a more adequate national policy for older Americans . . . it will fully consider the many fa[illegible] which have a special influence on the lives of the aging . . . it will address [illegible]e recommendations, not only to the Federal government at other levels and to the private and voluntary sectors as well."

The stated charge to the November 1971 White House Conference is to propose a plan of "national action to strengthen the means of older people for independent living and the improved use of their talents, and to lessen their isolation and increase their participation in family and community life."

In December 1970, the AMA House of Delegates stated "that it is encumbent on organized medicine to ensure that proper emphasis [at the Conference] is placed on improving and maintaining the health of the aging." To help accomplish this objective. AMA representatives have participated in various technical committees and task forces responsible for developing background materials prepared for community, state and national White House Conferences. AMA has also encouraged state medical associations to work closely with other state groups in planning for the multilevel White House Conferences.

In June 1971, the AMA House adopted a series of ten concepts, which, if implemented, would help meet the stated charge to the Conference. These concepts with interpretive comments are presented for the guidance of delegates to the White House Conference on Aging.

(1) There are no known diseases specifically attributable to the passage of time, but diseases and health problems which frequently develop in the elderly render the general health status of the aged not as favorable as that of younger age groups.

No one can predict that a specific condition will occur in any person after the passage of a specific period of time. It is recognized however that the health problems of the aged may be more pressing than those in younger age groups because of lower income, compulsory retirement, lack of meaningful activity, fear of becoming dependent, loosening of family ties, fewer community contracts, and other factors.

For the most part however the aged who are sick usually present the same many-sided problems to the physician as the sick of any age.

(2) Since the vast majority of older citizens are not sick any program on behalf of older citizens should place emphasis on keeping them well.

Only four per cent of the population over 65 are in institutions—nursing homes, homes for the aging, mental hospitals, and other long-term stay hospitals. The remaining 96 per cent, 19 million people, are living in the community, usually in their own homes or in the homes of children or relatives.

The chronic conditions most of the aged have are not disabling in terms of the individual's present activity and mode of living. In 1965–67 only 13.8 per

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*See statement, page 258.

[1] This paper contains concepts adopted by the AMA House of Delegates, June 1971, with interpretive comments.

cent of the aged in the community were unable to carry on their major activity, namely work or keep house. The term "chronic" refers only to the duration of a disease or disability, not to its severity.

The overwhelming majority of older people have the experience, skill, and knowledge to make greater contributions to society than they presently have opportunity to make. They constitute a major national resource.

(3) Encouraging older persons to assume functioning, valuable roles in the family and community will reduce their emotional problems and improve their general health.

Many of the medical ills affecting older people are the product of emotional complications which disturb normal physiological processes, intensifying disease processes, and interfere with healing. The older person may have the feeling that he is no longer needed or wanted by family or community, and, therefore, he has difficulty coping with the usual stresses of living.

Some people will have behavioral problems more harrassing than their medical problems. Often their solution lies primarily in restoration of a sense of worth. The more that an older person is encouraged to feel functioning and valuable, the less need he will have to resort to inadequate substitutes for self-respect.

(4) The health of all people—including those in the older age group—can be significantly improved by adoption of a positive health program including (1) periodic health appraisals, (2) planned regular physical exercises, (3) planned activities to challenge their thinking, (4) diet planning to avoid obesity and malnutrition, (5) modifications of habits that might be detrimental to health, such as the overuse of alcohol, drugs, and tobacco, and (6) participation in other preventive medical programs.

Good health requires not only the observance of a sound exercise, nutrition, and living program, but a reason for being well. A sense of purpose and the opportunity to contribute to others are vital.

Many factors operative in the earlier years may affect the health of the middle-age or aged individual. Therefore, greater emphasis must be placed on the importance of a periodic health examination as a routine procedure to be repeated throughout life.

In the early and middle years of old age, a planned program of physical exercise can help establish or maintain good muscular tone throughout the body and serve as an antidote for nervous tension and anxiety.

Later years can be a time of challenge. Learning capability does not necessarily decrease with age. Older people can learn and develop new interests in the same fashion as the young.

Many elderly people suffer from malnutrition, partly because of dietary fads learned in their younger years. Their requirements for proteins and minerals remain about the same as for young adults, but fewer calories, carbohydrates, and fats are needed.

The well aging, as do any other members of the community. need immunization as protection against infectious diseases. In general, infectious diseases involve a greater threat of serious morbidity or mortality among the aged than they do in younger age groups.

Out of frustration, fear, and ignorance, many people have looked for panaceas from persons who claim to have medical skills they do not possess. The public, particularly the aged, must be educated about the health hazards posed by chiropractic, naturopathy, naprapathy, and other unscientific cults.

(5) Financing long-term care continues to present a special problem for elderly persons. Means to provide protection from the catastrophic costs of such care should be explored as well as development of incentives to communities to make home health services readily available as an alternative to more costly institutional care.

Extended care benefits under Medicare were offered as part of a hospital insurance program as a method of preventing overutilization of high-cost hospital beds. Accordingly, the Social Security Administration has defined eligibility criteria for ECF benefits based on the need for general medical management and skilled nursing care on a continuing basis. Unfortunately, there has been a great deal of confusion in the implementation of the program resulting in some instances in retroactive denial of benefits.

Recent revisions in Medicare regulations, as published in the Federal Register, June 4, 1971, allow a presumption of need under specified conditions, thus reducing the threat of retroactive denials. The effectiveness of these changes cannot yet be evaluated.

No national program is addressed to the need for financing long-term institutional care designed to meet the social and rehabilitative needs of the chronically ill. Failure to address the many facets of this socio-economic problem distorts the operations and inflates the cost of medical programs.

Long-term institutional care requires the attendance of skilled health professionals, but of a more limited scope than that provided by hospitals or extended care facilities under Medicare. This type of care requires medical supervision but relatively little medical care. It is usually aimed at helping the patient achieve the highest possible level of function and comfort. The real need is to provide financing for room and board, personal-support services, and supervision by physicians and allied health personnel as needed for long periods of time.

Long-term institutional care presents a financial hardship for many families, frequently even for those in middle income or higher income groups. To protect individuals and families from the catastrophic cost of such care, means of financing long-term institutional care should be explored.

Institutional care for the aging has been a major expenditure under both Titles XVIII and XIX of the Social Security Act. Much of this expenditure occurs because of a serious lack of appropriate alternatives. Many patients could be discharged to their homes, and many hospitals and nursing home stays could be reduced if home health services could be provided. Although payment for home health services may be available under Medicare, Medicaid or some private health insurance, in many communities such financing and the services themselves do not exist. Incentives to communities to make available and adequately fund these services must be found.

(6) There should be no selective social discrimination against the aged solely on the basis of age.

Social attitudes towards the elderly frequently constitute a major roadblock to equitable treatment of the aged. There is an unfortunate tendency for some to look upon the aged as a dependent, debilitated group, all of whom need special treatment.

In fact, older people are not alike. Their abilities, attitudes and problems differ as much as they do among the young. For these reasons, the aged deserve consideration as individuals, some of whom need special treatment but most of whom do not.

Many older people do not want to be looked upon as different from younger persons. They resent strenuously any efforts in this direction. Older people do not want to be segregated or isolated; they want to be an integral part of the community.

(7) Since compulsory retirement and artificial barriers to employment based on age can be prime factors in the deterioration of health, middle-aged and older workers should be afforded equal opportunities with others for gainful employment, based on their personal desires and capabilities.

Compulsory retirement, tied to chronological age, does not consider the wishes of the individual, his fitness to continue work or his personal problems. Compulsory retirement may therefore impair the health of individuals whose job represents a major source of status, creative satisfaction, social relationships or self-respect. Job separation may well deprive such a person of his feeling of accomplishment and leave him floundering in a motivational vacuum. If so, he may soon overconcern himself with his own normal physiological functions and exaggerate minor physical or emotional symptons. The nation pays for failure to provide equal employment opportunities for older workers by increased dependency of the aged.

Current labor force participation trends indicate that one out of every six men in the 55–64 age category will no longer be in the work force by the time he reaches his 64th birthday. Ten years ago this ratio was only one out of eight.

Many middle-aged and older workers are unemployed or are forced into early retirement because they are not equipped for jobs in modern technology. Yet, older workers generally are capable of working in many occupations and, in many instances, may actually excell younger persons because of their superior judgment, experience and safety of performance. Technological advances, by taking away much of the physical stress of work, have placed a premium on the abilities that many older workers possess.

Progress has been made in opening up jobs for workers under 65 by passage of the Age Discrimination in Employment Act of 1967. More needs to be done, however, to create work opportunities for older workers to inform them

of such job opportunities, and to encourage industry to create situations for part-time employment.

Section 5 of the Age Discrimination Act of 1967 directed the Secretary of Labor to study institutional and other arrangements giving rise to involuntary retirement and report his findings with appropriate legislative recommendations to the President and to the Congress. A shortage of funds delayed this study, but apparently it is now well under way.

(8) Workers who are capable and who personally desire to postpone retirement should be encouraged to do so by modification of the work-income test under the Old Age and Survivors Insurance Program and by adoption of flexible retirement policies by both industry and government.

Biological age, not chronological age, should be used in deciding when a man should retire. Despite the benefits to both the older employee and the economy from such policies, the recent trend seems to have been the other way. Not only do fewer employers seem to be experimenting with deferred or flexible retirement, but compulsory retirement is increasingly being set at lower ages.

Flexible retirement plans can provide a period of transitional adjustment for increased leisure time during retirement years. These plans may allow phasing out through a reduced work week or employment at a less demanding level of responsibility. For an individual who prefers a less vigorous work schedule as he grows older, such an arrangement can give him an opportunity to continue providing worthwhile service.

The work-income test under the OASI program conflicts with the socially desirable goal of encouraging older persons to continue in employment if they so desire. Continued employment would not only help the aged to maintain a satisfactory standard of living, but would help them achieve benefit adequacy in final retirement. Modifying the work income test would also improve the financing of the social security system.

(9) A voluntary pension system transferable among employers (vesting) should be devised to encourage the expansion and improvement of private pension coverage.

A high proportion of pension coverage has already been achieved in major industries and in stable employment situations. A portable voluntary pension system, which would enable workers to preserve previously earned and vested pension credits even though they move from job to job, would encourage expansion of private pension coverage.

(10) A formula for fulfillment for the aged should include (a) independence and self-esteem; (b) opportunities for work, part-time or full-time, on a paid or volunteer basis; (c) continued meaningful participation in family and community life; (d) adequate housing; (e) ability to enjoy leisure time and participation in recreational activities; (f) continuing personal self appraisal; and (g) availability of protective services and medical and nursing care.

The older person needs to understand himself as an individual and to establish habits in keeping with his own self-image. He needs to accept himself as he is, with his strengths and limitations. He should be encouraged to be independent, yet involved with others for inspiration and stimulation.

Aging people should be provided during their middle years with opportunities to prepare for life in the years to follow. This means that they should be encouraged to adapt their work or activity patterns to their changing capacities. Some measure of activity is essential for meaningful living in retirement.

Regardless of age, getting the most out of life is an individual quest. However, as one grows older, barriers to meaningful living arise more frequently. The impact of these restrictions will be lessened if all people recognize that the greatest need of a human being, apart from physical survival, is a sense of purpose in life and recognition of his worth by others.

ITEM 3. PREPARED STATEMENT OF EDWIN C. BROWN,* SECRETARY-TREASURER, RHODE ISLAND AFL–CIO

We, of the AFL-CIO, are grateful to you, Senator Pell, for showing your concern for the health of the elderly by holding this hearing in the capital City of Rhode Island.

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*See statement, page 282.

Also, we of the AFL-CIO appreciate this opportunity to appear before this Subcommittee of the U.S. Senate because we believe we have a contribution to make in regard to improving health care of our Medicare recipients. We are not satisfied in the manner in which the health of our older neighbors is being cared for during their advanced years. Fears that come with advancing age must be alleviated and life made more enjoyable for this important segment of our citizenry.

When the time comes for our senior relatives and neighbors to actually lay aside the worries of the world of work and the day to day turmoil—they are confronted with the agonizing fear of their health care. How are they to receive their basic health care needs—and meet the ever increasing cost of health care.

During the past five years, we of the Rhode Island AFL-CIO, have been particularly concerned over the inadequacies of the American health care delivery system. The system has failed. It is medieval—fragmented—and far too expensive.

This is particularly true for those over 65 years of age. Due to the high cost of health care, retirement money benefits fall far short of meeting the need.

Because money is short, medical care is not readily available—hence, the concern and worries of our neighbors increase.

One of the objectives of the AFL-CIO is to devise a system where we can provide good health care to our Medicare recipients in a hospital based, nonprofit, prepaid group medical plan.

After five years of intensive health care planning, we believe we have some constructive proposals to offer to improve the inequities of Medicare under Social Security.

When Social Security was enacted 35 years ago, it was a bold and forward looking step. However, since then, benefits under social security have been playing catch-up—and not too successfully. Most of the steps to improve the program over the years have been far from bold. These steps have been aimed at alleviating the obvious hardships of the retired population that was struggling to keep abreast of the rising cost of living.

Five years ago a significant gain was made in the Social Security program. Medicare was added. The enactment of this feature came about after several years of bitter struggle.

This occasion provided Congress the opportunity to build a rational national health care system. However, Congress was not able to restructure the delivery system. The insurance industry, and pockets of the medical establishment, forced Congress to superimpose on the existing system a financing mechanism resembling private insurance. It was designed to follow the mechanism of the fee-for-service fragmented system. Insurance companies have taken a "public be damned" attitude about cost and quality controls. Bills are paid without question and the costs go up and up.

Medicare did recognize prepaid group practice systems, but concocted a reimbursement procedure that was inefficent, uneconomical, and unnecessarily burdensome. In spite of all the roadblocks, prepaid group practice plans proved successful because they acquired and retained enrollees despite the government's imposed obstacles.

Because of the built-in high cost factors, Medicare has been too expensive and the level of health care has been short of the needs. It is ironic that those who originally opposed the introduction of Medicare are the ones who have become rich and those who it intended to help have been the victims.

The experience under Medicare proved that by merely spending more and more money, the level of health care will not be improved. The health care in the United States is nowhere as good as the money being spent should provide.

In industry, high wages and high cost is offset by greater efficiency and high productivity. This is precisely what is lacking in the health care industry.

There is ample evidence that when health services are better planned and organized, costs can be contained and a high level of care can be provided.

There is no question that we must reset our priorities. That job must not be delayed any longer. The money barrier must be removed. We must stop restricting the right to life and good health to those who have the ability to pay—and deny this right to the poor and those in Medicare.

The do-nothing advocates present the argument—good health is too expensive. Tax increases will wreck the country. Doctors will be regimented. The fallacious argument of free choice of doctors is presented and the old threat of socialism will follow.

These arguments are specious and do not hold water. If we were getting our money's worth, America would be the healthiest nation and the longest lived

nation on earth. Why?—because we spend more money on health services than any other nation. More in total cash, more per person, and more as a percentage of gross national income.

It is perfectly clear we do not need to spend more money. We must restructure the health care industry. No other profession, no other craft or trade, is fragmented so chaotically and is so wasteful.

Bold steps are long overdue. We must not permit the next opportunity to improve our nation's health pass us by. There is something fundamentally wrong with a system that gears the earnings of doctors to the sickness of their patients. The earnings of hospitals to the number of beds they can keep filled.

Few people go to doctors until they feel sick enough to justify the expense in time and money. Then the doctor is faced with non-medical problems. Can the patient afford the treatment he needs? Does he have the money? Is he insured? Is he eligible for Medicare or Medicaid? Is his credit good? These are not medical questions, and it is unfair that the doctor should be forced to let them influence his medical judgment.

After some firsthand experience, we of the AFL–CIO believe we have the answer to many of the shortcomings of the present system. We will not go into a complete review of that now. We will mention some changes that should be made for the elderly.

We are convinced that Medicare requirements must be updated so that Medicare enrollees may have the opportunity of enrolling a prepaid group practice medical plan.

We believe that a hospital based, nonprofit, prepaid, group practice health maintenance organization will best serve this segment of our population.

Such a plan draws together a group of medical specialists so that a patient can receive comprehensive treatment at one location.

Fortunately, for the people of Rhode Island, such a health maintenance organization exists in Rhode Island.

On June 1st of this year, the Rhode Island Group Health Association started delivering services to a selected number of enrollees. It has met with growing success. In addition to treating people who are ill, the Plan features modern preventive medicine. The primary concern is to keep people well, rather than care for them when they are sick and the cost becomes expensive.

Therefore, we propose that the Congress make it possible for Medicare people to enroll in such prepaid HMO's. By doing so, the level of health care for subscribers will be raised and government will save tax dollars.

The cost to the government will be reduced because the Medicare people will not be visiting a physician on a fee-for-service basis. That is—each and every time he or she visits a physician at his office there is the usual office visit charged the government. On the other hand, in a HMO the patient may visit a center such as the Rhode Island Group Health Association as many times as it is medically required and the government will only be required to prepay the one set monthly charge.

There are other features that must be provided for our Medicare recipients—transportation.

Because of their age, and in some cases, infirmity, transportation must be provided so that they may be picked up and transported to a HMO and returned to their home.

In addition to the health care provided at the HMO family center, there must be provisions made to take advantage of some of the mobile medical units that provide health care.

Many of the health problems of the aged are concerned with eyes—feet—and dental. A mobile unit should be equipped to service these health matters on a regular schedule of visits to nursing homes—housing for the aged, so that on the spot care for Medicare participants can be rendered.

There are other mobile medical services that should be provided. Stroke—stroke is a fear of all, yet early detection of a possible stroke is a relatively simple matter.

There are many health care plans now pending before Congress . . . some good and others very bad. Some of these Plans have many meritorious features that will go a long way in helping to improve the delivery of health care to our elderly. These features provide for Medicare patients to receive complete care at a HMO, and the federal government will assume most of the total cost on a prepaid basis.

Among the good features of the Plans are:

(1) The benefits to the patients are comprehensive medical care—24 hours a day—every day of the year—in the doctor's office—in the hospital—and at home.

(2) Availability of consultants in all fields at no extra cost or delay.

(3) Availability of all hospital facilities—beds, lab, x-ray, special tests, etc.

(4) There are no deductibles and no co-insurance payments.

(5) The doctor-patient relationship is maintained as in private practice. The doctor can better serve the patient because he is assisted by ancillary medical specialists and is not bogged down by trying to run the business end of medicine.

(6) The cost of drugs are much, much lower.

(7) There are no insurance forms to be filled out.

(8) Preventive medicine is featured—regular complete medical checkups are provided with special attention to early detection of disease.

(9) Health care education for the patient—diet, smoking, hygiene, etc.

(10) These services are provided in an atmosphere that is friendly and the needs of the patient are primary.

The government will also benefit:

(1) It will save money.

(a) the economy of a group working together.

(b) preventive medicine and early discovery of the disease saves money.

(c) comprehensive testing available at the HMO, and easy availability of consultants.

(d) reduction in hospitalization saves money.

(e) HMO's avoid "over treatment" and excessive visits and tests. All lab tests, x-rays, EKG's are included in the one prepaid fee.

(f) minor surgery can be performed in a HMO. Presently, many patients receive minor surgery in a hospital, and this is expensive.

(g) less paper work—less administrative and clerical workers required.

(h) HMO's are easier to administer than several doctors in private practice . . . here you're dealing with a group rather than x number of separated doctors.

(i) the government can budget better because there is a set fee and there is control of the costs.

HMO's can render this better service because:

1. There is a large group of patients and sure payment by the government.
2. The government will provide grants and loans.
3. The proposed amount of premium to be provided by the government formula is generous enough to render high quality care.

In addition to the need to improve the HMO provisions of Medicare, there are other improvements that should be included in the Social Security system.

A carefully designed plan for Social Security reform has been introduced in Congress which would go a long way toward the needed improvements. Various proposals have included:

20 percent increase effective January 1, 1972. This increase would raise the minimum benefit to $120 a month in 1972. The maximum benefit (now approximately $190 a month) would go to $340 a month in 1974.

Thereafter, automatic increases geared to increases in living costs.

A widow's benefit at age 65 equal to the husband's benefit.

Improved benefits for workers retiring before 65.

Liberalized disability benefits.

An increase from $1,680 to $1,800 a year in earnings permissible for retirees without loss of any Social Security benefits and a liberalization in the treatment of earnings above $1,800.

Elimination of the monthly premium—for Medicare part B (doctor insurance).

Extension of Medicare to out-of-hospital prescription drugs.

Coverage under Medicare of disabled persons under age 65.

We are well aware that the purveyors of fear will preach that we are embarking on true "socialized medicine." This is just so much hogwash. HMO's are financed and operated by the private sector and the government will only pay for those services it purchases.

The government is already deep in the health care business. It owns and operates health care facilities—Veterans Hospitals—the U.S. Public Health

Service Hospitals, and medical facilities for armed forces personnel and their dependents.

So let's get on with meeting the need of the elderly and amend the Medicare provision of Social Security so that the elderly can live their lives in dignity and not be worried with the fear of their uncertain future health care needs being met.

Again we want to thank you, Senator Pell, for showing your concern and we look to your support in the enactment of legislation that will improve the delivery of health care to the elderly.

ITEM 4. PREPARED STATEMENT OF ELEANOR F. SLATER,* COORDINATOR, DIVISION ON AGING

MOBILITY OF SENIORS

Transportation may well be the "sleeper" as the prime issue at the soon-to-be-held White House Conference on Aging. Almost every state had Transportation as the top priority in the State White House Conferences. This makes sense when one stops to think about services and programs. How do poor elderly get to use services and participate in programs unless they have the means to get where services are available?

Today, many of you attending had to have transportation to get here. Transportation is a real problem; it is a worry, it is a frustration, it is unobtainable to many. To constantly be concerned on "how to get there", whether it be to a meeting with others, or for a hot meal or pleasant socializing, or to get to the doctor's office, a hospital, a clinic, or to go marketing for food or any other reasons, older people more than any other age group get worn down and become resigned to being unable to be mobile and thus may become isolated. Because of the large numbers of older Americans who live on limited incomes and the physical limitations of driving as years go on, the need for transportation becomes more urgent.

Public transportation and the present concept of public transportation has not met what is needed and wanted. Fares increase as fewer passengers ride. Transportation has got to be consumer oriented—geared to what passengers need and to where they must travel for needed services.

For instance, older people cannot walk too far for public transportation nor wait too long. Ofttimes they are physically not capable. Many times they are afraid to walk in certain neighborhoods. Violence has made living in some neighborhoods a nightmare.

What's to be done? For a starter, we believe we in Rhode Island in the Department of Community Affairs have a good idea. A grant proposal has been written and delivered to the Department of Transportation in Washington for a "Demand Delivery" Transportation system, a pilot project to be inaugurated in the Pawtucket-Central Falls-Attleboro area. With 16 passenger electric vehicles and using a computer to sort calls, a vehicle will pick up a passenger at his or her address, deliver to a particular destination making other pick-ups and deliveries enroute. This system would also make drop-offs at particular points on the present public transportation system, thereby acting as a "feeder" line. This system would be available to all people, commuters and normal users of public transportation. By its unique house-to-house service, it would be especially usable by elderly and disabled people. Embossed identification cards would be used to record the boarding and passenger miles used. Those who are receiving Old Age Assistance would be proportionately credited. This is all possible because of special equipment and computers. The important point is that *NO* cash is handled by driver or passenger.

We are awaiting at this date to hear from the Federal authorities about this grant. Funds were to have been available in June from the 1971 Federal budget but those funds, the Division on Aging was told by the Department of Transportation in Washington, had to be diverted to summer programs in big cities of this country. The grant is "still alive" from the latest contact we have had. So I live in hope.

The study report done for the Rhode Island Division on Aging titled "Aging in the Rhode Island Community, 1970" gives data on physical conditions which

*See statement, page 236.

do not necessarily hospitalize people but identifies those who can get around, however limited. For example: arthritis is one of the most prevelant diseases of the aged, yet only about 58% of the elderly in Rhode Island who have arthritis indicated having received medical help for this painful and crippling disease; only about 35% of those suffering from varicose veins received medical assistance. There are similar examples for hemorrhoids, anemia, constipation, and sinus as well as conditions which may mask early warning signs of more severe problems. Note that these are diseases for which hospitalization may not be required. Yet they are painful and frequently motion-restricting.

Only new and dramatic ways are going to answer this transportation problem in order that health problems can get better attention and care. It must be answered first in order to have elderly people mobile, able to get to where the action is for their own well-being, physically and mentally. We will keep trying! Older Americans must keep pushing for their needs. We are glad to have the attention and ear of the United States Senate Committee on Aging with our Senator, Claiborne Pell, a member of that Committee. Thank you, Senator.

ITEM 5. PREPARED STATEMENT OF DR. MARY MULVEY,* VICE-PRESIDENT, NATIONAL COUNCIL OF SENIOR CITIZENS

Senator Pell and Members of the Committee: I am happy to be given the opportunity to speak at this hearing on "Medicare and Medicaid" and related health care for the elderly.

Adequate medical care, at costs they can afford, is one of the principal problems facing our elderly persons today. Their ability to solve this problem is dependent upon their income, and the availability of medical care at a cost within the reach of their income.

This medical care and cost problem grows in proportion to the number of elderly people, who already total over 100,000 in Rhode Island. On the average, our aged spend more than 3 times as much for health care as those under 65 do—$590/year as against $195/year. At the same time, about half of the families in the 65-plus group have incomes considerably below the median for all Rhode Island families; while the aged persons living alone, with relatives, or others have significantly lower incomes.

There is wide variation of income among these citizens. A recent Rhode Island Survey by the Rhode Island Council of Community Services, reviewed in the Providence Evening Bulletin, January 18, 1971, reported that the median income for Rhode Island families in the over-65 group, in the 1967–69 period, was $4,347. The national median was higher—$4,802; while the median for the under-65 group was $10,085. In 1970 the national median for the over-65 group was $5,053, and for the under-65 group was $10,541. The median of 654 individuals alone or with relatives was only $1,951.

Fifty-three percent of the aged families in this State had incomes below the intermediate urban budget set by the U.S. Bureau of Labor Statistics.

The elderly poor are the only U.S. poor whose numbers are increasing. From 1965 to 1966, the poor under age 65 fell by a dramatic drop of 10%. In the same period the number of poor 65 and over rose nearly 2 percent. In 1969—the latest year for which official figures are available—close to 5,000,000 men and women age 65 were below the poverty line and millions more elderly persons were very close to it. The number of impoverished elderly increased by 200,000 in 1969 and has been increasing year after year for many years. Projections show that the aged will continue to lag in income between now and 1980.

Briefly, according to the poverty index used by the Office of Economic Opportunity, there are close to 30 percent of the non-institutionalized 65-plus people who live below the poverty level; and according to the Bureau of Labor Statistics' budget for an elderly couple, described as "modest but adequate," we find that more than 40 percent of the non-institutionalized aged fall below this level (U.S. Department of Labor, BLS, Retired Couple's Budget for Moderate Living Standard, U.S. GPO, Washington, D.C. 20402, 1968), This low level is particularly hazardous to them because of their critical health care needs and problems.

And for older persons in New England (including R.I.), and other Northeastern cities, the problem is even more crucial, since the cost of living for retired

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*See statement, page 255.

couples in this area is the highest in the country as revealed by BLS Survey mentioned above (See following chart). Total costs of a budget can vary from as little as $296 a month in small Southern towns to about $400 in large Northeastern cities such as Boston, Hartford and New York.

ANNUAL COSTS OF THE RETIRED COUPLE'S BUDGET, URBAN UNITED STATES, 39 METROPOLITAN AND NONMETROPOLITAN AREAS—AUTUMN 1966, INDEXES OF COMPARATIVE LIVING COSTS BASED ON THE RETIRED COUPLE'S BUDGET

[Adapted from U.S. Department of Labor, BLS report, 1968, by Dr. Mary C. Mulvey]

Area	Costs	100 percent = U.S. urban average cost
Urban United States	$3,869	100
Metropolitan areas	4,006	104
Nonmetropolitan areas	3,460	89
Honolulu, Hawaii	4,434	115
Hartford, Conn	4,352	112
New York-Northeastern New Jersey	4,323	112
Boston, Mass	4,298	111
Seattle-Everett, Wash	4,260	110
Buffalo, N.Y	4,204	109
San Francisco-Oakland, Calif	4,171	108
Portland, Maine	4,108	106
Milwaukee, Wis	4,083	106
Indianapolis, Indiana	4,076	105
Washington, D.C.-Maryland-Virginia	4,044	105
Champaign-Urbana, Ill	4,023	104
Cleveland, Ohio	4,010	104
Philadelphia, Pa-N.J	4,005	104
Los Angeles-Long Beach, Calif	3,991	103
Minneapolis-St. Paul, Minn	3,971	103
Chicago, Ill.-Northwestern Indiana	3,970	103
Cedar Rapids, Iowa	3,939	102
St. Louis, Mo.-Illinois	3,939	102
Pittsburgh, Pa	3,917	101
Lancaster, Pa	3,916	101
Denver, Colo	3,907	101
Baltimore, Md	3,873	100
Kansas City, Mo.-Kans	3,866	100
Detroit, Mich	3,849	99
Wichita, Kans	3,847	99
San Diego, Calif	3,840	99
Green Bay, Wis	3,814	99
Bakersfield, Calif	3,786	98
Dayton, Ohio	3,771	97
Cincinnati, Ohio-Kentucky-Indiana	3,760	97
Nashville, Tenn	3,721	96
Orlando, Fla	3,688	95
Dallas, Tex	3,639	94
Houston, Tex	3,628	94
Durham, N.C	3,608	93
Atlanta, Ga	3,581	93
Austin, Tex	3,534	91
Baton Rouge, La	3,486	90
Nonmetropolitan areas (places with population of 2,500 to 50,000)	3,687	95

Medical costs in Rhode Island run way ahead of the national average. The average reimbursement for hospital bills for the aged in Rhode Island under the Federal Medicare program in 1969 was $307, as compared to a national average of $237. The average Medicare reimbursement for out-of-hospital medical bills, mostly for charges by doctors, was $104 as against a national average of $87.

Federal Medicare for the elderly represents a great social advance but, because of the increases in hospital rates and other medical services, it pays less than half (45 percent) of senior citizens' health costs. Since the beginning of the Federal Medicare program, the out-of-pocket deductible for the first day of hospital costs under Part A has risen from $40.00 to $60.00, a 50% increase in four years—due to the spiraling hospital costs per day. Out-of-pocket premium payments by older people under Part B of *Medicare* have increased from $3.00 per month to $5.60 per month—an increase of 87% in four years; and the outlay by older people for Rhode Island Blue Cross Plan-65, which fills some of the gaps of Medicare, has increased by 64%. Thus, for only partial coverage for out-of-hospital medical care, older people must pay a total of $12.75 a month in premiums: for Part B ($5.60) and for Blue Cross Plan-65 ($7.15), making an annual outlay of $153.00. Many elderly cannot afford to enroll in Blue Cross Plan-65.

An additional financial burden is the cost of prescription drugs that our older people are required to pay, which many times exceeds the medical costs per year. Immediate improvements in the Federal Medicare must be made, namely the elimination of the financial barriers of deductibles, and premium payments for Part B, the inclusion in Medicare of the cost of prescription drugs, eye care, eyeglasses, dental care, dentures, hearing aids, and routine foot care, as well as the extension of hospital coverage to 365 days. All persons on Social Security Disability should be enrolled automatically in Medicare.

A graphical description of cost coverage by Medicare, Parts A and B and Blue Cross Plan-65 follows.

SUMMARY OF BENEFITS

Type of health care service—Pt. A	Social Security Medicare coverage—Pt. A	Blue Cross— Plan 65 coverage
1. Care as bed patient in the hospital, semiprivate room and board, and general nursing service, X-rays, drugs, supplies, etc.	90 days in full during a spell of illness, except 1st $60, and $15 per day for 61st through 90th days. An additional "lifetime reserve" of 60 days, paying all but $30 per day.	Pays 1st $60 and then $15 per day.
2. Extended care facilities (approved nursing homes, etc.)	20 days in full; 80 extra days with patient paying $7.50 per day. Patient must be admitted within 14 days after his discharge from hospital, and must have been patient in hospital for 3 days in a row.	No coverage.
3. Home health visits by nurses, physical therapists, home health aides, or other health workers under specified conditions.	Up to 100 visits	Do.
Pt. B	Pt. B	
4. Doctor and office calls or visits to the hospital or extended care facilities.	Pays 80 percent of reasonable charges after you pay $50 deductible each year.	Pays $50 deductible and remaining 20 percent of reasonable charges to give full coverage.
5. Surgeon, assistant surgeon, anesthesiologist.		
6. X-ray, other diagnostic tests in hospital outpatient department.		
7. Hospital outpatient treatment for accidents and medical emergencies.		
8. X-rays, taken in the doctor's office.		
9. Home health agency services (same as No. 3 above), ambulance service, prosthetic devices, and medical and surgical supplies for use outside the hospital.	Pays 80 percent of reasonable charges after $50 deductible.	No coverage.
10. Prescription drugs and medicines for use outside the hospital.	No coverage	Do.

Note: Pt. A: no premium; eligibility requirements. Pt. B: $5.60 monthly; no eligibility requirements except age (65+) $21.45 quarterly.

In addition to the shortcomings of Medicare coverage, many of our older persons are not getting reimbursed for their costs because they do not understand how to go about it. Some don't submit their bills. Others lose out because the information which they receive on statements for Medical Services under Part B does not explain why they will not receive what they expect. This misunderstanding arises in part because the information contained on such bills is that a part of the bill is "not covered by Medicare" or some similar notification. The fact is, of course, that the Medicare law allows the carrier to pay 80% of the reasonable charge. If the physician charges an amount beyond that which is determined as reasonable, the carrier is required by the Social Security Administration to cut the total amount back to what has been determined under the provisions of the law to be a reasonable amount.

If the physician charges an amount beyond "reasonable", the older person should be notified. However, neither the Administration, the doctors nor the carriers make any reference in their notice to beneficiaries about the reasonableness of the charge.

The Social Security Administration should require the carriers to notify the beneficiaries in clear, precise, and unmistakable terms the reason for the reduction in the amount reimbursed.

Older persons should be instructed thoroughly on all phases of applying for reimbursement under Part B. They should also be aware that it is not always a case of reimbursement. In other words, older persons are not required to pay their medical fees before they receive Part B Medicare coverage. They may present the physician's statement to the Part B carrier, namely Blue Cross, and receive payment due.

Still another problem arises because the Medicare Part B statements are submitted on Blue Cross letterhead. Because of this, many people over-65 assume that they are enrolled in Blue Cross. Again this fuzziness about the whole program should be eliminated.

Training in Senior Citizens Advocacy is in order so that they will learn all phases of benefits under Medicare, and all methods of collecting their health care costs, meager though they be.

To correct the deficiencies in Medicare, we support The National Health Security Bill, now pending in Congress, S–3 and H.R. 22—which would pay at least 70 percent of the health costs of all Americans, including the elderly.

That modern health services are not available to millions of Americans is generally recognized. A Louis Harris public opinion poll taken recently showed the U.S. public favors national health insurance by a margin of nearly two to one. The poll also revealed that four out of five Americans favor new arrangements in the organization and delivery of health services.

The idea that private insurance is providing or can provide adequate health services for all Americans is a dangerous myth. More than one in every five Americans—20 percent of the U.S. population—are not protected against the most costly care, namely, hospital services and surgery. More than half the people in the U.S. have no insurance protection against the costs of doctor bills for outpatient services, and only a miniscule number of Americans have insurance protection against dental bills.

Under S–3 and H.R. 22, the most comprehensive health insurance legislation before Congress, every American would be eligible to receive a wide range of health services under a program that imposes no out-of-pocket charges of any kind on beneficiaries.

Medical care today is a crazy quilt paid for with private and Government funds. Medical bills are paid in part by private health insurance, in part by workers' out-of-pocket payments, in part by public welfare funds, and in part by Medicare health insurance for the elderly.

National health insurance proposed under S–3 and H.R. 22 would be financed by taxes on employers, employees, the self-employed, and on unearned individual income, and by Federal general revenue. The workers' share—1 percent of wages and unearned income up to $15,000 a year—is not a new tax. Workers are now paying almost that amount for the Medicare program.

Moreover, S–3 and H.R. 22 would greatly reduce out-of-pocket, non-reimbursed medical expenses while providing better and more comprehensive health services. The employer's contribution under S–3 and H.R. 22 would be just about what many employers now pay for inadequate private health insurance for their workers.

Federal general revenue would, under this legislation, pay for approximately half the total cost of the program; so this would not be a new outlay since Medicare for those age 65 or over, and Medicaid, the Federal-State program for health care for the needy, and other Federal health care expenditures represent a large and growing portion of the Federal budget. National health insurance proposed under S–3 and H.R. 22 would absorb these present heavy outlays.

There is no reason to suppose the situation would change if Congress should turn over national health insurance legislation for administration to private insurance companies.

By contrast, national health insurance proposed under S–3 and H.R. 22 incorporates built-in financial, professional and other standards and incentives to encourage preventive medical care, and early diagnosis, as well as better treatment of disease and disability once it has occurred.

The pressing need for a genuine program of national health insurance is the worsening health outlook for the millions of low-and middle-income Americans.

These men and women can expect seven fewer years of life than their more affluent neighbors. Their babies have as much chance of surviving as babies in Equador while the mothers have as much chance of healthy childbirth as the women of Costa Rica.

Some of the specific benefits to the elderly that would result in passage of the National Health Security Bill are:

COMPARISON—MEDICARE AND PROPOSED NATIONAL HEALTH SECURITY ACT

IV. Elderly (those now covered by Medicare)

A. All elderly, all other residents, would be covered for all NHS services. Unlike Medicare (Part A hospitalization), eligibility would not depend on past employment status. Unlike Medicare (Part B physicians' services), eligibility would not depend on enrollment or payment of monthly premiums.

B. Covered services would be broader than under Medicare. Some services covered under NHS but not under Medicare would be:

Prescription drugs (with limitation)

No limitation on needed hospitalization or home health services: Eyeglasses, hearing aids, etc.

Preventive services

Psychiatric care (with lesser limitation than Medicare)

C. Like everyone else, elderly would pay 1% of income up to $15,000, except Social Security income. However, they would be relieved of:

1. Monthly premium—$5.60 for a single individual and $11.20 for a couple (beginning July 1, 1971)
2. Part A (hospitalization) payments:
   Deductible—$60.00
   Coinsurance—hospital ($15—61st to 90th day) and nursing home ($7.50 starting at 21st day)
3. Part B:
   $50 deductible
   20% coinsurance
   Additional doctor fees where doctor does not accept assignment (Medicare limitation on fee)
4. Cost of items covered under NHS but not under Medicare (see IV. B above)

ITEM 6. PREPARED STATEMENT OF WADE C. JOHNSON,* EXECUTIVE DIRECTOR, HOSPITAL ASSOCIATION OF RHODE ISLAND

Mr. Chairman: I am Wade C. Johnson, Executive Director of the Hospital Association of Rhode Island. The membership of our Association consists of all of the voluntary, non-profit and state government hospitals in the State of Rhode Island. We certainly appreciate this opportunity to speak before the Senate Subcommittee of Health Care for the Elderly on the problems of the delivery of health care to the elderly as the hospitals in our state view them. We will address ourselves this morning primarily to many of the concerns shared by the hospitals of Rhode Island relative to the problems of the Medicare and Medicaid programs and offer our suggestions on ways to improve the programs and some thoughts about the existing and pending legislation affecting the programs.

At the outset, I would like to make a few general observations. I assume that all of us are here not merely to look at the effectiveness of certain health programs in themselves, but more out of a concern for the net effect of all the programs on the quality of life for the millions of Americans whom we classify as the elderly. As you surely know better than I, this quality of life is affected by many variables—economic, social, environmental, as well as the important one of health services—which society needs to evaluate both by study and observation and by hearing from the elderly themselves.

Having sounded this note of caution. I can now say it is our impression that Medicare, despite its problems, has made a significant contribution toward improving the quality of life for the elderly in this country.

The Medicare program committed the Federal government to the responsibility of financing most health services for this major segment of the population. In so doing, Medicare relieved the elderly of both the financial roadblock and the "welfare" label as barriers to services which had become their right to expect. As you so well know, it is now widely accepted that health care is no longer a privilege for only those who can afford it, but rather it is an inherent legal right of all individuals.

Also, we think it can be said without contradiction that Medicare, more than any other single development in the health field in the last five years, has served to

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*See statement, page 261.

bring into focus the weaknesses and problems (as well as the strengths) of health care delivery in this country. In doing so, however, it has exacted a high price both in terms of the cost to the taxpayer and in terms of additional problems in the health care system generated by the program itself.

What impact the Medicare program would have on health care institutions and health care costs was little understood by the Federal Government before the program started. Millions of people were suddenly thrust into a system which was not structured to accommodate them. There was an increased demand for services, but limited supplies of medical manpower and facilities to meet the demand. Hospitals were also faced with increasing their patient service capabilities, especially since they were now providing services previously given by individual physicians. The result was the rapid escalation of hospital costs. In the first three years of both Medicare and Medicaid, hospital costs rose by 59 per cent; doctors' fees jumped 29 per cent.

While this sharp increase in hospital costs can be partly attributed to the general inflationary spiral affecting the country, we would also point out that Medicare went into operation at a time when hospitals were faced with compliance under the Federal minimum wage laws for all their employees. Hospitals, which for years had paid their workers less than most other workers, were faced with the enormous cost of "catching up." That these pay increases multiplied costs rapidly is due to the fact that nearly 70 percent of the total costs of hospitals' operation are for salaries and wages alone.

We would also like to point out that the Medicare program has had a significant impact on the administrative costs of a hospital, particularly in the financial department, causing health care costs to increase. These increases are due to such things as (1) the division of the Medicare program into Parts A and B, making it necessary for the hospital to send out separate billings; and (2) the requirement that hospitals maintain, by hand, Medicare program statistics for year-end cost allocations, because the computerized output from the Social Security Administration (SSA) is unacceptable and because SSA will not authorize funds to local intermediaries to program this data on their computers.

In addition, outpatient claim processing continues to be a massive bookkeeping problem caused by the deductibles and co-insurance feature, by considerable delays in the receipt of Explanation of Benefit forms, confusion on the part of the patient as to what he is responsible for, and resulting payment delays under the Medicaid program.

A moment ago, we referred to the lack of understanding on the part of the Government with respect to the impact of Medicare. We would couple with this, the almost total lack of fiscal planning to properly implement the program and meet all the objectives called for by the legislation. At the time the Medicare legislation was being prepared, actuarial and fiscal cost estimates made by Government officials and Congress were considered much too low by the voluntary health care system, which was called upon to carry out the services called for in the health program. Hospitals, at that time, had urged that cost projections be re-worked and increased, but this was not done. As a result, the costs of the Medicare program have repeatedly exceeded the original Federal estimates.

As with certain administrative aspects already cited, this financial embarrassment has contributed to serious problems in the closely related Medicaid program. Because of large cost overruns in Rhode Island's Medicaid program, State officials decided in October of 1969, to pay hospitals only 90 percent of their costs for services rendered to Medicaid patients. Faced with the threat of a court suit by the member hospitals of our Association, the State reverted back to the full reimbursement policy. But this did not permanently solve the problem—to which we shall refer later again in discussing prospective reimbursement.

Section 232 of H.R. 1, the Social Security Amendments for 1971, would permit each state to determine "reasonable costs" under the Medicaid and Maternal and Child Health Programs. The states would no longer be required to reimburse hospitals under those programs on the same basis as under Medicare.

We believe that H.R. 1 should contain a precise definition of "reasonable costs" and that the determination of "reasonable costs" should be uniform among the Medicare, Medicaid and Maternal and Child Health Programs. It is only with the precise, agreed-upon definition of "reasonable costs" that we believe progress will be made toward an effective and efficient reimbursement formula.

Since hospitals generally are not in a position to absorb any unreimbursed costs, any underpayment for Medicaid beneficiaries tends to be passed on to other patients, such as self-pay patients and Blue Cross patients.

The passage of the Medicare and Medicaid programs underscored the fundamental weaknesses in health care financing. The programs assumed the burden for the payment of health care bills of a large segment of the population, but explicitly renounced any obligation to share in the meeting of the total needs of our health care system, except as that system met the needs of the program beneficiaries.

Out of a deep concern for the need of greater financial stability within the voluntary health care system, the American Hospital Association, of which our Hospital Association is an associated member, issued a set of guidelines by which the financial shortcomings which have plagued hospitals for a long time, could be overcome.

In its *Statement on the Financial Requirements of Health Care Institutions and Services,* the American Hospital Association (AHA) declared that, collectively, all purchasers of health care, particularly all major third-party purchasers, have an obligation to recognize and share in all the financial requirements and needs of institutions providing that care. The AHA *Statement on Financial Requirements* identified these financial requirements of health care institutions as all the current operating needs related to patient care and all those related to capital needs. (The entire list of these financial requirements and their components are found in appendix A).

The provision of health care today has become the nation's third largest industry. More than $20 billion a year is spent on hospital care alone. We would strongly agree with the American Hospital Association that the financing of health care institutions must be carried out on a business-like basis.

Most industries in our economy rely on operating revenues to finance the production of their products or services and the means of producing them. The financing of the health care system, however, has been chronically insufficient to do this. Some institutions have been financed largely through community philanthropy, others have been dependent on government appropriations or grants, and only a few have been able to rely solely on operating revenues as an adequate source of funds.

The AHA *Statement on Financial Requirements* takes into account the following as necessary to the proper method of financing health care institutions: (1) The institution's responsibility to the community; (2) the need for systematic financing of all their operating and capital needs; (3) a rationale for proper planning of facilities and services with due regard for regional variations; (4) incentives for economy and efficiency in the delivery of high quality health care; and (5) the necessity for the maintenance of equity and the protection of the interests of both provider and purchaser.

The entire financing rationale proposed by the American Hospital Association recognizes the differences between the institutional health care system and the rest of the economy. In the free market, industry can alter either price or quality in order to insure that current revenues are adequate to meet operating and capital needs. Health care institutions do not have these options. If the quality of health services is to be maintained, the prices established through bargaining between individual providers and large groups of purchasers must provide revenue sufficient to finance these services.

The institutional health care system differs from the rest of the private sector in its philosophy toward the treatment of patients who are unable or unwilling to pay. Other members of the private sector maintain their right not to sell their products to someone who cannot afford it or is unwilling to pay for it. Community hospitals, because of their public responsibility, do not take such action. The right to receive service regardless of the ability to pay is extended to the entire community, and consequently, the entire community has an obligation to share in these costs.

Because of the significant problem in financing patient care operations created by these nonpaying patients, by the necessity to maintain standby services, and by the research and educational responsibilities of health care institutions, the limited capital payments that are currently included in contractual reimbursement schemes, often must be diverted toward meeting operating needs. Thus, the health care system has had increasing difficulty in maintaining the expanding its capital facilities to keep pace with population growth, community needs, technological advancements and the like.

The *Statement on Financial Requirements* corrects both operating and capital deficiencies by obligating all purchasers of care to share equally in meeting all the operating and capital needs. However, the statement recognizes that it can-

not ask this of all purchasers without the institution's full participation in the community's health planning mechanisms and recognition of its role in the delivery of comprehensive health care to the community.

Although a basic implication of the AHA *Statement on Financial Requirements* is expansion of the Federal Government's role in financing the care of the aged and indigent through the Medicare and Medicaid programs, the aggregate effect of such a rational systematic financing approach is unlikely to significantly increase total Federal payments, because this systematic approach will result in a more equitable determination of payments by all purchasers and a more effective distribution of payments among all providers.

Finally, as regards the *Statement on Financial Requirements*, we would point out that the American Hospital Association seeks a payment system which recognizes a planned approach to the financing of health care priced through rates which are prospectively determined between providers and purchasers. The incentives inherent in the prospective setting of prices are well-known in our economy. Therefore, methods of payment based on prospectively determined rates present real opportunities for improvement in meeting the objectives of public accountability, predictability and managerial effectiveness as well as the other objectives contained in the *Statement on Financial Requirements.* (Policy statement of American Hospital Association regarding implementation of its *Statement on Financial Requirements* contained in Appendix B.)

We are very encouraged to see that Section 222 of HR 1 would authorize the Secretary of Health, Education and Welfare to experiment with methods of reimbursement designed to increase efficiency and economy. Additionally, it calls for experimentation with methods of payment to providers of health care on a prospectively determined basis. The Hospital Association of Rhode Island and its member hospitals wholeheartedly endorse the concept of prospective rating and we would strongly encourage the Federal Government to continue experimentation in this method of reimbursement.

We would like to point out for the record that the voluntary hospitals of Rhode Island are all presently operating under a prospective reimbursement contract with Rhode Island Blue Cross. We can point with much pride to the fact that Rhode Island was the first state-wide group of hospitals since Medicare to come under a prospective rating mechanism where rates were negotiated between the payer and provider. What is particularly significant is that the agreement between the two parties was reached voluntarily.

Although the prospective rating mechanism has been only partially in effect for this present fiscal year (ending October 1, 1971), we already have some indicators that it is having a favorable effect on costs. Based upon preliminary data recently gathered by the Hospital Association, the hospitals in Rhode Island are presently "under budget" when the actual costs are compared with budgeted costs. It appears as though significant dollars will be saved in this one fiscal year alone as a result of the partially implemented prospective mechanism.

A recent development in the prospective reimbursement picture here in Rhode Island was the passage of a bill by the Rhode Island General Assembly making the State Government, through the State budget director, a party to hospital budget negotiations between all the voluntary hospitals in the state of Rhode Island Blue Cross for the hospital fiscal year beginning October 1, 1972. In addition to making the State a party to the budget negotiations, the new Rhode Island law paves the way for the State to enter into a contractual agreement with the hospitals to determine prospective rates it would pay, as a major purchaser of health care, for Medicaid and other patients. Presumably, this would come about with the passage of HR 1 and the provisions of Section 222 cited earlier.

Medicare and Medicaid principles of reimbursement are inadequate to the extent that they do not comply with the AHA *Statement on Financial Requirements*, specifically in non-reimbursement of their respective share of bad debts and community free service costs and failure to recognize growth working capital needs of health care institutions.

As a way of concluding our testimony this morning, we would like to address ourselves to that which we feel is necessary for changing the present health care system to insure the proper and adequate delivery of health care to the aged and indigent, as well as to all Americans. We have discovered the hard way, through Medicare and Medicaid, that to pour additional money into the existing system

will not solve our nation's current health care problems. What is really needed is a basic restructuring of the entire health care delivery system and a realignment of the financing mechanisms. Plans, which we feel can bring about these changes, are contained in Ameriplan, the national health care program recommended by a special committee of the American Hospital Association (AHA).

We need not point out, though, that Ameriplan is one of many national health insurance proposals to be considered by Congress during the coming year. Each of the proposals attempts to provide a minimum level of health care benefits for the entire U.S. population. Where they part company is how the needed reforms should be carried out and how they should be financed. Ameriplan offers proposals to restructure the entire system of delivering health care services, as well as a method of financing the services.

At the very outset of our testimony, we said that health care is no longer a privilege of the few who can afford it, but rather it is an inherent right of all individuals. It is upon this basic principle that the goals of Ameriplan were founded. The corollaries of this principle, as stated in the AHA health plan, declare that the dignity of the individual and better community life are functions of health care; that government must assure the preservation and maintenance of health; that health services must be delivered without regard to the ability to pay, or to race, creed, color, sex or age; and that health services must be accessible to all.

Some of the goals of Ameriplan call for long-range planning and increased national expenditures for health care. Others require little changes in the ways that health services are presently delivered. One far-reaching goal is that the delivery of health services must provide comprehensive health care, the five components of which are health maintenance, primary care, specialty care, restorative care and health-related custodial care. Another goal which reaches into the future is that the system must provide incentives to health care providers for keeping people well.

At the heart of Ameriplan are Health Care Corporations (HCC's) organized to manage and coordinate health services at the community level. The HCC would be responsible for providing the five components of care, either through its own resources, or through contracts with providers meeting approved standards. It would be approved for operation in providing services to a defined population group in a specified geographic area by a newly-formed independent agency, the State Health Commission. This commission would be answerable to a National Health Commission having the responsibility at the Federal level for establishing standards of quality and regulations for the scope of benefits and comprehensiveness of services.

Ameriplan would utilize both Federal Government and private financing. All health care benefits that are tax-supported would be financed at the Federal level, and all present Federal and private sources of financing, including prepayment plans and health insurance companies would be utilized. The broader Ameriplan benefits package (see Appendix C) would make Medicare and Medicaid no longer necessary. For the first time, all the people of our country would be secure from becoming financially dependent or suffering loss of dignity as a result of illness or accident. The total benefit packages of Ameriplan, when interrelated and delivered through the Health Care Corporations, would encompass a scope of benefits never before available to any individual or group at a cost this nation could afford.

Realistically speaking, none of the health care proposals being considered will be enacted into law in pure form. It is crucial, however, that final legislation gear the necessary changes to existing resources, patterns of delivery and financial mechanisms. It is important that the Federal Government recognize its role in helping to bring about these changes in an effective manner.

We acknowledge that Senator Pell has his own national health plan before the Congress at the present time. We would like to take this opportunity to publicly applaud him for the outstanding direction and leadership he has provided in behalf of better health care delivery in the State of Rhode Island, particularly in the areas of medical education, health manpower and neighborhood health centers.

We appreciate this opportunity to appear and present the view of the hospitals of Rhode Island on the problems of Medicare and Medicaid. We stand ready to cooperate with your committee in its efforts to improve the delivery of health care to the elderly.

APPENDIX "A"

ELEMENTS OF FINANCIAL REQUIREMENTS

(From the American Hospital Association *Statement on the Financial Requirements of Health Care Institutions and Services*, February 12, 1969)

A. CURRENT OPERATING NEEDS RELATED TO PATIENT CARE

1. *Direct Patient Care.*—Financial resources required to provide patient care include but are not limited to salaries, wages, employee fringe benefits, services, supplies, normal maintenance, minor building modification, and applicable taxes. This includes the monetary value assigned to services provided through services of their members by religious orders and other organized religious groups.

2. *Interest.*—Financial resources required to pay a reasonable rate of interest on necessary funds borrowed for operating cash needs and capital needs.

3. *Educational Programs.*—Financial resources required to support educational programs having appropriate approval.

4. *Research Programs.*—Financial resources required to support research programs related to patient care, provided that such programs have appropriate approval.

5. *Credit Losses.*—Financial resources required by the institution for the unrecovered financial needs arising from the care of patients who fail to fully meet the obligation incurred for services received.

6. *Patients Unable to Pay.*—Financial resources required by the institution for the unrecovered financial needs arising from the care of patients who, because of inability to pay, are relieved wholly or in part of financial responsibility for services received.

B. CAPITAL NEEDS

1. Plant Capital

(a) *Preservation and Replacement of Plant and Equipment.*—The governing authority of a health care institution bears the responsibility of maintaining, utilizing, and preserving the assets of the institution entrusted to its custody. Funds must be available, therefore, to finance projects involving plant capital assets that because of deterioration and obsolescence must be replaced in the best interest of the public.

(b) *Improvement and Plant.*—Advances in medical science, and in the technology of delivering health care services often require expenditures for new units of equipment and facilities. Such expenditures represent a different element from expenditures for preservation and replacement of plant and equipment. Sufficient financial resources must be available for continued additional investment in the improvement of plant and equipment so that health care institutions can keep pace with changes in the health care system.

(c) *Expansion.*—Health care institutions are expected to meet increased demands resulting from such factors as population growth, discontinuance of other existing services, and changes in the public's concept of the delivery of health care services. In order to be in a position to respond to changing community needs, health care institutions must anticipate their future growth patterns and plan for the needed expansion of their facilities. There must be assurance that adequate resources will be available to finance such individual programs.

(d) *Amortization of Plant Capital Indebtedness.*—Health care institutions increasingly use borrowed funds to meet plant capital needs. Prudent fiscal management requires health care institutions to provide sufficient resources so that funds can be specifically designated for the amortization of plant capital indebtedness.

2. Operating Cash Needs

Because of fluctuations in operating needs, the amount of operating cash required to meet fiscal obligations as they come due may be subject to frequent change. Adequate cash reserves are essential to current stability so that good business practices can be followed without excessive short-term borrowing.

3. Return on Investment

Investors in for-profit health care institutions are entitled to a reasonable return on their investments.

APPENDIX "B"

GUIDELINES FOR DEVELOPING PROSPECTIVELY DETERMINED RATES

(From American Hospital Association policy statement on the implementation of the *Statement on the Financial Requirements of Health Care Institutions and Services*, May 6, 1970)

1. The rates of payment for services during a specific period of time should be determined and agreed upon prior to rendering service.
2. The prospective rates should be in accordance with the principles set forth in the *Statement on the Financial Requirements of Health Care Institutions and Services.*
3. In each individual institution, the prospective rates should result in apportionment of financial requirements without discrimination among all purchasers of care with equal charges for comparable services.
4. The establishment of prospective rates must be supported by current and predicted costs derived through appropriate budget and accounting systems.
5. Institutional performance measurements and comparative evaluations should be based on operating cost rather than full financial requirements; the non-operating financial requirements should be separately evaluated.
6. In designing the payment system, consideration should be given to the method of handling any significant unbudgeted gain or loss in the previous period.
7. Provision should be made for a mechanism for determining emergency adjustments of prospectively determined rates.
8. Appropriate appeal mechanisms should be established to protect the rights of all parties.
9. The organizational entity responsible for administrative control over the payment process should be established on a statewide basis with appropriate local involvement in the determination of rates.
10. Designing and administering the payment method, cognizance should be given to the continuing relationship between provider and purchaser.

APPENDIX "C"

AMERIPLAN HEALTH BENEFITS

(1) HEALTH MAINTENANCE AND CATASTROPHIC ILLNESS BENEFITS PACKAGE

This package would be the keystone of Ameriplan. It would consist of benefits for health maintenance and benefits to protect every person in the United States against the major costs of catastrophic illness or accident. These benefits would be paid for by the Federal government in whole for the poor, and in part for the near-poor through general federal revenues, and for the aged and all others by a tax collected through the Social Security mechanism.

Benefits to protect against the cost of catastrophic illness or accident would become operative depending upon annual family income level, size of family, and amount of health care expenditures. Accordingly, the poor would receive the benefits immediately after exhausting the benefits of the Standard Benefits Package, whereas persons with higher incomes would have to expend a predetermined amount before becoming eligible for these benefits.

To be eligible for the Health Maintenance and Catastrophic Illness Benefits Package, to which all persons would be entitled, each person would have to demonstrate that he has purchased or been provided with the Standard Benefits Package and has registered with a Health Care Corporation.

(2) STANDARD BENEFITS PACKAGE

All persons would be uniformly covered by this package, offered by prepayment plans and private health insurance companies. Its benefits would consist of four components of care-primary, specialty, restorative, and health-related custodial care. These four components of care would provide all of the care most frequently required, such as physicians' services and acute hospital care, and would emphasize ambulatory services.

This Standard Benefits Package would be paid for in whole for the poor and in part for the near-poor through general Federal revenues. For the aged, the Stand-

ard Benefits Package would be paid for by a tax collected through the Social Security mechanism. All other persons would purchase the Standard Benefits Package from prepayment plans and private insurance companies.

(3) SUPPLEMENTAL BENEFITS

One of the basic precepts of Ameriplan would be that within reasonable limits those who are able to pay for their care should do so. Accordingly, for those persons there would be a gap between the benefits provided under the Standard Benefits Package and the benefits for protection against the cost of catastrophic illness or accident, provided in the Health Maintenance and Catastrophic Illness Benefits Package. Various packages of supplemental benefits to fill this gap would be available through prepayment plans and private health insurance for those who wish to purchase them.

ITEM 7. SUMMARY OF PREPARED STATEMENT OF DR. P. JOSEPH PESARE,* MEDICAL CARE PROGRAM DIRECTOR, RHODE ISLAND MEDICAL ASSISTANCE PROGRAM

I. Problem Areas and Areas of Injustice as They Relate to the Federal/State Effort To Provide for the High Quality Medical Care of the Elderly Citizens 65 Years of Age and Over

A. CRITICISM OF INCREASING EXPENDITURES FOR MEDICAL ASSISTANCE

1. People apply for and are accepted on a Medical Assistance Program primarily for medical reasons and the need of fulfilling medical needs. This represents one of the reasons for the dramatic increase in the utilization of serivces included within the scope of the Medicaid Program within a period of less than one year after its implementation.

2. I fail to comprehend the alarm and apparent surprise demonstrated by certain representatives of Federal and State Legislatures, community action leaders and administrators of the State Programs themselves, as it relates to this increase in the utilization of medical services by persons accepted on the program. In my opinion it simply means that we do have a live program in action rather than a paper program—which is of no real service to the people for whom it was developed.

3. We have vigorously opposed certain proposals made by certain critics of the State Medicaid Program. Proposals which have originated from frustration as it relates to their inability to cope with the expanding financial burdens imposed by these programs. There have been suggestions that we should not be permitting these eligible recipients to reach out and obtain medical services and supplies from the practitioners of their own choice. There have been those who maintain that these should be cleared through State-organized and administered clinics.

We do not feel that this approach can be justified. We feel that this approach would detract from the dignity of these recipients in need of necessary medical services and supplies. We are proud of the fact that in the Rhode Island Program, eligible recipients are entitled to obtain medical services and supplies from the private practitioners, Neighborhood Health Centers or hospital clinics of their own choice.

B. INCREASED EXPENDITURES IN MEDICAID PROGRAMS AS A DIRECT RESULT OF RESTRICTIVE INTERPRETATION OF FEDERAL MEDICARE POLICY SINCE 1969

1. Skilled Nursing Home care

(a) One of the underlying reasons for the increased expenditure for Skilled Nursing Home care must be attributed to the recently-imposed rigid interpretation of policy pertinent to qualification for admission to Extended Care Facilities as conceived by Federal Medicare.

(b) Since 1969, very few cases have been approved for the maximum 100-day Extended Care Facility allowance under the provisions of Federal Medicare

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*See statement, page 276.

(Part A), therefore, making it necessary for Medical Assistance to assume responsibility for the payment of the full cost of Nursing Home care at a time earlier than the anticipated maximum of 100 days.

(c) I would continue to pose the basic question pertinent to the intent of Public Law 89-97 as it applies to the utilization of Extended Care Facilities. I simply urge a more liberal approach to this important area of admissions of seriously-ill patients to Extended Care Facilities.

2. Visiting Nursing Services

(a) Our State planning for the cost of Visiting Nursing Services was predicated upon the fact that these services would, for the greater part, be paid for through the Federal Medicare Program. However, an apparent redefinition of standards and Federal Medicare policy, in 1969, has created a very real and serious problem for the Visiting Nursing Associations who are providing home visits to the elderly and to the State Agency which is responsible for 23.4 per cent of the population 65 years of age and over in Rhode Island.

(b) It appears that, since 1969, a substantial number of our eligible recipients whom we considered eligible for home health services under the provisions of title XVIII (A) and (B) no longer qualify for these skilled nursing services. The situation becomes all the more difficult to comprehend when we can obtain no satisfactory or logical answer to our queries as to why this restrictive policy.

(c) We object very strongly to this new policy by Federal Medicare. If these essential nursing services cannot be provided at home, then we may rest assured that they will be provided through unnecessary extended hospital stays or through unnecessary admissions to Extended Care Facilities, Skilled Nursing Homes or Intermediate Care Facilities.

(d) Title XIX has chosen not to eliminate the elderly and chronically ill from eligibility of payment for visiting nursing services. Title XIX chose to make payment to Home Health Agencies for essential proper skilled nursing ordered by a physician. No restrictions were required in terms of the patient being chronically ill or requiring long-term health care. The result of this more reasonable title XIX policy is, of course, calculated to an increased expenditure of title XIX funds for visiting Nursing services.

C. INCREASE IN FEDERAL MEDICARE PREMIUMS, DEDUCTIBLES AND CO-INSURANCE

1. When Federal Medicare was implemented on July 1, 1966, the monthly premium for the benefits under Part B was $3.00 per month. The premium has gradually increased up to the present assessment of $5.60 per month—an increase of 86 percent.

2. In addition, the deductible for hospital payments increased from $40 in 1966, to $60 in 1971, an increase of 50 per cent.

3. The co-insurance for hospitalization has increased from $10 per day to $15 per day after the 60th day of in-patient hospitalization—an increase of 50 percent.

ITEM 8. PREPARED STATEMENT OF DR. P. JOSEPH PESARE* MEDICAL CARE PROGRAM DIRECTOR, RHODE ISLAND MEDICAL ASSISTANCE PROGRAM

PROVISIONS, POLICIES AND PROBLEMS RELATING TO MEDICAL CARE FOR THE ELDERLY THROUGH THE MEDICAID AND MEDICARE PROGRAMS

I. Historical background

A. Provisions for payment of the costs of medical care by vendor payments under the Federal-State Public Assistance programs have been in effect since July 1, 1952, in all four categories. Until late in 1964, the State used a "pooled fund" into which per capita payments were made each month for recipients of Public Assistance money payments. The scope of services provided was comprehensive except that payment for nursing home care was provided within the money payment for maintenance.

B. On October 1, 1964, the State implemented a Federal-State program of Medical Assistance for the Aging for persons 65 years of age and over who were

*See statement, page 276.

not recipients of Public Assistance but who met certain criteria of medical and financial need. To help finance the program, the enabling legislation, which was enacted in April 1964, created a "Medical Care Fund" consisting of employees' contributions of ½ of 1% of wages paid by employers (or earnings from self-employment) up to $4,800 in any calendar year, "except that an employee adhering to a faith depending on spiritual healing is exempt from these provisions." A full scope of services was provided, including post-hospital nursing home care.

Rhode Island did capture the spirit of the Kerr-Mills Act and did provide for a comprehensive scope of medical services and supplies.

C. On July 1, 1966, the Rhode Island Medical Assistance Program was enacted under the provisions of title XIX of the Social Security Act.

CHARACTERISTICS OF THOSE WHO ARE POTENTIALLY ELIGIBLE FOR MEDICAL ASSISTANCE

1. The Rhode Island Medical Assistance Program provides payment for medical services rendered eligible Money Payment Recipients—those persons receiving Money Payments through the categories of Old Age Assistance, Aid to the Blind, Aid to the Permanently and Totally Disabled and Aid to Families with Dependent Children.

2. In addition, the Rhode Island Medical Assistance Program provides payments for medical services rendered to those persons who are determined to be Medically Needy Only. These are persons whose income and resources are sufficient to permit them to provide for their basic needs in the community but are not sufficient to pay for their medical needs.

(a) This group includes those persons who are:
(1) 65 years of age and over.
(2) Blind.
(3) Disabled.
(4) Children under the age of 21, deprived of parental support or care because of death, incapacity, absence or unemployment of parents.

(b) They may have an income of $2,500 for a single individual; $3,500 for two; and an additional $400 for each additional dependent child.

(c) Their assets may not exceed $4,000 of one individual; $6,000 for two; and an additional $100 for each dependent child.

3. Also included within the Rhode Island Medicaid Program are children under age 21 placed in licensed foster homes and in institutions operated by voluntary organizations.

4. Persons 65 years of age and over who are in-patients in mental health facilities represent another group of eligible recipients of the Medical Assistance Program.

II. Application process

A. Application for the Rhode Island Medical Assistance Program may be made by requesting an application form either in person or by phone or mail at the local welfare office in the community in which the person resides.

B. The form is then completed by the applicant or someone acting in his or her behalf and brought or sent to the office designated for the area in which the applicant lives.

C. An eligibility determination is made within 30 days of the receipt of the completed application except for those cases requiring additional medical information; in such cases, a decision will be made within 30 days. In every instance, the applicant is notified in writing regarding eligibility or ineligibiltiy. If the person is determined ineligible, the reason for his ineligibility is clearly stated.

D. SPECIAL PROBLEMS RELATING TO APPLICATION BY THE ELDERLY

We are aware of special problems relating to persons 65 years of age and over who apply for Medical Assistance. We realize many are homebound—residing in Skilled Nursing Homes and Intermediate Care Facilities. We have made special effort to reach out to these people in the following ways:

1. Assigning special social caseworkers to assist persons residing in Skilled Nursing Homes and Intermediate Care Facilities and confined to their own homes in making application for Medical Assistance.

2. Working closely with Social Service Departments of all hospitals to assist all who are potentially eligible.

3. Maintaining a close liaison with the Division on Services to the Aging.

4. Advertising the program through radio and television programs, brochures and leaflets.

We have tried to utilize every channel through which the potentially eligible may apply.

E. PERIOD OF ELIGIBILITY

1. The eligible aged, blind and disabled are certified for one year on a pre-enrollment basis.

2. Eligible family groups are certified for six months.

3. Before the certification period ends, a new application will be sent to each eligible person or family. This application must be filled out and returned to the local office of the Department of Social and Rehabilitative Services. Written notice of eligibility renewal or discontinuance will be sent to the person or family.

F. EFFECTIVE DATE OF ELIGIBILITY

1. Upon establishing eligibility, an individual is entitled to in-patient hospital services and in-patient physicians' services for a three-month period prior to the first of the month of application. For all other medical services provided under the program, an individual is eligible from the first day of the month of application, provided all conditions of eligibility were met in the month in which the services were rendered.

2. This is a refinement which was implemented prior to the implementation of the Rhode Island Medical Assistance Program and subsequent to the Kerr Mills Medical Assistance for the Aging Program implemented in 1964.

It was implemented because, in many instances, it was a serious current illness which necessitated application for this type of Medical Assistance.

The eligible recipient is in need of assistance prior to the date of application—not after the date of certification of eligibility.

3. *People apply for and are accepted on a Medical Assistance Program primarily for medical reasons and the need for fulfilling medical needs.* This represents one of the reasons for the dramatic increase in the utilization of services included within the scope of the Medicaid Program within a period of less than one year after its implementation.

4. I fail to comprehend the alarm and apparent surprise demonstrated by certain representatives of Federal and State Legislatures, community action leaders and administrators of the State Programs themselves as it relates to this increase in the utilization of medical services by persons accepted on the program. In my opinion it simply means that we do have a live program in action rather than a paper program—which is of no real service to the people for whom it was developed.

G. IDENTIFICATION OF ELIGIBLE RECIPIENTS

1. The check stub attached to the financial assistance check is used by Money Payment Recipients (OAA) as the method of current identification of eligibility during the month of issuance.

2. For persons certified as Medically Needy Only, an eligibility identification card is issued by the State Agency which specifies the eligibility period and expiration date.

3. In addition, all eligible recipients of the Rhode Island Medical Assistance Program are provided with a Plastic Plate which is used by pharmacists and certain other vendors as an imprinting device for billing purposes.

The State Agency has been the target of criticism by certain providers of medical services and a few recipients who maintain that this represents an impediment to the procurement of necessary medical services.

In answer to these criticisms, I would simply suggest that the State Agency would find it extremely difficult, if not totally impossible, to administer a comprehensive medical care program on a reasonable and sound basis if we were to attempt to function without a reasonable method of identifying those who are eligible for the benefits provided by the program.

III. Estimate of number of Rhode Island residents 65 years of age and over

A. According to the latest corrected census report provided by the U.S. Department of Commerce, Bureau of Census, for the year 1970:

Rhode Island has a total population of 949,723 persons. The total number of persons—age 65 and over—is listed at 103,032, approximately 10.8% of the total population.

IV. Scope of services provided for the eligible recipients of medical assistance in Rhode Island

A. More particularly, we are speaking about Old Age Assistance recipients and the Medically Needy Only recipients who are 65 years of age and over.

B. It should be noted that the scope of services available to both the recipients of Old Age Assistance and the Medically Needy Only who are 65 years of age and over are identical in quantity and type of service except for four types of services which are available to the Old Age Assistance Recipients but not available to those who are Medically Needy Only.

C. SERVICES NOT PROVIDED MEDICALLY NEEDY ONLY

1. *Podiatry services*

(a) With reference to podiatry services, it should be noted that Federal Medicare does have a program of benefits which is even more inclusive than those services which are available to the Money Payment Recipients. I refer now to the surgical services of a podiatrist which are not included within the scope of benefits.

2. *Optometric services*

3. *Ambulance services*

(a) However, we should note that ambulance services, for the greater part, are available to these persons through Title XVIII(B) of Federal Medicare.

TOTAL NUMBER OF PERSONS (65 YEARS OF AGE AND OVER) ENROLLED AS ELIGIBLE RECIPIENTS OF OAA OR WHO ARE MEDICALLY NEEDY ONLY UNDER THE PROVISIONS OF TITLE XIX

Type of assistance	1969–70	1970–71
OAA	4,613	4,829
Medically needy only	21,099	19,499

It would appear from these statistics that, at the present time, a total of 24,328 people or 23.4 percent of the total population of Rhode Island who are 65 years of age and over are eligible for benefits under the Medicaid Program in Rhode Island, whereas 84,684 persons or less than 10 percent of the total population are eligible for the Rhode Island Medical Assistance Program.

N.B.—Rhode Island implemented its program of Medical Assistance for the Aging (MAA) in 1964, and more recently, the Medicaid Program under the provisions of title XIX on the basis of Pre-Enrollment of Eligible Recipients who would be potential recipients of medical services and supplies.

CHART I.—DISTRIBUTION OF MEDICAL ASSISTANCE RECIPIENTS BY CATEGORY OF ASSISTANCE FOR THE FISCAL YEARS 1969–70

Category of assistance	1969–70	1970–71
Money payment recipients:		
OAA	4,613	4,829
AB	117	124
AD	3,938	4,320
AFDC	37,788	45,606
Total (money payment recipients)	46,456	54,879
Medically needy recipients only, recipients with characteristics related to the categories of—		
OAA	21,099	19,499
AB	93	92
AD	2,249	2,435
AFDC	5,219	6,166
Total (medically needy only)	28,660	28,192
Children in foster family care	1,572	1,563
Total number of eligible recipients of medical assistance	76,688	84,634

CHART II.—TOTAL NUMBER OF PERSONS (65 YEARS OF AGE AND OVER) COVERED BY FEDERAL MEDICARE (TITLE XVIII (A AND B)) BLUE CROSS 65 AND THE RHODE ISLAND MEDICAL ASSISTANCE PROGRAM TOGETHER WITH THE PERCENTAGE ENROLLED IN THESE PROGRAMS

Type of coverage	Number of persons 65 years of age and over enrolled	Percentage of total population 65 years of age and over enrolled
Federal medicare (title XVIII A)	102,130	98.3
Federal medicare (title XVIII B)	99,170	95.4
Blue Cross (plan 65)	63,070	60.7
Rhode Island medical assistance program	24,328	23.4

Note: Total population 65 years of age and over in the State of Rhode Island in the year 1970, 103,932. I consider these statistics highly significant in terms of adequate coverage of our elderly citizens under the provision of title XVIII (A and B), Blue Cross 65 and the Rhode Island medical assistance program.

CHART III.—PERCENTAGE OF THE AVERAGE MONTHLY CASELOAD THAT RECEIVED 1 OR MORE MEDICAL SERVICES BY CATEGORY OF ASSISTANCE (JULY 1, 1966, TO JUNE 30, 1971) (UTILIZATION RATE)

[In percent]

Category of assistance	Fiscal years—				
	1966–67	1967–68	1968–69	1969–70	1970–71
AABD	61.7	71.0	68.8	65.8	69.5
AFDC	67.7	71.5	73.9	73.9	74.2
Total money payment recipients	64.2	71.3	71.3	69.5	73.3
Total medically needy recipients	42.1	55.2	59.2	60.1	65.8
Total recipients of medical assistance	50.9	61.7	64.2	64.0	68.5

Note: This tabulation certainly would lend support to the fact that the Rhode Island medical assistance program is a live program which is certainly utilized by its eligible recipients.

CHART IV.—SCOPE OF MEDICAL SERVICES WITHIN THE PROVISIONS OF THE RHODE ISLAND MEDICAL ASSISTANCE PROGRAM ACCORDING TO CLASSIFICATION OF ELIGIBILITY

Type of service	Public assistance recipients (money payment recipients)	Medically needy only recipients
Inpatient hospital services	Yes	Yes.
Inpatient physicians' services	Yes	Yes.
Outpatient physicians' services:		
Home	Yes	Yes.
Office	Yes	Yes.
Diagnostic and therapeutic X-rays	Yes	Yes.
Clinic	No	No.
Outpatient clinic services:		
Clinic	Yes	No.
Accident room	Yes	No.
Diagnostic and therapeutic X-rays	Yes	Yes.
Pharmacy	Yes	Yes.
Drugs	Yes	Yes.
Dental services	Yes	Yes.
Optometric services	Yes	No.
Laboratory services	Yes	Yes.
Surgical appliances	Yes	Yes.
Visiting nurses services	Yes	Yes.
Nursing home care	Yes	Yes.[1]
Intermediate care facility	Yes	No.
Podiatry services	Yes	No.
Ambulance services	Yes	No.

[1] Nursing home care for the medically needy only recipients is limited to a maximum of 90 days, subject to prior authorization by the Office of Medical Standards and Review.

4. Out-patient department services

(a) There are certain out-patient department services included within the scope of our program; namely:

(1) Diagnostic and Therapeutic X-Ray Services.
(2) Clinical Laboratory Services.
(3) Pharmacy Services.

D. ELIGIBLE RECIPIENTS OF THE RHODE ISLAND MEDICAL ASSSISTANCE PROGRAM OBTAIN NECESSARY MEDICAL SERVICES IN THE FOLLOWING MANNER

1. When the eligible recipients require the services of a physician, dentist, pharmacist, etc., they are encouraged to seek these necessary medical services from the practitioner of their own choice, preferably a physician, pharmacist, dentist, etc. who will continue to provide these services on a continuous basis. We feel that this element of continuity of service provided by the same practitioner represents an important factor as it pertains to the quality of medical services available to these recipients.

2. Eligible recipients of the Rhode Island Medical Assistance Program are able to obtain needed medical services in the same manner as those who are not dependent upon a State-supported Medical Care Program for their medical care. In administering the Program, we have tried to remove every barrier or element which would differentiate these recipients from the average person paying for these services without State support. This is another indication that we have indeed captured the spirit of the Kerr-Mills Program and, more recently, the title XIX Program.

We have vigorously opposed certain proposals made by certain critics of the State Medicaid Program.—Proposals which have originated from frustration as it relates to their inability to cope with the expanding financial burdens imposed by these programs. *There have been suggestions that we should not be permitting these eligible recipients to reach out and obtain medical services and supplies from the practitioners of their own choice.* There have been those who maintain that these should be *cleared through State-organized and administered clinics.*

We do not feel that this approach can be justified.—We feel that this approach would detract from the dignity of these recipients in need of necessary medical services and supplies. We are proud of the fact that in the Rhode Island Program, eligible recipients are entitled to obtain medical services and supplies from the private practitioners, Neighborhood Health Centers or hospital clinics of their own choice. In fact, we are presently in the process of negotiating with the Rhode Island Group Health Plan in making provision for those eligible recipients who would seek to obtain their comprehensive medical care through this privately-administered health maintenance organization.

V. Significant aspects of certain types of services included within the scope of medical services provided eligible recipients of the medical assistance program

A. HOSPITAL SERVICES

1. When an eligible recipient requires hospital service, the attending physician will request these services through a community hospital. This patient will receive hospital services in accordance with the needs of his case. These services range from the coronary care unit and intensive care services to placement on a so-called "self-help unit."

2. There is actually no limit on the length of hospitalization. This is dependent totally upon the needs of the patient as certified by the attending physician and hospital utilization committees which are now active in all the hospitals. This does not mean that a patient can demand and receive unnecessary hospital services, but rather that he is entitled to benefits through the State Medicaid Program to receive necessary hospitalization in accordance with the specific needs of his case.

3. We do not require prior authorization for hospitalization. However, we do require that a Request for Extension be submitted by the hospital when hospitalization in excess of 15 days is needed by the patient. It should be noted that, in Rhode Island, 75% of hospital stays for eligible recipents of Medical Assistance fall within the 15-day period. We, therefore, feel that this requirement is reasonable since the majority of eligible recipients do not require more than 15 days of hospitalization.

(a) For those who do require in excess of 15 days of hospitalization, we as a responsible State agency, are simply requiring the hospital physician and, in some cases, the hospital utilization committee to certify that this hospitalization is necessary on the basis of the medical needs of the patient.

4. *Four persons 65 years of age and over, prior authorization for extension of hospitalization is not required until after 60 days.*—Since the majority of persons 65 years of age and over are entitled to benefits under the provision of Title XVIII(A), this means that:

(a) The State Agency is responsible for meeting the deductible of $60 which is required before Part A of Federal Medicare assumes responsibility for payment of hospitalization.

(b) The State Agency is responsible for payment of the co-insurance factor of $15 per day after the period of 60 days has elapsed.

(c) The State Agency also assumes responsibility of payment for the first three pints of blood which are *not* paid for by Federal Medicare.

Therefore, in an effort to avoid unnecessary expenditure of time and energy, the State Agency does not require prior authorization for hospitalization involving less than 60 days. It is quite clear that the State Program has very effectively complemented the hospital benefits which are available through the Federal Medicare Program which are available through Part A.

A constant careful surveillance is maintained for all hospital stays. All requests for extension beyond 15 or 60 days must be reviewed by the Medical Care Program Director who makes a decision in each case on the basis of the medical justification provided by the attending physician, the hospital utilization committee and, in many cases, an actual review of the complete hospital record.

5. In those instances involving patients 65 years of age and over who, in the opinion of the attending physician, are best cared for in private psychiatric institutions, we do make payment for up to 150 days of hospital care. This means that the State Agency would become involved in paying a co-insurance after the 60th day and up to the 150th day.

6. With reference to hospitalization, there is a third group who require hospitalization in a chronic disease facility. These are State-operated institutions. We feel that they are fulfilling a very real need for those elderly persons who require more than the type of service which could be obtained in an extended care facility, skilled nursing home or rest home, but less than an acute hospital service obtained in hospitals for acute medical and emergency care.

These State institutions are caring for a representative sample of our caseload* who should not be imposing an unnecessary burden on the average private community hospital but yet do require a constellation of medical services on a 24-hour basis which cannot be provided with equal effectiveness in an Extended Care Facility or Skilled Nursing Home.

7. Care for the Aged Mentally Ill in State mental hospitals is another provision of the Rhode Island Medical Assistance Program. It was not until 1965 that the Federal Government assumed broad responsibility for helping States meet the cost of treating the mentally ill. Even so, coverage under the provisions of the Medicaid Program is limited to patients age 65 or older.

Coverage for these patients in State Institutions became effective in 1965 with the passage of the Long Amendments of title XIX in the Social Security Act. The Long Amendments stipulate requirements which are designed to encourage States to develop an organized, comprehensive mental health care system.

It should be noted that the coverage under the Long Amendments is a State option and is not mandatory. Rhode Island opted to provide this coverage to its aged mentally-ill population. We have done so because we believe that these aged mental patients should not be relegated to a back ward existence in a State mental hospital.

Through the provisions of the Long Amendments, we have developed resources and services to provide alternate methods of care for these patients outside chronic care in mental hospitals. In addition, the State has developed methods for insuring that those who cannot be moved into alternate care arrangements are being provided needed services while they are in-patients—with regularly

*At the present time there are 1,638 persons residing in State public hospitals that are covered by the Rhode Island Medical Assistance Program.

scheduled case conferences and evaluations that determine whether optimum in-patient care is being provided.

Furthermore, Rhode Island, under its Medical Assistance Program also makes available to the elderly, as well as all of the eligible recipients of Medical Assistance, provision of payment for treatment in a psychiatrist's private office.

B. PHYSICIANS

1. An eligible recipient of Medical Assistance is entitled to the services of a physician of his own choice.

2. There is no prior authorization required for the initial visit to a physician's office or for a home visit.

3. We do provide for the visits by a physician for up to two visits per month for a chronic illness and up to eight visits per month for an acute illness. When visits in excess of these standards are requested, prior authorization is required to justify the need for these additional visits.

4. With reference to in-patient hospital visits for persons 65 years of age and over, the physician admits a patient requiring hospitalization to the hospital of the physician's choice. The physician provides the necessary care without any requirement for authorization except for cases representing long-term hospital stays. When visits in excess of 37 visits are required, then the physician is required to obtain prior authorization.

5. Services of Consultants. In addition to the services of the attending physician, *we also have provision for the payment of services of medical, surgical and other specialty consultants.* This provision contributes to a better quality of medical care.

6. Physicians are paid in accordance with an established fee schedule for medical services provided eligible recipients of the Medical Assistance Program. This fee schedule represents a negotiated fee schedule which is acceptable to the overwhelming majority of participating physicians.

For surgical services, physicians are paid in accordance with the Blue Shield Plan B of Rhode Island. Studies have indicated that, as of 1968, reimbursement on the basis of Blue Shield Plan B represented approximately 69 percent of the usual and customary charges of participating surgeons. This means that the physicians of Rhode Island continue to make a contribution to the needy of our State and the responsible State Agency. Contrary to public opinion, physicians and surgeons are not reimbursed in toto for services rendered.

7. There was a time when the physicians' fee schedule was not generally acceptable to the medical profession; there were some physicians who were billing patients in addition to the allowances made by the Federal Medicare and the State Medical Assistance Programs. The State Agency has made every effort to curtail this practice. As of this year (1971), we can state with confidence that Medical Assistance Recipients are not compelled to supplement payments made in their behalf by the State Agency in conjunction with the Federal Agency through Federal Medicare.

CHART V.—PHYSICIANS' EXPENDITURES FOR OAA AND MA RECIPIENTS TOGETHER WITH THE TOTAL PHYSICIANS' EXPENDITURES FOR ALL CATEGORIES OF ASSISTANCE

Fiscal year	Old-age assistance	Medically needy only	All categories	Percentage of caseload 65 years of age and over	Percentage of total expenditure for recipients 65 years of age and over
1970–71:					
Expenditure	$162,837	$919,653	$3,329,603	40.0	[1] 33.2
Number of bills	18,415	83,310	281,390		
Average price per bill	8.84	11.03	11.83		
Caseload	4,829	29,755	84,634		
Cost per eligible recipient	33.72	30.90	39.34		
1969–70:					
Expenditure	$153,758	$860,182	$2,676,577	45.7	[1] 37.7
Number of bills	18,490	83,429	248,826		
Average price per bill	8.31	10.31	10.75		
Caseload	5,570	29,821	77,340		
Cost per eligible recipient	27.60	28.84	34.60		

[1] It should be noted that physicians' expenditures for eligible recipients 65 years of age and over do not include any payments made by Federal medicare SMI benefits. The expenditure represents payments made toward the deductible and coinsurance amounts not covered by Federal medicare.

8. We have made every effort to facilitate physician participation in the program. An example of this is the development of a special billing form for physicians' services provided persons who are eligible for benefits from both title XVIII (B) and the State Medical Assistance Program. This revised form, developed in April 1967, eliminated the need for duplicate billing and, at the same time, made possible the effective administration of the State Medicaid Program with the significant advantage of avoiding duplication of charges against the State Agency.

SKILLED NURSING HOME AND INTERMEDIATE CARE FACILITIES

1. Scope of service

(a) All admissions to Skilled Nursing Homes and Intermediate Care Facilities are based upon prior authorization. (Medical and Social Service Review)

(b) For those recipients who are Medically Needy Only, Skilled Nursing Home care is limited to a maximum of 90 days in a nursing home per incident of illness.

(c) For the Money Payment Recipients (OAA, AB, APTD), Skilled Nursing or Intermediate care placements can be authorized for as long as this type of care is medically indicated.

2. Definition of types of care

(a) Skilled Nursing Home Care. This level of care is authorized for those in need of professional nursing services or whose needs are such that they cannot be accommodated at a lesser level of group care home.

(b) Intermediate Care Facility—I. This level of care is authorized for those who may not be fully ambulatory or whose needs include a requirement for some nursing services. Licensed practical nurse service is mandatory in Intermediate Care I homes on a 24-hour basis.

(c) Intermediate Care Facility—II. This level of care is authorized for those not in need of day-to-day nursing services but in need of room, board, general supervision and/or some assistance in daily activities, including the administration of oral medications.

(d) Group Foster Home Care for the Elderly. This level of care is interchangeable with Intermediate Care Facility—II. Foster Homes are used as a primary resource for the placement of patients from the Institute of Mental Health and the Geriatrics Unit of the Rhode Island Medical Center General Hospital who have mental or emotional disorders.

3. Expenditures for skilled nursing home and intermediate care facilities through title XIX

(a) Total group care expenditures have increased from $4,519,600 in the fiscal year 1967–1968 to $9,631,000 in the fiscal year 1970–1971. The caseload has increased (see attached chart) from approximately 2,500 persons in July of 1968 to approximately 3,300 persons in July of 1971.

(b) The most notable increase in group care expenditures can be seen for Skilled Nursing Homes (see chart) from the period 1969–1970 to the period 1970–1971 where the expenditures for Skilled Nursing Home care increased from $4,298,000 to $6,107,000.

CHART VI.—EXPENDITURES FOR SKILLED NURSING HOME AND INTERMEDIATE CARE FACILITY SERVICES
(1967–68 TO 1970–71)

Fiscal year	Skilled nursing		Intermediate care		Total group care	
	Average caseload	Total expenditure	Average caseload	Total expenditure	Average caseload	Total expenditure
1967–68	1,500	$3,317,600	1,000	$1,202,000	2,500	$4,519,600
1968–69 [1]	1,085	3,759,700	1,560	2,166,700	2,645	5,926,400
1969–70	1,635	4,298,000	1,360	2,891,000	2,995	7,189,000
1970–71	1,700	6,107,000	1,575	3,524,300	3,275	9,631,300

[1] In January of 1969, 30 skilled nursing homes were reclassified as intermediate care facilities, thus the drop in caseload for skilled nursing and the corresponding increase in intermediate care.

Some of this increase in cost can be attributed to an increase in caseload. However, we can note from the chart that the expenditure for Intermediate Care did not increase as drastically as the expenditure for Skilled Nursing care although the caseload for Intermediate Care increased proportionately with the caseload for Skilled Nursing Home care.

(c) One of the underlying reasons for the increased expenditure for Skilled Nursing Home care must be attributed to the recently-imposed rigid interpretation of policy pertinent to qualification for admission to Extended Care Facilities as conceived by Federal Medicare.

Since 1969, very few cases have been approved for the maximum 100-day Extended Care Facility allowance under the provisions of Federal Medicare (Part A), therefore making it necessary for Medical Assistance to assure responsibility for the payment of the full cost of Nursing Home care at a time earlier than the anticipated maximum of 100 days.

For example, in cases of cataract operations, Federal Medicare usually allows a maximum of five days of care, including hospital care, which usually means that only two days of extended care are authorized whereas under the Medical Assistance Program, we would normally allow up to 30 days of Skilled Nursing Home care after a cataract operation.

(d) Currently, out of a caseload of approximately 1,700 recipients of Medical Assistance in Skilled Nursing Homes, only 125 or 7.5% of these are currently receiving extended care benefits under Federal Medicare. National statistics show that only 5% of the some 340,000 beds certified as Medicare extended care are currently in use. Why such a small utilization rate?

(e) In planning for our Medicaid Program which was implemented in 1966, we anticipated that a large percentage of these patients would be cared for through the provisions of Title XVIII(A) of Federal Medicare in so-called Extended Care Facilities.

Our budgetary planning for Medicaid was predicated upon the fact that the State Agency would be relieved of a substantial burden as it relates to these people in Skilled Nursing Homes.

It is indeed frustrating to anticipate that our elderly recipients will be accepted by Federal Medicare as fulfilling their requirements for admission to an Extended Care Facility only to have their application denied without so much as an explanation for the denial. We consider this a very serious shortcoming of Federal Medicare as it applies to the administration of their Federal Medicare Program and certainly a very undesirable impact on our State Medical Assistance Program.

4. The following pre-requisites are required for Medicare coverage in an Extended Care Facility.

(a) The services furnished must be required for:

(1) Treatment of a condition or conditions for which the beneficiary was receiving in-patient hospital services prior to transfer to the Extended Care Facility:

(2) Treatment of a condition which arose while receiving Extended Care for treatment of a condition or conditions for which he was receiving in-patient hospital services.

(b) A physician's certification (and recertification when services are provided over a period of time) is required.

(1) This must include an estimate of the time required to accomplish rehabilitation;

(2) Certification that treatment of this condition or conditions requires skilled nursing care (not exclusively limited to R.N. or L.P.N. services but must include other paramedical services such as physical therapy and occupational therapy) on a continuing basis.

(c) Interpretation of Skilled Service—Are Too Restrictive

(1) The classification of a particular service as skilled is based on the technical or professional health training required to effectively perform or supervise the service. For example, a patient following instructions can normally take a daily vitamin pill. Consequently, the act of giving the vitamin pill to a patient who is too senile to take it himself would not be a skilled service.

(2) The importance of a particular service to an individual patient does not necessarily make it a skilled service. For example, a primary need of a non-ambulatory patient may be frequent changes of position in order to avoid development of decubiti. Since changing of position can ordinarily be accomplished by unlicensed personnel, it would not be a skilled service.

(3) The possibility of adverse effects from improper performance of an otherwise unskilled service does not make it a skilled service.

(4) In addition to meeting the definition of skilled nursing services, the services must be needed on a continuing basis. For example, a person may

require intramuscular injections on a regular basis every second day. If this is the only skilled service required, it would not necessitate the continuing availability of skilled nurses.

N.B.—I would continue to pose the basic question pertinent to the intent of Public Law 89–97 as it applies to the utilization of Extended Care Facilities. I simply urge a more liberal approach to this important area of admission of seriously-ill patients to Extended Care Facilities.

D. PHARMACY SERVICES

1. In the development of the Public Assistance Medical Care Program in 1952; consideration was given—from the beginning—to the inclusion of all those medical services and supplies which were considered basic requirements of adequate medical care. This approach was influenced by the conviction that certain medical supplies are essential, that high quality medical care for the needy represents a sound investment of public funds to prevent chronic dependence, and that physical and social rehabilitation of Public Assistance recipients restores many to gainful employment and self-help.

2. From the inception of the Public Assistance Program in 1952, provision was made for the payment of drugs provided to Public Assistance Medical Care recipients. The Rhode Island Medical Assistance Pharmacy program was developed in 1952. This program was developed through the cooperation of the Rhode Island Advisory Committee on Pharmacy and the Advisory Committee on Social Welfare of the Rhode Island Medical Society. The Pharmacy phase of the Medical Assistance Program has always had the close support and cooperation of the pharmacists of Rhode Island.

It should be noted that 100 percent of the Rhode Island pharmacists are participating in the Rhode Island Medical Assistance Program (239 as of September, 1971).

3. The Pharmacy phase of the Rhode Island Medical Assistance Program is a liberal one which does not impose hardships on the recipients and impediments to utilization of pharmacy services.

There is considerable evidence to prove that the elderly and all recipients of Medical Assistance in Rhode Island are receiving those drugs and medical services and supplies which are necessary to maintain good health.

We Continue to be Concerned About High Quality Pharmacy Services

Since the inception of our program in 1952 and the Medical Assistance Program in 1966, we continue to maintain real concern for the provision of high quality pharmacy services for our eligible recipients. If we were to agree to provide anything but the same high quality services which are available to all other persons in the community, then we would be guilty of an unreasonable act of discrimination.

It is for this reason that we have not insisted upon utilization of the following so-called control devices:

(1) Insistence upon the prescription of generic drugs.
(2) The establishment of centralized dispensing units.
(3) Insistence that prescriptions for Medical Assistance recipients be filled through hospital clinics or pharmacies.

It is an established fact that the history of our program supports our position to the effect that every reasonable effort is made to insure the personal physician-patient-pharmacist relationship which does prevail for all other citizens who are not dependent upon a State-administered program of Medical Assistance.

4. During the fiscal year 1970–1971, over 1 million prescriptions were provided to recipients of Medical Assistance. Of these 1 million prescriptions, over 180,000 prescriptions were dispensed to Old Age Assistance recipients in Rhode Island and an estimated 350,000 prescriptions were dispensed to Medically Needy Recipients over 65 years of age.

5. The Department of Social and Rehabilitative Services has designed its pharmacy program to eliminate serious hardships which may be incurred on the part of the elderly.

Witness the fact that, in March 1965, a revised policy allowed refills for Medical Assistance recipients for drugs classified as vitamins, tranquilizers and anti-depressants. Prior to that time, Medical Assistance recipients were required to return to their physicians each month to obtain a new prescription.

Elderly recipients who obtain an original prescription from the attending physician which provides for up to a 30-days supply of medication may, in addition

to the original prescription, be allowed three refills when indicated by the attending physician. This provides an additional 90-days supply of medication.

The Department of Social and Rehabilitative Services is currently reviewing a proposal which would provide for a 100-days supply of certain maintenance drugs thereby further eliminating inconveniences on the part of all eligible recipients of Medical Assistance.

While it is true that the pharmacy phase does not have restrictions, such as a 30-days supply of medication and prior authorization for drugs not included in the scope of our program, it should be noted that these restrictions were designed primarily to protect the Medical Assistance recipients.

CHART VII.—EXPENDITURES FOR DRUGS DISPENSED TO ELIGIBLE RECIPIENTS OF MEDICAL ASSISTANCE BY CATEGORY OF ASSISTANCE (1969–70—1970–71)

Fiscal year	All categories	Old age assistance	Medically needy only
1970–71:			
Total expenditure	$4,319,841	$682,252	$2,319,841
Number of prescription bills	1,072,335	180,302	511,381
Average prescription price	$4.03	$3.78	$4.54
Caseload	84,634	4,829	29,755
Cost per eligible recipient	$51.04	$141.28	$71.33
Number of prescriptions per eligible recipient	12.7	37.3	17.1
1969–70:			
Total expenditure	3,492,167	536,409	1,861,211
Number of prescription bills	896,122	149,407	464,345
Average prescription price	$3.90	$3.61	$4.00
Caseload	77,340	5,570	29,821
Cost per eligible recipient	$45.15	$96.30	$62.41
Number of prescriptions per eligible recipient	11.6	26.6	15.6

We are concerned about the premature approval of drugs which eventually prove to be harmful drugs—responsible for adverse reactions in those who use these medications.

It is for this reason that we employ the mechanism of prior authorization as a means of employing a reasonable and desirable control as it relates to the early usage of new and clinically untried drugs which can be classified as potentially dangerous. It should also be noted that many of these new and untried drugs are extremely expensive drugs. The additional expense cannot be justified by an established certainty that the new drugs are that much more effective than the older, more well-established drugs and of equal safety.

E. DENTAL SERVICES

1. Federal Medicare does not make provision for payment of dental services for those aged individuals entitled to Federal Medicare supplementary medical insurance benefits. In addition to this, the conditions for Federal participation in our title XIX Medical Assistance Programs does not require the State to include provision for payment of dental services. Rhode Island, has always considered dental care a very important facet of total medical care and, therefore, voluntarily included payment for dental services within the scope of our Medical Care Program since 1952.

The Rhode Island State Department of Social and Rehabilitative Services expended in excess of $1,000,000 for dental services provided for all categories of assistance entitled to Medical Assistance benefits under the provisions of title XIX during the fiscal year 1970–1971. Of this expenditure, in excess of $300,000 was expended for dental services provided eligible recipients 65 years of age and over.

2. The Rhode Island Medical Assistance Program does make provision for payment of dental services for Medically Needy Only Recipients as well as Money Payment Recipients. There is a uniform scope of dental benefits for all eligible recipients of the Rhode Island Medical Assistance Program.

3. With the implementation of the Kerr-Mills Program in October 1964, the dental phase of the Medical Assistance for the Aging Program did provide for a limited scope of benefits for eligible recipients classified as Medically Needy Only. However, with the implementation of the Rhode Island Medical Assistance Program in 1966, the dental phase was expanded to include the full scope of dental

services which previously had been provided only to Money Payment Recipients. This expansion of scope of services was particularly beneficial to those persons—65 years of age and over—since it included provision for payment of partial and full dentures.

4. On October 1, 1967, an upward revision of the Dental Fee Schedule was implemented with the concurrence and acceptance of the Rhode Island State Dental Society. The practicing dentists participating in our program have expressed an overall satisfaction with this fee schedule which has resulted in a more extensive participating in the program by the practicing dentists.

We are convinced that high quality dental care is available to all our eligible recipients of Medical Assistance; that these services are being utilized by our eligible caseload. We take pride in the fact that these services are provided for these recipients by the private dentist of their own choice.

CHART VIII.—DENTAL EXPENDITURES FOR OAA AND MA RECIPIENTS TOGETHER WITH THE TOTAL DENTAL EXPENDITURES FOR ALL CATEGORIES OF ASSISTANCE

[1969-70—1970-71]

Fiscal year	Old age assistance	Medically needy only	All categories	Percentage of caseload 65 years of age and over	Percentage total expenditure for recipients 65 years of age and over
1970-71:					
Expenditure	$34,568	$296,070	$1,004,191	40.0	32
Number of bills	829	7,349	21,158		
Average price per bill	$41.69	$39.79	$47.46		
Caseload	4,829	29,755	84,634		
Cost per eligible recipient	$7.15	$9.95	$11.86		
1969-70:					
Expenditure	$33,582	$281,258	$822,561	44.5	38
Number of bills	873	7,455	19,172		
Average price per bill	$38.46	$37.72	$42.90		
Caseload	5,570	29,821	77,340		
Cost per eligible recipient	$6.07	$9.60	$10.63		

F. VISITING NURSING SERVICES

1. Payment for visiting nursing services has always been included within the scope of our Medical Assistance Program. We have always looked upon the services of visiting nurses as essential services required for:

(a) the provision for medical care on a continued basis;

(b) prevention of any unnecessary hospitalization;

(c) facilitate the early discharge of patients from expensive hospital facilities.

(d) returning these hospitalized patients to their families and community at the earliest time possible in keeping with good quality of medical care.

We consider these services as essential for the intelligent administration of the Medicare Program.

In planning for the implementation of the Medicaid Program, the State Agency looked upon the provision of Title XVIII (A) and (B) for the payment of so-called home health services provided by visiting nurses. We considered these as essential for the intelligent administration of the Medicare Program and, more specifically, the hospital phase of the Medicare Program. We have always felt that if expensive hospital facilities are to be utilized only for those patients requiring these services, the early return of the patient from the hospital to the community would be predicated upon the provision of adequate home health services.

2. Our State planning for the cost of Visiting Nursing Services was predicated upon the fact that these services would, for the greater part, be paid for through the Federal Medicare Program. However, an apparent re-definition of standards and Federal Medicare policy, in 1969, has created a very real and serious problem for the Visiting Nursing Associations who are providing home visits to the elderly and to the State Agency which is responsible for 23.4 percent of the population 65 years of age and over in Rhode Island.

It appears that, since 1969, a substantial number of our eligible recipients whom we considered eligible for home health services under the provisions of

Title XVIII (A) and (B) no longer qualify for these skilled nursing services. The situation becomes all the more difficult to comprehend when we can obtain no satisfactory or logical answer to our queries as to why this restrictive policy.

N.B.—We object very strongly to this new policy by Federal Medicare. If these essential nursing services cannot be provided at home, then we may rest assured that they will be provided through unnecessary extended hospital stays or through unnecessary admissions to Extended Care Facilities, Skilled Nursing Homes or Intermediate Care Facilities.

3. Title XIX has chosen not to eliminate the elderly and chronically ill from eligibility of payment for visiting nursing services. Title XIX chose to make payment to Home Health Agencies for essential proper skilled nursing ordered by a physician. No restrictions were required in terms of the patient being chronically ill or requiring long-term health care.

The resultant of this more reasonable Title XIX policy is, of course, calculated to an increased expenditure of Title XIX funds for visiting nursing services.

For the fiscal year 1970-1971, we had anticipated a visiting nursing agency expenditure of $157,274; our actual expenditure was $185,964.00.

Federal Medicare Criteria for Eligibility for Visiting Nursing Services Under the Provisions of Title XVII(A) and (B)

In order to qualify for home health benefits under Parts A and B, the following must exist:

1. Federal Medicare provides payment for home health benefits following hospitalization of at least three days consecutive duration. (For Part A Only)
2. A doctor determines that home health care is needed and sets up a home health plan within 14 days after discharge from the hospital or a participating extended care facility. (For Part A only)
3. The home health care is intended for further treatment of a condition for which services were received as a bed patient in the hospital or extended care facility. (For Part A Only)
4. The beneficiary must be homebound.
5. The services received must fulfill the criteria of intermittent skilled nursing services.
   a. Skilled nursing services include two components:
      (1) The rendition of direct skilled nursing services, such as the changing of in-dwelling catheters, and the application of dressings involving prescription medications and aseptic conditions.
      (2) Skilled nursing observation and evaluation such as may be required in those cases where symptoms are quite likely to occur which will indicate the need to revise the patient's treatment regimen.

Reaction.—These criteria are quite broad. As a physician, I fail to comprehend or accept the very rigid—unilateral determinations that are made in denying benefits to specific cases.

Examples of Cases in Which Federal Medicare Has Denied Payment for Visiting Nursing Services

1. 86 year old woman—diagnosis of chronic brain syndrome
   Service provided—enema.
2. 77 year old woman—diagnosis of diabetic neuropathy
   Service provided—insulin.
3. 82 year old woman—diagnosis of ASHD with pacemaker
   Service provided—checking vital signs.
4. 85 year old woman—diagnosis CVA–left paralysis
   Service provided—physical therapy.
5. 93 year old woman—diagnosis fractured ankle
   Service provided—general care and instruction.
6. 82 year old woman—diagnosis of Entropion/trichiosis
   Service provided—remove ingrown eyelashes.
7. 82 year old woman—diagnosis of vascular ulcer left ankle, fracture right humerus
   Service provided—physical therapy and dressing.
8. 89 year old woman—diagnosis of chronic brain syndrome, decubiti on back
   Service provided—injection and general care.
9. 88 year old woman—diagnosis of mild congestive heart failure
   Service provided—Thiomerin injection.

G. AMBULANCE SERVICES

1. Ambulance services is one of the benefits provided under Part B of Federal Medicare. We call your attention to the fact that 100 percent of our Old Age Assistance caseload are entitled to benefits under Part B of Federal Medicare as the State Agency purchases this coverage for its eligible Money Payment Recipients 65 years of age and over, and that 94% of the Medically Needy Only are also entitled to Part B benefits. This means that the State Agency recognizes and assumes responsibility for payment of ambulance services provided persons 65 years of age and over:

(a) when there is a deductible to be met.

(b) when there is a co-insurance factor to be met.

2. A major problem confronting the State Agency and our elderly citizens relates to the failure on the part of the Federal Medicare Program to assume responsibility for certain ambulance services which are truly required. However, Federal Medicare maintains that certain ambulance services fall beyond the scope of their program.

VI. The rise in Federal medicare premiums, deductibles and co-insurance factors

A. As of April 1, 1968, the State Agency entered into a buy-in arrangement with the Federal Government to purchase Federal Medicare SMI benefits for all Old Age Assistance recipients.

Our latest estimates indicate that approximately 94% of our Medically Needy Only Recipients 65 years of age and over have voluntarily purchased coverage through Part B of Federal Medicare. We consider this a very significant indication that the vast majority of persons are eager to maintain their dignity in making every effort, even at personal sacrifice, to preserve their independence as it applies to payment for their medical services despite the fact that Federal Medicare has made it increasingly costly for them to continue to qualify for these benefits.

I consider this one of the most serious injustices of the Federal Medicare Program.

When Federal Medicare was implemented on July 1, 1966, the monthly premium for the benefits under Part B was $3.00 per month. The premium has gradually increased up to the present assessment of $5.60 per month—an increase of 86%.

In addition, the deductible for hospital payments increased from $40 in 1966 to $60 in 1971, an increase of 50%.

The co-insurance for hospitalization has increased from $10 per day to $15 per day after the 60th day of in-patient hospitalization, an increase of 50%.

For those who are eligible for the State Medicaid Program, the State has assumed responsibility for the payment of the increased deductible and co-insurance segments. However, I am thinking, at this point, about the persons who are not eligible for the State Medicaid Program and who must assume personal responsibility for these payments.

N.B.—Why has the Federal Agency permitted the creation of this hardship for approximately 80,000 elderly persons in Rhode Island?

I am aware of the arguments presented by the Federal Agency to the effect that the Federal Medicare Program represents an insurance program and, therefore, must maintain financial solvency. I fail to comprehend the wisdom of the Federal Legislators who have permitted these increases to be assumed by the beneficiaries of the Federal Medicare Program.

Certainly, if there is one area in which the Federal Government could be of very definite assistance to these elderly persons, it would be in this area of assuming responsibility for increases in monthly premiums, deductibles and the co-insurance factors that have been levied against this group.

Appendix 2

ADDITIONAL INFORMATION REQUESTED FROM WITNESSES BY SENATOR PELL

Subsequent to the September 20, 1971, "Problems of Medicare and Medicaid," hearing in Providence, R.I., Senator Pell requested additional information from certain witnesses. The following replies were received:

ITEM 1. SUPPLEMENTARY MATERIALS IN ANSWER TO SPECIFIC QUESTIONS RAISED BY SENATOR PELL: SUBMITTED BY DR. P. JOSEPH PESARE, MEDICAL CARE PROGRAM DIRECTOR, RHODE ISLAND

Question No. 1: You mentioned your support for the use of visiting nurses. I have heard that Rhode Island Medicaid only pays visiting nurses $8 for a visit that costs them $12.01. Is this true?

Answer: It is true that the Rhode Island Medical Assistance Program, as of January 1, 1971, does pay $8 for a visiting nursing home visit. However, to make a simple comparison between our fee schedule and the Visiting Nursing Association cost figures does not provide the whole picture of the inter-relationship between the Rhode Island Medical Assistance Program and Visiting Nursing Services within the context of our total Medical Assistance Program. The following factors have to be considered to give added dimension to the Department of Social and Rehabilitative Services' involvement in providing payment for visiting nursing services.

1. Visiting Nursing Associations are the only private voluntary health agencies for which the Rhode Island Medical Assistance Program has provision for making payment for services rendered eligible recipients of the Rhode Island Medical Assistance Program.

This favorable consideration has continued to prevail despite repeated attempts by a large number of other private voluntary health agencies to be included within the scope of our program.

It was in recognition of the essential and unique role of the visiting nurses in providing home health services oftentimes in lieu of direct physicians' services that provision of payment for this service was included as of 1957.

2. There is only one area in which the Rhode Island Medical Assistance Program makes provision for payment according to actual 'reasonable cost' of the service rendered; namely, hospital in-patient and out-patient clinics and emergency room services. This exception has been forced upon us by the legal requirement of P.L. 89–97 as it relates to payment for in-patient hospital services.

It is no secret that Rhode Island, together with many other States, has continued to object to this Federal regulation. In Rhode Island, this hospital expenditure continues to represent the 'back-breaker' of the State Medicaid Program.

3. Physicians servicing eligible recipients of the Rhode Island Medical Assistance Program are paid $10.00 for a home visit as compared to the $8.00 we pay for a visiting nursing visit. I think it is obvious that this differential is not very significant in view of the professional qualifications of the members of each of these two professions. Further, physicians are limited to making two visits per month without having to request prior authorization.[1] The visiting nurses, on

[1] For persons with chronic illness. In the case of acute illness, prior is required.
For Administrative Purposes: An acute illness is defined as a disease which usually runs its course within a period of 30 days.
A chronic illness is defined as a disease which usually extends beyond the period of 30 days and requires periodic review and evaluation.

the other hand, are allowed to make up to six visits per month without requesting prior authorization and up to 15 visits per month on the basis of prior authorization.

4. It should also be noted that the Rhode Island Medical Assistance Program does not impose rigid restrictions on the authorization of payment for visiting nursing services in accordance with the patient's diagnosis and the level of skilled nursing care required as is the practice of Federal Medicare. I respect and appreciate the value of visiting nursing services too highly to even contemplate employing the unreasonable regulatory restriction utilized by Federal Medicare in making payment for nursing visits on the basis of certain limited specific diagnoses.[2]

5. In order for Rhode Island to continue to afford and administer a comprehensive and liberal Medical Assistance Program, it goes without saying that the continuous use of judicious and reasonable controls is imperative.

The employment of an open-ended appropriation in meeting the costs of delivering health services through payment on the basis of so-called 'reasonable cost' without concern for fiscal responsibility would place the State of Rhode Island in the unenviable position of other States such as New York and California which have been compelled to curtail certain essential services and supplies.

Question No. 2: We have also heard testimony that the reason some skilled nursing homes do not accept Medicaid patients is because the State Medicaid Program does not reimburse them for the full cost of their services. Is this true, and why?

Answer: Skilled Nursing Homes are reimbursed for their services on the basis of their reasonable audited costs up to a maximum per diem rate. The current maximum rate is established at $15 per day.

N.B.—Approximately 75 percent of the Skilled Nursing Homes in Rhode Island are presently classified as homes whose per diem rates on the basis of reasonable audited costs are less than the $15 per day maximum. This phenomenon of 75 percent of the homes falling within less than the established maximum per diem rate is not created by the State Medical Assistance Program. This statistic does indicate that the $15 per diem maximum rate is not so unrealistically low as to fail to fulfill the requirements of the majority of Skilled Nursing Homes.

The Rhode Island Medical Assistance Program is presently providing payment for 1,700 of its eligible recipients residing in Skilled Nursing Home facilities.

Of this total of 1,700 recipients of Medical Assistance who are also eligible for benefits under the Federal Medicare Program, only 125 or 7.5 percent of our 1,700 eligible recipients are in Extended Care Facilities at the expense of Federal Medicare.

It should be further noted that Federal Medicare is currently assuming responsibility for approximately 300 of its eligible recipients (of which 125 are also covered by the Rhode Island Medical Assistance Program) within the State of Rhode Island who are presently residing in certified Extended Care Facilities.

It is quite obvious that Federal Medicare is assuming a very small portion of the burden in this area.

The Rhode Island Department of Social and Rehabilitative Services is doing an effective job in placing its eligible recipients in Skilled Nursing Homes. We can assure you that there are no patients who are hospitalized or continue to be hospitalized unnecessarily because a Skilled Nursing Home placement cannot be effected.

I wish we could say as much for the Federal Medicare Program.

While it may appear that there are a number of Skilled Nursing Home Administrators who are unhappy about the reimbursement formula of the Rhode Island Medical Assistance Program, it is nevertheless true that most Skilled Nursing Home Administrators are willing to accept Medical Assistance recipients in need of such care—in preference to the eligible recipients of the Title XVIII Program despite the fact that the Title XVIII Program does not impose a limitation on the maximum rate of reimbursement.

A rather curious phenomenon—not so curious when we consider the frequency with which retroactive denials of payment are made by the Medicare Agency.

The 25 percent of Skilled Nursing Homes whose per diem costs are in excess of the maximum rate of $15.00, as established by the Rhode Island State Agency, do continue to accept Medical Assistance recipients on a quota system.

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[2] Please refer to page 336 which lists a few examples of the types of cases for which Federal Medicare has refused to assume responsibility for payment.

This means that they will accept a certain number of our recipients at lesser than their reasonable audited cost when beds are available. These facilities, for the greater part, represent the newer—more recently constructed facilities—elaborately constructed for the purpose of attracting both private paying patients and beneficiaries of Federal Medicare.

If the maximum rates established by the Rhode Island Agency were not in effect, we would find many of our Medical Assistance recipients who are presently receiving excellent care in the older type facilities going to those newer facilities at a much higher cost to the State Agency.

The cost of providing Skilled Nursing Home care can very readily increase without a concomitant increase in the quality and level of care provided for those eligible recipients.

I can assure you that it is not always the most expensive provider of medical service or Skilled Nursing Home Facility which provides the best quality and highest level of care.

Question No. 3: I am going to list a number of changes being made in Medicare and Medicaid by H.R. 1, and I would like you to comment on each of them.

Answer: (a) The reduction of one-third Federal matching in grants for Medicaid patients staying in general hospitals after 60 days and the reduction by one-third Federal matching in grants for stays in Skilled Nursing Homes after 60 days would result in Rhode Island losing approximately $2,500,000 in Federal matching funds.

This loss would be experienced despite consideration of a projected gain of 25 percent in Federal funding in the areas of out-patient hospital services, clinic services and home health services.

This proposed increased matching obviously is to encourage a more extensive use of services provided outside of hospital and nursing home settings.

The fact remains, however, that the need for long-term care for the severely-ill or handicapped will not be eliminated through the implementation of this device of cutting back Federal matching funds for institutional care. The Rhode Island policy already promotes the maximal use of medical services outside of hospital and nursing home settings.

The principal effect of these curtailments in Federal reimbursement would be to burden the State with increasing costs of providing care for our aged and disabled citizens in our long-term care facilities (State Institutions).

(b) The position of H.R. 1 which requires that persons eligible for the Medicaid Program pay a premium set at graduated rates for receiving Medicaid services will probably decrease utilization of medical services by eligible recipients.

One may argue that this decrease in utilization of medical services will reduce costs. However, I think that the small savings realized from the decreased utilization will be more than offset by the increased administrative expenses incurred in establishing and maintaining a system to implement this provision.

It should be noted that this premium factor may deter persons of limited income from seeking necessary medical care which will negate the concept of the original Title XIX legislation which stressed preventive medical care rather than long-term chronic care. I would venture to predict that these savings would seriously detract from the utilization of preventive medical services and lead to a significant increase in payments for therapeutic services in expensive hospital settings.

In the month of January, 1969, we conducted a very careful program analysis for the purpose of determining the areas in which Medicaid expenditures could be reduced without sacrificing the quality of care. We took a very careful and close look at the possibility of requiring our eligible recipients to pay a premium or participate in partial payment for medical services through the medium of payment of a deductible and co-insurance factor.

The results of this careful analysis led us to the conclusion that we would not be achieving a significant financial saving and would undoubtedly impose unreasonable barriers to the utilization of essential preventive medical services. The reduction in utilization of these preventive medical services would only result in a more extensive use of the more expensive therapeutic services—namely, hospitalization and Skilled Nursing Home services.

(c) Yes, the increase in the deductible and co-insurance factors as outlined in H.R. 1 will increase Medicaid costs. We are most distressed at the increases in the Part B premium, the Part A deductible and co-insurance factors which have already been implemented. We are strongly opposed to further increases in these areas.

The resultant of these actions is simply a transfer of responsibility from Title XVIII to the Title XIX Programs. Any savings that are realized in the Title XVIII Program are being borne by the Title XIX Programs with the States having to assume a portion of the additional cost. In the case of Rhode Island, 49.74% of the additional expenditure must be met with State funds.

It is my impression that the current thinking in relation to welfare and Medicaid expenditures is to bring relief to the States by the Federal Government assuming more responsibility for funding these programs.

Question No. 4: H.R. 1 encourages State Medicaid Programs to use HMO's by providing increased matching grants to the States: Do you favor the use of HMO's?

Answer: The Department of Social and Rehabilitative Services, through Medical Standards and Review, is currently negotiating with two health maintenance organizations—The Rhode Island Group Health Association and The Providence Health Centers, Inc. Numerous sessions have been held with officials of these two organizations and, to date, these meetings and negotiations have proceeded smoothly.

The viability of Health Maintenance Organizations is predicated on the assumption that they can and will provide comprehensive health care on a significantly more economic basis than the procurement of these services on an individual fee-for-service basis.

It is our intent to negotiate capitation fees with these two Health Maintenance Organizations which will be at a level at least equivalent to, if not less than, the cost of providing similar services on a fee-for-service basis.

We support the concept of Health Maintenance Organizations provided that they meet certain criteria:

1. Easy access to medical services on a continuous basis.
2. Comprehensive health services.
3. Comparable health services can be obtained less expensively than the same services on a fee-for-service basis.
4. The Health Maintenance Organizations must fulfill their responsibility to participating third-party paying agencies and its eligible recipients on a responsible and total basis.

This means that these services must be available through the HMO mechanism and its staff on a 24-hour basis; that the eligible recipients are not placed in the position of having to seek essential services from other sources simply because the responsible HMO staff is not available to them at the time of their medical needs.

5. Providing that the HMO does not become so engrossed in its efforts to demonstrate provisions of services at less cost that it will fail to insure the provision of necessary expensive medical services and supplies.

What happens when the HMO finds itself in financial hardship and decides to alleviate this hardship by a reduction of services?

What happens when the HMO finds that it cannot, in fact, provide a constellation of health services at an established premium and, therefore, simply raises its premiums without concern for the ability of eligibility recipients to pay these higher premiums?

These are but a few of the questions to be answered before we can determine the validity of the HMO concept. The fact remains that all HMO's will not attain the degree of high quality performance attributed to the Kaiser Permanente Plan.

ITEM 2, LETTER FROM WADE C. JOHNSON, EXECUTIVE DIRECTOR, HOSPITAL ASSOCIATION OF RHODE ISLAND, IN RESPONSE TO SPECIFIC QUESTIONS RAISED BY SENATOR PELL

November 18, 1971.

DEAR SENATOR PELL: I hope you will forgive my tardiness in responding to your letter of October 15, with which you enclosed four questions in followup of our September 20 testimony in Providence before the Senate's Special Committee on Aging. We have been unusually busy with a number of activities including our Association Annual Meeting last week. In that connection, let me take this opportunity to express appreciation for the telegrams which you sent to the three recipients of our Association's first Distinguished Service Award. These telegrams were read by our President at the Annual Dinner, and I know that they were sincerely appreciated by the Award recipients.

Now, to get on with the responses to the four questions you sent us:

You ask whether we foresee a 50% increase in hospital costs in Rhode Island in the next year or two. In answering this, I think I should begin by saying that if some wholly new comprehensive health care plan were to be adopted within the next two years which completely changes and greatly enlarges the scope of that which is included in hospital costs, perhaps we could conceivably see increases of that magnitude. But if during the next two years, we continue to have more or less the present scope of hospital services and the present general pattern of delivery of health care, I think we can safely say that an increase in hospital costs of 50% is highly unlikely. If the system changes, the increase in costs of hospitals will depend on the nature and the timing of the changes, and the extent to which they were implemented between now and 1974—all of which are matters in which the Government and the Congress will obviously have a considerable voice, and which are by no means wholly within the power of hospitals to determine.

Your second question asks the position of our Association concerning health maintenance organizations and the role of hospitals therein. As I believe you are aware from our testimony, the Board of Trustees of the Hospital Association (representing all of the hospitals in Rhode Island) has endorsed, in principle, some time ago, the "Ameriplan" report of the American Hospital Association which advocates the establishment of health care corporations.

While the Ameriplan concept includes the characteristics of the health maintenance organization, the Ameriplan health care corporation covers a broader range of responsibilities which might or might not be hospital based. Our Association, therefore, has not taken a position on the question whether each of our hospitals should or should not be developed into a component of a health maintenance organization. But as a general observation, our Association is anxious to be supportive of changes in the health care delivery system if such changes will best ensure the proper level of quality health care being made accessible to all Rhode Islanders in an acceptable manner.

In answer to your third question, I think you would agree that there are some very definite similarities and also some differences between the Ameriplan proposal which our Association has endorsed on the one hand, and your bill, S. 703, on the other hand. I believe you are aware that the American Hospital Association, despite some debate within its ranks, has advocated non-profit health care corporations as distinguished from for-profit corporations. The Hospital Association of Rhode Island has not thus far taken any position on this particular issue of profit versus non-profit.

In response to your fourth question, our Association definitely does not favor the provision in H.R. 1 which would, in effect, allow each of the states to dictate rates of payment to hospitals under Medicaid which might be substantially less than the "reasonable cost" basis of reimbursement to hospitals presently in effect under Medicare. In fact, we are on record as favoring the development of an agreement between the hospitals and the State of Rhode Island whereby the State would reimburse hospitals on a negotiated, prospective rate basis comparable to that which we have in recent months worked so hard to put into effect between hospitals and Blue Cross in Rhode Island. It is our belief that prospective rating with incentives for cost economy are a much more desirable basis than any cost reimbursement.

Again, we appreciated the opportunity to testify on September 20 and we also appreciate this further opportunity to answer questions which time did not permit you to ask on September 20. If you feel that any of the responses to your questions need clarification, or if we can be of service in any other way, please do not hesitate to call upon us again.

ITEM 3. LETTER FROM ALBERT V. LEES, PRESIDENT, RHODE ISLAND ASSOCIATION OF FACILITIES FOR THE AGED, IN RESPONSE TO SPECIFIC QUESTIONS RAISED BY SENATOR PELL

November 4, 1971.

DEAR SENATOR PELL: In response to your letter of October 20, raising questions concerning Medicare and Medicaid, we would like to answer these as follows.

Question 1. What changes in Medicare and Medicaid would you suggest to cover the intermediate level of care problems?

Answer. We recommend the Geri-Care program as outlined by the American Association of Homes for the Aging, and would like to call to your attention the recommendations as contained on page 2 and page 4, especially the recommendation covering the request that this program be federalized and transferred to the Social Security Administration for administration and regulation. Enormous benefit would be derived from such a transfer, both in cost due to present duplication of staff and in efficiency of administration.

Question 2. Could you give us examples of problems caused by the current deficiencies in Medicare and Medicaid in this area?

Answer. The major problem in this field is the insufficiency of monies appropriated by the state. For example, the total reimbursement at the present time is $15.00 per day, which consists of $7.50 state funds matching federal funds of $7.50. However, just within the East Providence area there are no homes that provide care at $15.00 per day. We have personally surveyed five nursing homes within the area and the daily rates range from $17.00 to $33.00 per day. Geri-Care also points out some glaring deficiencies within the Medicare program.

Question 3. How do the non-profit facilities cover costs not now met by Medicaid?

Answer. The non-profit organizations have no other alternative but to conduct charitable drives, use income from endowment funds left their homes, and make appeals to their affiliated churches and organizations within the state. We also rely on volunteer groups to raise funds for our institutions as well as conducting our own fairs and bazaars to raise additional funds.

Question 4. Is it realistic to expect that Medicaid can pay for these costs in full?

Answer. As long as the state does not appropriate the necessary monies we certainly can not expect these costs to be paid in full. Therefore, we feel that the whole program has to be revised concerning the funding of both Medicare and Medicaid. For example, under present conditions the patient who is able to pay full cost in our skilled nursing homes is over charged as he or she has to underwrite the cost of the indigent person due to the insufficient cost reimbursement formula that is now being applied.

I personally enjoyed participating in the hearing in Providence and considered it quite an honor to be invited. If there is anything that I can do or that our Association can do, please call upon us. We will be very happy to oblige.

[Enclosure.]

GERI-CARE

A program of legislative and administrative goals advocated by AAHA which are designed to provide for the needs of today's aged in the area of institutional care and services.

I. Recommendations for improvement in health-care for the aged in the United States

NATIONAL HEALTH INSURANCE

Recommendation.—Any program of National Health Insurance should contain at least a provision which would require the Secretary, within an appropriate amount of time, to not only study but also develop a long-term care benefit which would provide total comprehensive care and services to the aged and chronically ill.

Comment.—It is possible that actuarial considerations will limit the amount, scope and duration of long-term care which can be provided for at the outset of a program of National Health Insurance. This, however, should not preclude planning and programming by the Secretary which will look to the eventual phasing-in of a long-term care benefit.

Because the lead-in time required for such a phasing-in would probably be considerable, it is now exceptionally critical that perfection and expansion should be pursued in the existing disparate programs, namely, Medicare, Medicaid, Intermediate Care and Housing for the Elderly, which together comprise a kind of national program of long-term care for the aged and chronically ill.

There is great danger that the pursuit of perfection in present programs will be lost sight of or diminished while National Health Insurance is being necessarily pursued. The best insurance that the problem of long-term care in a program of National Health Insurance will be resolved expeditiously is to perfect and expand existing programs. Everything is gained and nothing is lost by this approach. When National Health Insurance is effected, the present pro-

grams can be absorbed into it as the long-term care benefit or they can be gradually phased-out as separate programs while being phased-in as an integral part of National Health Insurance. The essential and all important point is that today's aged will be provided for as well as tomorrow's aged.

MEDICAID

Recommendation.—Transfer the program of care and services in Intermediate Care Facilities from Title XI to Title XIX.

Comment.—Presently under Title XI, this program is limited to the categorically-needy and by HEW interpretation, each State is free to determine the rules and regulations which shall apply to its program of Intermediate-Care. By transferring this program to Title XI as a part of Medical Assistance, two major items in the public interest could be obtained (1) the number of aged persons eligible for such care would be increased because the medically-needy aged would become eligible in addition to the already eligible categorically-needy aged, and (2) the confusion over whether the State or the Secretary has the authority to establish rules and regulations would be dispelled since the force of Sections 1901 and 1902 of Title XIX would come into play and the Secretary would thereby have the clear authority to regulate intermediate-care. This would result in a uniform program of intermediate-care for the aged across the 50 states.

Recommendation.—Apply the present Medicare reimbursement formula to Title XIX skilled nursing home care and to intermediate care as is already the case with Title XIX hospital care.

Comment.—The medicare reimbursement formula is designed to determine with a significant degree of accuracy the cost of care and services to the individual Medicare recipient and thus to the Medicare program. The formula can and should be refined and efforts in this direction should be continued. Nevertheless, of all the methods of reimbursement presently employed in programs of care for the aged, it represents the single best effort to determine the cost of care and services received by the individual patient. As such, it possesses a high degree of public accountability.

As presently constituted, the reimbursement methods employed in Title XIX skilled nursing home programs as well as those employed in Title XI intermediate care programs are characterized by their singular lack of any significant degree of public accountability. It is this lack of public accountability which more than any other element has contributed to not only the inefficient cost of these programs but also to the several abuses which mark these programs. If by efficiency, it is meant that the largest amount of necessary care is being purchased by the Federal health dollar, then methods of reimbursement such as prospectively negotiated rates, per diems, rates by patient-classification, point systems, rates by category of facility and the like are universally characterized by their lack of any assurance that the patient will receive the care and service which the program is thus buying.

The only proven method of reimbursement which offers any assurance that the health dollar is buyinig the largest amount of care and that the program is receiving the care for which it is making expenditures is a system which pays the reasonable cost of the care and services actually received by the individual patient, that is, a retrospective reimbursement based upon the auditable reasonable cost of care and service.

It is true that such a system may encourage "over-care," but this is to be preferred to a system which encourages "under-care" while making payment for "maximum-care" at a rate previously negotiated. While the total cost of the program is harmed by "over-care," at least the program would have purchased such care at the reasonable cost of the over-care. However, the important factor is that the patient is not harmed by the "over-care." Whereas, both the patient and the program are harmed by "under-care" purchased at "maximum-care" rates. Further, the abuse to the program of over-care at reasonable cost is more susceptible to policing, detection and elimination than is the immoral abuse of "under-care" and the fraudulent abuse of such "under-care" purchased at a "maximum-care" reimbursement rate previously negotiated.

There are those who argue that applying the Medicare reimbursement formula to Title XIX skilled nursing home care and to Title XI intermediate care would not only increase the costs of these programs but would cause such costs to skyrocket. This argument is made despite the absence of any study which would

substantiate the argument. To the contrary, there are those who maintain most vigorously that program costs would certainly not skyrocket, and some even argue that program costs would not increase but would remain where they are now. However, if cost reimbursement were to increase program costs, there is reason to expect that the increase would not be substantial and such an increase as there might be would be more than offset by both the tremendous increase in the cost-effectiveness of the programs and by the substantial gain in the care received by the aged patient. In short, there would be a greater health-return for both the Medicaid and the Intermediate Care dollar. Hence, from one point of view of cost effectiveness, the programs would gain in efficiency.

Finally, the application of the Medicare Reimbursement formula to other programs of institutional care of the aged would eliminate the need for a distinct part ECF in these facilities. This would then work to eliminate the audit overkill presently at work in Medicare. This, too, would be a gain in efficiency and would reduce costs. What's more, this would eliminate the needless movement of patients as well as reduce the fragmentation of care.

Recommendations.—Authority should be granted to the Secretary to determine norms for care regimens, length of stay required by diagnosis, and area-wide cost factors. Payment would be guaranteed whenever such norms were not exceeded. However, whenever such norms were exceeded, payment for the excess would be denied unless the facility or its utilization review committee or the attending physician, as the circumstances would dictate, could justify the excess.

Comment.—The record is replete with substantiating arguments for this change and its feasibility. Suffice it to state, that this change would go a long way to curb the abuse of "under-care" purchased by "over-reimbursement" as well as the abuse of "over-care." This would also work to achieve necessary care. Again, program efficiency would be increased.

Recommendation.—Federalize the present programs of care for the aged contained in the Social Security Act, in addition to the already Federalized Medicare, and transfer them to the Social Security Administration for administration and regulation. The funding of this combined program of health-care to the aged, other than that of Medicare, should be by general revenues. Under this arrangement, Medicare benefits would continue to be paid from the trust fund while all other health-care for the aged, such as the present Medicaid and Intermediate Care, would be paid from general revenues. All, however, would be administered by the Social Security Administration.

Comment.—This recommendation is predicated on the assumption of national, rather than local, responsibility for the health care of the aged. The inevitability of old age and its attendant health vulnerability is not attributable to the communities in which the aged reside. There is not a Kansas physiology of aging as distinct from a California physiology of aging. Old age and in its infirmities are attributable to no other cause than that of the nature of man which is universal and as such is the same in all the 50 states and their communities.

Further, financing the health-care of the aged from the comparatively progressive Federal income tax, as distinct from splitting the bill 50–50 with the States who largely raise their funds with regressive taxes, is a step forward in the direction of a more equitable way of sharing what is a common responsibility because of the universal human need thus involved.

Again, because the human need thus involved is universal, federalizing health-care for the aged would provide a uniform program across the 50 states. Hence, it would no longer be better to be old in one state rather than in another. Conversely, it would no longer be more tragic and a greater agony to be old in one state rather than in another.

Finally, federalizing health care for the aged should result in greater public accountability; in a more efficient program (audit over-kills and inspection over-kills would be eliminated); in greater quality in care and services; and, hence, greater security for America's aged.

Recommendation.—Section 1908(b) should be amended to provide that Boards of Examiners for the Licensing of Nursing Home Administrators should be precluded from having among their members a majority of members who have a direct or indirect financial interest in nursing homes or a majority composed of a combination of members who are employees of nursing homes with members who have a direct or indirect financial interest in nursing homes.

Comment.—The purpose of Section 1902(a)(29) is to raise the quality of care in nursing homes by raising the quality of nursing home administration and the

purpose of Section 1908(b) is to provide for a Board that is representative of the professions and institutions concerned with care of the chronically ill and infirm aged patients—and, in doing so, Section 1908(b) properly recognized the inter-disciplinary character of long-term care of the aged. The realization of the purposes of these sections is threatened if not nullified by Boards which are dominated by those who have a financial interest in the facilities whose administrators are licensed by the Board.

MEDICARE

Recommendation.—An increase in benefits by adding a long-term care benefit for those 80 years or older. Such a benefit is not to be limited by calendar days or kinds of covered care and services. In the form of institutional benefits, it would only require a physical or mental condition such that it could not be cared-for other than in an institution. In the form of non-institutional benefits, it would require only a physical or mental condition requiring such care and services.

Comment.—This would be a tremendous step forward in securing old age by means of an insurance program. The age group 80 years and older is selected because such a group is easily definable and predictable from an actuarial frame of reference. Further, almost all who have survived to 80 years and beyond are in need of some form of long-term care for some abiding infirmity or illness. For the foreseeable future, this is a fact of life. It is also a fact of life that those who have survived this long are in their poorest financial condition and thus least able than at any other time in their lives to purchase care and services.

Recommendation.—Combine Parts A and B.

Comment.—The record is replete with reasons for this improvement. The cost of such an improvement could be alleviated by a reduction in the number of covered hospital days. However, such a cut should not be less than thirty (30) days.

Recommendation.—Replace the present "insurance" definition of a spell of illness with an "illness" definition of a spell of illness. A new spell of illness should be generated by any of the following: a new development in the present illness; a reoccurrence of an old illness; or the onset of a new illness.

Comment.—The generation of a spell of illness should not be contingent upon an individual's ability to survive a certain number of consecutive days without need for institutional care or services nor should it be contingent upon his place of abode which is frequently attendant upon his financial resources.

Recommendation.—The present requirement of at least three days hospitalization in order to be eligible for other than hospital benefits should be eliminated.

Comment.—The existence of this requirement has contributed to over-utilization of the costly hospital setting in order to secure other Medicare benefits, thus contributing unnecessarily to the cost of the program.

The individual recipient should be able to be admitted directly to a participating institution other than a hospital upon certification by the attending physician that the recipient requires this care and does not require prior hospitalization because such hospitalization is not necessary, but the need for care other than hospital care does indeed exist. This should also apply to the need for home-health benefits.

Recommendation.—An additional institutional benefit should be provided under Medicare, namely, an Intermediate-Care benefit. This benefit should be similar to the extended-care benefit.

Comment.—The rationale for such a benefit is that an individual can reach a phase during a covered illness wherein he would not require skilled nursing care but would require institutional care and services greater than room and board but less than skilled nursing care. In the form of a post-hospital benefit, the intermediate-care benefit like the extended-care benefit would be required to be related to the condition for which the recipient was hospitalized.

Recommendation.—Authority should be granted to the Secretary to determine norms for care regimens, length of stay required by diagnosis, and area-wide cost factors. Payment would be guaranteed whenever such norms were not exceeded. However, whenever such norms were exceeded, payment for the excess would be denied unless the facility or its utilization review committee or the attending physician, as the circumstances would dictate, could justify the excess.

Comment.—The record is replete with substantiating arguments for this change and its feasibility. See comment under companion recommendation for Medicaid on page four.

Recommendation.—There should be a guaranteed minimum number of covered days of post-hospital benefits upon proper transfer from a hospital to another participating institution or to home-health care. The guaranteed covered period should be only for so long as is necessary for the receiving agency's utilization review committee to make a determination of the need for covered care and service.

Comment.—The present system of retroactive denial is unjust to both the patient and to the receiving agency. Both of these are penalized for the actions of those who proceed them in the continuum of care thus provided, namely, the transferring hospital and the attending physician. The assumption by the receiving agency that the patient would not be thus transferred unless he required covered care and service by the receiving agency is a proper one and should be honored. Neither the patient nor the receiving agency is in a position to assume otherwise. Hence a denial of benefits retroactive to the first day of care and service in or by the receiving agency is an unwarranted injustice not only to the receiving agency but to the patient who now becomes liable for the cost of the care and services thus denied as benefits.

Recommendation.—Amend the Medicare Act to provide that an allowance of a reasonable return on land, plant and equipment employed in the provision of patient care is allowable as an element of the reasonable cost of covered services furnished to beneficiaries by all providers of service, both non-proprietary providers, that is, those providers that are organized on a not-for-profit basis, as well as proprietary providers, that is, those providers that are organized and operated with the expectation of earning profit for the owners. Presently, proprietary providers are permitted a return on equity capital but not-for-profit providers are denied such a return.

Comment.—Presently, Medicare allows a return on equity capital to for-profit providers of service but denies a similar return to not-for-profit providers. In the Medicare Principles of Reimbursement for Provider Costs, this difference in treatment between for-profit and not-for-profit providers is explained as follows: "Proprietary providers generally do not receive public contributions and assistance of Federal and other governmental programs such as Hill-Burton in financing capital expenditures. Proprietary institutions historically have financed capital expenditures through funds invested by owners in the expectation of earning a return. A return in investment, therefore, is needed to avoid withdrawal of capital and to attract additional capital needed for expansion . . ." (the balance of the statement goes on to explain how the computation is to be made).

The argument here is that of the promoter-entrepreneur relationship wherein the Medicare program is cast in the role of promoter seeking entrepreneur to choose investment in the activity of providing services to Medicare beneficiaries rather than investment in some other activity; and in the manner of classic economics in order to succeed in thus attracting entrepreneurs, the program must allow a return on equity capital. Fair enough and clear. However, why it is thought that there does not exist a similar need on the part of the program to attract not-for-profit investment is neither clear nor fair.

There exists an analogy between the "philanthropic capital" furnished by not-for-profit facilities and the "proprietary capital" invested in for-profit facilities. These two differ from each other only in the way in which the return that would be earned by each is utilized. In the case of for-profit capital, the return is used for personal gain. In the case of not-for-profit capital, the return is not, nor can it be, used for personal gain, rather it is employed for philanthropic ends, namely, either to maintain the present activity or to expand it or to do the same to some other philanthropic activity, or to initiate a new philanthropic actvity. Hence, the Medicare program is now paying a return to those who use such gain for the good of their private person and denies a similar return to those who would use such gain for the good of the public.

The rationale for the return on equity capital in the case of for-profit providers is that of encouraging the investment of such capital in the field of providing extended-care and that of discouraging the withdrawal of such capital. We submit the same rationale exists for a return on philanthropic capital invested in not-for-profit facilities for a specific eleemosynary activity. Like any entrepreneur, the eleemosynary organization has a choice from among a host of eleemosynary activities to which it could apply, that is, invest, its resources (for example, a church could choose to invest its not-for-profit capital in educational activities or youth activities or day-care centers or care for the mentally ill or in a host

of other similar activities rather than extended-care for the aged). Hence, the Medicare program, as a promoter of investment, stands in relation to the not-for-profit entrepreneur in the same way it stands relative to the for-profit entrepreneur, that is, the Medicare program has need to attract not-for-profit capital into the activity of providing services to Medicare beneficiaries, rather than to have such not-for-profit capital invested in some other worthy eleemosynary activity.

It is evident that the inclusion of a return on equity capital in the case of for-profit facilities has succeeded in encouraging the investment of capital in such facilities: wtness, the phenomenon of the so-called "chain operators." The proliferation of for-profit institutions has not been paralleled by a similar increase in non-profit facilities. On the contrary, there is evidence that the number of non-profit voluntary homes has been diminished or frozen into place. No small factor in this is the lack of capital funds.

Charitable contributions have decreased. Less than one percent of Hill-Burton Funds have gone to not-for-profit ECFs and when Hill-Burton Funds have gone to ECFs, more often than not, such funds have gone to hospital-based ECFs. Housing Act monies (202 and 236) are not applicable to ECFs. Small Business Administration loans are available only to for-profit nursing homes. In fact, for all practical purposes, the only government program available to not-for-profit ECFs for capital purposes is that of FHA insured mortgages. This program, of course, is also available to for-profit ECFs and involves the private money market. Thus, there is little in the way of government funds for the not-for-profit ECF for capital purposes. Hence, not-for-profit long-term care facilities for the aged have had to go to the private money market for capital funds. Thus, again, there is need for equal treatment in Medicare reimbursement as between for-profit and not-for-profit providers of service.

Finally, there exists the very real possibility that if an increment similar to the return on equity capital enjoyed by for-profit ECFs is not soon made available to non-profit ECFs, we may likely witness the occurrence of a social phenomenon, with vast implications, wherein necessary extended-care services to the aging in America will be wholly or almost wholly a for-profit venture. Thus, the critical social importance of the far-reaching recommendation for change in the Medicare Reimbursement policy.

IN GENERAL

Recommendation.—Access by the Government to the financial records of a facility providing health-care to the aged for purposes of determining the true costs of the actual care and services provided by the facility should be made a condition of participation in health-care programs funded by the Government.

Comment.—The nursing home industry is characterized by its inordinate dependency upon Government sources for its income: $2 out of every $3 of income is derived from Government sources. Hence, the Government ought not to be forced to guesstimate when determining the cost of the care and services it purchases from this industry.

A recent survey by AAHA of the non-profit sector of providers of institutional long-term care for the aged indicated overwhelming support for this recommendation.

ITEM 4. LETTER FROM RICHARD J. KRAEMER, M.D., VICE-PRESIDENT, RHODE ISLAND MEDICAL SOCIETY, IN RESPONSE TO SPECIFIC QUESTIONS RAISED BY SENATOR PELL

NOVEMBER 19, 1971.

DEAR SENATOR PELL: Thank you for your letter expressing your appreciation for my participation in your hearing in Providence on September 20, 1971.

You have submitted five questions which you have asked me to answer, and replies are cited below. Rather than reflect only my personal views I preferred to poll our state-wide committee on Aging, and the replies are a composite of the opinions of the committee.

Question 1. Under Part B of Medicare doctors have the option of being paid directly by the Social Security Administration or having the Social Security Payment made directly to the patient and then receiving the payment directly from the patient. Since the SSA will only pay doctors' fees at the level of 80 percent of the prevailing rate, I understand that many doctors in Rhode Island do

not accept direct Medicare payments because they can get more money by charging the Medicare patients directly. IS THIS TRUE?

Comment: The record in Rhode Island clearly indicates that this situation is not true.

The rate of assignment of Medicare claims nationwide has been reported as averaging 61%. In Rhode Island the rate has averaged 80%, and we have been typically among the top three states in the country relative to assignment rates.

Question 2. Some witnesses have suggested that doctors are reluctant to accept Medicare and Medicaid patients because of the paper work involved in filing claims. IS THIS TRUE? Do you have any suggestions for improving the payment of fees?

Comment: Patients are not asked what type of coverage they have when making appointments, and therefore this precludes any discrimination of Medicare or Medicaid patients. It is only after seeing the doctor that the question of third party payment is apt to arise.

Physicians do find the paper work for state and governmental health programs a great problem. Many physicians do not have an office staff to cope with the increasing volume of such work, and there is a continual request from doctors for more simplified report forms.

There are many problems related to Medicaid patients that do not exist with Medicare recipients. Many physicians have been disturbed by the failure of Medicaid patients to keep office appointments, to return for follow-up examinations, and for failure to follow the advice given. As a result some physicians undoubtedly are reluctant to continue to accept such patients after such experiences.

However, through the State Medical Society's Committee on Social Welfare, we are continually working with the State Welfare Department to improve the methods to bring welfare beneficiaries into the "mainstream" of health care. Recently a program was developed with the Rhode Island Hospital accident room staff whereby children would be referred to pediatricians for continuing care, and such developments as this will do much to improve the situation.

Question 3. H.R. 1 allows the SSA to put limits on the prevailing rates which will be paid physicians, such as an increase in physician rates will only be allowed to the extent that an increase in physician payments reflects real increasing costs of physician care. Do you support this provision?

Comment: Inflation and the changing economy have affected every business and profession. If the same restriction that H.R. 1 would make of physicians were applicable to all other professions and businesses then we would certainly find the principle satisfactory.

Certainly every physician should not be required to undergo a cost accounting of his individual practice to justify a rate increase when the entire cost of living area is experiencing a rising cost. If the physician's rate was calculated on the basis of fluctuation in the cost of living index to reflect his increased overhead expenses of office, etc., in line with the rest of the population, then this restriction would be acceptable.

For years the Rhode Island Medical Society has supported the principle of price adjustments on the basis of the cost of living index. Interestingly, when the Rhode Island Blue Shield asked for rate increases based on the rise in cost of living rises as publicized by nationally approved indices, the proposal was turned down.

Question 4. H.R. 1 encourages Medicare and Medicaid patients to use health maintenance organizations in which physicians are reimbursed on a prepaid contract basis rather than a fee-for-service basis. Do you support this provision?

Comment: Health maintenance organizations are not new in America. For decades we have had group health associations in various parts of the country, cooperatives, etc., but in spite of their claims of offering a better system of delivery of health care, the public generally has not found such to be the case.

We have supported the pluralistic approach, as you know, in Rhode Island. You are familiar, we are sure, with the labor group plan, the Neighborhood Centers, and the proposed Bristol Medical Associates plan. We believe all should demonstrate their ability to provide a better program of quality care, at lower cost than any other method, and with the individual allowed free choice to accept the prepaid or the fee-for-service method.

There is not clear evidence that group plan with salaried employees has or will render a better system. Therefore, it is presumptuous for the Federal govern-

ment to specify to its beneficiaries that they should have only such a choice of organization to which they may turn for their health care. Rather, the Medicare and Medicaid beneficiaries should be given freedom to choose the best plan for their needs, and most importantly, the right not only to select the physician by whom they wish to be treated, but also to be free to change physicians in the interest of their personal care.

You are aware, we are sure, of the work being undertaken by SEARCH in Rhode Island to develop reliable statistical data that will help to evaluate some of the new systems proposed for the delivery of health care. Since the concept of the HMO as now being envisioned by some planners has not yet been tested for patient acceptance, quality, accessibility and economy, we are hopeful that a close study of the programs in Rhode Island in the coming years will provide answers.

Question 5. Recently, there was a publication in Rhode Island which says that 18 senior citizens died of malnutrition in the recent period of 12 months. This publication also indicated that there may be 33,000 senior citizens suffering from malnutrition. Have the doctors of Rhode Island found much evidence of malnutrition among the elderly? What do you think are the causes of this malnutrition?

Comment: We find the publication to which you refer is FOCUS, issued by the Rhode Island State Office of Economic Opportunity. An interview of 10,631 individuals in Massachusetts over a two year period reportedly showed that as a general rule at least 5% of those examined suffered from *some* nutritional deficiency.

Applying this figure to Rhode Island a conclusion was drawn that "50,000 to 100,000 Estimated To Suffer from Malnutrition".

This is a generalization freely asserted, and equally freely denied. The Massachusetts report spoke of some nutritional deficiency, not extreme malnutrition endangering life. In the report the question is even asked "How could an 85 year old woman die of malnutrition, even if she did not feel like eating?" Does this imply that an aged person, ill and with little or no desire to continue life, should be forced, even with intravenous feeding, to maintain life?

A poll of the Society's Committee on Aging brought replies that seldom is malnutrition in evidence unless due to disease or personal idosyncracy. One physician reported that obesity and overnutrition is a problem for 30% of his elderly patients. One member with a large geriatric practice reports he has never seen a case of malnutrition that was not due to some organic disease. and that among the elderly, physical, emotional (psychological) and social aspects of aging play an important role in eating habits.

Deaths from malnutrition would need to be carefully documented to rule out any underlying cause, such as cancer, alcoholism, etc.

The establishment this year of a nutritional center in Providence, funded under the Regional Medical Program, and staffed by the State Nutrition Council, to which anyone may turn for counsel, and the announcement within the past week that the State Department of Community Affairs has received $11,721 from the Federal Department of Health, Education and Welfare to plan a half-million dollar nutritional program for the elderly in Rhode Island, should give our citizens access to good advice in nutritional matters.

ITEM 5. LETTER FROM GUSTIN BUONAIUTO, PRESIDENT, RHODE ISLAND NURSING HOME ASSOCIATION, INC., IN RESPONSE TO SPECIFIC QUESTIONS RAISED BY SENATOR PELL

November 29, 1971.

DEAR SENATOR PELL: Regarding your letter of October 15, 1971, I am happy to furnish you with the following information. I apologize for the delay; however, compiling the necessary documentation required contacting a number of people not readily available.

Question 1. Can you give some examples of the problem of retroactive denials under Medicare and the hardship this causes patients and nursing home operators?

Answer: Documentation attached.

Question 2. Would the total elimination of the fiscal intermediary result in a more efficient and economical health care program for senior citizens as far as nursing homes are concerned?

Answer: I feel that if the fiscal intermediary were properly used as a liaison between the provider and the Federal agencies on a consulting as well as administrative basis, it would be meaningful and helpful to the program. However, currently the fiscal intermediary who, I am sure, has many knowledgeable people, has been used only as a tool to carry out the mandates of the Social Security Administration, has no authority, and is not being utilized as a non-partisan representative of both the Federal Government or the provider. If the fiscal intermediary is compelled to function in this manner, I feel that his elimination is warranted and that a substantial savings could be realized by the Federal Government.

Question 3. Are substantial numbers of patients covered by Medicaid now rejected for admission to nursing homes, and if so, why?

Answer: I believe that many patients covered by State Medicaid are being rejected for admission into nursing homes (at least here in Rhode Island) because of the below-cost reimbursement the State provides. Many newer and more modern facilities have been built over the past few years to meet Federal and State requirements. Yet the same people in our State who set these requirements have another standard of reimbursement which, in many cases, is far below the facility's cost of operation. The nursing home provider who is considering the admission of a patient who may not qualify for Federal Medicare benefits but will definitely be eligible for State Medicaid benefits, may be forced to reject admission for fear that the liability of that patient will be his at a financial loss for a long period of time. As you know, the State ceiling in Rhode Island for skilled nursing care coverage is $15.00 per day. This can only mean that the newer and larger facilities may be compelled to deny admission to many patients who are on the State Medicaid program.

I hope this information will be of some help to you. If I can be of any further assistance, please do not hesitate to contact me.

GRANDVIEW NURSING HOME, INC.,
Cumberland, R.I.

DECLINATIONS

1. Robideux, Remeo. HIC No. 037-12-2934 A. Admitted 8/30/71 to 9/22/71. After 13 day Hospital stay. Letter of declination, retroactive until day of admission.

This patient was reviewed by URC, 14 days after admission and approved for medicare for 19 days, total stay in ECF. Decision was overruled by medicare and coverage denied completely.

2. Ducharme, Elizabeth. HIC No. 038-20-9356 A. Admitted 8/13/71 to 9/22/71. Letter of Declination to 8/31/71.

Reviewed by URC, 32 days after admission, approved for 30 days more.

Intermediary requested discharge summary on 3 occasions without approval or declination. Discharge Summary not available for Nursing Home to send.

On 9/22/71, after 41 days ECF stay, approval granted thru 8/31/71 but retroactive denial of 22 days.

3. Robichaud, Rose, HIC No. 028-26-1619 A. Admitted 7/23/71 to 9/21/71. Letter of Declination to 9/3/71.

Reviewed 18 days after Admission by URC. Approved until next meeting. Second URC review after 51 days in ECF, approved for 2 weeks more. Declined after 43 days by Medicare with retroactive denial of 18 days.

4. Kennedy, Margaret. HIC No. 038-22-3605 A. Admitted 9/8/71 to 9/17/71. Letter of Declination.

Reviewed by URC after 6 days in ECF, approved to total nine. Retroactive denial by intermediary to day of admission, or 9 days.

5. McDermott, Edith. HIC No. 578-01-6003 A. Admitted 9/16/71 to 9/22/71. Letter of declination to day of admission. Question of Presumption of payment.

Had *verbal* approval for at least two week coverage before patient admitted. Reviewer, who had given approval, no longer employed, coverage denied by her replacement.

6. Sabourin, Lionel. HIC No. 038-18-5973 A. Admitted 9/17/71 to 9/22/71. Letter of declination. Non-Covered from day of admission.

Required IPPB Treatment, occasional suction, narcotic for pain and antibiotic, oxygen therapy. After admitted, elevated temperature, required same treatment on admission. Still terminated.

7. Sweeney, Anna. HIC No. 038–18–4789 T. Admitted 8/13/71 to 9/20/71. Letter of declination retroactive to 9/13/71.

8. Coulombe, Exerine. HIC No. 036–05–0910 A. Admitted 9/3/71 to 9/22/71. Letter of declination day of admission. Question of Presumption of payment.

On 9/9/71, hospital discharge summary requested with no approval, No Declination. Discharge Summary not available to Nursing Home from Hospital. On 9/22/71, letter of declination received, Retroactive to day of admission.

THE TRAVELERS,

Lowell, Mass., August 10, 1970.

Attention: Mrs. Frances McDermott, Administrator

GRANDVIEW NURSING HOME,
Cumberland, R.I.

DEAR MRS. MCDERMOTT: Your performance in following the level of care procedures that have been outlined in various Travelers publications has been observed closely. It has been determined that you appear to be attempting to conscientiously follow the program. Therefore, your E.C.F. is granted "Presumption of Coverage."

The effect of this is as follows: When you submit an admission form with a Skilled Care Determination Form noted "Questionable," payment will be made until the date that we either make a decision or we ask for additional information (either oral or written), whichever is earlier; subject to the following:

1. The matter is truly a questionable one and not one which should have been apparently non-covered to the E.C.F.
2. You submit the admission notice with the Skilled Care Determination Form (or acceptable equivalent) within forty-eight hours.

The benefit to you will be that you need not fear retroactive denials in most questionable cases that are submitted in the manner prescribed. The exception is when additional information is solicited and a denial subsequently made. Payment would not be made beyond the date the additional information was solicited.

Please remember that "Presumption of Coverage" is subject to withdrawal if it is found that a facility ceases to conscientiously follow the program.

Very truly yours,

THOMAS K. KELLY,
Medicare Administrator.

GRANDVIEW NURSING HOME, INC.,
Cumberland, R.I., October 5, 1971.

SOCIAL SECURITY ADMINISTRATION,
Woonsocket, R.I.

DEAR MR. FENTON: Please find copy of letter regarding Presumption of Coverage.

Your inquiry regarding Exerina Coulombe is an example of this. She was non-covered from day of admission.

As per telephone conversation, I don't recall this presumption actually working.

I try very hard to screen patient before admission. The R.N., Nursing Supervisor, submits a skilled care determination form and checks, (in her opinion) if it is covered or non-covered care.

Additional information may be requested that I cannot supply. For instance, a discharge summary. I cannot send a copy of this until the hospital sends it to me. In many cases this takes months.

What I consider an acceptable equivalent for the Skilled Care Form (Namely the copy of transfer form from the hospital) is not acceptable to Travelers, therefore coverage is denied.

Mrs. Coulombe was admitted after 2:00 P.M. on Friday before Labor Day. An admission notice and copy of transfer form from hospital were forwarded that day. Being a long holiday week-end and non-work days, a skilled care determination form followed on September 7, 1971.

On September 9, 1971, a hospital discharge Summary was requested from Travelers with no approval. I cannot send, what I don't have. The discharge summary was mailed on September 15, 1971. On September 21, 1971, I received a phone call stating Mrs. Coulombe was non-covered from day of admission.

This has happened in numerous cases. I have strongly objected to this, but in each case been overruled because of exceeding the 48 hour period, not checking it as questionable (we do check it in our opinion and it is honest) etc.

My question is, *do* we have assumption of payment or not?

Very truly yours,

FRANCES MCDERMOTT, *Administrator.*

Enclosure.

GRANDVIEW NURSING HOME, INC.,
Cumberland, R.I., October 12, 1971.

ELIZABETH MCGUIGAN,
Assistant District Manager,
Social Security Department,
Pawtucket, R.I.

DEAR MRS. MCGUIGAN: This will confirm our telephone conversation on September 5, 1971, regarding problems that I am having with the Medicare program.

To Enumerate:

1. *Presumption of coverage:* It is my understanding that this is granted when a home conscientiously attempts to follow the program, that is outlined by the intermediary. Grandview has had presumption of coverage since August 1970.

A misconception exists here that I find intolerable. Patients are admitted to me believing that they have coverage until told they do not. This really has not been the case. As Administrator, one of my duties is screening of the patients before admission. I am also a Registered Nurse. I admit patients who (in my opinion) are in need of skilled care. When patient is admitted, an R.N. Supervisor submits a skilled care determination form and checks (in her opinion) if care is covered or not. Travelers then reviews this information and approves or declines coverage. If (in our opinion) this is covered care, I feel it is unjust for coverage to be denied. On September 22, 1971, I had eight declinations. Some were from day of admission, some partial, retro-active denials. In my opinion, these patients should be covered until I was told they were not. I question, the actual need of a review being made at this time, but am baffled by a declination from day of admission. This is unjust to both the patient and nursing home. Is there such a thing as "Presumption of Coverage?" If so, why these eight Denials.

2. *Utilization Review Committee Decisions:* Bearing in mind the aforementioned: Each Medicare patient is reviewed by a committee of at least three physicians at least every thirty days, and more often in questionable cases. On many occasions, patients are reviewed by URC just days after admission to ECF. This may be considered covered care in the opinion of:

1. administrator admitting patient
2. R.N. submitting skilled care for
3. Attending physician and three URC members, who are qualified physicians.

This decision can and is being over-ruled by a reviewer from intermediary.

I spend a considerable amount of money for each committee meeting. It takes days of preparing forms for the meeting, (done by R.N.'s). I must have at least three physicians that are paid for this meeting. I spend hours, after the meeting notifying families of the URC decisions. By law, the URC has to give the family a three day notice before declining coverage. Great weight has to be given the opinion of the attending physician. If a patient is terminated by URC, I send letters with actual date of termination.

A review by Travelers can terminate a patient retroactively or without notice, over-ruling any decision of the URC. Travelers also sends out letters. The dates are usually different thus creating a conflict. Family knows that Medicare has terminated, but it takes much of my time to clarify when.

It would seem fair to me to require a review, but by *either* the URC or Travelers. Duplication is costly and (in my opinion) needless.

3. *Rectro-active Denials*:

In many instances where partial coverage has been allowed, then coverage denied, families will appeal the decision. Many times before placement of patient can be arranged, a sizable bill accumulates, that is difficult to collect. Family is billed each month. Then after months, from the appeal, we may get a declination from the day of admission. Payments that have been made by Medicare is simply withheld from the nursing home's next billing.

We then, must try to collect from family, not only from amount that accumulated after declination, till time of placement, but also what they and we thought was settled and paid for, most of by Medicare. These accounts are impossible to collect. Patients has deceased and estates settled or they just are not financially able to settle these accounts. The families, in most cases, do not really understand what has happened nor why. They have been told by me on admission, that we will know in a week or two if Medicare will cover or not. Then told that medicare is covering. Then months later find that this decision has been reversed and they are totally responsible. They do not blame Medicare. They are sure the operators of the Homes are at fault for allowing this to happen. This is very damaging to the reputation of the Home, in addition to the financial loss the Home must take.

Again, (in my opinion) this seems a great injustice to the patients, and the Nursing Home. I feel that is unfair for these decisions to be made after admission to ECF. I think the patients and the Homes should have *assurance of payment before admission.* It seems so unbalanced, to me—we must decide if it is covered care or not, but our decision really doesn't count. (Right or wrong, we lose)—we must have a URC, whose decision doesn't count—after payment has been allowed, it is withheld, with no recourse for the Home.

In a government as good as ours there, there must be some method for prior approvals, (before admission to ECF) where decisions can be made that will stick. It seems wrong for this burden to be completely carried by the home.

Very truly yours,

FRANCES MCDERMOTT, *R.N., Administrator.*

THE TRAVELERS,
Lowell, Mass., *July 31, 1970.*

GRANDVIEW NURSING HOME,
Cumberland, R.I.

DEAR SIR: The information submitted on the above captioned beneficiary has been reviewed.

☐ The information received identifies a medical need and sufficient covered services for approval of ECF coverage. (See NOTE below.)

☐ ECF coverage approved. If you anticipate that the confinement will extend beyond 8/15/70, please send additional documentation prior to this date to substantiate the need for continued covered care, including comments by a URC physician. (See NOTE below.)

NOTE.—This medical evaluation is subject to SSA determination of Benefit Eligibility shown on the BLUE copy of the SSA 1453 completed by our office. A CHANGE IN THE LEVEL OF CARE which might raise a question as to covered care requires the prompt submission of a Skilled Care Form or other appropriate documentation.

☐ Confirming our telephone notification of _____, the information received (see below) is insufficient to substantiate a covered level of care. This determination is subject to reevaluation upon receipt of additional information.

Our determination was based on a review of the information indicated below:

☐ Admission notice
☐ **Skilled care form**
☐ Physician's orders
☐ **Nurse's notes**
☐ UR, Physician-consultant comments
☐ **Hospital discharge summary**
☐ Laboratory record
☐ **Medication record**
☐ **Other:**

☐ Please submit the information indicated below:

☐ Skilled care determination form
☐ **Physician's orders**
☐ Physician's progress notes
☐ **Physiotherapy records**
☐ Nurse's notes
☐ **UR, physician-consultant comments**
☐ Hospital discharge summary
☐ **Laboratory record**
☐ Medication record
☐ **Complete attached form**
☐ Other:

Respectfully,

MRS. EILEEN TOBIN, R.N.,
Medicare Claim Department.

THE TRAVELERS,
Lowell, Mass., August 24, 1970.

GRANDVIEW NURSING HOME,
Cumberland, R.I.

DEAR SIR: The information submitted on the above captioned beneficiary has been reviewed.

☐ The information received identifies a medical need and sufficient covered services for approval of ECF coverage. (See NOTE Below.)

☐ ECF coverage approved. If you anticipate that the confinement will extend beyond _____, please send additional documentation prior to this date to substantiate the need for continued covered care, including comments by a URC physician. (See NOTE Below.)

NOTE: This medical evaluation is subject to SSA determination of Benefit Eligibility shown on the BLUE copy of the SSA 1453 completed by our office. A CHANGE IN THE LEVEL OF CARE which might raise a question as to covered care requires the prompt submission of a Skilled Care Form or other appropriate documentation.

☐ Confirming our telephone notification of _____, the information received (see below) is insufficient to substantiate a covered level of care. This determination is subject to reevaluation upon receipt of additional information.

Our determination was based on a review of the information indicated below:

☐ Admission notice
☐ Skilled care form
☐ Physician's orders
☐ Nurse's notes
☐ UR, Physician-consultant comments
☐ Hospital discharge summary
☐ Laboratory record
☐ Medication record
☐ Other:

☐ Please submit the information indicated below:

☐ Skilled care determination form
☐ Physician's orders
☐ Physician's progress notes
☐ Physiotherapy records
☐ Nurse's notes
☐ UR, Physician-consultant comments
☐ Hospital discharge summary
☐ Laboratory record
☐ Medication record
☐ Complete attached form
☐ Other:

Respectfully,

HECTOR R. ARBOUR,
Medicare Claim Department.

THE TRAVELERS,
Lowell, Mass., September 10, 1970.

RE: Medicare—Part A–ECF, Mrs. Katherine Knowles, 036–01–2301–B

MR. JOSEPH KNOWLES,
Pawtucket, R.I.

DEAR MR. KNOWLES: Following receipt of a telephone call from Mr. McVicker of our Providence Office relative to the decision made on your wife's claim for Extended Care Facility Benefits beyond August 15, 1970, medical records were obtained from the Grandview Nursing Home.

It was the determination of our Medical Staff upon review of this information, that the level of care required by Mrs. Knowles subsequent to August 15, 1970 did not constitute covered care. Therefore, payment cannot be made under the Medical Insurance Program for services rendered after that date.

Sincerely,

HECTOR R. ARBOUR,
Medicare Representative.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL SECURITY ADMINISTRATION,
September 10, 1970.

MRS. KATHERINE KNOWLES,
Grandview Nursing Home,
Pawtucket, R.I.

This refers to the claim for Hospital Insurance benefits submitted on your behalf for services you received from: Grandview Nursing Home; admission date 07–17–70.

We are unable to make payment on this claim for the reason shown below.

We regret to inform you that the kind of care required by you subsequent to August 15, 1970 does not constitute Extended Care Service and is non-covered care. Therefore, the Medicare Hospital Insurance Program cannot pay for this care.

If you believe that this determination is not correct, you may request that your case be re-examined. If you want this reconsideration, you must request it not later than 6 months from the date of this notice. You may make any such request through your local social security district office. If you go in person, please take this notice with you.

THE TRAVELERS,
MEDICARE DIVISION,
Lowell, Mass., April 23, 1971.

Re: Mrs. Katherine Knowles, 036-01-2301-B.

MRS. FRANCES MCDERMOTT,
Administrator, Grandview Nursing Home,
Cumberland, R.I.

DEAR MRS. MCDERMOTT: Please find enclosed a copy of the reconsideration determination for the captioned beneficiary.

As indicated in this notification our decision of making payment for the services rendered by the Grandview Nursing Home from July 17, 1970 through August 15, 1970 has been reversed and the claim has been denied totally.

We therefore, must adjust the billings submitted by Grandview and reimbursed by Medicare. The total amount of payment to be recouped is $673.00. This adjustment will be made on the next billing submitted for payment.

You may of course, look to the beneficiary for payment of the services as they do not constitute covered care under the Medicare Program.

If you have any questions, please advise.

Sincerely,

JOHN P. ANTON,
Medicare Representative.

KATHERINE KNOWLES—CLAIM NO. 036-01-2301B

EXTENDED CARE BENEFITS

Mrs. Katherine Knowles was admitted to the Grandview Nursing Home on July 17, 1970, directly following a 7-day stay at Pawtucket Memorial Hospital. Her admitting diagnosis were fractured right shoulder and congestive heart failure.

The hospital insurance program allowed benefit payment from the date of admission through August 15, 1970. Payment was denied from August 16, 1970, through August 24, 1970, on the basis that she was not receiving covered extended care.

On January 25, 1971, Mrs. Knowles, requested the decision to terminate benefits after August 15, 1970, be reconsidered. She stated that she received the same treatment and physical therapy during her entire extended care stay. Therefore, the entire stay should be covered.

Section 1814(a)(2)(C) of the Social Security Act requires that in the case of post-hospital extended care services, such services are required to be given on an inpatient basis because the individual needs skilled nursing care on a continuing basis.

Section 1862(a)(9) of the Social Security Act provides that no payment may be made for any expenses incurred for items or services where such expenses are for general supportive or custodial care.

The Health Insurance Act does not permit Federal interference with the practice of medicine or the administration of medical facilities. In keeping with this provision the program does not determine when a person should be admitted to or discharged from a hospital or extended care facility. However, it is the responsibility of the program to examine the services needed and rendered to determine whether such services are of a level for which payment may be made.

A review of Mrs. Knowles' medical records shows that from the date of her admission to the extended care facility the care she required and received was primarily general supportive or custodial care. She received doriden 0.5 grams at bedtime for sleep, darvon 65 mgm. every four hours as required for pain,

peri-colase at night as required for bowel management, and thorazine for anxiety and tension. Mrs. Knowles was to receive active physical therapy to the right shoulder daily for 3 weeks and then 3 times weekly. She was to receive circumduction exercises to improve motion and active assistance to improve abduction. Her collar and cuffs were to be removed for one hour 3 times daily to improve active elbow motion. She needed assistance moving from the bed to the chair and received a regular diet.

The health insurance program prohibits payment for services which, though given in an extended care facility, could be performed satisfactorily in another type of environment. Such "noncovered" services are assistance with bathing, dressing, walking, administration of oral medications, local applications or minor treatments as ordered by the physician, routine catheter and skin care, the performance of functional maintenance exercise routines and protective observation to prevent injury. None of these measures require the presence of a skilled nurse on a 24-hour basis, and then could be furnished in a setting other than an extended care facility.

Physical therapy is a skilled service. However, since the statute defines extended care as skilled nursing care on a continuing basis, the need for this single skill would not justify a finding that she required skilled care. There were no modalities of physical therapy given to her which could not have been administered at home by a visiting therapist under another hospital insurance plan.

On the basis of the evidence in the medical record compared with the standards established in the Medicare law, it is determined that the services provided to Mrs. Knowles for the period July 17, 1970, through August 15, 1970, was noncovered custodial care, and incorrectly allowed to be paid. The period in question (August 16, 1970, through August 24, 1970) was also considered custodial care. Therefore, the cost of the services provided to Mrs. Knowles by the Grandview Nursing Home for the period July 17, 1970, through August 24, 1970, is not payable under the hospital insurance program.

ITEM 6. REPLY FROM ARTHUR F. HANLEY, CHIEF EXECUTIVE OFFICER, RHODE ISLAND BLUE CROSS AND BLUE SHIELD, IN RESPONSE TO SPECIFIC QUESTIONS RAISED BY SENATOR PELL

Question No. 1. A HEW study which I had required in an amendment last year has predicted that health care costs will rise by 50 percent between 1972 and 1974. Do you expect a 50 percent increase in cost of premiums for plan 65 in the next 2 years? If so what steps can be taken to reduce the impact on senior citizens of this expected increase?

Response. Assuming the HEW study prediction of a 50% increase in health care costs between 1972 and 1974, it would *not* be expected that the impact on Plan 65 would be as high as 50%.

While a nearly direct effect might be felt in complementing Part A (because of the SSA Part A deductible and co-pay formula), Plan 65 would not feel a *full* impact in its coverage of the Part B deductible—unless such deductible were increased. A full impact would be expected in coverage of Part B's 20% co-pay.

To the extent that the 50% health care cost increase includes a forecast of greater volume of services, an impact would be expected in Plan 65.

Perhaps the answer to your query as to "what steps can be taken to reduce the impact" is contained in our testimony of September 20th, a copy of which is attached—we refer you to page 8, items No. 4 and 5.

Question No. 2. Some people have suggested that the fiscal intermediary is an unneeded middle man whose existence only adds to the cost and confusion of health care programs for the elderly. How would you respond to this comment?

Response. Blue Cross-Blue Shield touches the lives of nearly 100 million people—a system of that magnitude must possess a significant amount of accumulated skill, material and resources that are responsive to changing needs and demands in the administration of a Health Program.

The record shows that Blue Cross-Blue Shield can operate in a variety of circumstances as is demonstrated in the private market, in Medicare, the Federal Employee Program, and CHAMPUS. Medicare is a program that has shown

many of our strengths—ours was a significant role in the starting and maintaining of the administrative success of Medicare.

If Congress had failed to exploit the assets of Blue Cross and Blue Shield, it would have meant a needless duplication of investment and skill. In addition, it would have seriously undervalued the worth of a blending of public and private capabilities in getting things done.

By relying on the federal sector, we would be establishing a monolithic bureaucratic hierarchy too rigid to be innovative or responsive to changing health care needs.

This is not to say that Government should not have a significant role in the management of the system. Government should guide, not direct; motivate, not demand; assist, not provide; and evaluate, not ordain. It should formulate policy, establish objectives, fashion incentives, evaluate results, and always, protect and promote the public interest. Government should accept the challenge of governance which it is designed and equipped to do and not attempt extensive operations which it is less designed and equipped to do.

Government should continue to capitalize on the considerable assets of the private sector through performance contracts based in major part on specifications of desired outcomes rather than specific methods of operations.

Question No. 3. Will an increase in the size of deductibles & the cost of coinsurance in the Medicare program result in an increase in premium in plan 65 and if so how much of an increase will it be?

Response. The question posed does not specify the size of the deductible and coinsurance increase, nor does it indicate whether such increase relates to Part A, Part B or both. It is not possible, therefore, to quantify an impact on Plan 65.

To provide a generalized reply to the question, it is reasonable to expect that any Medicare deductible or co-pay increase assumed by Plan 65 would call for raising rates—subject to the following considerations:

1. Program reserve level.
2. Present rate adequacy.

Assuming considerations (1) and (2) do not preclude the need for an increase in rate, the amount of increase would be dependent upon the weighted effect of the deductible and co-pay increase on the total program. As an illustration, the 13.33% Part A deductible and co-pay increase effective January 1, 1971 will increase Plan 65 premium income requirements by approximately 3% and was considered in the 1971 Plan 65 rate filing.

A portion of our testimony submitted to your committee in Providence on September 20th (copy attached), made reference to deductibles and coinsurances. We refer you to page 5, Section III, A.

Question No. 4. What is your opinion of HMOs as a means of delivering better care to senior citizens in the future?

Response. Blue Cross-Blue Shield is in full accord with the need for experimenting with alternatives to existing health care delivery systems. Among them is the principle of Health Maintenance Organizations.

Much is to be said for this particular approach, not as the sole vehicle to provide health care, but as an individually elective alternative. It will not satisfy the needs and desires of all. HEW statistics show that, given a free choice, less than 20 percent of those eligible, join a group practice prepaid plan. Many Americans are well satisfied with their own doctors and prefer to wait for the need for medical attention to arise before worrying about it.

Blue Cross-Blue Shield is actively pursuing the development of a variety of approaches to Health Maintenance Organizations on a National basis. Here in Rhode Island, we are currently participating in four different approaches:

1. With R. I. Group Health Association in an administrative and partial underwriting capacity.
2. With the Bristol County Medical Center on a totally underwritten basis.
3. With the emerging Providence Neighborhood Health Centers Program on an advisory basis, with a commitment to provide some underwriting and administrative services.
4. With the R. I. Hospital Center for Ambulatory Care in an advisory role.

We believe that the choice of HMO's as an alternative should be made available as an option to the elderly as well as the rest of the population, but not mandated until the concept is fully developed and acceptable to the beneficiaries.

o

We do not believe that there is, as yet, any unanimity in Congress as to the role of HMO's as illustrated by the variances in H.R. 1 (Social Security Amendments of 1971); S. 1182 (Health Maintenance Organization Assistance Act of 1971); S. 1623 (National Health Insurance Partnership Act—Title I, National Health Insurance Standards and Title II, Family Health Insuranace Plan).

ITEM 7. LETTER FROM SHIRLEY A. WHITCOMB, R.N., DIRECTOR CRANSTON DISTRICT NURSING ASSOCIATION, IN RESPONSE TO SPECIFIC QUESTIONS RAISED BY SENATOR PELL*

December 20, 1971.

DEAR SENATOR PELL: In response to your request of October 20, 1971 for more information relative to your hearing on "Problems of Medicare and Medicaid":—

Question 1 with respect to specific changes in Medicare:—I feel my strongest recommendations are included in my testimony.**

Question 2, however, with respect to Medicaid is a sore subject. In Rhode Island, the Medicaid program is administered by the Medical Care Program within the Department of Social Welfare (now the Department of Social and Rehabilitative Services) and is subject to the rules and restrictions of that Department.

After a great deal of thought, it seemed easiest and clearest to demonstrate the difference between what Medicaid pays and our cost by enclosing the actual statements from Dr. Pesare and attaching the Cranston District Nursing Association fee card for that period. In 1970, the Cranston District Nursing Assotion made 1,777 visits under the Medicaid program for a loss of $7,533.50 (difference between what each visit cost and what Medicaid paid, assuming all visits were paid).

The Cranston District Nursing Association's costs vary slightly from other such Agencies in Rhode Island but, in general, represent an average figure.

You will notice that Dr. Pesare's letter of February 18, 1970 (attached), instructs the Agencies not to submit forms for charges beyond the 80 percent Medicare—so this also is a loss.

Another phase of the problem is that Dr. Pesare's office tends to restrict numbers of visits, for example, limiting visits to only fifteen per month no matter what the need. Since the Agency does not refuse service, other visits then are never paid for, thus causing further financial loss.

How do we pay for these unmet expenses?—our United Fund voluntary dollar has to be used to subsidize the Medicaid program. Some Home Health Agencies have been forced to use invested funds.

I hope this gives you some idea of how serious a financial problem Medicaid presents to the Home Health Agency.

Sincerely,

SHIRLEY A. WHITCOMB, R.N.,
Director.

[Attachments.]

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS, DEPARTMENT OF SOCIAL WELFARE, OFFICE OF MEDICAL SERVICE

FEBRUARY 18, 1970.

To: All Visiting Nursing Agencies of Rhode Island.
From: P. Joseph Pesare, Dr. P.H., M.D., Medical Care Program Director.
Department: Social Welfare.
Subject: Revision of the present billing procedure used by the visiting nursing agencies in submitting claims for services provided eligible recipients of the Rhode Island Medical Assistance program.

On February 4, 1970 representatives of the Office of Medical Service, Blue Cross/Blue Shield and the Visiting Nurses Association of Rhode Island met to discuss the billing problems encountered by the Visiting Nursing Agencies.

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*Senator Pell asked Shirley A. Whitcomb the following questions:
1. What specific changes would you recommend in the Medicare program to provide the home-health services now most urgently needed by senior citizens?
2. Can you give examples of where Medicaid does not cover the full cost of your services? How are you able to pay for the portion of your costs not covered by Medicaid?

**See testimony p. 268.

Following a discussion on these problems, a new billing procedure was agreed upon by all parties present at the meeting.

NEW BILLING PROCEDURE

Under the new procedure the Fiscal Intermediary for Title XVIII, Blue Cross/Blue Shield will provide the computed SSA–1487 form directly to the Office of Medical Service.

The Office of Medical Service will then forward these computed forms to the appropriate VNA Office.

On receiving the computed SSA–1487 forms the VNA Agency will match them to corresponding MA–501 cards.

After the forms have been matched to the cards, the VNA Agency will submit to the Office of Medical Service *only* those forms on which they can expect to be reimbursed in accordance with the existing fees for Visiting Nursing services. Reimbursement is usually made when the fifty dollar deductible has not been met and when the number of visits allowed by Federal Medicare has been exhausted.

In cases in which the VNA Agency receives the 80% reimbursement from Federal Medicare, they should *not* submit these forms to the Office of Medical Service since the 80% reimbursement usually constitutes a payment above the Department of Social Welfare's fee schedule which provides payment for Visiting Nursing Services on the basis of demonstrable, reasonable cost *up to* a maximum allowance of $6.00 per visit.

Effective date: This policy will take effect on March 1, 1970.

P. JOSEPH PESARE, DR. P.H., M.D.,
Medical Care Program Director.

CRANSTON DISTRICT NURSING ASSOCIATION FEE CARD, SUBMITTED BY SHIRLEY A. WHITCOMB

Office Hours: From 8:00 A.M. to 4:00 P.M. daily; closed Saturdays, Sundays and Holidays. Calls for Saturdays, Sundays and Holidays must be made during regular office hours.

Charges per visit: (Effective January 1, 1968)

May be adjusted for those who cannot pay:

Nursing	$9.50
Physical Therapy	11.60

It is requested that daily payment be made.

DEPARTMENT OF SOCIAL AND REHABILITATIVE SERVICES, DIVISION OF COMMUNITY SERVICES, MEDICAL STANDARDS AND REVIEW, PROVIDENCE, R.I.

DECEMBER 28, 1970.

To: All Visiting Nursing Agencies.
From: P. Joseph Pesare, Dr. P.H., M.D., Medical Care Program Director.
Department: Social and Rehabilitative Services.
Subject: Revision of fee schedule for visiting nursing services provided eligible recipients of medical assistance, effective January 1, 1971.

It is a pleasure to announce a revision in the fee schedule for Visiting Nursing Services when provided by an official Visiting Nursing Agency to eligible recipients of Medical Assistance *on or after* January 1, 1971.

As of January 1, 1971, the Rhode Island State Department of Social and Rehabilitative Services, through its Medical Assistance Program, will provide an increase in the allowance for Visiting Nursing Services from *up to* a maximum allowance of $6.00 per visit to payment on the basis of reasonable cost as listed and approved for each Nursing Agency by the Fiscal Intermediary of Title XVIII, *up to* a maximum allowance of $8.00 per visit.

In order to make payments on the basis of your demonstrable, audited reasonable cost up to a maximum of $8.00 per visit, will you please make available to

the Department your most recently certified official cost figures as they apply to the types of visits included within the scope of our program.

N.B.—The Rhode Island State Department of Health will continue as the primary resource for payment of maternal and child health nursing visits provided for patients who are eligible recipients of Medical Assistance under criteria established by the Maternal and Child Health Divison.

The following revisions pertain to other phases of the fee schedule for Visiting Nursing Services:

1. The allowable fee for each additional patient seen on the same day at the same address will remain at $3.00.
2. The maximum payment allowable for a single visit—regardless of the number of persons seen—will be increased *from* $9.00 to $11.00.
3. The maximum payment allowable for a single patient visited more than once within a 24-hour period will be increased *from* $9.00 *to* $11.00.
4. Payment for nursing services provided in the Visiting Nursing Agency's office (office visit) will remain at $3.00.

It is indeed unfortunate that the current interpretation of Federal Medicare policy serves to eliminate many of those elderly and chronically ill from eligibility of payment for Visiting Nursing Services under the provision of the Federal Medicare Program (Title XVIII).

As a result of this more restrictive policy by the Federal Medicare Program, many of the Visiting Nursing Agencies had discontinued submitting those patients whose eligibility for Visiting Nursing Services was questionable under current Federal Medicare eligibilty criteria.

Please note carefully that the Department of Social and Rehabilitative Services continues to require that all Visiting Nursing Agencies submit requests for payment to Blue Cross/Blue Shield, the Fiscal Intermediary for Federal Medicare, for Visiting Nursing Services provided eligible under the provisions of Titles XVIII (A and B). This requirement continues to be necessary though the services provided may not be ultimately reimbursed by Federal Medicare under their current interpretation of eligibility for these services. It is only after this procedure is followed that the Department of Social and Rehabilitative Services is able to determine the amount of liability for payment which remains with the Rhode Island Medical Assistance Program.

You have been very cooperative in this respect—your spirit of cooperation is greatly appreciated. We have been receiving notification of Form SSA1487 HOME HEALTH AGENCY REPORT AND BILLING from the Fiscal Intermediary for Federal Medicare advising the Department of Social and Rehabilitative Services when a patient no longer qualifies for Visiting Nursing Services provided under the Federal Medicare Program. In these cases, the claims have been processed according to the Rhode Island Medical Assistance fee schedule.

You are reminded that the initial receipt of Form SSA–1487 HOME HEALTH AGENCY REPORT AND BILLING by our Department is not sufficient to satisfy the total requirements beyond a period of six months. We are, therefore, asking that you resubmit each case to the Fiscal Intermediary of Medicare at the end of each six months period of service. This procedure will enable us to maintain on file a current verification that the resource of Federal Medicare has been explored and, in fact, there is no eligibility for payment for these services under the provisions of Title XVIII (A and B).

You should know that those of us responsible for the administration of the Rhode Island Medical Assistance Program are not alone in our adverse reaction to these more recently-developed restrictions as they relate to the criteria which must be fulfilled by Visiting Nursing Services in order to qualify for reimbursement under the provisions of Title XVIII (A and B). We shall continue to make every effort to seek a more reasonable and liberal interpretation of the Visiting Nursing Services provided eligible recipients of Federal Medicare for which reimbursement can be expected through Title XVIII.

I want to take this opportunity to express my sincere thanks and appreciation for the continuous spirit of cooperation manifested by all participating visiting Nursing Agencies of Rhode Island in providing high quality medical services for our eligible recipients of Medical Assistance.

P. JOSEPH PESARE, DR., P.H., M.D.,
Medical Care Program Director.

CRANSTON DISTRICT NURSING ASSOCIATION FEE CARD, SUBMITTED BY SHIRLEY A. WHITCOMB

Office Hours: From 8:00 A.M. to 4:00 P.M. daily; closed Saturdays, Sundays and Holidays. Calls for Saturdays, Sundays and Holidays must be made during regular office hours.

Charges per visit: (*Effective July 1, 1970*)
May be adjusted for those who cannot pay:

Nursing	$10.50
Physical Therapy	12.25

It is requested that daily payment be made.

ITEM 8. LETTER FROM ALEX M. BURGESS, JR., M.D., CHIEF, DIVISION OF PLANNING AND STANDARDS, IN RESPONSE TO SPECIFIC QUESTIONS RAISED BY SENATOR PELL

February 16, 1972.

1. How can the State and Federal governments cooperate most effectively to provide health care for senior citizens?

Since basically, the State and Federal governmental aims tend to be identical, there should logically be no problem. However, the nationwide focus of the federal programs leads to the establishment of objectives, procedures, and even standards which do not reflect the variability of the individual states' needs and objectives. As I have mentioned before, the smoothly functioning system set up under the "Hill-Burton" legislation provides a worthwhile model. Here, the Federal establishment furnishes certain over-all guidelines and regulations, and the state develops its own detailed plan, within the latitude that national policies provide.

My plea, then, is for systems which do not impose "all purpose" plans and procedures on state agencies to the extent of impairing their ability to approach local problems, which may be unique to the particular area. Our developing new systems will need to take account of this problem with particular care if the citizens, young or old, is to get maximal health benefits.

2. What are the major deficiencies in Medicare and Medicaid that should be eliminated in an ideal plan of health care for the elderly in the future?

The major deficiency, overriding all others in my opinion, is the existence of these parallel and basically similarly motivated programs side by side. In fact, the existence of programs aimed at limited aspects of the problem of health care will guarantee problems. If some further federal program or programs comes to sit beside these two, even more outrageous duplication and unnecessary administrative expense will result. I see, in some of the pending legislation, a real risk that this could happen.

The infusion of money and new programs will not solve the health care program, and may compound the factors producing ineffective care. What is needed, in short, is not more and better Medicare and Medicaid programs, aimed at the elderly but some constructive approach to the entire system, for persons of all ages.

3. Is the replacement of the current multiplicity of health care systems by a single system the best approach to pursue in planning for the future?

The multiplicity of different bills now before the Congress, in itself, guarantees that further "boiling down" must take place before a single alternative can be selected. I feel, however, that the need for a single over-all approach is an urgent one.

We have too many other fiscal and administrative problems, to continue to tolerate those that are based on duplicative parallel systems of payment and quality control. The cost in terms of extra administrative personnel alone in the State and Federal establishments and in the business side of the health care providers' establishment is undoubtedly high, and would be unnecessary if a single system of payment, record-keeping, and quality standards implementation were in force.

Appendix 3

ADDITIONAL MATERIAL SUBMITTED BY WITNESSES

ITEM 1. LETTER TO SENATOR PELL FROM VERONICA MURRAY, PROVIDENCE, R.I.*

DEAR SENATOR PELL: I was allowed a short time to speak at the end of the meeting, but was not allowed enough time to finish what I had to say, as you were tired, and I also was tired, as I was at that meeting from 10 a.m. until it finished; however, I will finish now, Senator Pell.

We, the elderly, know best what we need.

We, the elderly, are sick and tired of surveys and studies of aging. That money that is spent for surveys, etc. should be in our pension checks instead.

1. Higher Social Security pensions for those in the lower bracket. If the poverty level is considered to be $3,300 a year, why are we receiving such low pensions? Why are we not receiving what we should be receiving?

2. Housing for the elderly—Many of us are unable to get into public housing, as there is a long list waiting to get in, and when you are called for an interview, a single person is only allowed an efficiency apartment, which consists of one large room (very small kitchenette and bath). At least we should be allowed two large rooms and bath.

3. Transportation for the elderly should be improved.

4. Last but not least, a good medical bill covering such as foot doctors, dentists, eye doctors, eyeglasses, and chiropractors. I believe if these things were met, many problems would be solved, and less money would be required. Let's forget about sending men to the moon to bring back rocks; also let's forget foreign aid until our people are taken care of.

The elderly are sick and tired of money being spent on Studies and surveys on Aging. We feel we know what we need and it certainly is not surveys and studies, it is higher Social Security Payments for those in the lower Pension bracket. Those receiving the higher Social Security payments benefit by the small raises in Social Security but those in the lower bracket don't as the raises are too small and should be corrected at once. Many are forced onto the Welfare rolls that are very much against charity and they should not be classed as Welfare People as they worked all their lives for small wages and long hours only to find when they no longer could work they seem to be penalized for becoming old.

Could those people in Congress live on the small Pensions many are forced to live on? Why don't they try and then they would find out how long before their health would break down. Now is the time for a change, not 1972–73. Now. Also Senator Pell the Pension Age should be lowered to at least 58 years of age and the ones that were forced to take their Pensions at 62 years of age, through no fault of their own (just that their health broke down) should be given the amount they lost by taking their pension at 62 instead of 65 years of age. Why must the elderly Poor have to suffer so Senator Pell? Many doctors have become wealthy on the elderly and they know how the elderly are suffering but I don't see them speaking out. Let's wake up Senator Pell and do something about these conditions.

*See testimony p. 292.

ITEM 2. LETTER TO SENATOR PELL FROM MILDRED A. DEAN PROVIDENCE, R.I.*

DEAR SENATOR PELL: I understood that there was only 7 minutes for each one so I cut short one of the things that is surely needed. The program for entertainment for the institutionalized elderly at Hospitals. The R. I. Association of Senior Citizens and Senior Citizens Clubs Inc. has devoted much time to this program as the Doctors at the Medical Center has often commended the lift it gives to the patients. I have carried on with little help this past year and this program as well as Grand Parents day of Rhode Island will also go out of existence. I have been very proud of these programs and am very discouraged to see them pass on. Thanks for all your help.

Sincerely,

MILDRED A. DEAN.

*See testimony p. 245.

Appendix 4

LETTERS FROM INDIVIDUALS AND ORGANIZATIONS

ITEM 1. LETTER TO SENATOR PELL FROM DORIS E. JOHNSON, LIBRARIAN, PROVIDENCE, R.I.

September 28, 1971.

DEAR SENATOR PELL: I am so sorry that I could not be present at the conference that you held recently in Providence regarding the problems of senior citizens. I am writing this to call to your attention an injustice (inequity is a better word) regarding social security payments. Knowing your deep interest in helping the elderly, I feel sure that you will be interested in my point of view. At first glance, you may not agree with me, but if you will bear with me a little, I believe you will see some merit in my arguments.

When a working person retires, he is entitled to social security payments from which money is deducted if more money is earned—$1800 a year may be earned without deductions, I believe. However, if the person retiring happens to have income from investments, real estate or other holdings, he may collect his full social security without any deduction being made. In other words, the working man who could not manage to save or make other investments and who feels obliged to go on working to supplement social security payments is penalized, while the more fortunate person may actually be wealthy and not even need the social security.

I am not contending that the more fortunate man should lose his social security payments, or even have them reduced. What I believe is that when a worker has paid income taxes through the years, he should be entitled to his social security as a *right*, regardless of whether he goes on working or not. If this were true beginning at age 65, there would not be too many who could collect, and go on working because many firms require their employees to retire at that age. However, if a man were well enough and lucky enough to be able to work, I think he should be allowed to do so without any deductions being made. Most people at age 65 only want to work part-time, but the limitations on what they can earn keep them in a low financial bracket and count against them in accepting special work that they alone may be qualified to do well.

In these days of heavy unemployment, some people would say right away that if the older people go on working, they would not make way for younger men to fill their jobs. My belief is that there would only be a small group able and willing to work, and probably not for more than a couple of years. But this would give them a chance to save something more for retirement and make up for some of the time when they couldn't save because of high taxes and high cost of living. Here, in brief, are the advantages of letting older citizens have their full social security with no strings attached:

1. They would, of course, pay income taxes on their earnings plus social security payments.
2. The clerical work involved in keeping track of their exact earnings and the ratio to their social security would be eliminated.
3. They would not be competing for poorly paid jobs because they could work at their own specialty at a higher rate and might not need more than a few hours a week to supplement their income.
4. Those who are now employed full-time and are not compelled to retire could work less and collect social security. In other words, they would not feel forced to go on working full-time because they could not live on their social security payments alone.
5. The difference in cost to the Government would not be great for those who are working part-time and getting social security. Some social security is being paid them anyway. The difference would also be offset by less clerical work in keeping track of their accounts.

Old age is a dark threat to many people. I do not believe there are actually many opportunities for them to earn money once they have retired. People who are well, who are doing a good job and who could for a very few years get a bonus in social security deserve a break. There won't be too many of them. Forced retirement on a low income with no hope is the last thing that anybody wants. If an elderly person can supplement his income after retirement, then I say God bless him and let him have whatever he can earn without deductions. The time is short at best.

Thank you for bringing to your office as Senator such great qualities and for spending so much of your time in the public interest. I want you to know that I think you have proved to be one of the most conscientious and devoted Senators that our State has ever had.

Very Sincerely yours,

(Miss) DORIS E. JOHNSON, *Librarian.*

ITEM 2. LETTER FROM ARISTIDE B. MORSILLI, JOHNSTOWN, R.I.

DEAR SENATOR: I am writing this letter to you with the hope that in the not too distant future this problem will be a thing of the past.

In mid June of this year, my wife was rushed to R.I. Hospital for a condition which cannot be treated. After several weeks of tests, I was notified of the results of the tests and was told she would have to be hospitalized in order for her to be medicated so that she will not lapse into a deep sleep as she did when stricken. As of today she no longer talks, hardly recognizes anyone and is confined to bed. This is the result of premature brain damage which I am told sometimes happens to young people. Doctors cannot account for the condition, nor do they know of any treatment. As my wife is only 62 years old, she does not qualify for any aid program. This condition began when she was 58 and she was hospitalized in 1968 and was examined again in Oct. 1970 at the Lahey Clinic, Boston.

When discharged from R.I. Hospital, the Social Service Dept., of the Hospital assisted me in placing her in a nursing home for which I am paying $196.00 weekly for her care. Now you can well appreciate that at these rates, I cannot survive very long financially as my weekly salary certainly does not amount to what I am paying for her care. Consequently what lifetime savings we made together will not last very long.

It seems to me that a country as great as ours should have a program whereby no such thing should occur. I think it is about time for our government to be concerned with our own problems and let the rest of the world contribute a bigger share to their own problems. The time has come to spend more on our citizens' health and well being instead of all that money being spent for unnecessary killing and subsidizing of other countries.

No doubt, there are many cases like mine and I am not trying to be looked upon as a special case, but I am hoping that some program will eventually be introduced to give our people security and care throughout their days. This, of course, can only come about by your efforts and the efforts of others in your position. I hope we will soon have the best health programs in the entire world.

Sincerely yours,

ARISTIDE B. MORSILLI.

Copy to Senator Claiborne Pell.

ITEM 3. LETTER TO SENATOR PELL FROM ANTHONY J. AGOSTINELLI, EXECUTIVE DIRECTOR, THE URBAN COALITION OF RHODE ISLAND

September 21, 1971.

DEAR SENATOR PELL: We respectfully request that the attached reports of our Health Task Force become parts of the Senate subcommittee's records which received testimony on health in Rhode Island yesterday.

Thank you for your interest.

Sincerely,

ANTHONY J. AGOSTINELLI,
Executive Director.

Attachments.

THE REPORT OF THE TASK FORCE ON HEALTH

Dr. CHARLES J. MCDONALD, Chairman. The Health Task Force of the Urban Coalition of Rhode Island was organized to provide health leadership in the community. It was organized to address itself forthrightly to important health issues. We consider our main role to be that of a supporter, critic and coordinator for the various providers of services and the consumer.

The first organization meeting of the Health Task Force of the Urban Coalition of Rhode Island was held on February 5, 1970, at the Providence Public Library. Attendance of provider groups was exceptionally good, however, there was very limited attendance on the part of the "consumer" group or inner city poor. Therefore, the original intent of the meeting was abandoned and it was decided to hold another organizational meeting in an area of greater accessibility to at least one segment of the inner city poor. The second organizational meeting was held on February 25, 1970, at the Opportunities Industrialization Center Building. At that meeting the process of electing four members from the Task Force's general membership to the Working Committee was carried out.

Keeping in mind the charge of the Urban Coalition of Rhode Island, a set of ten goals were outlined for the Health Task Force. Some were considered immediate, others were considered future goals. All were considered attainable. They were as follows:

1. To reaffirm our belief in, and restate our endorsement of the Neighborhood Health Center concept as a vital force in the delivery of health services to the urban poor.
2. To seek ways and means of extending the health center concept into other communities.
3. To broaden and strengthen the association of the existing health centers with the community hospitals.
4. To increase the moral and financial commitment of the State Departments of Social Welfare and the State Department of Health to the Neighborhood Health Centers.
5. To pursue the concept of group practice in the urban areas of Rhode Island where physicians are not now available. The groups may or may not be directly aligned with the existing or future health centers.
6. Anticipating difficulty with Item 5, we turned to an additional goal. To pursue the use of physician's assistants or semi-physicians in the areas of concern. We would thus reduce the need for physicians in these areas, and in all probability reduce the cost of delivering health services.
7. To study and make recommendations regarding health manpower. We recognize that the Coalition has appointed a Task Force on Manpower. However, it was the consensus of the Health Task Force that we, as a group of health professionals, i.e. physicians, nurses and administrators, and consumers having an intense interest in the future of, the expansion of, and the betterment of the health care system, were best suited to pursue this particular task.
8. To improve Dental Health Services to the urban poor.
9. To consider how best to improve public education in matters of health, and delivery of health services.
10. To consider approaches to the vital matter of improving nutrition in the inner city. We cannot improve health without improving nutrition.

With these goals in mind, the Working Committee of the Health Task Force held its first meeting on March 11, 1970. In attendance at that meeting and in weekly meetings thereafter were members of the Executive Committee and Board of Directors of the Coalition, the four community representatives, and representatives chosen by the Chairman from the following organizations—Blue Cross-Blue Shield, State Department's of Health and Social Welfare, Progress for Providence Health Centers, the Hospital Association of Rhode Island, and the Directors of the Miriam, Rhode Island, and Roger Williams Hospitals. I wish to add, that on occasion, representatives from the Neighborhood Advisory Boards of Progress for Providence, and the Rhode Island Fair Welfare Organization attended as observers.

The Working Committee, after appraising the enormity of its goals, elected to pursue immediately the solutions to those that were either immediately attainable or were attainable with minor changes in our present system. To that end the following Subcommittees were formed.

1. Health Center Financing, Immediate and Future, Father Francis J. Guidance, Chairman.
2. Group Practice and Insurance, Albert Brennan, Chairman.
3. Health Education, Dr. Joseph E. Cannon, Chairman.
4. Health Manpower and Employment, Jack R. Fecteau.
5. Physicians Assistants, Dr. Arnold Porter.
6. Dental Health, Dr. Joseph Yacovone.

The report and recommendations of these subcommittees are on file in the UCRI office. They will be summarized below.

Prior to summarizing the subcommittee reports, I would like to allay a fear that has been expressed by members of our Working Committee and members of the Task Force-at-large. That in attempting to focus on too many issues, our efforts are diluted, thus, our accomplishments will reflect this dilution. It is argued that the Neighborhood Health Centers should be the main focus of all our attention. The solution of its problems would lead to the solution of our Health Care problems. I agree fully with this premise. Therefore, let me point out how the conclusions of our subcommittees, in most instances, relate to the delivery of Health Care via the Neighborhood Health Centers.

The Subcommittee on Group Practice and Insurance in a very thorough assessment of the situation has made the following recommendations—that we accept the premise that proper Health Care is "obligatory" in much the same sense that in education it is the obligation of the State to provide educational facilities and of the individual to utilize those facilites. In the matter of health care, the medical professionals must provide and the consumers must seek. The "third party" or administrative agent must supply the financial and administrative "bridge" between the two. The subcommittee concluded that the four basic disciplines necessary for proper health care, preventive, diagnostic, curative and rehabilitative are available but not accessible to poor people. There is a need to pull down the "barriers of inaccessibility" between the "seekers of services" and the "providers of services"—barriers that range from geographical to psychological, from intellectual aloofness to ingrained apathy, from haughtiness to condescension—but most of all, from high cost to low or non-existent incomes.

Fundamental to accessibility of the four disciplines, particularly for the disadvantaged is the concept of the "Neighborhood Health Center". We support the theme of binding the nine existing centers together through a single Corporate entity having administrative and financial jurisdiction over each, without relinquishing the totality of autonomy of the individual centers.

Group Practice, in combination with Neighborhood Health Centers, would evolve into comprehensive community health facilities that would mobilize and organize all the skills of a community in such a way as to make use of people and equipment in providing all health services to a neighborhood within a city. Each of the centers should have a multi-specialty professional staff that would include the disciplines necessary to provide comprehensive medical care to the community.

Vital to the delivery of proper Health Care via Neighborhood Health Centers is an alliance with, and reliance upon hospitals.

The key element to the success or failure of the concept of Neighborhood Health Centers is the stabilization of income. They cannot operate without assurance that enough dollars will be made available on a timely basis in an orderly business-like manner. We suggest that income stabilization would best be met through capitation, i.e. that each of the Center's registrants pay, or have paid on his behalf, a preset annual fee that would cover the total cost of his care. The payment source of the capitation fee would be through reshaping or redirecting programs already in effect, both government and private. I might add here that meaningful discussions have been held with sponsors of the Rhode Island Group Health Association regarding participation in such programs.

The subcommittee concludes with the following statement. "It is also assumed that the 'disadvantaged' do not own exclusive rights to the lack of accessibility of proper Health Care, giving rise to the very real possibility of Neighborhood Health Centers acceptance of other than the traditional 'disadvantaged'."

The Subcommittee on Financing of the Health Centers report is summarized as follows. Procedures for the incorporation of the Health Centers, within the guidelines set by the office of Economic Opportunity, are completed. The Corporation has been supplied with additional OEO working and planning funds that when added to funds from other sources are sufficient to carry the Health

Centers an additional year. It is anticipated that money will be available from federal sources for prolonged operation of the Centers once new proposals have been submitted.

Additional sources of federal funds include the HEW and Model Cities Projects. Additional sources of State funds include the State Department of Social Welfare whose contribution to the Health Centers should be increased to meet the actual costs of the care of patients whose health service costs are the responsibility of the Social Welfare Department. Perhaps a system of capitation as suggested by the Group Practice and Insurance Subcommittee is the most feasible method for this department to pay its share of the patient costs.

Local sources of funds which of necessity must be private include the Dexter Fund, and the United Fund. Partial private funding will eventually be necessary when Federal funds have "dried up". Planning for such an occurrence must be made now.

Other local funding sources include the Hospitals, primarily, the Miriam, Roger Williams, Rhode Island, and St. Josephs. Direct financial assistance may not be feasible. However, assistance in terms of management manpower, cooperative training programs, items of equipment, etc., are entirely feasible.

The Subcommittee on Health Manpower and Employment stresses the need for augmentation on the principle of "upward mobility". It is ludicrous for this nation to have shortages of "health manpower" both professional and nonprofessional, and high unemployment rates among the inner city poor. The greatest problem appears to be the inability of a worker to enter the health employment field and be allowed to grow financially and professionally. He is stopped by licensure practices, professional mores, personnel policies and attitudes of peer groups within an individual hospital or health organization.

The subcommittee intends to combine forces with the ad hoc Health, Manpower and Education Committee of the Hospital Association of Rhode Island and the Governor's Task Force on Health Manpower to pursue a concept of "opening up" the health field to the disadvantaged through accelerated efforts in training, education and motivation along with altering the attitudes and traditional barriers without lowering the quality of performance.

This subcommittee intends to work with the Neighborhood Health Centers to upgrade training programs and accelerate the "upward mobility" of its trainees.

The Dental Health Subcommittee is calling for the initiation of a comprehensive dental health program for the poor of Rhode Island. This program should include dental care, preventive dental measures and health education. New methods of delivering dental care are to be explored, evaluated and initiated.

The Health Education Subcommittee has pointed out the lack of available manpower in the State of Rhode Island to initiate a meaningful program of health education. The Urban Coalition should strongly endorse the recent actions of the State Board of Education in appointing a committee to develop a comprehensive Health Education Curriculum for our Elementary and Secondary Schools. The Coalition should support a concerted effort on the part of our state-supported colleges and university to develop programs for the training of Health Educators. We must have Health Educators to teach within the guidelines set by our new health curriculum.

The Urban Coalition should join the Medical Society and other interested groups in endorsing a unified health education program rather than piecemeal programs as now exist. We must urge each community throughout Rhode Island to demand that health education programs be introduced in each school.

The Subcommittee also feels strongly that the concept of "peer group" education be strongly endorsed. This type of educational program works ideally through the Neighborhood Health Center. Center nurses and aides from teams to seek out neighborhood people and inform them regarding health practices and available health resources.

We must also consider as an important facet of health education, the correction of the attitudes of health professionals, semi-professionals and non-professionals, toward the "poor" consumer and vice versa. Far too often, the attitude of these groups is cited by the poor consumer as one of the prime causes of his lack of utilization of available health services.

The Subcommittee on Physicians Assistants has not had sufficient time to formulate its thinking. The Chairman of this subcommittee was selected in absentia and has only recently been able to begin the formulation of his task and the members of his subcommittee.

Before closing, I would like to express my sincere appreciation to the members of the Task Force, and especially the Working Committee, for their initial efforts to bring together a workable and effective program for the delivery of health care for the urban poor of Rhode Island.

I hope that they will continue to work just as hard in the ensuing months to bring our proposals to fruition. Because, after all, we have only made proposals, we must now stop the dialogue and proceed on a course of action. Our goals, we must remember, are those which are immediately attainable.

[Attachment.]

To: Dr. Charles J. McDonald, Chairman of the Health Task Force.

From: Charlotte J. Montiero, Community Liaison for Health Services and Programs.

Subject: Progress Report for Health Task Force of the Urban Coalition of Rhode Island, Inc.

I. NEIGHBORHOOD HEALTH CENTER CORPORATION OF PROVIDENCE

The Community Liaison for Health Services and Programs has been participating as a member of the "planning team" of the Health Center Corporation in developing the Comprehensive Health Care package to be submitted to OEO in Washington, D. C., in late February. The planning team is composed, of course, from the staff of the Neighborhood Health Centers' administration under the direction of Mr. Michael Gerhardt, Planning Director of the Health Corporation. Various organizations (agencies) are represented on the planning team: the Department of Social Welfare, the Health Department, the Regional Medical Program, Progress for Providence, Miriam and Rhode Island Hospitals, and Blue-Cross-Blue-Shield. Several representatives from other agencies have been given the task of preparing various sections of the proposal. A copy of the assignments for the draft proposal is included in this report.

The Comprehensive Health Care package will provide a capitation scheme for the nine (9) de-centralized health centers. The capitation scheme is presently being prepared and will be considered by the Department of Social Welfare and Blue-Cross-Blue-Shield. Before such a plan is submitted to Washington, it must also be approved by an ad hoc planning review committee of the Neighborhood Health Centers' Corporation Board. Vital statistics concerning the capitation scheme will be made available at a later date.

II. NEWPORT VISITING NURSES' ASSOCIATION

The Visiting Nurses' Association of Newport indicated in November that they wanted to explore the possibility of expanding their child health conferences into Family Health Care Centers, for the local civilian hospital offers no outpatient service other than the emergency room. The only ambulatory services offered are given by private physicians or at clinics operated by the Visiting Nurses' Association. The Visiting Nurses' Association presently provides a generalized public health program for Newport and three adjacent towns, serving a population of 77,093 people. Statistics provided by the State Department of Health and community surveys show a great need for the following services: OB-GYN, Pediatrics, Family Planning, Chronic Disease Screening, Speech and Hearing Clinics, Nutrition, Internist.

The Visiting Nurses' Association selected several persons from various health agencies and their board to serve on a planning committee. The planning committee selected as their consultants Miss Lynn Cowger, Regional Medical Program, Mrs. Irene McGovern, Visiting Nurses' Association, and the Community Liaison for Health Services and Programs. We are initially preparing a proposal for a centralized Family Health Care Center to be located in the Visiting Nurses' Association's facility. The Visiting Nurses' Association is located in a high-rise building for the elderly with 7,500 square feet of office and clinic space. This building is also located in the "heart" of the largest "prime" target area. There is a strong possibility that the Regional Medical Program will make available $20,000 seed money for planning. We are exploring funding possibilities at present and propose to have the proposal for the comprehensive Family Health Care Center completed by early March.

III. ST. XAVIER'S ACADEMY HEALTH CAREER CO-OP PLAN

For the past year, Sister Lucretia of St. Xavier's Academy has been exploring the possibility of establishing a co-op plan for all students within the academy who are interested or involved in the health curriculum. She contacted the Community Liaison for Health Services and Programs for support and guidance in developing her ideas. She initially contacted Mr. Jack Fecteau, Director of Roger Williams General Hospital, who encouraged her to develop her plans and offered the services of his hospital in such a plan. Our tentative plan of action is as follows.

A. Enroll approximately 15–20 students from grades 10, 11, and 12 into the Health Career Co-op Plan initially.

B. The selected students will participate in an intensive 16-week program that will provide an orientation to the many different health fields available using consultants from many health agencies and technical services; provide each student, through on-going classroom instruction, with a foundation for entering the health field, i.e. anatomy, biology, math, first aid, basic chemistry, and various laboratory techniques, including rudimentary nursing skills.

C. After the 16-week program, students will be placed into the co-op plan in which they will participate in classroom studies for half of the school day, and in hospital programs or health centers the remainder of the day; or alternate each day from classroom to health institutions. (These tentative plans are very flexible.)

IV. PROGRAM ON ALCOHOLISM

In the past few months, the Community Liaison for Health Services and Programs attended two conferences sponsored by the "Hope" Council on Alcoholism. The council invited approximately 75 Providence organizations to participate in the seminars. The purpose of the seminars was to fully acquaint all agencies with the problem drinker, available resources for treatment, the structure and operation of the State's Division on Alcoholism and to provide statistics concerning the incidence of alcoholism in the state. The attending agencies' representatives will be asked very soon to serve on working committees. These working committees will be involved in the planning of new and improved programs for the alcoholic and the development of educational programs for the citizens of Rhode Island concerning alcoholism.

V. The Health Task Force of the Urban Coalition of Rhode Island realizes that it cannot continue to talk about "comprehensive family health care" unless such care includes components of mental health and nutrition. Consequently, a representative from the Mental Health Association has been invited to serve on the task force's working committee. A subcommittee on nutrition is now in the process of being organized. Representatives from the State Department of Health, Nutrition Division, the University of Rhode Island, and several other agencies dealing with nutrition will be serving on this committee.

To: Freeman Pollard—The National Urban Coalition; Elwood E. Leonard, Jr., President, The Urban Coalition of Rhode Island; Anthony J. Agostinelli, Executive Director, The Urban Coalition of R.I.; William B. Baptista, Sr., Associate Director, The Urban Coalition of R.I.; Dr. Charles J. McDonald, Chairman, Health Task Force, UCRI.

From: Charlotte J. Montiero, Community Liaison of the UCRI.

Subject: Progress Report—March 31, 1971 to June 23, 1971.

THE PROVIDENCE HEALTH CENTER CORPORATION—HEALTH NETWORK PROPOSAL

The Providence Health Center Corporation submitted its second draft to the Health Affairs Office of the Office of Economic Opportunity in April, 1971. At that time, several changes had been made at the request of the funding agency. The major change resulted in a more centralized system of health care delivery. Initially, the Corporation requested ten (10) de-centralized health centers in eight (8) poverty areas. The funding agency was not amiable to such a plan. After several lengthy discussions it was decided to operate eight (8) comprehensive health centers in six (6) poverty areas in the City of Providence. Such an operation will be the result of combining two (2) health centers into one central location in each area with the exception of two (2) large health centers which presently serve two (2) different communities.

For example: The two health centers in South Providence will combine to form one (1) large Comprehensive Health Center. The funding agency was most excited about the Providence Plan and by June 30, 1971 the Health Affairs Office of OEO will notify us of their decision. A copy of the plan is available at both the local coalition and the national coalition offices.

PROPOSED "NEWPORT COMPREHENSIVE FAMILY CARE CENTER"

For some time, consumers and providers of health services in Newport County have been concerned about the availability and utilization of ambulatory health services. The Visiting Nurse Service of Newport hosted a number of discussions during the past few months about the possibility of developing an ambulatory health program by utilizing existing resources. One of two prime planners for this project has been the Community Liaison for Health Services and Programs of the Urban Coalition of Rhode Island.

There was general agreement that the idea of expanding the use of existing resources was feasible. However, the group also agreed that the orderly expansion of these services to meet the needs of Newport County would require careful planning based on hard data and directed to specific objectives. That this planning would be more effective if it were done in conjunction with a pilot demonstration of the services assumed to be needed, was also agreed upon.

Funds have been made available through a one-year contract with the Tri-State Regional Medical Program to provide a part-time medical director for the demonstration program of ambulatory services, and personnel with planning expertise to assist the providers and consumers of health services in Newport County to:

1. Plan for the development of regional ambulatory health services;
2. Develop a means of ongoing financial support for these services, and
3. Develop an evaluative mechanism for these services which provides for periodic review of costs and utilization.

Project Title.—Planning a Regional Family-Centered Ambulatory Health System for Newport County.

Sources for Financial Support:

1. Tri-State Regional Medical Program	$15,250
2. New Visions for Newport County, Inc	15,000
3. Newport Visiting Nurse Service	7,920
Total	$38,170

Sponsoring Agency.—Newport Visiting Nurse Service.

Project Director.—Miss Mary Dwyer, R.N.

Project Emphases.—1. Planning for the future; 2. Simultaneous demonstration program of services for evaluation.

Planning.—1. Analysis of data from patients using the services of the demonstration program; 2. Determination of the needs of those people who do not use these services.

ANTICIPATED SERVICES IN DEMONSTRATION PROGRAM

1. Pediatric clinics.
2. Venereal disease clinics.
3. Family planning clinics.
4. Community outreach (note: training of clinic aide and clerical aide has already begun).

ADVISORY COMMITTEE

The Board of Directors of the Newport Visiting Nurse Service is the applicant for this contract with Tri-State Regional Medical Program. The Visiting Nurse Service will therefore be responsible for operating the pilot demonstration project, and for coordinating the planning activities for one year. The Board does not necessarily envision the permanent operation of an ambulatory health center as a continuing function of the Visiting Nurse Service. It is intended that a thorough exploration of all possible plans will be made with the assistance of an advisory committee.

The Board of Directors of the Visiting Nurse Service will appoint the Advisory Committee for the planning project to provide them with sound alternatives

and suggestions for implementation of a workable ambulatory care plan. Representation will include, but is not limited to:

1. Newport Hospital.
2. Newport County Medical Society.
3. Newport County Dental Society.
4. Consumers (equal in number to professional representatives).
5. New Visions of Newport County, Inc.
6. Comprehensive Health Planning.
7. Rhode Island Department of Health:
   - Division of Public Health Nursing.
   - Division of Epidemiology.
   - Division of Maternal and Child Care.
   - Division of Dental Public Health.
8. Tri-State Regional Medical Program.
9. The Urban Coalition of Rhode Island.
10. Rhode Island Department of Welfare.
11. Rhode Island Department of Community Affairs Services to the Aging.
12. Health Planning Council, Inc.
13. Newport Visiting Nurse Service.
14. Family Planning of Rhode Island, Inc.

CAREER MOBILITY STUDY

As you are aware, a proposal for Health Career Mobility in Rhode Island was submitted to the National Urban Coalition's Health Manpower and Development Program in November of 1970. The Community Liaison for Health Services and Programs has continued to communicate with the Health Manpower and Development Program and was successful in hosting two meetings concerning the plan. Dr. Sumner Rosen of the HMDP Advisory Board and Mr. Robert Sneed, HMDP staff person, joined the CLHSP in an onsite visit to test the commitment and support levels of hospital administrators and statewide educators. Both meetings, May 7 and June 24, 1971, were very productive. It was recommended that the CLHSP alter the design and plan to carry out specific small scale demonstrations in cooperating institutions.

The institutions involved in the demonstration program will be asked to convert their contribution from a cash basis to a commitment to work jointly to carry out the design. In this way the basis for implementation of the design is built into the study itself. Same for the cooperating educational institutions. It is hoped that they will permit innovative approaches to accredited professional education for participants of the pilot project, to assure a workable educational design and to build a basis for confidence and commitment to carry through after the design phase. The CLHSP is now in the midst of re-writing Phase I and II of the proposal in order that it might include the recommendations of the HMDP. From all concerned, the funding outlook appears optimistic.

WASHINGTON COUNTY HEALTH PLANNING BOARD

The Citizens for the Advancement of Negro Education (CANE) of Washington County were awarded a grant in December of 1970 to employ eight (8) VISTA workers to develop health and educational programs in connection with projects sponsored by CANE. As the VISTA workers became involved in both the health and educational aspects of various on-going projects, it became apparent that further research was necessary in order to ascertain the health needs of the community and its available services.

After the several months of collecting various kinds of data, the discussion centered around the need of providing health services to the rural poor of Washington County.

The VISTA workers solicited the help of CLHSP in order to evaluate the collected data and to advise them on designing a comprehensive health care plan. At the preliminary planning meeting, the CLHSP made several suggestions as to resource persons in and around the state who could be of service in designing a plan and method of organizing collected data.

Since one of the prime funding sources in this area for demonstration projects is Tri-State Regional Medical Program the CLHSP invited Miss Lyn Cowger of that program to share in the planning experience.

Formal planning will begin the first day of July 1971.

Appendix 5

STATEMENTS SUBMITTED BY THE HEARING AUDIENCE

During the course of the hearing a form was made available by the chairman to those attending who wished to make suggestions and recommendations but were unable to testify because of time limitations. The form read as follows:

DEAR SENATOR PELL: If there had been time for everyone to speak at the hearing on "Problems of Medicare and Medicaid," in Providence, Rhode Island, on September 20, 1971, I would have said:

The following replies were received:

MS. LOUISE HELTZEN, PROVIDENCE, R.I.

DEAR SENATOR PELL: Medicare should cover: dental work, eyeglasses, feet work.

Mr. EUGENE TERRIER, WOONSOCKET, R.I.

SENATOR PELL: Our raise in Social Security is evaporated already. Blue Cross is higher now; the cost of living is higher.

You raise 5 percent of Social Security next year; it is not enough. It should be at least 15 percent—at least—and that would still not be much.

Mr. DANIEL J. MCCULLOUGH, PROVIDENCE, R.I.

That the money Rhode Island senior citizens are receiving from the Federal Government amounts to less than $1 a year per person if we all needed it.

We need a 25 percent increase in Social Security to live a normal life. Thank you for all you have done.

Mr. WILLIAM E. DAVIS, PROVIDENCE, R.I.

I have listened to the panel's recommendations and proposals, but they overlooked an important issue that is important to the elderly. I propose that Medicare pay for prescribed medicines. The majority of elderly who are above the so-called poverty level have been knocked off State Medicaid due to raises in Social Security.

They are the victims of circumstances beyond their control.

Prescriptions cost, my own and wife, an average of $200 per year. They could cost more in the future.

The majority of the elderly keep alive on pills. It is not asking for too much to convince the Congress that benefits under Medicare should be broadened to include this proposal.

Thank you and the best of luck.

Miss ELLEN CULLEN, PROVIDENCE, R.I.

I am in favor of bill S. 1588 because being deaf, I am concerned about the deaf elderly people here. There is no deaf centre for them, and many may have to go to the Medical Centre to spend their last days because of lack of communication and understanding with the public. There is a deaf single girl living all alone on the top floor—16th—in Bradford House and nothing to keep her occupied or any community social affairs for her. How sad.

I am in favor of increased allowance for outside earnings because many of us senior citizens are able to keep working and yet are forbidden to earn more money except to a certain limit. I was forced to retire at 65 as a teacher for the deaf, and being a childless widow of twenty-five years, I find it hard to live decently and keep up my appearance with this high cost of living. I am so ambitious, and yet I cannot work more than 20 hours a week. I am not ready for the rocking chair, so please do your best to pass these bills—S. 1768 and S. 1307.

Mr. JAMES A. GOODE, PROVIDENCE, R.I.

My DEAR SENATOR PELL: I was present at the Golden Agers Conclave this morning and I certainly admire your cool.

I am in my Seventieth Year and still have a zest for living. Yet this morning I couldn't help but think some of the requests (nay demands!) were far fetched. The colored Lady in the audience who sneered at "a measly $100 a week" was out of order. I think. Senator, as they tell you in A.A.—money is not the answer.

You have correctly stated, so often, for the Elderly. Inflation is the cruelest tax of all. Wouldn't further benefits aggravate the Budget, Mr. Mills, etc.

It's hell to grow old—But I'm going to hang on. We can't be selfish even in our days of adversity. I still owe you another vote.

Kindest regards.

MARSHALL L. HOOD, PROVIDENCE, R.I.

Cut the $50 deductible from Medicare and raise the S S benefit for monthly allottment to a living wage.

To me the scale is far too low for the real worker. Of course I realize it is a sharing of wealth, hence some one must lose, it is the big pay fellow, it seems very small after drawing large pays.

The meeting was good, it was necessary, but too much relative to holdups and the like, any aged person must guard themselves against this type of kids joy.

It is the dollar we live by, and the dollar that makes the world go round.

I know you will do what you can, but it is always the question, How much?

PAUL COFFEY, PROVIDENCE, R.I.

The meeting was good, it was necessary, but too much relative to holdups and good time to draw attention to the problem of epilepsy and what is being done about it—AND THAT IS VERY LITTLE.

Almost a year ago I thought I would have to administer first aid to a college professor for shock when I mentioned to him that I doctored for it.

Though I hold permanent employment with the Department of Community Affairs and am an everyday associate of Mrs. Eleanor Slater.

Education for the ignorance that surrounds it I consider first and foremost.

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