

HEARING
Before the
Advisory Commission on
Intergovernmental Relations
on
Intergovernmental Problems
in Medicaid

San Francisco, California
September 19, 1968



Advisory Commission on Intergovernmental Relations
Washington, D.C. 20575

ADVISORY COMMISSION ON INTERGOVERNMENTAL RELATIONS

September 1968

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PREFACE

On September 19, 1968 the Advisory Commission on Intergovernmental Relations conducted a public hearing in San Francisco to obtain the views of selected witnesses on the general subject of the intergovernmental problems associated with health care, and more specifically on a draft report on Medicaid which the Commission considered the following day. This was the second time the Commission held a regional hearing on any subject, the first being in Chicago in connection with its draft report on *Urban and Rural America: Policies for Future Growth*.

Commission members present at the San Francisco hearing were Vice Chairman Price Daniel, Mayor Neal S. Blaisdell, Professor Dorothy I. Cline, Commissioner John F. Dever, Congressman L. H. Fountain, Mayor Jack Maltester, Commissioner Angus MacDonald, Mayor Arthur Naftalin, Commissioner Gladys N. Spellman, and Mayor William F. Walsh.

The Commission was urged to conduct regional meetings by both the Senate and House Subcommittees on Intergovernmental Relations on the basis of their five-year review of the Commission's operations in 1966. They felt that such meetings would strengthen the Commission's role as a forum for discussing and hopefully resolving intergovernmental conflicts, and help bring the Commission's work to the attention of State and local officials and the general public.

At its February 1968 meeting, the Commission voted to undertake a study of the intergovernmental problems in Medicaid. This subject was chosen from a number of competing study topics. It was particularly urged on us by representatives of the States. The National Conference of State Legislative Leaders had voted in December 1967 to request formally that we undertake an analysis of the program covering "the legislative background as well as the program and its implications for the States."

The ACIR study focused mainly on basic policies affecting the intergovernmental sharing of responsibility for financing Medicaid. It directed attention to certain specific non-fiscal problems involving constitutional, legislative, and administrative changes in operation of the Medicaid program. It did not attempt to examine the nature and magnitude of medical need or evaluate Medicaid's overall performance in meeting that need. Neither did it undertake to grapple with the major problems of organization, manpower, facilities, and supply that confront the whole health services "industry" and which are the root of much of the recent cost escalation.

The Commission adopted the report on *Intergovernmental Problems in Medicaid* on September 20, 1968. The report reflects a number of suggestions offered by the witnesses at the hearing.

This document is a record of the statements presented by the witnesses. Their contributions are gratefully acknowledged.

Farris Bryant
Chairman

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**STATEMENT OF
SUPERVISOR HENRY BONEY
CHAIRMAN, BOARD OF SUPERVISORS
SAN DIEGO COUNTY, CALIFORNIA**

Gentlemen, it is a pleasure to appear before you today representing the counties of California. Your interest in Medicaid, in the role of the counties, and in the future development of medical care is sincerely and deeply appreciated by California county government.

The counties of California have been in the forefront of the provision of medical care to the needy for years. I must relate any examples that I use, of course, to our experience in San Diego County. But I believe that our experience exemplifies what has happened and what will happen in California. As early as 1869, the county of San Diego provided medical care to its residents. In 1963 we dedicated a 623 bed general hospital costing 12 million dollars. The services that were provided included those normally obtained at a general hospital, as well as emergency services and an out-patient clinic.

In addition to the general hospital, we also have a 570 patient geriatric hospital and a 100 bed psychiatric facility.

The important point here is that the counties have long recognized their responsibility for the provision of medical care and have made the necessary investment in facilities and staff required to provide a high level of medical care. But what has been the impact of Medicaid? It has been significant in that the role of the counties has changed as a result of their involvement with the Federal Government and with the State Government.

This is best exemplified by the involvement of California counties in the development of state legislation necessary to implement Medicaid in California. There was a tremendous pressure during a regular and a special session of the State Legislature in 1965 to implement the program. Counties recognized the great shift in operating responsibility and involvement and the great financial implications that were inherent in the implementation of Medicaid in California. For these reasons, the so-called standard and option provisions which are now contained in the legislation implementing Medicaid in California were developed and placed into the final legislation as a result of county involvement in the legislative process. It was not the intent of the counties to diminish their role in the provision of medical care. It was their full intention, however, to make sure the limited property tax base of California counties was not adversely affected by the implementation of Medicaid. If the counties had not assumed this strong role at this particular juncture of intergovernmental relations, it is our belief that the program would have been adversely affected.

California counties are characterized by a high level and degree of professional staffing. Our directors of county hospitals and medical institutions, as well as our administrative staffs, were able to recognize the implications of Medicaid and to bring this matter to the attention of their respective boards of supervisors and to their California Supervisors Association in such a way and at such a time that the counties met their responsibilities both to their property taxpayers and to their partners in the Federal and State Government.

As I have reviewed your draft report entitled, "Intergovernmental Problems in Medicaid," I have been strongly impressed by your awareness that the Nation is committed to providing adequate care for the indigent and for the medically needy. The determinations that your Commission makes will, I am sure, as they have in the past, have a significant impact upon the further development of this Federal-State-Local program and of the role of the various levels and units of government involved in the administration of the program.

In evaluating the role of the counties, you should recognize one basic fact, namely that we are closest to the people and must in the final analysis make the determination as to the quality of care that is provided in our institutions. You may have heard that in California approximately one year ago there was an effort to control the cost of the Medicaid program by limiting various services that were available. This action by State Government, although it was later overturned by a court ruling, left the counties in a position where they had to decide whether to provide only the care that was authorized under the then existing rule or the care that was needed to properly provide for those persons in need of medical assistance. We made the determination that people are sick regardless of whether Federal or State money is available or whether Federal or State regulations make certain types of treatment available.

Accordingly, we expended significant amounts of local revenues to provide the care needed at that time. If in your considerations you choose to recommend a closed-end appropriation, recognize that you are leaving the counties at the end of the line in the same way that we were left at the end of the line in 1967.

I know also that there has been significant and continuing concern with the sudden increases in the cost of medical care. I don't believe that your understanding of this pattern of increased costs would be complete if you did not recognize that prior to Medicaid, it was possible for a significant number of California counties to obtain volunteer assistance from the medical profession in their communities. Countless hours of volunteer staff time was provided as a public service in San Diego County and in other counties at this time. With the advent of Medicaid and the establishment of the "main stream" of medical care, the profession has chosen to no longer make this service available. Thus, again, a decision by the Federal Government and as implemented by the State Government has had a significant impact upon the manner in which medical assistance is provided to the medically needy.

Finally, gentlemen, I think you should recognize that California counties are willing to continue to exercise a significant role in the further development of Medicaid or any similar program. The California counties are competent; they are willing; they are objective; and they recognize their responsibilities.

**STATEMENT OF
ASSEMBLYMAN GORDON DUFFY
CHAIRMAN, ASSEMBLY COMMITTEE ON PUBLIC HEALTH
STATE OF CALIFORNIA**

I would like to thank the Advisory Commission on Intergovernmental Relations for inviting me to testify concerning Medicaid, and I would also like to commend the Commission and its staff for the excellent and thorough draft report on "Intergovernmental Problems in Medicaid." I will make a few general remarks, comment upon some of the more important recommendations in the report, and then give you some of my own recommendations.

My first observation is that unlike Medicare, which represents a significant departure from traditional public health program financing, Medicaid is merely an extension of two older programs, and its main impact has been fiscal rather than substantive. I think that is quite clear from the reaction of Congress to rising Medicaid costs, but the direction that reaction has taken also shows that Congress either does not fully comprehend or is unwilling to come to grips with the central problems posed by Medicaid.

The draft report implies that the major reason for this cost increase has been because of increased services and more recipients. It is true that the Medicaid program, when viewed alone or compared with the old PAMC and MAA programs, shows an increase in both services and recipients. However, when the other programs which, at least in California, have been added to Medicaid are considered, the increase is not nearly as great. Those programs include: county hospitals and clinics, state hospitals for the mentally ill, Short-Doyle community mental health programs and the Crippled Children Services program.

What happened in California, and I suspect some other states, was that we took money that was being used for health care services and matched it and made it available for new services. From a policy standpoint, there was nothing wrong with such an approach, especially if it had resulted in a real gain in the quantity or quality of services provided. However, in California there were at least two important factors which contributed to the fact that the federal money we received did not result in an equal increase in services.

The major reason for this was the much discussed inflation in health care costs. Although there are no really solid figures concerning inflation in our Medicaid program, I suspect that it has been considerably greater than general health care inflation. The reason for this is that our rates of payment under the former programs were less liberal in relation to usual charges than are the present rates. I think the most extreme example of this is found in physicians' fees. Before our Title 19 program began we had a fee schedule with a conversion factor of \$4 on the Relative Value Scale. Two years later, the conversion factor is approaching \$6, which is close to prevailing fees, because we are paying on the basis of usual and customary charges rather than a fee schedule. I don't mean to imply that paying usual charges is undesirable as long as they are reasonable, but what must be realized is that by and large our public programs were not doing that before.

I recall comparing physician fees with the Welfare Director of Pennsylvania who told me that at the time they were paying only \$2 for an office visit while California was paying close to \$6. I asked him why the physicians in Pennsylvania put up with such a situation, and he told me that it was simple. Before Medicaid, they were paid nothing for an office visit. Medicaid has made it possible for that portion of the health system which provides services to the poor to receive higher payments, some even approaching those received by their colleagues who care for the more affluent members of society. It has also enabled the salary demands of nurses and other health personnel to be met, thereby bringing them more in line with comparable salaries in other professions.

A second reason for the lack of increased services is that federal money has been used to replace state and local money which would have been expended had there been normal growth under the old programs,

so the federal money did not really purchase new services. Such an assertion is based mainly on conjecture and is made even more difficult by the inadequacies or prior reporting and accounting systems. We do know that total federal expenditures in California for social welfare and health care services now covered by Title 19 have increased by approximately 90% over the two year period from 1964-65 to 1966-67, while state and local expenditures for the same services only increased about 30%. I have a feeling that if we were required to pay from state and county funds for the same level of services that the state and counties provided prior to Title 19, our share of program costs would be considerably larger than it is.

These reasons for the increase in the federal share of the Medicaid program which has concerned Congress shed some light upon the question of meeting the 1975 goal of Title 19. I feel that the escalating cost of health care is not evidence of our inability to meet that goal, but only of our inability to do so under the present system. The response to increased costs by both Congress and some states has been to either limit or reduce the number of recipients or services offered. This is the easy approach, and it makes it unnecessary to make the hard examination and correction of the reasons for the rapid increase in costs. It is clear that merely opening the purse strings and allowing access to the present health care market place results mostly in increased costs, but not a commensurate increase in services.

The fact is that we have woefully neglected the expenditure of our financial resources to develop adequate health manpower and facilities during the last twenty years. We have also not been able to adequately marshal our organizational and technological abilities to bring our systems of providing health care services into the latter half of the twentieth century. However, we can certainly not wait until we have an optimal level of manpower and facilities before we begin to tackle the problems of those persons who have little or no access to needed health care. We need a many-faceted attack upon the problem including intelligent, realistic planning and stronger efforts to restrict health care cost inflation and unnecessary and inappropriate utilization.

The draft report repeats the statement that "health care has come to be regarded by many as a matter of right." This to me is merely a way of stating that it is in our state and national interest to insure that all citizens receive adequate health care within the limits of our resources, just as it is in our interest that they receive an adequate education. This does not mean that government must provide or even pay for all such care. What it means to me is that government will assume final responsibility, and when private means are not available, government means will be provided to the extent possible.

I think that in this light, the 1975 goal is a meaningful one. It says that we wish to assure that adequate and comprehensive health care is available even though a person may not be able to pay for some or all of such care. I don't know that this can be accomplished by 1975, but neither am I in any position to suggest a better date. I do think that the statement of the goal by the federal government strongly implies continued support for expansion of the program as well as support in meeting the manpower and facility requirements that such an expanded program will create. Without that support, the attainment of the goal will be extremely difficult if not impossible.

Concerning eligibility for the program, I feel that the federal government has a national interest in defining on a nationwide basis the persons who are considered needy and medically needy. Federal resources should be devoted to insuring minimum levels of health care throughout America. It would seem to me that Congress should establish both minimum and maximum limits of eligibility for the program with state or regional variations based upon the cost of living. To qualify for federal funds, a state would have to provide minimum services to those persons who meet minimum eligibility standards. However, those states which wished to do so, should be able to increase their eligibility standards and the services they provide to the federal maximum and still receive matching funds. In fact they should be required to move in that direction in order to meet the 1975 goal. If federal funds are in short supply, it might be desirable to have a sliding scale for matching funds with the largest amount of funds provided for basic services to those who meet minimum eligibility standards while a smaller amount of federal funds would be provided for additional

services or for services to those whose income is above the minimum eligibility standards.

Concerning the method of federal funding it seems to me that there is a possible alternative which lies somewhere between closed-end and open-end appropriations. One of the major problems with the former as far as the states are concerned is that we have practically no control over caseload. Once the eligibility level is established, any number of factors including changed national economic conditions and migration, over which the state has little or no control may greatly increase or decrease the number of recipients. Since the federal government has greater budgetary flexibility than most of the states, it is easier for it to bear an increase in caseload, especially if it sets minimum and maximum eligibility standards.

Therefore, I would suggest that Congress make funds available on the basis of the number of recipient-months covered by a state program. Such an approach would depend upon good statistics concerning costs in the states for the program to date. As I envision such a system, it would require information on the number of recipients in categories which are statistically relevant for determining health care costs, for example, sex, age, disability and others. It would then require information on the costs of providing each service to each category of person. This information may not be readily available in all states, although I know that in California we have a good deal of it compiled. I also think that it is good basic information to have even if such an appropriation approach is not taken.

There are a number of problems involved, and I do not have solutions to them all. One would be how to set dollar amounts for states with varying levels of services. Another is the present spend-down eligibility system for the medically needy which is used in California and would skew both the information and appropriation system since such persons only become eligible when they need care.

If the states were provided funds on the basis of the type of recipient they actually served and the level of services provided, as I suggest, there would be one extremely important added advantage. At the present time the amount of federal funds expended depends upon the actual cost of the program. If this were not the case, there would be considerable incentive for states to develop economical and efficient programs which would make the federal dollar go as far as possible in order to save state dollars. States with well run programs would save money while those with poorly run programs would feel the full impact of their ineptness since the federal government would not be sharing the cost every time an excess dollar was spent. Such an incentive would appear to be beneficial to all, provided that cost reduction does not result from lowered quality or cutting corners on providing services which would appear to be the main danger to be guarded against.

I have considerable difficulty with the recommendation that the federal government assume the full cost of medical assistance for the categorically needy and the categorically related needy. Such an assumption appears completely unrealistic at this time in light of present federal fiscal problems. More important, it seems to me that it has serious policy drawbacks. There are two ways that this might occur. One which I do not believe was contemplated would be to place all such persons under the Medicare system since they would be a complete federal responsibility. This would leave a great deal to be desired since I feel that Medicare has generally been as lax, if not more so, as Medicaid programs in many of the states in coming to grips with some of the important issues in this area. If there is any validity to "creative federalism" it is in the possibility that states can develop new and better ways of doing things which might easily escape a monolithic national program. I think California has that potential! I would hate to see it slip from us.

If, on the other hand, the state is to continue to administer the program with 100 percent federal dollars, there are other objections. I do not envision that the role of the states is to act as agents for the federal government. Equally important is the basic irresponsibility of the states' position. When one has no money at stake in an enterprise, it can often lead to decreased diligence. The states would not have to raise any of the funds, but, at least in the beginning would have some voice in how they are spent. This situation might well lead to loose control of costs which would invite tighter and tighter federal controls.

We might as well let the federal government establish its own administrative structure which leads us full circle back to Medicare.

I agree with the recommendation that the federal government provide matching funds for medical assistance for the noncategorically related needy and medically needy as sound policy and also as necessary to meet the 1975 goal. However, I would like to comment upon the statement that the federal government would be getting its priorities out of line if it provided medical care for these people when it does not provide funds for their basic maintenance needs. I do not feel that this is necessarily true. Priorities must be related to resources, and it is less expensive to meet the health needs of these people than their basic needs. Also, lack of adequate health care may, in some cases, be a major contributor to their dependency and inability to meet their basic needs. I may be overly "health conscious", but I don't think it is possible to place too high a priority on meeting health needs. I also feel that there is considerable merit in divorcing the medical assistance program from the welfare system and allowing it to stand on its own merits.

I fully concur with allowing departure from the "equality of services" requirement upon approval of the Secretary of HEW. The equality of services requirement is a laudable objective, but it is unsound public policy in light of our limited resources. On a strictly cost-benefit basis it makes more sense to provide complete preventive services to children before we do so for adults. Also, this provision tends to hamper some of the more imaginative approaches to the problems of cost of care.

Let me give you two examples. In California, we are developing pilot projects to test methods of delivering health care services. Some of the projects which have been proposed are based upon closed-panel group practice, and such proposals appear to conflict with Title 19's freedom of choice provision. One solution would be to eliminate this provision entirely, but I do not favor such an approach. Another would be to recognize that we do not have complete freedom of choice now since some providers will not participate because of low fee schedules and others are not allowed to because of poor practice habits. What we really should strive for is an adequate number of choices so that the recipient has the freedom to reject a provider and go to another. Thus we would only approve those providers who have demonstrated their ability to keep costs within reason.

On the other hand, we might attempt to allow the recipient to make a choice based upon different levels of services. Thus if one provider can furnish two more services than another provider for the same cost, the recipient could be advised of this difference and make his choice accordingly. This type of arrangement is much easier said than done, but we cannot even make the attempt until the equality of services requirement is at least modified as recommended.

The second example involves our approach with the medically needy. I consider the spend-down method of eligibility determination to be unduly harsh and would rather see a system where the medically needy made small monthly payments based upon income and family size, whether they are sick or well. I don't think it is practical or wise to require them to do so, so we would have to depend upon their voluntary action. If the services they would receive were the same in either case, there would be little incentive for them to prepay and many would probably gamble on their continued good health. On the other hand, if they received greater benefits by prepaying, especially preventive care for their children, I think they would be more likely to do so. Neither of these approaches can be tried as long as the equality of service requirement remains.

A number of the recommendations deal with the types of guidelines which the federal government should develop for the administration of the program. There is not time to discuss them in detail, but I do recommend that the guidelines be as flexible and general as possible to allow the states maximum freedom in developing their own ways of providing adequate health care.

I would also recommend that HEW be more realistic in some of its regulations concerning the qualifications of providers under the program. A desire to upgrade qualifications is certainly commendable, but in those states with licensing provisions some deference should be made to the judgment of the states concerning qualification. I am speaking here specifically about the problem of physical therapists and medical laboratories. If HEW is going to set standards in these areas, then they should place as much emphasis upon experience and proven ability as they do upon academic accomplishments in approved institutions. Using the latter criteria is much easier but it is not more equitable.

I would also recommend that HEW be careful about requiring comparability between Medicare and Medicaid regulation. There are differences between these programs and they should be recognized. The classic example is the application of extended care facility standards to skilled nursing homes under Medicaid. As I understand the function of an ECF, it is to serve as a halfway point between acute care and a person's home or custodial care. On the other hand, many older patients under Medicaid require long term nursing home care. This is a lesser level of care than required in ECFs, and if all our nursing homes were to gear up to provide such care it would be extremely costly, and unnecessary. Such total gearing up is obviously not going to occur in California or elsewhere.

I suppose the invention of the intermediate care facility was designed to solve this problem, but the lack of coordination at the federal level has only made matters worse. While California was in the process of decertifying a number of nursing homes for Title 19 because of federal insistence, the intermediate care regulations were not yet adopted. Although it is probable that many of these facilities might qualify for intermediate care, there is no way for them to bridge the gap between their decertification and the institutions of intermediate care. The decertification has been halted here by a state court because of the failure to observe proper administrative procedures, but that by no means solves the problem. It is my opinion that the whole area of long term care for the aged, whether medical or nonmedical, is in a state of near chaos and requires careful rethinking.

There is one other area which has been completely ignored by both the federal and state governments and which I feel deserves careful attention. It involves two types of persons. The first is persons who are able to afford health care coverage but have a great deal of difficulty obtaining it because they are poor risks. The second is those persons who have adequate health care coverage for ordinary purposes, but are hit with a catastrophic condition which exhausts their coverage. The major option available to them now is to deplete their income and resources to the point of near exhaustion in order to obtain protection. Both of these problems are addressed by Speaker Unruh's Cal-Med proposal which I consider worthy of your serious consideration. My staff has been working on this proposal and has presented your staff with a detailed description of it.

Finally, I would like to close by saying that I have approached this meeting in the same way that the Commission has approached its report, within the context of the present program. I fully understand the basically fiscal nature of Title 19 and that it does not really address itself to the basic underlying problems of health care in this country. It will not create additional personnel or facilities nor will it insure their availability in our inner cities or rural areas. These problems and many others will be solved through other means in other programs. The states play vital roles in fields such as licensing and education and now in comprehensive planning. The federal government should do all it can to encourage maximum state participation and responsibility in solving these problems. I can assure you that the State of California and the California Legislature can and will make a significant contribution towards developing innovative solutions to our health care problems.

**STATEMENT OF
SPENCER WILLIAMS, SECRETARY
HUMAN RELATIONS AGENCY
STATE OF CALIFORNIA**

Mr. Chairman, Members of the Commission, Ladies and Gentlemen:

Tomorrow it will be exactly a year ago that Governor Reagan, in this very city, warned representatives of 10 of our larger states that we must couple our responsibility to help the poor with assurance to the taxpayers that the need is genuine and that the cost of the program is carefully controlled so as not to spend a disproportionate amount of our limited local, state, and federal tax resources at the expense of the many other essential government services.

There were those who deemed Governor Reagan's cautions too pessimistic, who felt that medical assistance to the poor must take precedence over all other demands of our society, that sufficiency of funds should be the last question to be considered.

History has proved the Governor's concerns well justified; in February of this year President Johnson said of Medicaid: "We must find ways of improving it, of reducing its costs, and estimating them more precisely". State after state has had to face the necessity of adjusting its program in one way or another so that the medical assistance pattern can be made to fit the fiscal cloth. California has been no exception. However, thanks to administrative controls, to constructive legislation, to the diligent collaboration with responsible leadership in the health professions, we are at the moment solvent. But we must remain vigilant lest the spiral of continuing inflation of health care costs and excessive generosity outstrips the capacity of our tax resources.

Government and the private sector alike must recognize their responsibilities to assure that quality health care services are available to all of our citizens, whether their citizens can afford the services or not.

The good health of our citizens is one of our nation's most important resources. Good health is frequently necessary if people are to retain or achieve self-sufficiency. The success of our disadvantaged citizens in breaking the cycle of dependency on governmental assistance may frequently hinge on the state of this health.

It is for these reasons that this high responsibility must be recognized and assumed by government agencies and private groups alike. But, while this is critical, we must never become so obsessed in our determination to meet these goals that we overlook a parallel responsibility: the responsibility to see that these services are delivered in the most effective and efficient manner possible. Government agencies that expend large percentages of their budgets for health care services, insurance companies whose premium-paying participants bear the brunt of escalating costs, and citizens who pay for their own health services, are all entitled to assurance that they are getting a high quality service for the money they spend. They are also entitled to a good buy for their buck.

Our private enterprise system has built for Americans the greatest health care system in the world. Therefore, while each and every responsible citizen is concerned about escalating health care costs, it is irresponsible to talk of scrapping our free enterprise system and of turning to rigid government control or, more unacceptable, full government operation. Our concern for escalating health care costs should deepen

our determination to solve this problem through our existing free enterprise system rather than outside of it, or in conflict with it. Thus, we should unceasingly strive for the development of an effective partnership between government and private enterprise for an improved delivery of health care services, with each member of the partnership recognizing the extent of its responsibilities, as well as the limitation of its authority.

The increasing demand for health care services is due to many causes, not the least of which is government financing of the gigantic Medicare and Medicaid programs. It is thus appropriate that government do its utmost to eliminate overlap, duplications and, through comprehensive health planning, assure that we are making the utmost use of our limited resources.

We should also encourage the entry of more persons into the health manpower field so that the needs and demands of our citizens for services can be met, and furthermore we should encourage sensible means of financing the construction of necessary facilities to serve the growing requirements of our people. In California the people will be asked to approve a constitutional amendment authorizing State Government to extend its credit to the purpose of underwriting long-term construction loans for private, non-profit health care facilities.

State after state in our nation is faced with escalating health care costs. This is compounded by requirements of the Federal Government that by 1975 the states provide complete services to all their needy. Yet, the Federal Government has refused to state whether they will lend financial support for these additional services or will require the full additional burden to be financed by the state. If the Federal Government is to impose such requirements on state and local government, it must face up to its responsibilities and assist in the funding thereof. I for one concur that there is a federal responsibility here and believe that the Federal Government should clarify its position as to how it will meet its obligations.

One item of major concern to me is the fact that missing from the market place of health care services is the normal restraint on the one hand of the consumer who must determine whether he can in fact afford the services he seeks, and, on the other, the normal restraint on the part of the provider who must determine what the purchaser is willing to pay. In situations where the consumer is fully funded by government treasury there is no inhibition to resist over-use of available services. Furthermore, there are those providers who believe the treasury is a bottomless well of available funds and that there is no limit to what the traffic will bear. Some substitute for these absent market-place forces which would tend to minimize the over-use of services or the overcharging for services must be instituted in government-financed programs if we are to keep the costs within reasonable bounds.

It is my suggestion that the Commission conduct a study of the possibility of requiring a modest co-payment of persons covered by these programs. Such a co-payment could be required only for non-essential services. In view, of course, of the limited means of most recipients, essential services should be exempted from the co-payment feature. I also believe that we should continue, where it already exists, and institute, where it does not exist, a system of program review by peer review committees. Here, groups of professionals review the practices of their fellows for charges, utilization, and quality of care. This self-policing system can be and should be the most effective method of assuring to patients a high quality of care and the taxpayer of a good return on the tax dollar. Guidelines and standards must be established that would permit government to obtain an accurate evaluation of the performance of providers while still protecting the traditional patient-doctor relationship and the integrity of the health care practitioners.

In conclusion, it is my belief that government has and must recognize its responsibility for assuring health care services to all of its citizens. It must commit and re-commit itself to the principle that, to the maximum extent feasible, these services should be delivered through an effective, self-policing, free enterprise system. The private sector, on the other hand, has and must recognize its responsibility and see that its services are rendered in the most effective and efficient manner possible. Government-financed pro-

grams, moreover, must develop some system that will automatically protect against over-utilization of the program by patients and providers alike and prevent unnecessary and unreasonable escalation of costs.

If the conditions are met we can look forward to the successful fulfillment of our objective of insuring good health care for all our citizens.

If these conditions are not met. . .if we fail, and we need not fail, we face serious consequences, not the least of which may be discontinuance of the free enterprise system for the delivery of health services to the poor.

**STATEMENT OF
CAREL E. H. MULDER
DIRECTOR OF DEPARTMENT OF HEALTH CARE SERVICES
STATE OF CALIFORNIA**

Mr. Chairman, Members of the Commission, Ladies and Gentlemen.

The Governor and the Honorable Spencer Williams, his Secretary of Human Relations, have asked me to attend your sessions in their entirety and to contribute to your search for solutions.

I submit that the major issues which merit your consideration are:

Is the 1975 goal of comprehensive medical care for all medically indigent realistic in the light of the total obligations imposed upon the nation with respect to defense, improved educational opportunities, the problems of the large cities, agriculture, employment, etc.?

If this goal *is* deemed realistic, is the current formula for federal, state, and local financing the most equitable and workable that can be devised?

Particularly are we concerned with the persistence of the categorical approach to federal funding. There is *no* federal financial participation in the medical care for the middle aged person who is temporarily disabled and who can benefit most from medical intervention, but there *is* for the person who has been found permanently and totally disabled. Likewise, the wife of the marginally employed father who kept his family intact is barred from the federal treasury, but access is granted to her if he deserts, divorces, or quits his job. There is no doubt that these restrictive financial provisions impede sound program administration; their only doubtful virtue is that they provide ample work for accountants and lawyers.

A close look should be taken at the rigidity of the federal regulations which implement the provisions of the law. I would most strongly recommend greater flexibility for the states so that program may more closely correlate to the conditions existing in the various states. Likewise, the rigid "comparability" provisions of Title XIX have led some states to deprive children of needed care because it was financially impossible to provide such care for all recipients of all ages.

Another anomaly of the law, as interpreted by HEW, permits a state to exclude drugs entirely from its program but prohibits a program feature which would pay for prescriptions on condition that the patient pay the first 50 cents or one dollar.

Your staff has done an excellent job in tracing the history of the parts our local, state and federal governments have played in financing health care services over the years, and in identifying the problems encountered.

The summary of major findings is concise, complete, and wholeheartedly concurred in.

As to the 14 recommendations before you, we urge as follows:

1. Modification of the 1975 goal provision.
2. To leave the determination of the medical indigency level to the various states, as was the case prior to the 1967 amendments.

3. To continue assurance of federal funding through open-ended appropriations – with more effective information and reporting systems to aid in estimating funding needs as recommended by the Secretary’s Task Force.
4. We do not recommend 100% federal financing.
5. Federal financial participation needs to be available for all medically needy, not just those who are “linked” to the categories.
6. The states should have more freedom with respect to liens and responsible relatives, thus adding to the financial resources which can be utilized for the purchase of care.
7. The limits on resources should continue to be a matter of state decision.
8. The exclusion of care for patients under age 65 in institutions for mental disease should be abolished.
9. The provisions relating to state-local financing should remain as they are.
10. States should be encouraged to remove any barriers to the use of prepayment systems and group health systems, both of which have become recognized components of the “mainstream” of care.
11. The rigid requirement of the application of the Medicare hospital reimbursement formula should be carefully re-examined.
12. Experimentation with different payment systems and health care delivery systems should be encouraged.
13. States should be permitted to modify the comparability of services so that limited funds may be utilized on a professionally developed priority basis.
14. States should be encouraged to use the “declaration” form of application, but there should be no mandatory requirement.

Again, we believe that the vicious cycle of sickness and poverty needs to be broken by a sound medical assistance program. In principle we favor the enactment of Title XIX, which expanded the beneficiary population from the aged (as provided for under the old Kerr-Mills law) to additional population groups. But we also believe that the law can stand sensible revisions in the areas mentioned above.

As I stated before, I shall be glad to attempt to answer any questions either now, or at any time during the course of your meetings.

**STATEMENT OF
DR. KENNETH M. McCAFFREE
PROFESSOR OF ECONOMICS
UNIVERSITY OF WASHINGTON
SEATTLE, WASHINGTON**

Thank you, Mr. Chairman. Members of the Commission; ladies and gentlemen. I appear before you as an individual. I do not represent any organization or any agency of the government. Accordingly, any judgments which I express are entirely my own.

My interest in health affairs, and in Title 19 problems in particular, arises from experience, both personally and professionally, in the analysis of economic problems in the health area. I am now a professor of economics at the University of Washington where I offer courses in the economics of health and have participated in several research projects on the economics of health care. In addition, I am an Associate Staff member of the Health Resources Study Center which is a part of the Medical School at the University. Not only am I a consumer of health services, albeit as infrequently as possible, but I served for ten years as a member of a board of trustees of a consumer controlled health care organization which provides health services to over 100,000 persons in the Seattle area, and was president of the Group Health Association of America, the national organization of group practice prepayment health care plans, from 1964 to 1966. Finally, I am now a member of the Washington State Comprehensive Health Planning Council and of the Governor's Task Force on Vendor Payments in the Department of Public Assistance.

My comments this afternoon shall be confined to an analysis of the economic problems in two major areas under the Title 19 program. First will be a brief examination of the feasibility of the goal of comprehensive care for substantially all the needy and the medically needy by 1975, as is set forth in Section 1903(e) of Title 19. Second, I want to discuss two problems in the administrative area, particularly in administrative procedures and the relationship between Title 18 and Title 19.

The Goal of Comprehensive Care for the Needy

I seriously question the practicability of attempting to provide comprehensive care for substantially all the needy and medically needy by 1975. I reach this judgment for the following reasons:

In the first place, an attempt to provide comprehensive care for substantially all of the poor in this nation will expand the demand for health services by at least 10 percent, and by perhaps as much as 20 percent annually over present levels. Such an expansion of expenditures for medical services will only intensify the current crisis of spiraling prices and costs of health care. There is no evidence now that the health industry can expand its supply of services fast enough to accommodate even present levels of demand without inflationary price trends. It is no accident that increases in hospital daily service charges have been 16 to 20 percent in each of the last two years and that physician fees have gone up at the rate of 6 to 8 percent per year.

This is precisely the period during which substantial expansion of expenditures for health services has taken place under Medicare and Medicaid. Thus to extend the Federal Medicaid program at this time toward the comprehensive care for substantially all the poor is to compound the economic problems which the

health care industry now faces and to force upon all the American people a further substantial rise in the cost of their health care.

In the second place, the expansion in the number of persons eligible for the presenting themselves for care will overtax the health system's ability to provide these services without serious deterioration of the quality of care. There is some evidence that the quantity of health services available and delivered to the poor has indeed increased during the last two or three years. But at the same time, doctors and health professionals have clearly been overburdened. More consultations are made by telephone than previously. Shorter doctors' visits are the rule. Some consultations are in fact being eliminated. Physicians everywhere complain of long hours, overwork, and insufficient time to advise patients properly. In some areas of the nation inpatient care is also in very short supply, frequently in old and inadequately equipped hospitals. All of this adds up to the threat, if not the actuality, that the quality of care has, as a matter of fact, declined for most citizens. It is no secret, at least in my part of the United States, that the public assistance patient may be the most adversely affected.

Consider the consequences of an expanded Title 19 program on the rest of society. Given the shortage of health services and the inability of the health industry to expand services rapidly, the quantity as well as the quality of services available to the great American middle class, may in fact have declined as health resources are bought by Departments of Public assistance and directly diverted to the care of the needy. Rapidly rising health costs will force more and more families into the categories of the medically needy and even the needy, and further increase the already burdensome cost of the Title 19 program.

As an economist, I cannot within the limits of my discipline properly question the equity in this redistribution of health services from the middle class to the poor which, in my judgment, is occurring. I would, however, like to offer the following observations:

First, for those equalitarians who seek to equalize income levels among the American people, the Medicaid program only reshuffles from the middle incomes to the bottom incomes and fails to reach or touch the high income groups who in fact can readily afford medical care at even higher prices.

Second, if one looks behind this present generation, the welfare of the "poor" has been more substantially improved and in much greater amounts by increases in the productivity of the American economy than by any equalitarian proposals to redistribute current income from the "haves" to those who have less.

Finally, I would predict, and I suggest this is worthy of consideration by elected public officials, that, given these considerations and the circumstances which I have described above, we may soon see a "revolt of the middle class" if further upward pressures on medical care prices and health costs are continued by a further expansion of the Title 19 program.

Comprehensive Care for all the People

It appears to me that the appropriate goal for social policy in the health field is the establishment of a system of comprehensive health care for all the American people and not alone for the poor and the disadvantaged. To this end there are clearly two steps to be taken, which in my judgment, far surpass in importance any increase in expenditures for health care under the Title 19 program.

In the first place, it is imperative that the supply of health services be increased at a very rapid rate until the upward spiral of prices and costs has appreciably slackened. Health personnel of all types are seriously in short supply. Training facilities are greatly needed. Medical schools now in the process of development must be assisted to achieve capacity operation quickly. New occupational classes of personnel in the health field, such as physician assistants, midwives, subprofessionals of all types, are needed and can

be used effectively to reduce costs and increase the efficiency of the health care system. Alternatives, substitutes, and supplements for intensive inpatient care must be developed, such as convalescent centers, nursing homes, home care programs, and similar activities.

The second step toward comprehensive health care for the American people is the abandonment of our traditional and, I say, archaic system for the organization and delivery of medical care. The reorganization of health care into a viable, efficient, and effective system is called for now. No one, except possibly physicians and a few other health care providers, seems to gain from the fragmented organization of medical care which is based today upon the independent, solo practice of medicine. It is financed primarily by an indemnity insurance and fee-for-service mechanism, which rewards providers for treating illness and disability rather than for maintaining and preserving the health of the American people. The technology of medicine has changed and with it must come changes in the organization and delivery of health services. We can no longer depend upon or afford a health delivery system which requires, consumer-patients to move from one solo practicing specialist to another, each treating and responsible for only a part of a whole man. We must develop now new and alternative forms of medical care organizations and a more efficient health care system.

The relative success of prepaid direct service group practice plans, such as the Health Insurance Plan of Greater New York, the UAW's Community Health Association in Detroit, and many others across the nation, in reducing the costs of high quality comprehensive care commends this type of organization. Indeed, the predominance of "custom-made" shops in health care must give way to the concept of the "supermarket" where health care is delivered by multispecialty groups of physicians and a great variety of supporting semi-professionals and paramedical personnel, working together as a team to meet all the medical needs of the individual. Hospitals must be organized with salaried physicians on their staffs who provide outpatient as well as inpatient professional services, clinics of all types should be developed where some physicians can work for other physicians under all manner and types of employment and partnership arrangements. Private organizations of various kinds should be established whose business it is to provide health services to the patient-consumers. The notion that only a health professional, primarily a physician, must manage the business of health care is false. All types of administrative and payment arrangements, both for consumers and for health professional are feasible and required. There is nothing sacred about solo independent medical practice and the fee-for-service payment system. Nor is this system necessarily most efficient in every situation and circumstance. Rather efficiency will clearly be increased by further rationalization of medical care organization and by increased competition among the forms and types of medical care organizations.

If the delivery system for health care is to be improved, action is required to remove legal limitations on various potential new forms of organization of medical care. Positive steps must be taken to encourage experimental organization as well as to promote those delivery systems which have already proved their worth. Licensing laws in most states must be rewritten to legalize what may be done by subprofessional personnel and to recognize that medical care provided by a team, headed by a specialist physician, is entirely different than permitting such subprofessionals to practice on their own in independent practices. Group practice prepayment plans are effectively excluded in 20 states, for which there is no economic or, in my judgment, health care basis whatsoever. In Washington State only a licensed dentist, except for the School of Dentistry at the University of Washington, is permitted to own dental equipment. This is sheer economic nonsense. Yet similar restrictions and limitations on the types and forms of medical organization and payment systems for health care exist elsewhere. These must be, I repeat, must be, repealed in the interest of economic efficiency and, I say, to improve the health of the American people.

I am confident that a variety of health care organizations of different types dedicated to the delivery of high quality health services, will develop with the removal of many restrictions and limitations. The urgency of the situation however, dictates positive support by governmental and collective action. Funds can be used through Hill-Burton grants, or by special low interest rate guaranteed loans direct from various

governmental programs to encourage experimentation and to establish a wider range of health care organizations. Support should clearly be given, and in my judgment in massive amounts for the development of multi-specialty group practice prepayment plans. These organizations now promise the most immediate and direct method by which the goal of comprehensive care for substantially all Americans can be achieved in the near future.

My comments have been much too brief, but if comprehensive health care at prices we all can afford is to come to the American people we must reorganize the health system, and we must increase the supply of health services. Increasing the efficiency of our system and increasing the quantity and quality of health services will be major steps forward in improving the health and welfare of all of the American people.

Problems in the Administration of Title 19

There are two problems in the administration of the medicaid program which are primarily economic in content and which stand out with respect to both Title 19 and Title 18 of the Social Security Act. The first concerns the doctrine of "reimbursement of reasonable cost" for hospital care and its companion principle of compensation for physicians on a "usual and customary" fee basis. The second problem is the development of utilization control programs in connection with health services for these on public assistance.

Reimbursement of "reasonable" cost and "usual and customary." As an economist, if I were asked to develop an inefficient system of reimbursement or compensation for hospital services, I would find it extremely difficult to develop a more inefficient one than "reimbursement of reasonable cost." If costs are reimbursed on an individual hospital basis, there is no incentive for any hospital to be "cost saving" or "efficient" relative to any other hospital or health care provider. Any "reasonable" cost is reimbursed, and economic efficiency – the economic use of resources – in any sense becomes irrelevant. Let me illustrate this point.

If I were a hospital administrator and presently employing, say five nurses, in a particular wing of my hospital, I would ordinarily consider whether the additional cost of the sixth nurse brought at least equal benefits or improvement in the operation of that wing of the hospital. Under a doctrine of reimbursement for reasonable cost, at my own hospital I would have incentive to look only at whether I could show that the addition was "reasonable" since, in that case, my costs would be reimbursed. There is no way within the present system of reimbursement on reasonable cost basis to assure that benefits commensurate with costs have been obtained by marginal expenditures. In fact, the number of full time employees per patient in the hospitals of the nation range from less than two to over three, and so far as I know, no tests have been made by the administrators of the Title 18 or 19 programs to determine which of these employee-patient ratios, if any or all, are economically most efficient, nor is there any reason to do so under the present reimbursement policies of Title 18 and 19.

Let me give you another example from the city of Spokane, which has four hospitals for its 250,000 people. There are now three cobalt machines, which you know are extremely expensive pieces of equipment, for the treatment of cancer. I understand that two machines are adequate to treat the cases among a 250,000 population. We now have a fifth hospital going up in Spokane, which wants also to install a cobalt machine. Thus, we will have four pieces of equipment, twice what we need for that community in terms of medical needs, and yet every one of those hospitals will be, and is being, reimbursed full cost of operating those machines under the reimbursement of reasonable cost principle.

Some modification of the policy on reimbursement of reasonable costs is clearly in order. A first step would be the establishment of rates for given services which will be reimbursed thru the medicaid and medicare programs. These rates will need to be set on the basis of costs, but costs which represent a group of hospitals, and not the costs of a single hospital. This can be accomplished by looking at the costs of a group

of hospitals in a particular area, city, or region where wage rates and the prices of hospital supplies are likely to be closely comparable. A careful audit and analysis of the cost of various services provided in each hospital must be made, and then the rate for reimbursement based on the *median* cost among the group of hospitals. In this case, the high cost, inefficient hospitals – those in the upper end of the distribution – have incentive to improve in order to bring their costs down to the point where they are covered by the rate of reimbursement. Those under the median have continued incentive, through their margin or receipts over costs, to keep their costs low. Appropriate standards of care and services must also be set and continually reviewed, in order to assure an adequate quality of hospital care.

With respect to the “usual and customary” fees for physician services, we can make essentially the same observations. There are no built-in incentives, in the absence of competition among physicians, to control the upward spiral of fees, and the establishment of successively higher and higher levels of “usual and customary fees.” The problem of regulation, however, is of a somewhat different kind because of the unit of service concept, or piece work basis, upon which physicians are paid. Although the setting of fees is a possibility, I think that the principal way rapidly rising costs of physician services can be held in check, is to insist that a large proportion of physicians, in one way or another, be placed on a “capitation” basis of payment. In this case the physician is paid so much per month per person for whom he is responsible for providing services. Under such a payment plan, the physician is compensated to get persons well and to keep them well rather than be paid for each service provided only when persons are ill.

Utilization control programs. The last point upon which I wish to comment, and this issue is referred to in a number of places in the preliminary report of the Commission, is the need for the States to develop utilization control programs under Title 19. This is probably the major administrative problem in the medic-aid program at the state level, and for which, so far as I know, no satisfactory solution has yet been found.

There are several major considerations if “over utilization” and “unnecessary” services are to be avoided in the Title 19 programs. The first is the setting of standards for health care. Cooperation between the physicians and health professionals and the Departments of Health and/or Public Assistance is essential. I am not sure how this will be accomplished since the medical profession has not been especially cooperative and to date we have not been very successful in the state of Washington. At the least, the actual patterns of practice can be observed and standards set from these. On the other hand, setting standards of utilization and health care should also involve some professional judgment, and there the physician plays a role. Once the standards are set, and note that I am using the word “standards” rather than “controls,” patterns of practice and utilization will follow. Costs can be kept within reasonable bounds. Let me illustrate.

Most providers will keep a patient in the hospital between five and seven days for an appendectomy. Let this be the “standard” for the utilization of hospital and physician services for the care of a welfare patient under Title 19. It seems to me that efficient use of hospital and health services would follow from comparing the services on a particular case to this standard. It is not at all impossible for the local welfare or Title 19 administrator to call the doctor or the hospital administrator on the fifth day, and ask “How is our patient?” Such an action does not mean that the patient is to be sent home, or that the doctor is told how to treat this patient in this particular case. On the other hand, it lets the physician and the health care provider know that there is some surveillance on the relation of specific care to reasonable standards. If, therefore, some cooperation can be obtained from the health professions to establish the standards, there will develop a self-policing system which I believe will work reasonable effectively in regulating utilization. This system has been used to a limited extent in the State of Washington, and as I understand the statistics, the average length of hospitalization of welfare patients in the state is one of the lowest in the nation. Of course, some may claim that poor people are sent home when they are still sick. This statement implies that physicians in Washington send people home from the hospital when they should not. I have found no evidence to support this claim. The system of utilization standards and control which I have outlined merits careful consideration for adoption in the Title 19 program.

Thank you very much for your attention and for the consideration of these remarks.

**STATEMENT OF SENATOR
JAMES I. GIBSON
NEVADA STATE SENATE**

Thank you Mr. Chairman and ladies and gentlemen of the Commission. I appreciate this opportunity to participate in your meeting here concerning this vital question which faces all of us, and I am especially grateful that there has been an opportunity afforded here to hear from a representative of a small State. As I looked over your report prepared by the staff and consider the magnitude of the figures mentioned there I realize, of course, that what happens in Nevada is of rather slight significance to the overall program. Yet we find in Nevada that this has had a major impact and is a very serious program for us in its fiscal implications as well as other general implications and priorities for utilization of our resources.

In Nevada, we were quite hesitant to enter into Title 19. We had a great anxiety about its effect on our ability to properly finance as well as our ability to maintain those programs which need financing and financial increase. And so we went into the program with great hesitation and anxiety and with some reluctance. It was an experience in intergovernmental relationships, however, because the State was pressured both from the Federal position and from the local government position to enter into this program.

In the Special Session in 1966 an effort was made to adopt the Title 19 program. The effort was not successful at that time because we were unable in our deliberations to reach any kind of conclusion as to what the cost of the program might be in the future and as to what our obligation in the future would be. We sought the assistance of the Federal people in the regional office in helping to explain the impact of the program and while we were informed, we did not receive any help. The law that was before us specified that we would accept the Federal regulations that would be forthcoming. When we attempted to find out what these Federal regulations were, we found that they had not yet been written. We were informed too that the people to write them had not yet been employed. Because of this we could not accept the program in such a session.

Pressures continued to mount and in the regular session of 1967 we entered into Title 19, effective with the beginning of the fiscal year in July. At that time, the bill as adopted was intentionally designed to contain only the minimum requirements that would meet the regulations specified by the Federal Government in the Federal program. And so in the beginning in our program we accepted or adopted the program that would meet only the categorically needy for which we were already providing under our welfare statutes.

By October of 1967 after only four months of practice, it was obvious, after a study we had made in an attempt to determine cost, that we were woefully under-financed. It became necessary in a Special Session in 1968 in February to consider substantial supplemental appropriations to carry out this minimum program of Title 19. The need for additional expenditure was caused by the fact that we had no effective control over the cost and the fact that we had not been able to develop a workable program. Looking back, it would have been much better had we authorized entering into this program at some date in the future, giving lead time for the State departments involved to prepare procedures and programs which would take care of the immediate program.

Again, we sought Federal assistance in guidelines for specifics of management control and were not able to receive any assistance there. We went to all of the other States that we had communication with,

and certain of those were of a similar size, and out of the suggestions from them plus our own thoughts on the matter, we began to evolve a program with controls on the management procedures.

I met yesterday with our people in the State departments who are responsible for Title 19 and we find that the controls and administrative procedures are being effective. The upward cost of this program now has been arrested and we are stabilizing. The information that is coming in now is more accurate and we have greater confidence in the fact that it actually represents the condition as it is.

In our first year's experience we found that the cost was approximately 50 percent greater to the State and the county than had been the Kerr-Mills program of which we had previously been a part. In this cost we found a major factor of increase to be in the area of nursing home care. We have heard and seen a lot of publicity on the costs of physicians' fees and I think there was a general feeling that this is an area of greatly increased expenditures, but the facts and statistics did not bear this out. In Nevada prior to the institution of this program through arrangements with the State Medical Association the medical care of indigents and those in the need of medical help had been on a donated basis, and while physicians' fees now paid are definitely on the increase, they are not a substantial portion of our overall costs. In Nevada, over the past year the most important components of our costs have been hospital inpatient care, which has been 40 percent of the total cost. Physicians' care has been 12.9 percent, pharmacists 6.4 percent, and dental 4.6 percent.

The great problem area that we have in cost control is in the matter of nursing homes. Here again we find some difficulty in proceeding to try to arrest the cost in this area because we have to maintain separate standards which will fit in with the Federal programs. I am informed that there is yet no definition of an intermediate care facility, and yet obviously there are many of our patients in the skilled nursing homes that can be very well taken care of in intermediate type facilities at much less cost.

One of the problems that we found too in the initial phases of the program was the zeal of the professional social welfare worker in attempting to bring the services of the program to people throughout the community. We had instances where the case worker advised people in one level of nursing home to transfer to a different home where they could get more care at considerably greater cost. Another interesting factor that came out of our study of the application of the program in Nevada was the fact that private institutions' costs — at least those that are being paid for out of the Title 19 program — were running about half the cost of public institutions for similar care.

Among the controls that we perfected in the last year we have instituted utilization committees of the professionals. We have hospital and nursing home care utilization committees that are being very effective and help reduce our costs there. Our initial studies indicated — as other speakers here talked about — that the stay in a nursing home or a hospital for a similar purpose or treatment was averaging two or three times the length for the patient under Title 19 as it was for private patients. There is a similar statistic of Title 18 for Medicare. This has been cut down through the use of utilization committees. We have also named committees of the professions which now are helping us to screen the application of the program in those professions. We have received after initial coolness good cooperation from the professions — medical profession, dental profession, pharmacists, and others involved in the various types of care. We have strengthened the pre-authorization. One of the things we found was that at the beginning of the program many cases were coming in for care without authorization and at a level that had not necessarily been reviewed ahead of time and that they were receiving care. This was particularly true in the matter of dental care. Now we have strengthened the pre-authorization requirements and this has helped considerably.

In the future development of the program in Nevada we are attempting to move in with greater emphasis to the areas of preventive and earlier care with the idea that this will help cut down the severity of cases later on. We are looking very seriously at increasing the home health aid program with a view to cutting down the present cost of nursing home care.

Our major concern in Nevada is in what the future holds as far as the Federal attitude towards us goes. We have felt the impact of this in past programs where we begin as a partner of the Federal Government although we often feel we are unevenly hitched because we are required to share in the financing but have very little to say about the regulations. But we found that after getting into a program the Federal Government has backed out and we are left with the major cost of the program, which puts a great strain on us in attempting to follow it up and we are concerned in this particular program. We are now financing at the State level a program which takes 10 percent of our general fund revenue at the present time where three years ago the expenditures in this area were less than half that large. We feel great anxiety as to what the trend of the Federal Government's concern or interest may be in the program financially.

Also we are concerned that too much uniformity is sought in the program as it expands and develops, and too little account taken of the differences of communities, States and regions which in effect override the knowledge and concern and interest that the local people have in such programs. We feel that this would be detrimental and would not be necessarily helpful in the overall presentation of health care to our citizens. We do feel considerably better about Title 19 today than we did three years ago and are thoroughly alleviated in our concern over the fact that we do see opportunities to make greater improvements in the program.

Now we have one or two other things of concern. We find that we don't always understand Federal language. I have been reading the Federal manual, the regulations on Title 19. It is an arduous task for a country boy to go through those repetitive pages, words upon words, and try to find the points that are applicable or really understandable. We are trying to simplify the manual for the State of Nevada and we were interested the other day in seeing that one of the parts of the manual had been adopted as a Federal regulation and had not been changed; but of course, I think the length of it was three times what it was as initially offered in this State. We would like the opportunity – and I think the Commission might express some concern in this matter – to be able to have a chance to review and comment on these regulations as they are developed so that we might not only have a voice in the development of such regulations, but have a better understanding of them when they are developed so that we can implement them in a better manner. We believe that there is a great gap of communication between the Federal people responsible for administering this program and those on the State level. For example, in our Special Session this year in February we wrote to the regional office requesting certain information for our enlightenment. I admit that the questions might have seemed very simple, but to us they were important. And finally, we received an answer in June. Of course the Special Session had been over for four months and by then we were on down the road. But there is a lack of communication here that I think is one of our problems in trying to properly implement this particular program.

We would like to request that the goals that have been enunciated be modified with respect to the dates that must be met. We have no present hope that we can possibly have the full program including the so-called medically indigent in Nevada, and the financing, by 1975. We are working towards it. Our hope is to improve our participation, but with our present projection of revenues and needs, we don't see how we can possibly meet that date.

We will endorse any recommendations that leave greater determination in the application of this program to the local officials. We are opposed to Federal standards, especially minimum standards, and we are opposed likewise to 100 percent Federal financing because we feel this is not in the best interest of us Federal taxpayers as well as State taxpayers. We do feel that if the Federal Government requires expansion in the program to cover those who are medically indigent including the noncategorical, that there should be some participation from the Federal Government in financing such programs.

We do not like the carrot and stick approach, and it has been a problem for us in all of these programs that come to us from the Federal level. We hope to maintain our independence. We have a tradition of taking care of our own and we certainly intend to continue to see that no one in the State suffers from

lack of care. We would like the opportunity to be able to establish priority for ourselves within the goals and the resources which we have available.

Thank you.

**STATEMENT OF
DR. H. D. CHOPE
DIRECTOR OF PUBLIC HEALTH AND WELFARE
SAN MATEO COUNTY, CALIFORNIA**

First, may I thank the Advisory Commission at this hearing. Your problem is one of great interest to all physicians and health personnel.

Second, no one could help but be impressed by the monumental amount of basic information, tables, discussion, and possible proposals provided by the staff in the preparation of the "draft" for this hearing.

Third, the universe in which I work is microcosmic in comparison to the problems faced by your Commission.

The universe in which I have served for the past twenty years is San Mateo County, just to the south of San Francisco. If you flew into San Francisco, you landed in San Mateo County, where the San Francisco Airport is located, as well as the San Francisco water supply, their cemeteries, their garbage dump, the jail and their juvenile camp. San Mateo County is a small county (448 square miles) facing easterly on San Francisco Bay and westerly on the Pacific Ocean. A large part of the southwestern part of the county is still covered with heavy redwood forests. Most of the 554,000 population live in the bay side of the hills which is relatively free of fog. The population is young, only 7.2% over age 65 and 34% under 18, giving a median age of 30.6 years. The county is relatively rich, being rated as the fourth wealthiest county in the nation, with an average income per household of \$11,748.00 (1967). The educational level of the community is high, 30.2 percent of the population being college graduates. The principal industries are the airplane industry, electronics, publishing, and insurance.

The county has an unusual organizational pattern dating back to 1933, when the citizens adopted a charter. This charter provided for a combined department of Health and Welfare. In the last two decades, to the existing Public Health Department and the Social Service and General Hospital have been added a Tuberculosis facility, now used for geriatrics, a Rehabilitation Center, and a Community Mental Health Service.

It is from the direction and efforts at integration of these humanitarian services that I have distilled my opinions. They are relatively simple, and are presented for your consideration.

I feel very strongly that the American professionals, the American public, and the American needy have been captured by two cliches, namely — "Mainstream medicine" and "Elimination of segregated medical care" at the "Usual and customary fees." Mainstream medicine is presented as providing for the needy the same kind of medical care the highly qualified physician provides to his rich patients or his well-insured middle class patients. This concept can function for the poor who are motivated and for certain conditions which can be handled on a short-term basis, such as an appendectomy, child birth, all too frequently without prenatal care, trauma due to accidents. The question is: Will mainstream medicine be successful in the prevention of pulmonary fibrosis, or pulmonary emphysema, or lung cancer due to excessive smoking? Can mainstream medicine prevent gastric ulcers, which Hans Selye, the distinguished Canadian physiologist, has demonstrated is the result of intolerable stress? Can mainstream medicine do much for the case of coronary occlusion — rich or poor — which Dr. Paul White holds is associated with stress and lack of exercise? Can mainstream medicine do anything to prevent the knifings and shootings which occur in the ghettos, except

to patch up the wounds? What can mainstream medicine do to prevent the suicide gestures with the overdose of barbituates or the slashed wrists, except to pump the victims' stomachs and sew up the slashed wrists? What can mainstream medicine do to prevent the common usage in all economic levels of our youth of tobacco, alcohol, marijuana, amphetamines, goof balls, or LSD? A survey¹ of 18,744 high school students in our county, conducted in June of 1968, showed a varying usage of dangerous drugs ranging from a high of 64.9% for alcohol, 32.0% marijuana, 16.3% amphetamines and only 10% LSD.

Other conditions which plague our society and are not susceptible to elimination by mainstream medicine are: the distressing disease of ulcerative colitis which many physicians feel has an emotional causation; the advanced cirrhotic with bleeding esophageal ulcers due to chronic alcoholism; the battered child syndrome, resulting from abnormal emotional reactions of parents; and the severe asthmatic whose attacks follow emotional stresses. This list of examples could be enlarged ad infinitum, but I am sure the point has been made that mainstream medicine can no more solve these health problems for the needy than they can, acting alone as a solo practicing physician, for the wealthy. And, so, does MEDICAID only support a system known to be ineffective?

A second long-term observation has confirmed the impression that certain elements of the needy group are not motivated to seek medical care, accepting general poor health as a "way of life." A few years ago, we did complete physical examinations on a group of AFDC recipients in the northern part of San Mateo County.² A total of 704 individuals was examined, including parents (mostly women) and children. It seems safe to generalize that much of the AFDC caseload is pretty well damaged before their first application for aid. The picture of these families is one of inadequate opportunity, together with undeniable lack of ability or education. Often these families had been on the move for a long time. Their opportunities for medical, dental, or psychiatric care had been limited, their needs considerable, and their efforts to seek out such care as might have been available most confused. These families were reservoirs of long-term untreated illness. The adults were sicker than the children because they had had a longer time to acquire their pathology.

A typical profile of the women examined would be as follows:

- women between the ages of 18 and 45
- each with from two to six children and several unproductive pregnancies
- obese, because they lived on a carbohydrate diet
- suffering from nutritional deficiency anemia
- many with symptoms of thyroid deficiency
- in need of dentures, or, if they still had teeth, in need of extensive dental care
- a high percentage in need of glasses
- suffering from varicose veins and/or hemorrhoids

¹Mimeographed report to Chairman, Narcotic Advisory Committee, by Lilian S. Blackford, Health & Welfare Statistician, July 29, 1968.

²Mimeographed Project Report, "Coordinated Health and Welfare Services for Aid to Needy Children Families," H. D. Choep, M.D., Dr. P. H., and Lilian S. Blackford, Health & Welfare Statistician, June 1963.

- complaining of “female trouble” or pregnant
- allergic
- severely accident prone
- complaints of constant “nervousness”

These findings were extremely depressing and disturbing to me as a health officer and a county medical director with the responsibilities of promoting health, particularly in a rich county with a skilled medical profession, P.A.M.C. medical funding available, as well as a modern, well-equipped outpatient facility.

These are only two examples from my own limited experience in the field of attempting to provide health services to the needy. Many more could be cited, but time does not allow. A major question which concerns us all is: Can the nation afford to pay 4.5 billion dollars for these services, as now projected by 1969, for mainstream medicine and private hospital care for citizens which neither doctor nor hospital can really reach, cure, or restore to maximum potential function?

Mr. Scott Fleming, in his minority report to the Secretary’s Advisory Committee on Hospital Effectiveness³ has stated:

“I suggest that the industry’s purpose is wrongly conceived; the industry should develop the capability of delivering comprehensive health care for *people* rather than merely providing episodic treatment for *patients*. In a pluralistic society there will be various organizational approaches: the ‘systems’ to which the Secretary referred. Physicians exercise primary authority over how health care resources are used; comprehensive, integrated systems in which they will participate with economic responsibility hold most promise. But by whatever means, it is important that physicians and hospitals join in developing economically self-sufficient modes of functioning before public impatience with irrationalities in the health care industry forces a political ‘solution’ as the ‘least worst’ alternative.”

A suggestion which I would like to leave with the Commission is as follows: Would it not be more intelligent to provide more funds for the new section of HEW, known as the National Center for Health Services Research and Development (NCHSRD) than to continue banging our heads and our largess against the impenetrable wall of ignorance, deprivation, poor motivation, and social and professional resistance? I fully realize that research is frequently used as a method of delaying action until the ideal line of approach can be determined. In the MEDICAID problem the implementation is on the law books before the research has even been initiated. However, it would seem obvious that, unless some better methods of delivery of medical services to our population are delineated, the cost will continue to skyrocket without delivering to the citizenry the type of medical care visualized by the authors of Title XIX. The type of research I conceptualize would be performed on a very broad base, involving not only physicians and health personnel but anthropologists, sociologists, demographers, representatives of the insurance industry, and other vendors of medical care. Congress has authorized \$20 million for the NCHSRD for the current year and \$40 million for next year. However, as far as I know, this amount of appropriation has not yet materialized. To continue basing our aspirations for good medical care on mistakes of the past would seem to be totally irrational.

³Secretary’s Advisory Committee on Hospital Effectiveness Report, U. S. Dept. of Health, Education, and Welfare, pp. 35-36, U. S. Govt. Printing Office: 1968, 0-295-545.

**STATEMENT OF
CHARLES H. SHREVE
DIRECTOR, REGION IX
U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE**

Mr. Chairman, ladies, and gentlemen. It is a privilege and a pleasure to be with you today and to follow the distinguished persons who have already testified on the important problems in Medicaid. Before beginning my remarks, it might be well to outline briefly for you my relationship to Medicaid.

As Regional Director of the Department of Health, Education, and Welfare, I am in charge of that Department's activities in the States of Alaska, Arizona, California, Hawaii, Nevada, Oregon, Washington and the Territories of American Samoa and Guam, as well as certain activities in the Trust Territory of the Pacific Islands. The principal agencies which comprise the Department of Health, Education, and Welfare are (1) the U.S. Public Health Service, including the Food and Drug Administration; (2) the Social and Rehabilitation Service, including the former Welfare Administration, Vocational Rehabilitation Administration, Children's Bureau, and Administration on Aging; (3) the Social Security Administration; and (4) the Office of Education. My duties include personally representing the Secretary of the Department to the Governors of the States and Territories served, as well as supervising the administrative and technical staffs of the various component agencies and bureaus located in the Regional Office; reporting to the Secretary on problems, successes, failures, and making recommendations for needed legislation, changes in administration, organization, programs; and providing leadership, coordination, evaluation, and administrative supervision of the multiple activities of the Department within the geographic area assigned, wherein the Department's grants and Social Security payments total five billion dollars a year.

Obviously then, I am not a technician nor an expert in any of the 230 programs administered by our Department. Title XIX of the Social Security Act as amended, Medicaid, is actually administered through the Medical Services Administration of the Social and Rehabilitation Service with a small staff in each Regional Office. However, even though I am not a technician, I have a close association with the Medicaid program, as it is one of the larger programs of the Department and one on which I have conferred with each of the Governors in my seven States on a number of occasions, and one on which I frequently confer with my Regional Commissioner of Social and Rehabilitation Service and his professional staff concerning details of the program.

May I say, in opening, that I am quite impressed by the Commission's draft of "Intergovernmental Problems in Medicaid." The staff of the Advisory Commission deserves considerable credit for this comprehensive and factual compilation and the 14 recommendations and several alternatives. They are on a par with the best previous work of the Commission.

Many of the problems reviewed in the draft on "Intergovernmental Problems in Medicaid" have been experienced by States in Region IX. During the first week of September 1968, my staff talked with State officials in all States, to update our information on problems in Region IX Medicaid programs. Their experience parallels the problems in the Commission's draft. There was general agreement that the major problems in this Region centered around four areas. One of these problem areas is probably unique to our Region. As I did not find it touched on in the Commission's draft, I will bring it to your attention now.

1. SPECIAL PROBLEM IN ALASKA AND ARIZONA

The only two States in Region IX which have not implemented the Medicaid program are the States of Alaska and Arizona. The primary reason for not implementing the program is the question of how many of the Alaska natives and Indians in these States would transfer their medical care from the Division of Indian Health of the Public Health Service to the Medicaid program. If many did, both States say they could not finance a program. At present, full-scale medical attention, including hospitalization, is furnished to Alaska natives and Indians by the Division of Indian Health completely at Federal expense. If substantial numbers of these persons now being given health services without any State contributions chose to use Medicaid, and under present regulations it is a primary source, the State would in effect have to pay approximately 50 percent of the cost of their care, which could be disastrous to both States.

Some indication of the size of the problem to Alaska and Arizona is enlightening.

The entire population of Alaska in 1960 was 226,000. Today, it is estimated to be 265,000. The Alaska native population, that is, Indians, Eskimos, and Aleuts, totals almost 44,000, roughly 20 percent of the total State population.

In Arizona, the situation is a little less drastic but still serious. The total population in 1960 was 1,300,000, and is today estimated at 1,600,000. American Indians on reservations in 1963 totaled over 83,000, about 6 percent of the total population.

The large Alaska native population and the reservation Indian population in Arizona would be eligible for a State Medicaid program. These States are afraid to implement programs for fear they would not be able to finance them should many of these people transfer their health services and hospitalization and complete medical care from the Division of Indian Health Services to the State Medicaid program. They allege a disproportionate number of Indians are on welfare programs.

Discussions with the Governors and the State health and welfare directors in these States have revealed some suggestions which would make it possible for these States to implement the Medicaid program. These include such alternatives as:

1. Being able to consider Division of Indian Health Services a prior or primary resource for medical care. (Suggested by both States.)
2. A change in requirements which would not require States to provide medical care for reservation Indians. (Suggested only by Arizona.)
3. A higher medical assistance matching formula for these States. (This was suggested by both.)
4. Reimbursement by the Federal Government for Medicaid services provided Alaskan natives and reservation Indians in Arizona. (Suggested by both States.)

If such concessions could be made, it would seem they would have to be made under a specific plan which was directed toward phasing out such special treatment after a reasonable length of time.

I should add that Nevada, for a while, was equally concerned with this problem of Indians. The legislature even considered repealing their action which had provided for their Medicaid program. I was able to reassure Governor Laxalt in Nevada's case because the figures were less worrisome. Out of the 1960 total population of 285,000, Nevada had only 6600 American Indians on reservations, or a little over 2 percent. With the phenomenal growth in Nevada and the 1968 population approaching 500,000, there has been no comparable increase in the number of Indians, so the percentage is even smaller. Furthermore, I

was able to reassure Governor Laxalt because his modest program will cover only those on welfare and the number of reservation Indians on welfare in the State is only in the hundreds, so that if all of them chose to shift to Medicaid, the cost still would not be catastrophic.

2. FISCAL PROBLEMS

Aside from the two States in this Region which have not implemented a Title XIX program, the other five all are having problems meeting the escalating costs of care. The increases in expenditures for medical care do not represent increases in the *amount* of service, but are due to increases in the *costs* of services. All of the States in this Region feel they will be financially unable to provide comprehensive medical care services to all medically needy by 1975.

While it is not necessary to dwell on the difficulties the States find in estimating costs, their feeling that they cannot financially provide the needed services by 1975 is as questionable as their experience so far in estimating costs, which has been rather sad.

During the fiscal year ending June 30, 1968, California budgeted \$305,000,000 for Medicaid. The abortive attempt to reduce services because of high estimates of costs which were predicted to greatly exceed the budgeted funds, was fortunately nullified by the courts. When the fiscal year was over, the actual cost of Medicaid in California turned out to be \$208,000,000, about one-third under budgeted costs and little over one-half of high estimates.

Fortunately, such highly inaccurate estimates of cost will have been offset by factual records of costs for a number of years well before 1975, so that it is quite possible the States will find their costs leveling out as administration improves, and hence not nearly as serious a problem as they now anticipate.

In the area of costs, I find that all five States fear being tied in with Medicare methods of payment. Apparently, they would favor your recommendation #11. There is general agreement that the reasonable cost method has greatly increased the cost of hospital care. There is unanimity that it offers little or no incentive for efficient operation, does not assure improved quality of care, and in some instances (especially county hospitals) results in Medicaid paying higher rates than the public pays for similar services. There is great concern that the Federal Government may require reasonable costs to be paid to nursing homes. This, State agencies feel, would be little short of disastrous.

The States allege that they cannot control Medicaid expenditures when the Federal Government specifically defines the people to be covered, the minimum services to be provided, the prices to be paid, and the utilization control methods to be followed. The States say that if this is to continue, there will be need for greater Federal financial participation in Medicaid.

3. COORDINATION OF TITLES XVIII AND XIX

The States in this Region feel that following the same standards for hospitals as have been established for Medicare is appropriate. However, they do not feel that it is appropriate to follow the same standards for nursing homes. They reason that Medicare is not meant to cover long-term care and the services given are primarily post-hospital care. By medical necessity, Medicaid must often provide long-term nursing home care for many patients.

There is considerable frustration in the Medicaid agencies at not being able to obtain information from the Social Security Administration which would aid in evaluating potential Medicaid program changes and assist in the administration of the Medicaid programs. Examples of such desired information include

physician fee profiles and hospital and nursing home audit reports. I am glad to be able to inform you that recent changes in Social Security Administration policies allow release of hospital and extended care facility cost reports for the first two years. Thereafter, such information will be available on a cost-sharing basis.

Some States objected to Medicaid paying Medicare deductibles and coinsurance on the basis that it is quite costly administratively, and does not control utilization. The largest State, California, did not share in this opinion.

On the matter of coordination between Titles XVIII and XIX, the last paragraph on page 4-52 of your draft seems to be out of date. It states that:

“So far only six States have adopted the (uniform) billing procedure.” The experience in this Region is that all seven States are using the Title XVIII billing form. This includes Alaska and Arizona, which have not yet implemented their Medicaid programs, as they are paying for Title XVIII deductibles and coinsurance under their non-Title XIX medical programs.

Oregon requested extensive changes which were negotiated with Social Security Administration. The other six States in this Region are using the SSA form without major revisions. I suggest that there has been considerable “push” by HEW Regional Offices and that a recheck would find many more than six States nationally using the common form now.

4. COVERAGE

There was general agreement that people should not be excluded from the Medicaid program by diagnosis and that there should be discontinuance of need for categorical linkage. It was felt that the payments for patients in mental institutions and tuberculosis institutions should be extended to all ages (your recommendation #8) and that mental illness should include the mentally retarded. Because such people do not have a permanent disability and are between the ages of 21 and 65, they are not now eligible for Medicaid. This is depriving many people who are in need of medical care and works in opposition to the goals of the program. Frequently, it results in long unnecessary unemployment and may ultimately result in total and permanent disability.

The States, and particularly the State of California, would like to see some modification on the comparability of service requirements. It is felt that there is a real handicap to providing services which are of the greatest need for children and which are not as great a need for adults. This is an area where there is great potential for providing preventative health and dental services and moving toward the ultimate goals of the Medicaid program. Your recommendation #13 would be well received by the States in this Region, although after July 1, 1969, State plans may give special services to persons under age 21, thus reducing pressure for this change.

In closing, I would be remiss if I did not thank the Advisory Commission for the leadership it has given us in the executive branch of the Federal Government in adjusting to and meeting the challenging problems of our times. The racial unrest and civil disorder, the economic and fiscal and social crises in our cities, the rising tide of crime and juvenile delinquency, all call for new and innovative approaches.

The Ninth Annual Report of the Advisory Commission, like its earlier reports, gives us many leads on revisions needed to bring our Federal system up to date to meet new and changing problems. In our Department of Health, Education, and Welfare with its many Federal-State programs, we are deeply involved in strengthening State and local governments and decentralizing decision making from Washington to our Regional Offices which are so much closer to the place where the problems arise.

Long desired innovations like the block grants provided in the Partnership for Health Act, and close coordination of the four Great Society agencies, HEW, HUD, Labor, and OEO in the Model City and Neighborhood Service Center programs, have been immeasurably helped by your research and findings. If we in the executive arm of the Federal Government accomplish our purpose of making democracy work, our success will in no small measure be traceable to the leadership and guidance received from the Advisory Commission on Intergovernmental Relations. I am sure I speak not only for myself but for the great majority of Federal executives when I say, "Thanks, and keep up the good work."

