MEDICARE AND MEDICAID FRAUDS

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

IN COOPERATION WITH THE

SUBCOMMITTEE ON HEALTH

AND THE

SUBCOMMITTEE ON OVERSIGHT

OF THE

WAYS AND MEANS COMMITTEE
U.S. HOUSE OF REPRESENTATIVES

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Medicare and Medicaid Frauds:
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Part 2, Washington, D.C., November 13, 1975.
Part 3, Washington, D.C., December 5, 1975.
Part 4, Washington, D.C., February 16, 1976.
Part 5, Washington, D.C., August 30, 1976.
Part 6, Washington, D.C., August 31, 1976.
Part 7, Washington, D.C., November 17, 1976.
Part 8, Washington, D.C., March 8, 1977.
Part 9, Washington, D.C., March 9, 1977.
(Additional hearings anticipated but not scheduled at time of this printing.)

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MEDICARE AND MEDICAID FRAUDS

WEDNESDAY, MARCH 9, 1977

U.S. SENATE SPECIAL COMMITTEE ON AGING,
IN COOPERATION WITH THE SUBCOMMITTEE ON HEALTH
AND THE SUBCOMMITTEE ON OVERSIGHT
OF THE HOUSE WAYS AND MEANS COMMITTEE,
Washington, D.C.

MORNING SESSION

The committees met, at the invitation of the House Ways and Means Committee, at 10 a.m., in the House Ways and Means hearing room, Longworth House Office Building, Hon. Frank Church, chairman of the Senate Special Committee on Aging, presiding.

Present: Senator Church; Representatives Gibbons, Rostenkowski, Corman, Rangel, Gephardt, Stark, Pickle, Bafalis, Jones, Pike, and Martin.

Also present: From the Special Committee on Aging: William E. Oriol, staff director; David A. Affeldt, chief counsel; Val J. Halamandaris, associate counsel; John Guy Miller, minority staff director; David A. Rust, minority professional staff member; Patricia G. Oriol, chief clerk; Alison Case, assistant chief clerk; Thomas G. Cline, research assistant; and Eugene R. Cummings, printing assistant. From the Subcommittee on Health: Paul C. Rettig, staff director; John Salmon, counsel; Mary Nell Lehnhard and Erwin Hytner, professional staff members; and Harvey Pies, assistant minority counsel. From the Subcommittee on Oversight: Larry J. Ross, counsel, and Julian Granger, professional staff member.

Senator CHURCH. The committee will come to order.

Representative ROSTENKOWSKI. Senator Church, on behalf of my cochairman of the House Ways and Means Subcommittee on Oversight, Sam Gibbons, the members of my health subcommittee, we would like to welcome you to this side of Capitol Hill.

Senator CHURCH. Thank you very much.

Representative ROSTENKOWSKI. We found that certainly the hearings yesterday were most enlightening and, I am sure, are going to bear fruit in legislation.

I would like to say to my colleagues that in working with Senator Church's committee, we are working under Senate rules so the cameras and recording devices are allowed in the committee room.

Senator Church, we want to again express our desire for full cooperation to build on this record so that people in the health community will be serviced by their Government in the manner in which we intend through legislation that they be served.

I welcome you again.

Now, Mr. Chairman, I am sure we are ready to proceed.

OPENING STATEMENT BY SENATOR FRANK CHURCH, PRESIDING

Senator CHURCH. Thank you very much, Congressman Rostenkowski. I appreciate coming over here to the grandeur of the House; it is the first time that I have ever been able to preside in this splendid room.

The cooperation of the Ways and Means Committee, along with the work of our committee on aging staff, has enabled us to collect the evidence that we are presenting through these hearings. I, too, appreciate the support and assistance of the Members of the House in connection with these hearings.

Before we call the first witness this morning, I would like to comment on the recognition that the new administration is giving to the revelations that began over a year ago when the Moss subcommittee of the Senate Special Committee on Aging commenced its investigation into fraudulent practices in the medicaid program. Those hearings led to a series of very shocking disclosures concerning medicaid mills, overtreatment, double billing, and widescale fraud.

The subcommittee also examined the nursing home field and uncovered a whole pattern of fraudulent practice, including the secret rebates that were given by pharmacists and other suppliers to nursing homes in order to secure lucrative contracts and then the inflated bills were being passed on to the Government.

Yesterday we really commenced a new phase of this investigation; we began our look at the medicare program. The average Federal contribution to medicaid nationwide may be two-thirds of the total amount, but where medicare is concerned the Federal contribution is 100 percent. We are also looking at the title XX homemaker/chore services in which the Federal contribution is 75 percent and here again we are beginning to uncover the same pattern of fraudulent practices.

So I am gratified that the administration itself is beginning now to respond to the disclosures that our investigations and hearings have uncovered. This recognition has been shown in several ways.

First, the Carter budget contained references to the massive fraud in medicare, medicaid, and other programs and asked for increased financial support from the Congress to stem the tide.

Second, Attorney General Griffin Bell recently issued a warning that medicare and medicaid cheaters are undermining the integrity of Government health programs and promised a high priority Federal campaign to prosecute the offenders.

Finally, as today's papers reveal, Secretary Califano has announced a reorganization plan which is justified in part by the need to place heavy emphasis upon the need for more effective investigation and prosecution of the fraud we know to permeate these programs.

So, I think, gentlemen, that our hearings are producing results. The response of the executive branch is encouraging but I think it is also clear that legislative remedies will be required. We may need a restructuring of the program and enhancing the capacity of governments at all levels—Federal, State and local—to handle the investigative and enforcement problems which confront us.

[The prepared statement by Senator Lawton Chiles follows:]

STATEMENT OF SENATOR LAWTON CHILES

Mr. Chairman, first of all, let me congratulate you for spearheading this review of the procedures of medical care agencies and the investigations into medicare and medicaid fraud.

My Governmental Affairs Subcommittee on Federal Spending Practices conducted an extensive investigation into the problems that were pervasive in the health care industry in the State of Florida. After a year of thorough investigations and study, the subcommittee held hearings on the issue in Florida.

The subcommittee, which I chair, heard witness after witness tell of irregularities, abuses and outright fraud in the home health care industry. Florida offered a classic case study of, and provided insight into, the problems that have arisen all over the country with regards to the private nonprofit home health care agencies. These agencies are practically self-regulatory and virtually independent of meaningful guidelines for operations.

Mr. Chairman, everyone agrees that the intent and validity of home health care programs is, without a doubt, a vital and important part of the lives of millions of elderly persons all over this country. The payment, for those services, as provided by the law, under medicare is also of great importance to the persons most involved—the American taxpayer. The concern for quality home health care was and is uppermost in the minds of everyone. There is considerable concern over the administration of the agencies. We have disturbing reports about some health care in Florida involving private, nonprofit home health agencies and medicare payments, which include:

Reports that persons were tested for respiratory function tests when they were not physically able to do so.

Reports that medicare has had trouble collecting from an agency which has a vast amount of money owed to medicare.

Reports that bribes and rebates are all too common in the referral of medicare payments.

The tremendous proliferation of home health agencies in the State.

Overutilization of services allowed by medicare simply because they are allowed.

Reports that some medical supply companies advertise in the media about "cost free" equipment for medicare patients.

Reports that oxygen abuses are continuing in spite of the fact that medicare authorities have been notified about this abuse.

Reports that in New Jersey, for instance, a wheelchair that cost $168 to purchase was rented for 72 months at a total cost of $1,080.

A hospital bed that cost $283.50 was rented for 58 months at a cost of $1,654.20—medicare funds pay 80 percent of rental cost.

Although these are perhaps isolated items they underscore the potential abuse that can exist in the rental equipment.

Perhaps one solution is to raise the amount that the law allows for full, immediate reimbursement for equipment from $59 or less to a higher figure. When we consider the fact that the amendment allow-

ing $50 was passed in 1968, illustrates that Congress in this respect has not kept pace with rising costs.

At any rate we need to close the "end" on equipment rentals.

Finally, I think Congress is committed to provide high-quality health care for the elderly and closing the loopholes that presently exist in the medicare/home health field.

In hearings held in Tampa and Miami, Fla., the subcommittee heard from a total of 28 witnesses. The theme remained the same: abuses and illegalities are certainly present in the program and proper safeguards are not!

The subcommittee felt that several key and important aspects of the investigation should be developed in the hearings. Those special areas were:

One: The great discrepancy between the "cost of operation" of public and private nonprofit home health agencies. The particular costs which were most obvious were skilled nursing care, nursing aide care, administrative salaries, pension plans, et cetera.

Two: The illegal payments of rebates, referral fees, bribes and kickbacks with involving false medical reports and highly questionable medical practices.

Three: The overutilization of home visits by private, nonprofit home health agencies often to the detriment of the patients involved. The investigation by subcommittee staffers turned up instances where many patients were forced to turn to public agencies after being dropped by the private agencies after their allotted medicare visits had been exhausted.

Four: The overutilization of durable medical equipment to the extent that many times the original cost of the item has been greatly exceeded in the payments of rental fees.

Five: The steady proliferation of private, nonprofit home health agencies in Florida because of the ease involved in the establishment of such an agency.

Six: The possible conflict of interest that exists when a doctor owns or has substantial vested interest in a home health agency where he refers patient/clients.

Seven: The deliberate evasion of certain aspects of the law in order to gain an unfair competitive advantage by some durable medical equipment dealers. Prime example of this type of practice is the agreement that the DME dealers customarily forgive the 20 percent co-pay and instead turn it over to the private, nonprofit home health agency "for doing the necessary paperwork."

Eight: The addition of an "administrative markup" to the DME providers invoice by home health agencies and the submission of the larger figure to the Bureau of Health Insurance for payment. Such a "markup" is in violation of BHI regulations.

Mr. Chairman, it is my hope "That the patient will not become the 'forgotten person' during the entire controversy, that the importance of proper home health care for the elderly will ultimately gain from this investigation."

There is no real incentive to keep the cost of health care down. The government—State, local, or Federal—to the payee, seems to have limitless funds for those who would "let the government pay."

So, abuses continue and payments to the agencies by the government skyrocket.

It is very clear, Mr. Chairman, that somewhere along the line, the Government has got to put a stop to the abuses and illegalities that abound and eat up hard-earned tax dollars.

Mr. Chairman, if there are no objections, I would like to submit the findings of my Federal Spending Practices Subcommittee and conclude with my personal observations concerning public, nonprofit home health agencies.

The image of a nonprofit home health care agency has historically been that based on the actions of organizations such as the Visiting Nurses Association. Characteristically, the public nonprofit organizations like the VNA and the County Nurses Association have operated on the principle thesis of providing services to the poor and the elderly at minimal cost to community and the taxpayer.

The supreme dedication of many of these public spirited and highly motivated persons has led to not only a high level of care for many patients, but also a firm appreciation for the worth of these agencies to the communities in which they serve.

From all the evidence presented by the subcommittee, I have been extremely impressed with the quality of services provided by the public, nonprofit organizations and even more impressed with the sincerity of effort put forth by the public nonprofit agencies. The subcommittee investigators held hours of interviews with clients and other personnel involved in home health care and generally conceded that those persons who staffed and maintained the public agencies were of high caliber and expertise.

Although I was not in the Congress during the enactment of the original medicare bill, I am assured Congress had the image of public agencies involved when they wrote the provision for the private, nonprofit agencies.

During the almost year-long investigation of home health agencies, the continuing story of gross irregularities and administrative coverups by agency administrators was repeated over and over again. We heard evidence of records were forged, claims were billed for visits never made, personnel wrote in diagnosis for patients before they were seen and reports were prepared for doctors who merely signed sheets depicting actions never in effect, taken.

Medicare officials were billed for some expenses that defy explanation—such as the Christmas party by Unicare, Inc., of Miami. While the total expenses of some $4,000 was not a tremendous amount it represents the idea that as long as medicare pays, it doesn't matter what the expense is billed for.

The entire question of the interrelationships of persons involved in home health agencies must be clearly defined. Doctors who own home health care agencies must allow for complete disclosure of that ownership and the patient and medicare officials must take special note of that ownership. Monitoring procedures by the intermediary must be particularly stringent for these agencies. Because of the abuse in overutilization and referrals by doctors themselves, medical firms, hospitals and/or nursing homes should be restricted to involvement in only one area of patient care which is reimbursed by the medicare program or National Health Insurance Act.

The subcommittee investigated the entire scope of involvement and interrelationships of medical supply companies and home health agencies. The abuses concerned with central billing procedures, signed and/or vocal agreements to actually circumvent the law by forgiving the 20 percent co-insurance and annual deductible were widespread and accepted practices. Any medical supply company that blanketly forgives the deductible or co-insurance a specific category of patient or agency should be considered guilty of an abuse of the act and subject to the the penalties provided by the act. Intermediaries should be carefully instructed to insure against incorrect payments to chain medical supply companies using central office billing procedures.

The subcommittee lends its support to a certificate of need requirement as developed by the Florida Department of Health and Rehabilitative Services.

Medicare officials must begin to establish some limits on salaries, pension plans, and charges that are uniform and reasonable. The Bureau's current policy is much too lenient and leaves too much to agencies to decide.

The practice of comparing private, nonprofit agencies to one another is not practical. First of all, it establishes a false charge and salary rate. Normal competition practices do not apply because the private nonprofit agencies do not have to justify costs to the customer but rather to the Government which is not the customer but is the payee. So as long as agencies are allowed to set their own rates, those rates will be excessive.

It is the imperative that the governmental agency responsible for correct monitoring be allowed to establish proper rates for charges and salaries.

The private, nonprofits, or so-called 100 percenters, have absolutely nothing to lose by going into business at total government expense. The current system of cost reimbursement provides no incentive for efficiency. In order to establish some type of financial security, a bonding process must be established. In the present situation, private nonprofit agencies may manipulate charges and submit cost estimates that are far out of the realm of reasonableness and secure funds under the interim payments that can be used by them for any purpose. The repayment of those funds is interest-free and comes from a deduction of their medicare account. This entire process can lead to definite abuses. The beneficiaries receiving the services have no idea as to the amounts reimbursed since notices to the beneficiaries list only the number of visits and no amount of reimbursement per visit. Therefore, the beneficiary does not act as a damper on overutilization.

The obviously profit-motivation of the so-called nonprofit agencies has been more than substantiated in testimony and other inquiries made before the Subcommittee on Federal Spending Practices. I am now more convinced than ever that real reform has to be properly instituted if the program is to be saved for those persons most in need—the elderly—by those most concerned—the taxpayers.

Specific guidelines and regulations along with legislation may not eliminate all of the problems we face with the administration of this program. However, I feel that public support and credibility can be restored if public officials and medicare administrators implement the desired changes in the program recommended in this report.

Further, I want to reiterate my support for quality health care for the elderly through the medicare program. Such care is vital to the well-being of many of the elderly in the State of Florida and across the Nation. The very fact that this care is so vital makes it even more important that it become as fraud-free as possible.

The subcommittee is indebted to those persons whose primary interest goes beyond job security and cooperated with subcommittee investigators on this inquiry.

If the projection for medicare as a program is to be a healthy one, then abuses and illegalities have no place in this prognosis.

The subcommittee found that the additional action which should be taken included the following provisions either to be instituted through proper legislation or guidelines from the Bureau of Health Insurance:

One: That there should be adequate formal—education—training for full-time administrators in the health care agencies. That education should be in one of the health fields with experience in administration of a health facility. Many of the agency administrators interviewed in hearings and through the investigation had backgrounds in totally unrelated fields to that of health care service.

Two: That the membership of the governing body or the advisory committee of a home health agency be comprised of legal residents within the geographical area served by the home health agency. This action would eliminate administrative expenses such as transportation and lodging which are now charged to medicare.

The number of high-salaried administrators must be limited. One agency in the survey by the subcommittee defined 9 persons in an agency of less than 100 as top administrative personnel.

Medical directors who can be classified as "in-house" should be restricted in the percent of the total clients that he can refer to "his" agency. No more than 25 percent would be reasonable.

Three: Special investigation by the fraud and abuse section—should include careful scrutiny to identify those agencies which:

First: Knowingly provide services to patients not truly "homebound," which also add services to those initially requested by the patient's doctors, and permit personnel to do those things not included in needed services.

Second: Solicit discounts and kickbacks.

Third: Arbitrarily add "administrative markups" to bills for goods purchased by them or services performed for them.

Agencies that are identified as conducting these abusive practices should be penalized either by immediate nonacceptance of claims or by placement in a probationary status for a stipulated time period which could result in a "nonacceptance" status. Where actual attempts at fraud is obvious the administrator should be quickly prosecuted.

The subcommittee thoroughly investigated the situation and found that the interrelationship of durable medical equipment suppliers and home health agencies often led to abusive practices.

Acceptable legislation should result in the following results:

Four: 100 percent reimbursement for durable medical equipment under part B either to the patient or to the dealer accepting assign-

ment when the patient's request and authorized the need for the equipment and is entitled to and receiving home health care from a licensed agency.

Five: The role of a home health agency should be strictly defined in the hospital discharged process. An agency, either public or private, should be definitely restricted from doing the actual discharging of medicare patients but instead should be available for service if called by the hospital.

Six: In the area of contracted service personnel, contracts should be limited to those personnel providing skilled services dealing directly with the patient, such as a physical therapist or speech therapist.

Seven: Franchise fees should not be viewed as reimbursable by medicare rather as an administrative expense incurred by the agency.

Eight: Total office expenses including initial furnishings, rent and space size should have the same limiting criteria, including geographical considerations as previously stated for charges, salaries, et cetera.

Further luxury automobiles and sports cars should be prohibited for agency rental and use to be billed to medicare. Documental cases of abuses in this area includes rental of Corvettes and other sports cars by private, nonprofit agencies.

Nine: Any financial relationships between durable medical equipment dealers and home health agencies should be entirely forbidden.

Ten: The dealer should be required to present the option of purchase or rental of equipment to the patient. The option agreed to should be in writing and properly submitted to the intermediary for reimbursement.

Eleven: Cases where the period of use will exceed the present retail price of the item should be encouraged and the offer of sale should be properly documented.

Twelve: Certain items should never be sold.

These items should require documentation in writing of reasonable follow up procedures on a regular basis for the established rental fee, or require emergency backup at all times.

Durable medical equipment to be rented only

Dialysis equipment
Flowmeters
Fluidic breathing assistors
Humidifers (oxygen)
Infusion pumps
IPPB machines
Iron Lungs
Nebulizers
Oxygen humidifers
Demurrage on oxygen tanks
Oxygen regulators (medical)
Oxygen tents
Oxygen walker systems
Respirators
Suction equipment

Durable medical equipment to be sold only—(when need is for more than 1 mo.)

Bed pans (autoclavable hospital type)
Canes
Commodes
Crutches
Face masks and cannulas (oxygen)
Gel flotation pads for wheelchairs
Heating pads
Heat lamps
Masks (oxygen)
Oxygen
Postural drainage boards
Qual canes
Sitz baths
Traction equipment
Urinals (autoclavable hospital type)
Vaporizers
Walkers

Durable medical equipment to be sold or rented

Alternating pressure pads and mattresses	Mattress, with hospital bed only
Bed side rails	Patient lifts
Gel flotation mattresses	Rollabout chairs
Hospital beds	Trapeze bars
Pneumatic compressor (lymphedema pump)	Water and pressure pads and mattresses
Lymphedema pumps (nonsegmental therapy type)	Wheelchairs

Further, the subcommittee found that in instances where sales are made, those sales should carry restrictions and conditions similar to those previously listed. Sales should be made as follows:

One: Dealers should be required to offer to the patient to sell or rent.

Two: Intermediaries should be required to notify dealers the allowable sales price on all items of equipment.

Three: Lumpsum payments by the intermediary should be made to the dealer or to the beneficiary at the time of sale, and that payment, should not be subject to the annual deductible or coinsurance.

Four: The patient should be allowed to use an amount up to the prevailing price disclosed by the intermediary toward the purchase of any quality of equipment that the patient wants.

Example 1

The medicare allowable price for a wheelchair is $175. The patient could use $50 of this and buy and pay in full for a used chair.

Example 2

The patient could apply this $175 toward the purchase of a new, $350 wheelchair and pay the difference to the dealer himself.

Five: The dealer should be required to document the offer of sale and the transaction.

Six: The determination of the validity of the sale should be the patient or the patient's own physician.

Seven: Provision should be made for repairs on items previously sold through medicare.

FINDING NO. 1

As evidenced by the committee's report and testimony heard by the subcommittee, the subcommittee submits that there is a decided absence of hard, specific guidelines and instructions from the Bureau of Health Insurance (Social Security Administration).

The fact that many agencies seized the opportunity caused by the absence of specific guidelines to raise salaries to unreasonable levels was totally indefensible.

The private nonprofit administrators set salary levels for themselves and other supervisory personnel at those high levels because they (the administrators) could not show the funds received as "profit."

CONCLUSION

The Bureau of Health Insurance (SSA) should develop guidelines which would limit or place a "cap" on the charges that the Home

Health Agency can impose for skilled nursing care, home health aide visits, as well as those for physical therapist, speech therapist, et cetera. Limits which should be placed on the salary for administrators of private, nonprofit home health agencies could be based on the comparison of the executive directors of visiting nurses associations or the administrators of 50-bed hospitals.

Unquestionably, the salary of administrators and top personnel should be completely divorced from the gross revenue that the agency takes in.

CHANGES IN THE PRESENT SYSTEM

This change would not demand changes in legislation but would demand guidelines from the Bureau of Health Insurance (SSA).

FINDING NO. 2

Gross irregularities in administrative procedures were alleged by home health care personnel. Backdating and alterations of records by home health personnel with the primary purpose of defrauding the U.S. Government, were claimed to be fairly common occurrences. General administrative coverups included the forging of client records, claims being billed for visits never made, diagnosis being made by unqualified persons, nurses aides and general office staff—general abuses of car allowances and gas allotment.

CONCLUSION

The need for aggressive monitoring of the administrative claims by the Bureau of Health Insurance is paramount. The prevailing feeling among many private nonprofit home health agencies was that any cost could be charged because the present monitoring system would not pick up the irregularities that occur.

CHANGES IN THE PRESENT SYSTEM

An enlargement in the fraud and abuse section of the Bureau of Health Insurance so that investigators could closely monitor alleged abuses. The system for checking and auditing records should not involve 3 weeks to a month prior notice. Auditing should be done on short notice so that tampering with official records could not be adequately accomplished.

FINDING NO. 3

Pension plans for the employees of private nonprofit home health agencies are not designed to conform to any specific guidelines and limitations.

CONCLUSION

Pension plans should have ceilings imposed to assure that conditions the subcommittee learned about are not continued nor repeated. The subcommittee feels that an 8 percent limit would be more than sufficient but would defer the Bureau of Health Insurance guidelines on the matter.

CHANGE IN THE SYSTEM

No guidelines on pension plans presently exist. The Bureau of Health Insurance should develop those guidelines and submit recommendations for legislation.

FINDING NO. 4

Private nonprofit agencies do not have to establish financial stability in order to start soliciting clients and go into business. Franchise fees, initial consulting fees, should not be reimbursable items from medicare.

CONCLUSION

Either a proper bonding procedure should be established or a private, nonprofit home health agency should have to document the existence of substantial permanent capital to cover possible overpayment to the agency.

CHANGE IN THE PRESENT SYSTEM

The basic change in the reimbursable system to accommodate the above conclusion must be achieved by statute.

FINDING NO. 5

Under present legislation a private, nonprofit home health agency generally excludes all patients except medicare eligibles.

Currently, all administrative expenses are charged to medicare. The committee found that some of the expenses billed to medicare were very dubious.

CONCLUSION

By statute, a requirement that at least 25 percent of the patients of a provider be other than medicare eligibles in order for certification to be granted. Justification for such legislation can be found in the statutory requirement relating to the formation and operation of health maintenance organizations—50 percent of the participants in an HMD must be under the age of 65.

CHANGES IN THE PRESENT SYSTEM

The significant change in the system to conform to the above conclusion must be by statute.

FINDING NO. 6

The subcommittee found that durable medical equipment suppliers and some private nonprofit home health agencies have entered into agreements to circumvent the law, particularly in providing for an administrative markup on items sold by the suppliers on referral by the agencies.

CONCLUSION

The actual cost for items should be documented by having a copy of such items attached to claims submitted.

CHANGE IN THE PRESENT SYSTEM

Guidelines could be established by the Bureau of Health Insurance, or appropriate legislation.

FINDING NO. 7

The subcommittee found that many items were rented to patients at a total cost far in excess of the total cost of the item in many cases. This abuse has been documented through appropriate records in the SSA as well as interviews with suppliers and clients.

CONCLUSION

Provisions should be made for the lump sum reimbursement for the purchase of durable medical equipment where long-term need has been clearly documented by the attending physician.

CHANGE IN THE PRESENT SYSTEM

By the appropriate statute.

FINDING NO. 8

The subcommittee found proliferation of private, nonprofit home health agencies to be a definite problem.

The tremendous growth of this type of agency—private, nonprofit—with little or no controls attached to their certification requirement doubtlessly led to some of the abusive practices that occurred.

CONCLUSION

A certificate of need provision must be included in the requirement for certification by the private, nonprofit home health agencies.

CHANGE IN THE SYSTEM

By statute, the certificate of need should be required on a national basis.

FINDING NO. 9

The subcommittee found that normal investigative procedures for the fraud and abuse section of the Bureau of Health Insurance depend solely upon responding to a complaint. The section does not, it seems, allow investigators to act on their own initiative.

CONCLUSION

The fraud and abuse section does not presently have the manpower capability to properly investigate instances of alleged abuses and illegalities that have been reported in the home health care field.

CHANGE IN THE FIELD

By guidelines from the Social Security Administration or appropriate legislation.

FINDING NO. 10

The subcommittee found that many problems existed in determining which services were truly needed that were being administered to clients under the guise of needed services. Many agencies overprescribed services and had no accountability to the State after certification.

CONCLUSIONS

In order to help restore public credibility in the area of home health care, private nonprofit home health agencies must be required to:

Undergo periodic review of a State home health agency advisory council, appointed by the Governor, which would also advise the public nursing section or any other official health agency in matters relating to regulations, standards of care, policies governing services, and expansion of home health care programs in the State.

The Council would be composed of a licensed physician, a registered nurse, a physical therapist, a speech pathologist, a medical social worker, an occupational therapist and three citizens interested in the development of home health care programs. Such a council will provide representation from the various disciplines rendering service who have expertise in these areas and are knowledgeable about standards of care and operational procedures for their professions.

Agencies should also organize their board of directors to conform to having at least seven members, no more than two of which are relatives.

FINAL RECOMMENDATIONS

Additional recommendations that the subcommittee found include the following:

One: The administrative records of an agency that does not deal with the individual patient should be open to public inspection, such as administrative salary levels, charges for visits, amount paid the agency by the intermediary, et cetera.

Two: The utilization review program performed by the intermediary be expanded to conduct, not only onsite inspections but a complete followup concerning assurances from the patient's doctor as well as a comprehensive number of patients that the services rendered were both needed and requested by the patient's doctor.

Three: The large body of regulations and guidelines that are established, and will be established, be made available to every agency licensed by the State so that the limitations placed on cost can be uniformly applicable. Agencies can only adhere to "reasonable" cost when they, the agency, know what "reasonable cost" are.

Four: Rental arrangements between doctors and laboratories or doctors and home health agencies or doctors and pharmacies or any other above combination should be carefully reviewed by the Bureau of Health Insurance with the stated power of the Bureau to terminate such agreements when medicare payments are in any way involved.

Five: That any form of compensation in terms of rewards, prizes, gifts, and so forth shall be considered a kickback when it involves a medical supplier and/or a home health agency receiving Federal funds for medical care.

[End of prepared statement.]

Senator CHURCH. Now, today we continue with another case which relates to in-home services provided to California residents. Before we call those witnesses who are regularly scheduled to appear, the Chair would like to accommodate a representative of the Governor of California, Governor Brown, Mr. Mario Obledo, who has asked to be the first witness.

If Mr. Mario Obledo will come forward and take a seat at the witness stand, we will be glad to hear him at this time.

Mr. Obledo, all of the witnesses in these hearings have been sworn so if you would, please raise your hand and take the oath.

Do you solemnly swear that all the testimony you will give in these proceedings will be the truth, the whole truth and nothing but the truth, so help you God?

Mr. OBLEDO. I do.

Senator CHURCH. You may proceed.

STATEMENT OF MARIO OBLEDO, SECRETARY, CALIFORNIA HEALTH AND WELFARE AGENCY, APPEARING ON BEHALF OF GOV. EDMUND G. BROWN

Mr. OBLEDO. Good morning, Mr. Chairman and members of the committee.

At the request of the Governor of the State of California, Edmund G. Brown, Jr., I come to offer the full support of the State in your effort to uncover fraud and abuse in the health care services field.

My name is Mario Obledo, and I am the secretary of the Health and Welfare Agency which has the responsibility in California for the medicaid and the title XX programs.

Last fall when the Senate Subcommittee on Long-Term Care was receiving national attention for its excellent exposure of medicaid fraud, I wrote to Senator Frank Moss, the chairman of the subcommittee, to compliment his good work and to offer our cooperation.

Speaking for Governor Brown and for the agency which I direct, I am here to strongly emphasize our intention to continue that cooperation in attacking fraud and abuse in the various health care programs we must administer. I need not point out to you the necessity for close coordination between the Federal Government and the States in monitoring these important programs.

California is prepared to do its part. In that regard I recently wrote Mr. Thomas Morris, the newly appointed Inspector General of the Department of HEW, to offer him the same complete cooperation which I am today extending to this committee.

California is a big State and we administer a very large amount of the funds that the Congress appropriates for these health care programs. In light of our size, we have an enviable record compared to other States for monitoring fraud in these areas. As reported in this committee's publication on medicaid mills, California receives 13 percent of all medicaid funding and we have presented at least 35 percent of all of the pending fraud cases nationwide.

In comparison, New York, which administers 23 percent of all medicaid funds, is responsible for only one-tenth of 1 percent of all pending fraud cases.

While California is proud of this record, we are in no way content. I would be the first to point out that the degree of fraud and abuse currently under these programs appears to be extensive so that the time has arrived to undertake their investigation in a most comprehensive and detailed manner.

Several months ago Governor Brown mandated that I make a thorough investigation into the types of abuses referred to yesterday and in previous hearings. As a result, I instituted a new system of fraud and abuse controls known as the surveillance and utilization review system which we refer to as SURS. Basically SURS is designed to detect patterns of practices by doctors and others that are inappropriate or abusive.

This is accomplished by analyzing computer reports and other records produced by our fiscal intermediaries. When abusive practices are suspected, additional documentation is gathered such as paid service claims, profiles of all services received by the patient's hospital treatments that appear questionable and profiles of all services claimed by the practitioner for the previous year and then a case is assembled.

The SURS team which consists of physicians, nurses, dentists, and pharmacists then visit the office of the practitioner and compare the case documents with office records. If the office review confirms the suspicion of abuse, appropriate corrective action is undertaken. This may consist of educating the office staff on program requirements, policies, and billing procedures. If the abuse is significant, administrative action is taken to place the provider on 100 percent prepayment review or to suspend him from the program altogether. If the intent to defraud is apparent, legal action is begun. In all cases overpayments identified in the review are recovered.

A 6-month project will continue through September 1977 and will include reviews of doctors, hospital in-patient and outpatient services, optometrists, clinical and X-ray laboratories, psychiatrists, dentists and other provider groups. The sample will include providers whose practices exceed group or regional norms for certain key service categories and a random group of unexemptional providers.

The reviews of the latter group will be used as controls to validate the efficiency of their criteria used to select the primary group.

When the pilot project is completed the SUR staff will use the accumulated data to make projections of both the scope of abuse and the monetary impact it has on the medicaid program. From this information it then will be possible to evaluate and refine the SUR program to determine what the future scope of the review system should be in order to guarantee the maximum level of control relative to efficient use of resources and to accurately predict where abuse will be found.

Additionally, a few weeks ago I formed strike force teams comprised of auditors, investigators, program specialists and data analysts to investigate and audit, a selected sample of nursing homes, homemaker chore programs and regional centers for the developmentally disabled. The purpose of the review is to uncover fraudulent and abusive practices, to identify problems and to develop a fraud detection system to be implemented on a statewide basis. The 12 strike

force units are presently in the field and will be reporting to me on April 1.

Beyond this I have appointed a special assistant in the Office of the Secretary to coordinate the fraud detection activities of all of the nine departments under my jurisdiction.

In the meantime, however, we have not been inactive. In 1975 and in 1976 investigations were made of almost 15,000 complaints resulting in convictions of over 100 providers and administrative actions against 438 others. Altogether fraud and abuse controls in the State of California have resulted in program savings of $86 million in 1975 and $146 million in 1976.

The actions taken by California to prevent fraud and abuse such as preservice, prepayment and postpayment utilization controls apply equally as well to the home health care services for the aging.

Let me address the title XX program if I may. In 1974 the homemaker/chore program was at a level of approximately $80 million. In 1977 the proposed budget is approximately $126 million. In order to control cost and fraud we have drafted regulations scheduled for public hearing next month and for implementation on June 1. The major provisions call for awarding block grants to counties, for denial of domestic services; if an able-bodied person is residing in the home, a medical evaluation will be required of every intake client and services will be available only to those persons which clearly may require institutionalization if the services are not provided. We are striving to contain costs while providing services to those persons that require them.

We have also increased the number of auditors assigned to the homemaker/chore program. My feeling is that we will uncover widespread abuse. We in California believe that the actions we are presently undertaking represent a comprehensive, effective means of controlling fraud and abuse.

Yesterday, Mr. Chairman, I asked the legal counsel of the Department of Health to ascertain whether the State could force the counties in which Unicare, Inc., conducts business to cancel their contract on the ground that its officials had refused to cooperate with this committee. We in California will not do business with organizations or individuals guilty of impropriety or the semblance of impropriety. We intend to clean up the entire health care business in the State.

We want to insure that persons entitled to health care receive such attention, but only from providers of honesty and integrity.

In order to assist the States the Federal Government may do well by adopting the recommendations of the National Governors Conference task force on medicaid reform and beyond that by passage of H.R. 3. I am informed that most of H.R. 3 provisions are currently law in California.

While uncovering fraud we should make every effort to control cost. Last year our State decided to reimburse hospitals at a rate not higher than 10 percent over the previous year's cost. Our decision has been challenged in the courts by the California Hospital Association and even though we lost the case at the trial level I am confident that we are going to prevail on appeal.

So on behalf of Governor Brown I would like to request the continued support and cooperation of both the Senate and the House committees. Specifically your investigators are always welcome to California to work closely with us and help make these programs accountable to the public to insure that all public money are utilized in the public interest.

The integrity of the entire health delivery system has been called into question because of numerous dishonest providers. I am sure that decent law-abiding ethical providers do exist although that assurance sometimes seems to falter.

Until we start severely penalizing the lawbreakers, I have doubts as to whether our efforts to cure the health business will succeed.

The unethical providers in California should here and now take notice that the Brown administration will not tolerate their dishonesty, their greed, their theft of public money or the unlawful abuse of the health care of its citizens.

Upon return to Sacramento I will recommend to the Governor the appointment of a special prosecutor for health care programs so that enforcement activities can receive the highest priority.

Thank you, Mr. Chairman.

Senator CHURCH. Thank you, Mr. Obledo, for your testimony. It is most welcome to hear about the steps that you are taking to perfect and to implement new regulations dealing with the home care and the title XX homemaker/chore elements of this program.

Now, we have been looking into two cases, one the case of Flora M. Souza and the other the one that we will get into today, the case of Peter C. Gottheiner. These were the two largest providers of title XX home care in California by far.

Prior to the Federal investigation of these two providers, did you have occasion at any time to investigate or to prosecute or to take any action against these two providers in the home care field?

Mr. OBLEDO. I have been informed, Mr. Chairman, that the Department of Health did conduct an audit of the Gottheiner operation in San Francisco and that as a result of that audit the Federal authorities took interest in the case and working together in cooperation were able to uncover certain instances of alleged improprieties.

I understand that Mr. Gottheiner has formed another corporation and is doing business in another State, but insofar as my personal knowledge is concerned, we have no contractual relationship with him in the State of California.

In regard to the other entity under question which is the Home Kare, the medicare operations, I have been informed that we never conducted a fiscal audit of that operation because the State money is minor in that operation and——

Senator CHURCH. That is the very point, if I may interject there.

Mr. OBLEDO. Yes.

Senator CHURCH. That is the very point I was hoping you would make because if we are going to clean up this mess it is obvious that we are going to have to have the cooperation of State and local governments who are principally charged with law enforcement and better equipped than the Federal Government to deal with these problems.

It is true that whereas in the medicaid program there is a good deal of State money at stake and naturally an interest on the part of the State government to protect that money, there is little or no State money at stake in the medicare program. We learned yesterday that as far as title XX was concerned, the bulk of the money being Federal and the State Government administering the program through the county governments that actually award the contracts, that the effective administration of the program had been delegated to county governments who had nothing at stake; that is to say, the county budgets themselves did not carry any portion of the program, so that there is very weak motivation here for effective policing of these programs. This is one thing perhaps we can correct by legislation.

Now, I am delighted to have your testimony because it does underscore that State governments will be naturally more interested in protesting and pressing those programs in which there is a substantial investment of State funds and that may mean to us that the principal focus for Federal enforcement should be in those programs where all or nearly all of the money is Federal. That is something for us to consider.

In any event, we welcome your statement and I am wondering in the light of yesterday's hearings if you are planning further investigation of the Souza operations?

Mr. OBLEDO. We are, Mr. Chairman. Late last night I received a copy of a State audit of the Unicare, Inc., operation in San Jose. I had an opportunity to glance through the audit. It raised very serious questions in my mind about the operation and I intend to do some followup work. I believe the committee will be furnished a copy of the audit.[1]

I noticed one thing that glared at me was the statement in the audit that our State persons had been denied access to books of other entities and I feel very strongly that that is where this matter of cooperation comes into play because if we go into entities that have Medicare money and title XX money or State moneys in some respect and we are denied access to books that may have a bearing on the State expenditures but we have no jurisdiction, so to speak, I don't believe that we get the full flavor of the operation and that is why a team effort is necessary. I might add that your counsel has been working with us very closely and I am very appreciative. As a team effort we will be able to get at these problems, and that is one reason why I formed the strike forces.

I learned that the Department of Benefit Payments had their auditors and another department has investigators, a third department had another component and we were going to the providers to conduct our audits separately so the auditor would be there, but, as stated by the Travelers Insurance person, "I am an auditor; I am not an investigator."

So these review teams or strike force teams take persons of different disciplines, group them together and go to the provider and are able to develop a comprehensive and detailed audit not only from the fiscal and program standpoint but from any criminal aspect as well.

[1] See app. 4, item 2, p. 1212.

Senator CHURCH. Yes; that would seem to me to make good sense.
Any questions of Mr. Obledo?
Mr. Pike.
Representative PIKE. Two questions, Mr. Chairman.
First, I was amazed by your statistic that New York has 23 percent of the funds under the Medicaid program but has accounted for only one-tenth of one percent of the fraud prosecutions. As of what date is that statistic?
Mr. OBLEDO. I believe it was the end of last year.
Representative PIKE. My other question is, you said something—and I don't have your statement but I am going to come close—we will not do business with those whose businesses are conducted with impropriety or the semblance of impropriety.
I have no trouble with impropriety but who is going to make the judgment as to the semblance of impropriety?
Mr. OBLEDO. I believe that that decision would ultimately come to my desk.
Representative PIKE. Don't you have a little trouble with the concept that you can turn off a business from doing business with the United States of America in a sense because of what you deem to be the semblance of impropriety?
Mr. OBLEDO. That decision is going to be a difficult decision, but it is my intent so long as I am Secretary to conduct a program or to conduct a health care delivery system that is above reproach in every aspect and I believe that there are sufficient——
Representative PIKE. I think your position is very, very popular at the present time, but I think that you are going to have a great deal of difficulty when you get into the courts on cutting off business based on the semblance of impropriety.
Mr. OBLEDO. I don't believe, Mr. Pike, that the State has any obligation to contract with anyone and does not have to offer any particular reason for failing to contract.
Representative PIKE. It is a very interesting concept.
Senator CHURCH. Mr. Corman.
Representative CORMAN. I am pleased to welcome my fellow Californian to the committee.
Mr. OBLEDO. Thank you.
Representative CORMAN. I certainly appreciate your statement.
Let me ask, who is the fiscal intermediary for Medi-Cal?
Mr. OBLEDO. That is the so-called Blues.
Representative CORMAN. Blues?
Mr. OBLEDO. Yes, sir, it is called Blue Cross-Blue Shield in northern California and I believe they subcontract with a system out of Dallas, Tex.
Representative CORMAN. What is your evaluation of what we get or what we spend with the intermediaries?
Mr. OBLEDO. Well, I have received some preliminary briefings because when I became Secretary it came to my attention that we had an enormous contract with our fiscal intermediary and yet there had been no accountability, so I formed a group of lawyers and auditors to check into the situation and preliminary indications to me are that

there has been an unreasonable profit by the fiscal intermediary in the conduct of the contract. So presently we are trying to renegotiate our contract.

Representative CORMAN. What about the quality of their work? Are you satisfied that they supply you sufficient information to red flag the problem areas?

Mr. OBLEDO. I believe that they do, Mr. Corman, yes.

Representative CORMAN. What kind of cooperation do you get from the California Medical and the California Hospital Associations? Besides their fuss with you about how much money they should get, how are they helping you with the investigations of impropriety?

Mr. OBLEDO. I have personally been in touch with the physicians as such. I am scheduled in a meeting with the president of the California Medical Association to ask for their assistance and cooperation in the conduct of our investigation.

Representative CORMAN. Have you run up against any problems with the alleged sanctity of the doctor-patient relationship in your attempts to audit accounts?

Mr. OBLEDO. Some of that has been called to my attention but I don't have any firsthand evidence or knowledge.

Representative CORMAN. Thank you very much.

Mr. OBLEDO. Thank you, sir.

Senator CHURCH. Mr. Rangel.

Representative RANGEL. Thank you, Mr. Chairman.

Thank you, Mr. Secretary for your testimony here this morning. Your State must be in a lot of trouble when they have to use New York State as an example to compare themselves with. [Laughter.]

Mr. OBLEDO. I might add, Mr. Rangel, that I believe that we are doing better than almost any State.

Representative RANGEL. Very good.

Mr. OBLEDO. Yes.

Representative RANGEL. Most of the cases that have come before this committee involve outright criminal fraud and some of the things that are immoral appear to be legal even though it is not the intention of the Congress that money be used in that manner.

As relates to titles XVIII and XIX with the case that we went through yesterday it appears to me that if you exclude those cases where Home Kare was padding the visits or listing visits that they didn't fully make, or extending the length of time of the visit, that there is really no handle as to whether or not they should be reimbursed if in fact a visit was made, notwithstanding the fact that two or three visits were made. Is that correct? Can you visit a patient as many times as the doctor prescribed and still be under the framework of the law?

Mr. OBLEDO. Probably. In California we have a so-called prior authorization procedure where they have to get prior authorization before the visit is given official sanction and——

Representative RANGEL. Prior authorization from whom? Well, counsel, please feel free to interrupt. I just want to get clarification so I can understand the rest of the testimony. I was under the impression that Home Kare was able to keep within that $18 figure merely because of their high volume reflected in higher charges per patient.

Mr. HALAMANDARIS. That is correct.

Representative RANGEL. If they dealt in volume, my question to the Secretary is, could they deal in volume legally? Can they actually have more than a medically necessary number of visits and be compensated for it and yet not violate the law?

Representative MARTIN. Will the gentleman yield?

What we found yesterday is that, apparently aside from the problem of fraudulent misrepresentation of expense accounts which amounts to a certain drain on the public funds, this particular concept that Mr. Rangel is raising with you amounts to a far larger drain, a far larger abuse of the public programs. In the first place, it means that someone can be the low bidder and get the contract and then by high volume float the profit to the same size as the high bidder might have gotten.

Senator CHURCH. Or beyond.

Representative MARTIN. Or beyond.

And, second. That it ends up costing us more money than if the provider had made the necessary number of calls.

Further, what can you do about that in California? We are going to have to solve that problem.

Mr. OBLEDO. The title XIX programs and the title XX programs?

Senator CHURCH. Before you answer the two questions, let me add a third element to it.

We heard allegations yesterday that in some cases, several calls were charged separately, allegedly made in a single day. Now, does that immediately suggest the program is out of control?

Representative RANGEL. We are talking about title XIX.

Mr. OBLEDO. In title XIX we have in California a so-called prior authorization procedure. Specifically title XIX is our Medi-Cal program or the so-called medicaid program at the Federal level, so that providers must gain the authorization of the State before they can provide the services in order to be available for the reimbursement.

Representative RANGEL. Does the State authorize the number of visits before there is reimbursement to the provider?

Mr. OBLEDO. Well, no. I am a little confused. Visits to the doctor's office?

Representative RANGEL. No, the doctor visiting the patient.

Mr. OBLEDO. For the doctor visiting the patient there is a prior authorization.

Representative RANGEL. How would you have any way of knowing how often it is necessary for a doctor to visit a patient? How could you determine unless the doctor tells you?

Mr. OBLEDO. Well, we have doctors on our staffs who clear these prior authorization procedures. They are on call and they get a telephone call.

Representative RANGEL. Are you saying that for every recipient of medical services under title XIX, prior to a visit, for purposes of reimbursement, the necessity of that visit has been checked out and authorized by the State?

Mr. OBLEDO. That is the way that I understand it, sir.

Representative RANGEL. Will counsel explain to me how can we then accuse the private sector of too many visits if in fact those visits have been authorized by the doctor not only——

Senator CHURCH. I think there is an explanation for this. It is a very good question that you raise.

We were looking yesterday into an agency that was dealing 96 percent with medicare, not medicaid, and the medicare program is not subject to the same check or prior authorization that the Medi-Cal program is in California which we normally refer to as medicaid. I think that is the answer.

Representative RANGEL. Then with the medicare do you have any trouble at all?

Mr. OBLEDO. No, we have nothing to do with the medicare program, the title XVIII program.

Representative RANGEL. Does the American Medical Association work with you at all to provide ethical guidelines for their members?

Mr. OBLEDO. I have never communicated with the American Medical Association as such. Perhaps the director of our Medi-Cal or medicaid program in the State Department has. There are some technical questions. The gentleman is here and I will be glad to respond insofar as that operation's budget.

Representative RANGEL. Thank you.

Mr. OBLEDO. Getting back to Mr. Martin focusing on title XX on the homemaker/chore program, Mr. Gary Macomber who is the deputy director in charge of the social services in the department of health will be testifying and perhaps you can get the answer to that question.

I understand that we are on an hourly rate basis and that is one method of controlling costs. I may point out one additional thing if I might. With the social services program, Mr. Martin, the Federal Government has placed a ceiling or cap on the moneys available to the States. For instance, California receives about $245 million. Out of that approximately $50 million is devoted to the homemaker/chore program.

Well, you know, we have that base. The program has grown enormously in the last 3 years which means that money must come out of the State general revenue fund and so we are becoming extremely concerned because it seems to be an open-ended program. While the Federal Government has placed a cap or limit on the amounts awarded to the States, the State must of necessity provide the excess and so we see this program at the rate it is going now to become a $200 million program in the next 2 or 3 years, so that of necessity we have to take into consideration some type of cost containment.

Representative MARTIN. I gather you regard what you just described, namely, the requirement that the State has to make up for the excess in cost as a desirable control factor, as a desirable incentive for the State to keep a close watch on the systems——

Mr. OBLEDO. It is a very strong incentive.

Representative MARTIN. Very strong what?

Mr. OBLEDO. Incentive.

Representative MARTIN. Philosophically you would approve of that kind of incentive?

Mr. OBLEDO. Well, I am an idealist without illusions. I know that we have so much money in the general revenue fund. Our medicaid program, for instance, Senator, our budget there was $2.6 billion this

year. It is going to $3.2 billion. Last year we conducted a study and concluded that if everyone that was eligible to utilize that program would utilize it it would bankrupt the State of California in 3 or 4 months.

Representative MARTIN. Let me ask you this. The evidence we got so far indicates there was a greater utilization of this unnecessary high volume of house calls in the medicare program which you do not administer, than was true of the medicaid program which you do administer. Apparently you must have some systematic early warning system to alert your people to excessive numbers of house calls.

Mr. OBLEDO. Well, prior to the creation of this surveillance and utilization review system which is the new system because now we have got the capability of using our computers, but prior to that time we had as checks the prior authorization, the prepayment utilization control system and beyond that the postpayment utilization control system and so we were using those systems as a method to check fraud and abuse so that is where we are.

Are there any other questions?

Senator CHURCH. Yes, sir.

Representative GEPHARDT. We are to hear testimony this afternoon from the auditor of audit region IX for the special committee and he will apparently testify with regard to title XX that the Department of Health, Education, and Welfare made recommendation to your State department of health in order to correct some problems in San Francisco with regard to the rate proceedings by the county administration, and that they recommended that the State require the county to negotiate provider profit after considering factors for risk and investment.

He is further apparently going to testify for the California State Department that the hourly rates were reasonable and that each of the contractors made excessive returns on investment. He is going to say that the State indicated that competitive solicitation procedures would be strengthened by that primarily on the ground that the funds have already been spent, that the State has not attempted to recover the excessive expenditures of State and Federal funds from San Francisco County and refund the Federal share.

From that testimony and testimony we heard yesterday, at least in title XX programs and perhaps the Medi-Cal or medicaid program, there appears to be a lot of buckpassing between the Federal, State, county, and intermediary officials.

How do you think that we can best correct this situation so that we can identify who is responsible for auditing both fiscal and performance?

Mr. OBLEDO. I believe that perhaps legislation should be enacted to place accountability in one unit of Government for some particular program such as the National Conference Task Force on Medical Reform has, I believe, recommended.

The title XX program has tremendous problems, particularly the homemaker/chore, in the State of California. I am not acquainted with the specifics of the San Francisco situation. I was informed that when the State enacted guidelines for competitive bidding on the homemaker/chore contracts that San Francisco refused to comply

with our guideline and that it was the only county in the State that so refused and that we have taken sanctions against the county.

Now, Mr. Gary Macomber, the administrator of the title XX programs, will be testifying here today and perhaps that particular question can be posed to him for his answer.

Representative GEPHARDT. Thank you.

Senator CHURCH. Mr. Stark.

Representative STARK. Welcome, to the committee, Mr. Secretary.

In regard to the facilities operated by either Mrs. Souza or Mr. Gottheiner, do you or does your staff have an opinion on the quality of services that they provide? Have you looked into that?

Mr. OBLEDO. I have not looked into it personally. I have been informed by staff that the quality of services was good.

Representative STARK. For both Gottheiner and Souza?

Mr. OBLEDO. Yes, sir, if I recall correctly, but particularly for unicare.

Representative STARK. Then do you have an opinion as to the cost per visit? Whoever pays for it, State or Federal, if the quality is sufficient would you say that the price is about average, low or high in both the Souza and the Gottheiner operations?

Mr. OBLEDO. I would not be able to say, Mr. Stark. I am not really acquainted with the market or the rates that are presently being paid. I am acquainted with our capitation rate in the health program and our nursing home rate. Of course, all the providers claim that our rates are extremely low.

Representative STARK. Thank you.

Senator CHURCH. Would the gentleman yield at this time?

Representative STARK. Yes.

Senator CHURCH. I think that it ought to be underscored that the evidence yesterday showed that although Unicare was the lowest bidder under California law, the practice is that the county will award the title XX programs to the lowest bidder. It was enabled to bid lower by virtue of passing a portion of its costs to another corporation owned by the same people who in turn charged the Federal Government, so in the end the taxpayers of the country enabled, through this fraudulent practice, Unicare to be the lowest bidder.

So unless you get an accounting and investigative system that extends beyond a single corporate entity in a single program, you are not going to find out what is really going on at all. I think that is the point that you are making, Mr. Obledo, that you are going to have to reach beyond one program in order to get a real idea of how the cat is getting skinned.

Mr. OBLEDO. During my tenure as Secretary I have had occasion to meet what I call very sophisticated providers that seemed to know the methods of operation in order to insure nonaccountability for public money.

Senator CHURCH. One further question and then I am finished. You mentioned the need to establish some kind of Government agency in connection with policing and enforcement of these programs and I think that is a very good point. You have also established that if the State has money involved it is more likely to be interested in protecting that investment and thus will focus its attention on programs of that kind.

If the Federal Government were to assume full responsibility for policing medicare but were to pass to the State government the full responsibility for policing medicaid and title XX programs, allowing the State in connection with such enforcement and prosecution to retain whatever is recovered, do you think that might prove helpful?

Mr. OBLEDO. Absolutely. I think that would be a grand idea and it would provide initiative to the States to monitor and enforce.

Senator CHURCH. And through improved enforcement it might even save the Federal Government a good deal of money.

Mr. OBLEDO. I understand that special teams and investigators, et cetera, have resulted in savings to the Government.

Senator CHURCH. Yes, but what we know of it so far in the State of New York, the special prosecutor and his investigative team looking into nursing home fraud has more than paid its own way. In fact, he is gathering in more in penalties and recoveries than the total cost of the investigation and the prosecution, and they are just beginning to get into gear.

Well, thank you.

If there are no further questions of this witness, we appreciate very much your testimony, Mr. Obledo.

Mr. OBLEDO. One further thing, Mr. Chairman, is that we can have a battalion of auditors, an army of investigators, a great number of accountants and yet some fraudulent practice will still continue to exist. Ultimately it depends on the integrity and the characteristics of individuals and providers as to whether or not the system will ultimately be scandal free so to speak. That would be my hope. As with everything else, it comes back to the individual person and their morality and their integrity, particularly when you are dealing with public moneys.

Thank you very, very much.

Senator CHURCH. Thank you, Mr. Obledo.

We will next hear from a panel of witnesses consisting of Gerald A. Hawes and John Williams who are the managing auditor and auditor general respectively of the joint legislative audit committee of the State of California; Herbert Witt, who is the regional audit manager of the HEW audit agency in San Francisco; and Gary Macomber who is the director of the department of social services, State department of health in the State of California.

Senator CHURCH. Do each of you swear that the testimony you will give will be the truth, the whole truth, and nothing but the truth, so help you God?

Mr. WILLIAMS. I do.

Mr. HAWES. I do.

Mr. WITT. I do.

Mr. MACOMBER. I do.

STATEMENT OF JOHN WILLIAMS, AUDITOR GENERAL, STATE OF CALIFORNIA, SACRAMENTO, CALIF.

Mr. WILLIAMS. Mr. Chairman, I am John Williams, auditor general of the State of California, Sacramento, Calif.

I welcome this opportunity to speak to you this morning about only one of the many programs administered by the California Depart-

ment of Health which, in our opinion, is mismanaged and substantially out of control.

This program, the homemaker/chore program, has been in existence in California for upward of 4 years and during that time and up to today the management of that program is yet embryonic, while the spending is mature.

I applaud Secretary Obledo for the statements that he made this morning concerning his strike forces and the efforts that he and the administration are going to take to combat the fraud elements.

It is my belief, Mr. Chairman, that while those efforts are worthwhile and necessary, they are attacking only symptoms rather than the causes of the problems, and it is that subject that I would like to address this morning in addition to two audits that my office has conducted over the last 2 years of this program.

You have already heard testimony relating to some of these problems yesterday and in testimony before Congress by the members of my staff some 16 to 18 months ago on this program. I wish I could say today that substantial improvements in the management of the homemaker/chore program have occurred. I am not prepared to offer those assurances today.

We understand that improvements are on the horizon. Secretary Obledo indicated that draft regulations are supposed to be issued next month or to be discussed in hearings. However, we continue to view the positive statements of the California Department of Health with caution as they continue to make unfulfilled promises.

The regulations that the State of California is mandated by Federal regulation to establish to implement this program have not yet been established, and time and time and time again they have been promised and further delayed.

Now, our office has conducted two audits of the homemaker/chore program in California; the first in June 1975,[1] and we indicated therein 13 recommendations to improve the management of this program now running in excess of $100 million a year in California alone.

The second report[2] which we prepared at the request of the California Legislature was issued in November 1976 and reported, among other things, that only 1 of 13 recommendations that we made in 1975 have been implemented—not only that, it had been inadequately implemented.

We found that the department of health not only did not monitor this program, but had not established appropriate regulations to control costs, and had not taken measures to insure the fiscal integrity of the providers. They had not established standards of quality nor provided a comprehensive system of adequate and proper home care for the elderly.

We also reported that at least one proprietor provider was diverting assets from a parent company that was doing business in nine California counties. I submit today these audit reports——

Representative GIBBONS. May I interrupt here and ask a question, because I want to get this firmly in my mind.

Did you start this audit in 1975?

[1] See appendix 2, p. 1132.
[2] Retained in committee files.

Mr. WILLIAMS. Our first audit was conducted, and the report was issued in June 1975.

Representative GIBBONS. When did you make the report to the legislature and to the other State officials?

Mr. WILLIAMS. It was made in June 1975.

Representative GIBBONS. Who is in charge of that program now? Was it the witness we have just heard?

Mr. WILLIAMS. I don't believe the secretary was in charge at that time. I became auditor general in 1976, so I am not certain who was in charge in 1975.

Representative GIBBONS. Who was the Governor at this time?

Mr. WILLIAMS. In 1975, Edmund G. Brown, Jr.

Representative GIBBONS. Thank you.

Mr. WILLIAMS. Now, to continue, Mr. Chairman, I will submit for the record today copies of those reports which we issued. I believe committee staff have them, but we have more available if you wish to examine them.

I am aware that this hearing has concentrated on California practices and that yesterday's testimony by their staff and General Accounting Office staff pointed out problems in California, and the testimony from the HEW audit agency has also focused on California.

I would like to point out that it is the policy of the California Joint Legislative Audit Committee, to which I report as auditor general, to report on the misuse of public funds whether those funds be local, State, or Federal if administered by the State of California.

It is also our policy to issue audits that may result in Federal exceptions to Federal funds administered by California, and the withholding of Federal funds from the State. This policy makes my office unpopular with the executive branch, but it is a policy that we adhere to.

As you know, the homemaker/chore program requires a 25 percent match at the local or State level to earn the Federal support necessary for the continuation of these services—services which the department of health estimates are saving $40 million annually in California by precluding the more expensive institutionalization of people who would not be able to remain in their homes without such support.

You may not be aware that California in the last fiscal year spent $28 million more than was necessary to earn the Federal matching funds. This expenditure in excess of the Federal ceiling resulted in the net effect of a 52 percent Federal match instead of a 75 percent.

There are two related problems. The first is the ceiling on Federal funding that has existed since 1972 despite inflationary pressures that have been rampant since the ceiling was established.

Now, the second problem, and from our vantage point perhaps the more important one, is that the overfunding that occurs in California has resulted in a California Department of Health attitude expressed in an answer to an HEW audit that reads as follows, and I quote:

The homemaker and chore service program is heavily supported with State general fund money. Federal funds are not being used to pay for excessive costs. Although there were excessive costs, Federal financial participation was nonexistent or minimal at most.

Now, what the State department of health in California appear to be saying to HEW is that since over $28 million in unmatched tate moneys is being spent on the program, the HEW auditor must nd at least $28 million of Federal exceptions before a legitimate claim exists since we have a commingling of State and Federal funds.

This laissez-faire attitude, if you will, on the part of California has resulted in a number of differences in the operation of the program.

For example, 57 out of our total of 58 counties each determines eligibility standards, provider methods, provider services, and provider rates. In short, we have 57 separate and distinct homemaker/chore programs in California and have had since the program inception. It is costly, it is inefficient, and demonstrably ineffective.

Abuses of public moneys have become a commonplace event from outright fraud to the more subtle abuses stemming from inattentive or incompetent management of public funds. Abuses which have occurred in the homemaker/chore program, in my opinion, are not markedly different from those which the public has experienced in the military-industrial complex. While program abuses cannot be tolerated and must be curtailed, a more important issue must be addressed and that issue is inefficient, uneconomical, and ineffective human service program management.

Fraud and questionable spending practices by providers of public goods and services are but symptoms of a larger problem and account for only a small portion of excessive program costs and poor delivery systems. Yet because of public outrage it receives perhaps the greatest attention and the more important issues remain veiled in the bureaucracy and perpetuate.

I submit to this committee and Members of the Congress that the greater fraud is inept, inattentive, and incompetent public program management. I would like to quote from the California Legislature, chairman of the joint legislative audit committee, on this particular program after having read the report that we issued in November of this year.

"If the department of health deliberately set out to avoid State eligibility for Federal matching funds, it could not have succeeded more admirably. Assuming that professional health personnel are literate"—and this refers to the department of health—"then one can only conclude that they either do not read Federal regulations, do not understand Federal regulations, or are incompetent."

These same professional personnel similarly have not responded to a chorus of recommendations on this program in prior reports by the auditor general, the director of finance, the legislative analyst, and the director of health.

A long history of reports on public programs has been issued by the Comptroller General of the United States under whom I used to serve. Also, reports by the HEW audit agency and the office of auditor general of California, clearly evidence that improper management of programs far overshadows fraudulent activities. Moreover, it is improper management which fosters the outrageous actions of providers of public goods and services.

We cannot legislate competence any more so than we could mandate that a retarded child earn a college degree. Some say that the Cali-

fornia Department of Health is too big, too cumbersome, too complex to effectively manage; hence, perhaps it should be split into smaller, more easily managed units. Those are points made by some factions. In my experience this simply does not work and is not necessary. History shows that similar attempts in the public sector were soon replaced by the fad to consolidate. If this presumed panacea to organizational ills—that is, this splitting up of a major department—were viable, then perhaps we would not have such organizations as General Motors, American Telephone & Telegraph and so on. They far outshadow the size of our California Department of Health.

Now perhaps with the issue of sunset legislation that is going across the country in State legislatures, perhaps it is that Sunset should be directed not so much toward programs but toward program managers in civil service positions.

Now, we have made a strong case in our audit reports and we hope that greater efforts will be taken by the California Department of Health to strengthen and move these regulations along in a timely fashion and properly manage this program and cut down on the abuses of it.

It is also our hope that the U.S. Department of Health, Education, and Welfare will be more aggressive in pushing not only California but other States as well into a posture that will insure uniformity of programs within each State and closer adherence to Federal and State regulations that now exist.

Mr. Chairman, I have with me today a member of my staff on my right, Mr. Gerald Hawes, who has been closely involved with both of those audits and who has been following events in California over the last 4 months in regard to this program and he would like to report briefly on those recent developments in the program as well as expand on information that has come to our attention since the release of our audit.

Thank you.

Senator CHURCH. Thank you.

Mr. Hawes.

STATEMENT OF GERALD A. HAWES, MANAGING AUDITOR, JOINT LEGISLATIVE AUDIT COMMITTEE, STATE OF CALIFORNIA, SACRAMENTO, CALIF.

Mr. HAWES. Members of Congress, as Mr. Williams has stated, I have been involved with two audits of the California administration of the homemaker and chore program. I have had frequent contact with the California Legislative Human Resources Committee which has taken an increasingly active role in the oversight function of this program. I have seen draft regulations that have been issued which the secretary of the health and welfare agency referred to this morning. I am not sure that I have seen the latest draft. The one I have is dated, I think, January 11.

I am not prepared to offer this committee any assurances that things are going to get better in California. The current drafts appear to me to continue to violate the law, they don't set up uniform standards for service delivery systems. We are talking, in effect, about

block grants of Federal and State money to the counties that administer the program with minimal restrictions on how the money is spent.

The department of health's office of legal affairs has indicated in a memo dated October 4, 1976, that individual providers in Los Angeles are in fact employees of that county and therefore the county has the obligation to pay workmen's compensation costs and otherwise meet its obligations as an employer.

Los Angeles County does not do this for individual providers. They consider them to be the employees of the recipients even though the county controls the working hours and the working conditions. To my knowledge, the policy people in the department of health have taken no action to enforce this law and their own counsel's interpretation of it.

The current program in California was hastily established in 1973 to replace the attendant care program and it has been plagued with poor management and, as Mr. Williams said, inadequate regulations and runaway program costs. One reason for the cost overruns appears to be that the State continues to do business with certain proprietary providers year after year in spite of questionable activities on the part of those providers.

The brief history of one such provider I think illustrates my point rather well. At least as early as September 28, 1967, the director of the California Department of Health Care Services considered the suspension of a provider you have already heard testimony about for "billing for visits not rendered." By 1971 this company was involved in disputes with medicare involving over $800,000. This dispute, to the best of my knowledge, has never been resolved. No prosecution was attempted even though action was recommended by medicare.

On December 8, 1967, a supervisor of the investigation section of the California Office of Health Care Services recommended that because of this provider's past performance, surveillance of his future claim should be maintained. This kind of surveillance gets very expensive. I don't know what the investigation cost that was discussed in yesterday's hearing was, but I am sure it was very expensive.

This gets us around to responsible bidders and whether or not responsible bidders should be required to meet certain standards so that people who have a poor track record can be excluded from taking part in these kinds of programs. By 1974, the provider that I had mentioned was also offering homemaker services in other States, including Utah and Illinois. By June 1976, things seemed to be coming to a head. The provider resigned from his corporation after securing a large loan, $200,000 I believe. This visiting service firm, 2 months later, filed bankruptcy leaving the individual providers unpaid and clients without service. I believe that same provider, who will I believe testify before you today, has now formed another company called the National Home Care, Inc., and that he is currently doing business in Illinois. I also believe that he is the low bidder in a San Diego County, Calif. contract but that the contract has not been awarded.

The whole problem of the bidding process in California is that it is on an hourly bidding basis, it encourages proprietary providers at least to offer as many visits as possible. You heard testimony yester-

day that if Unicare was put out of business that visiting nurses would come in and charge $30 an hour for nursing services and $45 an hour for a speech therapist. That might be the case, but I doubt that they would be there as long. I think that some of the bidding practices should be thought of in terms of episodes of care rather than on an hourly basis.

Senator CHURCH. Isn't this just like a cost-plus method of doing business?

Mr. HAWES. That is exactly what it appears to be like.

Senator CHURCH. I think for a time during the Second World War we were financing our military with cost-plus contracts. We learned that all of the incentive was to build the costs as high as possible because that increased the profit as cream off the top.

Mr. HAWES. That is right.

Senator CHURCH. The lesson to providers is clear: the bigger the costs, the bigger the profit, so bilk the Government in every possible way. Some years ago we learned, as we renegotiated some of those contracts as a result of a congressional inquiry into that, of hundreds of millions of dollars that had been lost to the Government.

Now, we are trying to operate a health care program the same way. So the whole incentive is to build up the costs one way or another, bilk the Government, take the profit off the top, the higher the cost the bigger the profit. Isn't that the case?

Mr. HAWES. Yes.

Senator CHURCH. Well, then, we are never going to get a handle on escalating costs without finding a new and different way to finance and administer the program. Do you think that is true?

Mr. HAWES. Social service programs have in the past been funded on a request-for-proposal basis rather than an invitation for bid. With an RFP you get away from hourly rates, and you get to the point where you are talking about results. I think some of the social and health service delivery systems that were funded on a request-for-proposal basis with certain guarantees that it might be more responsive and halt some of these runaway costs. The provider guarantees to deliver, for a specified amount of money, a person who no longer needs a homemaker, a person who no longer needs a speech therapist, because 4 or 5 visits will be sufficient instead of 10, 15, or 50. I think that may be one answer.

Perhaps the new HEW Inspector General, the Comptroller General and the California auditor general continuing legislative oversight at both the State level—and it is obviously occurring at both the State and national level—can provide some objective and independent information that will make human services both fiscally responsible and humanistic in their approach to Government-financed programs.

I think I could go on but probably other people have made many of my points. I might make one more point about the testimony of the secretary of the California Health and Welfare Agency. He testified before you this morning that he applauded the investigation of Senator Moss's subcommittee staff in terms of medicaid mills in the fall of last year.

At that time I was trying to help Senator Moss' subcommittee obtain Medi-Cal cards. I have here before me a copy of a memo that I

sent to our file dated July 8, 1976. It details to some extent my efforts to get a hold of those cards which included a meeting in the Governor's office with both Dr. Lackner and the Governor's legislativ liaison person.

I was told by Dr. Lackner that the reason that the department of health wouldn't cooperate with either our committee or the U.S. Senate Committee on Aging was because there was concern that too many investigators would discourage providers of medicaid from accepting medicaid patients and the department of health didn't want to exacerbate the delivery of Medi-Cal services to low-income Californians.

He concluded by assuring me that the U.S. Senate committee was resourceful enough without the State department of health to do that. Well, as a matter of fact, we did get those cards 24 hours later and the Senate investigators were able to come into California but it was without the California Department of Health's cooperation.

[The memorandum referred to follows:]

INTEROFFICE MEMORANDUM

Date: July 8, 1976—3 p.m.
To: File.
From: Jerry Hawes.
Subject: Attempts to secure Medi-Cal cards for the U.S. Senate Committee on Aging.

In early May, telephone discussions between Val Halamandaris, associate counsel for the Senate Committee on Aging, and Jerry Hawes of the auditor general's office, indicated that there was an interest expressed by Senate Committee on Aging staff to secure valid California Medi-Cal cards for an investigation that committee was conducting on the medicaid program.

During the week of June 21, Mr. William Batt of this office contacted Mr. Al Brown and Mr. Burns in the Medi-Cal division requesting the issuance of such cards. Mr. Batt was assured that the cards could be made available.

Mr. Hawes made telephone contact with Mr. Al Brown in the morning of July 6, 1976, and he assured him that there would be no problem in obtaining cards for the Senate investigators and that he should work out the details with his assistant, Mr. Leeper. He also requested a letter, which is attached, to Mr. Helsel formalizing the request. A phone call was made to Mr. Leeper that same morning. He also assured the auditor general's office that there would be no problem if he had a letter formally requesting the issuance of such cards. Said letter was hand-carried to his office at 3:45 p.m. on July 6, 1976.

Mr. Leeper called back on the morning of July 7, 1976, and requested birthdates for the persons whose names would appear on the cards. These were provided at 10:55 a.m. on that morning. Mr. Leeper assured this office that there would be no problem in getting the cards.

Later that afternoon, he again called the auditor general's office to get another letter specifying exactly what the investigators were going to do and that this letter should be on U.S. Senate stationery. Mr. Hawes informed him that there would be a logistical problem in getting such a letter from Washington to Sacramento by the morning of July 9, when the cards, by previous agreement, were to be turned over to the Senate investigators.

Mr. Leeper then suggested that Mr. Hawes call Lee Helsel and discuss the issue with him. Such a call took place at 4:30 on the afternoon of July 7. Mr. Helsel expressed reservations concerning both economic liability and problems of professional ethics regarding issuance of such cards. When it was pointed out to him that his own department of health investigators routinely used this kind of device to assess Medi-Cal provider integrity, he replied that the department of health was not going to cooperate with Senator Moss (the first time his name had been mentioned in all of the previous negotiations) because Senator Moss would use his findings to attack the California Department of Health.

On the morning of July 8, Mr. Hennessey and Mrs. Hawes met with legislative counsel, and at their suggestion, called Mr. Cullen to see if his intervention

might assist the auditor general's office in its efforts to supply support for the U.S. Senate investigators.

Mr. Cullen and Mr. Hennessey arranged for a meeting between Marc Poche of the Governor's staff and Mr. Hawes at 2 p.m. on the afternoon of July 8. Mr. Hawes attended that meeting. He spoke with Mr. Poche for about 10 minutes, assured Mr. Poche that the purpose of the cards was to develop a standard of adequate performance with which to measure the experience the Senate investigators had encountered in New York, that there was no intention of attacking the California Department of Health, and that previous Moss committee reports had lauded California and Michigan for having better controls than the State of New York against abuses found in clinical diagnostic laboratories.

Mr. Poche then called in Dr. Lackner, the director of the department of health, who happened to be in the next office; and Dr. Lackner informed Mr. Hawes that the reason that the department of health would not cooperate with either the Joint Legislative Audit Committee or the U.S. Senate Committee on Aging, was because there was concern that too many investigators would discourage providers of medical care from accepting Medi-Cal patients, and that he did not want to exacerbate an already difficult situation regarding adequate medical care for low-income Californians. He concluded by assuring Mr. Hawes that the U.S. Senate committee was resourceful enough to get cards without the cooperation of the State department of health.

The meeting, at all times, was very friendly and courteous and firm in the stand taken by both Mr. Poche and Dr. Lackner.

Enclosure.

JOINT LEGISLATIVE AUDIT COMMITTEE,
OFFICE OF THE AUDITOR GENERAL,
CALIFORNIA LEGISLATURE,
July 6, 1976.

Mr. LEE HELSEL,
Deputy Director, Medi-Cal Division,
California State Department of Health,
Sacramento, Calif.

DEAR MR. HELSEL: A member of my staff, Mr. Jerry Hawes, has had contact with your office relative to a request from the U.S. Senate Special Committee on Aging, which is conducting a national investigation of the medicaid program. It now appears certain that the Senate investigative staff will be in California on July 9 and will require eight valid California Medi-Cal cards for the month of July. Ideally, four of these cards would show recipient addresses in the northern part of the State, while the other four would show recipient addresses in the southern part of the State.

This office has had an excellent working relationship with the Senate committee for 8 months, and we are anxious to help them in this phase of their investigation. Consequently, we would like to impose upon the department of health to assist us in meeting this request to acquire the needed Medi-Cal cards. As previously discussed, it would also be helpful if Mr. Vern Leeper could be available in Sacramento on July 9 to brief the Senate investigators on the use of these cards.

Thank you for the cooperation you have given us in the past and for any help you can give us on this request.

Yours very truly,

JOHN H. WILLIAMS,
Auditor General.

Senator CHURCH. Thank you for your very forthright testimony.

I think before we go to questions we might hear from the other members of the panel if that is all right with members here at the committee.

STATEMENT OF HERBERT WITT, REGIONAL AUDIT MANAGER, HEW AUDIT AGENCY, SAN FRANCISCO, CALIF.

Mr. WITT. Mr. Chairman, my name is Herbert Witt and I am the regional audit manager, HEW Audit Agency, San Francisco, Calif.

Mr. Chairman, we are pleased to be here today to discuss the results of our audit [1] on the purchase of homemaker and chore services by the San Francisco County Welfare Department. The audit was made after we learned of a State of California Department of Health program review which indicated that problems existed in this area.

Incidentally, when we came in we found that the conditions continued to exist and as of the present time based on our best information San Francisco rates have not been corrected and still remain at the high level we found in our audit report.

The audit involved an examination of the procedures used to contract for the purchase of social services by public agencies. Under the California State plan, the responsibility for negotiating contracts for the purchase of homemaker and chore services has been delegated to the individual county welfare departments.

Our audit of three proprietary organizations disclosed that excessive hourly rates of payment were established by San Francisco County for the purchase of services. The rates were set by the San Francisco Social Services Commission, a five-person board whose members are appointed by the mayor of the city and county of San Francisco.

The service providers were selected by the commission during 1971 and 1972 without publicly soliciting bids or proposals. The commission negotiated the initial rates and subsequent increases using incomplete and inaccurate cost data.

For example, even though on at least one occasion the commission specifically asked for financial statements certified by the contractor's CPA to support rate increases, no such statements were ever furnished. Additional rate increases were, however, granted by the commission.

As a result of the rates approved, the San Francisco County welfare office made excessive payments of $981,596 out of the $5,416,193 expended during the period July 1, 1972, through September 30, 1975.

Beginning October 1, 1975, new regulations (45 CFR 288.71) took effect, specifically prescribing documentation supporting the reasonableness of rates paid for purchased services as a condition to Federal financial participation. Our review showed that payments of $713,390 made between October 1, 1975 and February 29, 1976, were not eligible for Federal financial participation because they were not so supported.

The following are some examples of how excessive payments occurred:

One contractor had unsupported or ineligible costs as follows: In the one contractor who has been discussed earlier this morning——

Senator CHURCH. Now, that contractor is Peter C. Gottheiner, is it not?

Mr. WITT. That is correct, yes.

Senator CHURCH. We will hear from him later?

Mr. WITT. That is correct—$91,276 was claimed for payroll and fringe benefit costs of an affiliated corporation which were unrelated to contract performance, based on documentation which was available. Mr. Gottheiner may state that the audit was not correct, however this

[1] See appendix 3, p. 1153.

was based on his written records and he was unable to provide us with any other documentation or any other support of this $91,000.

In addition, $57,566 of training, travel and promotion expenses for which there was no documentation supporting the relationship to contract performance.

Also, $13,691 in Federal income taxes, tax penalties, interest and organization expenses which had nothing at all to do with Federal reimbursement.

Senator CHURCH. You mean he was charging as expense his income tax to the Federal Government?

Mr. WITT. That is right.

Senator CHURCH. And tax penalties or failure to pay as well?

Mr. WITT. Yes.

Senator CHURCH. That never occurred to me before. [Laughter.]

That is a new one. Is that legal?

Mr. WITT. These were corporate income taxes which were indicated as being costs of doing business in presentations made to the county. Now, these costs were undetected by the county since no close examination was made of cost reports. During the period covered in our audit hourly rates for one contractor were increased as follows:

February 1, 1971—initial rate—$5 per hour.

July 1, 1971—Increase at contractor's request but unsubstantiated—$6 per hour.

July 1, 1972—Increase at contractor's request—$7 per hour.

The $7 rate has remained in effect through July 30, 1976. Rates for the two other contractors since July 1, 1972 have been $6 per hour. These are the other two proprietary contracts.

During July 1972 the commission rejected proposals from two other companies to provide the same services at rates ranging from $4.75 to $5.75 per hour.

I might say, parenthetically, there was no analysis or review and no basis nor anything in the record as to why these other proposals were not considered.

Further, the commission awarded rates to providers without adequately considering such factors as risk and investment. One contractor in 1973 earned a 35.25-percent profit on costs, and a 982-percent return on investment. This is after making the disallowances and considering these unallowable costs as profit.

Another contractor in 1974 earned an 18.76-percent profit on costs and 339-percent return on investment. A third contractor, for its fiscal year ended January 31, 1974, earned a 24.57-percent profit on costs, and 7,232-percent return on investment.

Inadequate consideration of risk factors was illustrated by the commission's award of a rate to one contractor which exceeded the provider's current cost requirements in July 1971 to make up for losses incurred in the previous 5 months.

I would like to add that this was just based on his statement without checking as to his records. The commission, by this action, appeared to be assuming essential elements of risk in protecting the contractor from ordinary operating losses.

Senator CHURCH. May I just go back to your figures. There were three contractors, three providers in San Francisco.

Mr. WITT. Yes, three proprietary providers.

Senator CHURCH. Three proprietary providers.

Mr. WITT. Yes.

Senator CHURCH. And even after disallowing improper or unlawful claims for reimbursement or for claims that were made, one contractor earned 35.25-percent profit on costs which represented a 982-percent return on investment in just 1 year?

Mr. WITT. That is right.

Senator CHURCH. Another contractor after the elimination of any improper or questionable claims earned 18.75-percent profit on costs which was a 339-percent return on investment in just 1 year.

And a third—this seems unbelievable—had a 24.50-percent profit on costs and a 7,232-percent return on investment in just 1 year?

Mr. WITT. That is right. Now, that is after disallowance of certain costs and considering those as profit and this is what the return would be. Incidentally, on this third contractor it was right after it started doing business and therefore without much investment and it was able to earn this much money.

Senator CHURCH. Is there no mechanism at all for determining the profit being made by these proprietary providers in awarding them their contracts and in paying them their fees?

Mr. WITT. The normal procedure under negotiation would be the request for proposals and the review of the proposal to obtain historical experience reports from the contractor. A review is made of these to see that they have been audited to assure that the records are correct so that you have a review of what the record has been in terms of profit.

Now, in this case San Francisco did not go through the normal procedures, they just accepted what the contractor presented to them as gospel. This meant that they were unable to detect that the contractors were making exorbitant profit and were including the cost of affiliated companies or promotional expenses and liquor and entertainment, and so forth, as part of these costs.

Senator CHURCH. I see.

Mr. WITT. The State agency relied primarily upon county administration for assuring that reasonable procurement practices were reflected in county contracts for homemaker and chore services. Also, when problems were identified, the State relied primarily upon voluntary corrective action by the county. Thus, the State of California did not require the county to promptly reduce rates of payment which were identified as excessive.

We made several recommendations to the State department of health in order to correct the problems. We recommended that procedures be established to assure that hourly rates are approved only after receipt and analysis of complete and accurate contractor cost data. We also recommended that the State require the county to negotiate provider profit or fee only after considering such factors as risk and investment. In addition, we recommended that the State department of health strengthen its controls over the program by establishing guidelines defining reasonable cost and profit and by taking action to correct identified problems. These are the highlights of the 90-page audit report. We would be glad to answer any questions.

Representative GIBBONS. I have a question.

Senator CHURCH. Yes, Mr. Gibbons.

Representative GIBBONS. You are the Federal auditor, is that correct?

Mr. WITT. Yes.

Representative GIBBONS. What happened to your audit after it reached the Federal Government?

Mr. WITT. Our audit report was issued at the end of October 1976. The department of social and rehabilitation service has asked the State to reply to the report. At this point a reply has been received and they are considering what further action is to be taken. The reply from the State was received in approximately the last sixty days.

Representative GIBBONS. Based upon your experience, when do you think the Federal Government will act, if ever?

Mr. WITT. Well, the Federal Government is relying primarily upon the State of California to take corrective action in this regard.

Representative GIBBONS. But you didn't answer my question. I am asking you when, based upon your experience—and I assume you have had a lot of experience—do you think that the Federal Government will ever respond to the audit?

Mr. WITT. I think so.

Representative GIBBONS. When?

Mr. WITT. I can't answer.

Representative GIBBONS. Who is responsible for responding?

Mr. WITT. The local commissioner of the Social and Rehabilitation Service.

Representative GIBBONS. I am talking about the Federal Government.

Mr. WITT. Yes, that is within the Federal Government—Social and Rehabilitation Service.

Representative GIBBONS. The local commissioner?

Mr. WITT. Yes, sir.

Representative GIBBONS. Are you talking about somebody in the California government?

Mr. WITT. No, this is a regional commissioner of the Social and Rehabilitation Service.

Representative GIBBONS. He is also in San Francisco; is that right?

Mr. WITT. Yes, sir.

Representative GIBBONS. Well, now, does anybody above him ever get to see this audit before it gets filed or tossed away?

Mr. WITT. Yes. There is a followup procedure concerning what action is taken by the Social and Rehabilitation Service. If the audit agency, for example, comes in on the followup review and determines that corrective action has not been taken, then we so report it.

Representative GIBBONS. How long does that take?

Mr. WITT. Well, that can vary depending on the individual circumstances. The Regional Commissioner of the Social and Rehabilitation Service issues a formal action statement and we will review it and determine at what point we will go in to follow up.

Representative GIBBONS. What worries me is that it sounds like we have a gigantic paper shuffle going on here when you know you have a serious problem. When is somebody who will take some affirmative action going to get hold of it and do something about it? That is my question. How long does it take?

Mr. WITT. Well, one thing, in terms of action based on our audit report, we have asked for money back. That is one action.

Senator CHURCH. Who is going to get it?

Mr. WITT. That will be done automatically by the Social and Rehabilitation Service as the action is taken. However, they will reduce the money in the quarterly expenditure report from the State. Now, the State, however, has a right to appeal but that is one type of example of the action taken.

Representative GIBBONS. To your knowledge, do your audit reports ever get to the Congress?

Mr. WITT. Well, I know Mr. Halamandaris was very interested in the report and we got a copy to him.

Representative GIBBONS. If he comes to find it, he can get it.

Mr. WITT. Pardon?

Representative GIBBONS. To throw some classification on it, that makes it impossible for you.

Mr. WITT. No. The HEW Audit Agency reports are all available to the public and to the Congress and we would be more than happy, if you have not received copies of these, to make them available.

Mr. GIBBONS. It would seem like there would be a lot of good leads to some corrective legislation in that, because by the time it gets to the congressional level, frankly it is usually so old that it is not of much formal use to us. I would hope that we could find some way to get the reports to us rapidly and that the Congress can respond more rapidly. I understand the necessity for asking the States agency to comment, but frankly it is my impression that it is just a paper shuffling operation.

Finally, you are going to assess the State of California for a lot of money and then they are going to come in and bargain and then eventually the whole thing will be forgotten or washed away. It looks like you and your staff have done good work. What worries me is that there is no followup, no cleanup and it just goes on and on and on.

Would you like to respond to that, please, sir? Is my observation correct that it just goes on and on and on?

Mr. WITT. In some cases there are problems in obtaining corrective action. I would hope in this particular case that action will be taken.

Representative GIBBONS. In this particular case with the notoriety it has gotten there is going to be some corrective action taken but I am worried about the ones we don't know about.

Mr. Chairman, I won't take up any more time.

Senator CHURCH. I think you have made your point, Mr. Gibbons.

Mr. Corman.

Representative CORMAN. Mr. Chairman.

We keep hearing title XX is a very difficult program to monitor. And that if the States have a larger stake in it than their present 25 percent share, that somehow it will be the magical formula to make them monitor better. Do you believe that it does not work out well? I assume from your testimony that the 25-percent State contribution is not really sufficient to assure the program is monitored carefully.

Mr. HAWES. If I may speak to that, in California the non-Federal cost has gone up to 48 percent of the total cost because of ceiling on

title XX. They have taken the posture in California that it is a county administered program and a State supervised program and the regulations have been minimal. Perhaps the regulations that are developed over the next several months and that are promised to become effective on July 1 will make the State more responsible for controlling these costs.

Currently the State has not shown that much interest until the program appears to be running out of money and then there is an emergency request to the legislature for an appropriation to keep the program alive.

Representative CORMAN. Do the counties have any money in the title XX programs?

Mr. HAWES. They have some money. I think last year they spent $7 million.

Representative CORMAN. That is a relatively small amount compared to the total coverage.

Mr. WILLIAMS. May I add, are you concerned about whether the vested interest would provide any greater oversight or control? We have in California programs that are 100-percent State funded, that are run no better than this one.

Senator CHURCH. Then maybe there isn't any answer.

Mr. WILLIAMS. I certainly hope there is.

Representative CORMAN. The least efficient way programs are funded is jointly. The Congress should decide how much is going to be spent for these programs, then totally fund and monitor them. It is very difficult to do otherwise.

Title XX responds to people with unusual and changing social service needs. It would be difficult to develop contractual specifications for providing these services on a low bid or performance basis, unless there is a very large population group. How long, for example, should a stroke victim be rehabilitated?

It is not clear that private contracting procedures can ever respond to these complicated individual situations.

Education and police services are not put out for bid or paid according to a performance contract, title XX services are even more complex.

A different approach must be used. Business principles work well in many situations, but not for home health and certainly not for the specialized title XX services.

Thank you, Mr. Chairman.

Senator CHURCH. I want to say that Mr. Obiedo testified that before anyone could make a home service call under the California medicaid—Medi-Cal—program it had to be first approved by the agency. If that is the case, and it takes that degree of effort to control fraud, the State of California might just as well take over the program and administer it in its entirety.

Mr. Macomber, you have the audit on the Gottheiner case; is that correct?

Mr. MACOMBER. That is correct, Mr. Chairman.

Representative MARTIN. I just want to pursue one item in the statement.

You say incidences of abuses which you term as audit exceptions make your office unpopular with the executive branch.

Mr. WILLIAMS. Yes, sir, that is correct.

Representative MARTIN. That seems to me a terrible pregnant phrase and I ask what you mean by that?

Mr. WILLIAMS. I guess as a legislative auditor in California, I presume you could classify me as the natural enemy of the executive branch. I provide the legislative oversight function for the California Legislature and program management.

Representative MARTIN. Do you mean to say that you are implying no more than you assumed that you are unpopular?

Mr. WILLIAMS. That is correct. That is an assumption. I think some of the news releases, press releases in rebuttal to our reports indicate some displeasure.

Representative MARTIN. That is a field disclosure. There has been no overt effort to restrain your auditing.

Mr. WILLIAMS. No, sir, none whatever.

Representative MARTIN. Fine. Thank you, sir.

Representative GEPHARDT. Mr. Chairman.

Senator CHURCH. Yes, Mr. Gephardt.

Representative GEPHARDT. Mr. Witt, Mr. Gibbons asked you about what action the Federal Government could take under the law to have the HEW cut off funds that are going into California for that program because of the inability or the lack of desire on the part of the State department to do something to correct the actions you have asked them to take?

Mr. WITT. Under certain circumstances they can find the State out of conformity, but this is a sort of difficult process. Normally the Department would hope to try to work with the State in getting the corrective action taken.

Representative GEPHARDT. When was your audit report released?

Mr. WITT. Our audit report was released on October 29, 1976.

Representative GEPHARDT. And to date not only have we not gotten the excessive payments back from the dates prior to that but there has been no change in current policy; is that correct?

Mr. WITT. That is correct.

Representative GEPHARDT. And the excessive rates are still being charged and paid under the program; is that correct?

Mr. WITT. That is correct.

Representative GEPHARDT. And you are telling Mr. Gibbons that you are not clear on exactly when some action might be taken either to cut off funds or to get some compliance or whatever?

Mr. WITT. The State delayed in replying to our final audit report. The State has to answer to the so-called Social and Rehabilitation Service. Within the last 60 days the response was obtained and at this point SRS is considering what action is taken. I see the State responding around the first of the year and then from there SRS will take whatever action is required.

Representative GEPHARDT. Mr. Hawes, you seem to have some faith that there can be fiscal and performance auditing with regard to these kinds of programs. Do you think that audit function should be placed at the Federal level or at the county level or through private concerns, intermediaries?

Mr. HAWES. I think it should probably be placed at the local level, the lowest level, as much as possible, with some oversight and recheck-

ing at the subsequent higher levels on a sample basis. I don't see how it can all be done at the Federal level. I think most of it should be done locally. I think that in the business of home health care and the homemaker/chore programs if there were simply some ground rules on statutes and regulations that when a person contracts to provide a public service that they be required—whether it is a proprietary agency, a public agency or a nonprofit agency—to submit who they will be subcontracting with and who the principals in that subcontractor are and I think that would prevent a lot of the abuses you heard about in the last 2 days. If that simple mandate were made so that as a requirement of getting public funds the method of spending those funds would be spelled out.

Representative GEPHARDT. Do you think that the regulations for determining, for instance, reasonable cost are sufficient that they give adequate guidelines so local officials can understand what they are supposed to do in enforcement?

Mr. HAWES. I am not sure that I feel qualified to say whether or not the reasonable cost guidelines are sufficient.

Mr. WILLIAMS. May I add a few points to that?

Representative GEPHARDT. Yes.

Mr. WILLIAMS. When we get into large multimillion dollar programs of this nature where there is a significant amount of contracting going on, there ought to be some firm guidelines and criteria for what constitutes an allowable cost and what is an unallowable cost. Now, Federal procurement regulations have had those for years in defense contracts, particularly cost type contracts. Those specific unallowables are clear cut.

There certainly are some gray areas. That type of thing does not currently exist in this situation.

To answer further a question as to what level of performance of auditing or the audit oversight should be, I would tend to agree with Mr. Hawes that at the local level might be an idea, but I don't think it is practical. No. 1, most of the county agencies do not have adequate resources to perform an audit. California particularly would have 58 different types of audits—58 counties—and it would seem to me that the function of auditing and oversight of these providers would more logically fall at the State level, statewide, applying the same cost principles and audit procedures.

Representative GEPHARDT. With the hope that when problems are found sanctions are imposed and that seems to be one of our problems.

That is all, Mr. Chairman.

Senator CHURCH. Mr. Pickle.

Representative PICKLE. I would like to make a request of the staff regarding the role of the intermediary. I am fuzzy on what is expected of intermediaries like Travelers when they make an audit. When they testified yesterday, though I was not there for all the hearing, I had the feeling that they were trying to account for dollars more than passing judgment on whether something was being done right or wrong.

Now, these gentlemen are taking a much more militant approach; it is an oversight approach. I would like to know from the staff what is the responsibility of Travelers in this case, the intermediary, what are they supposed to do in the audit and would that differ from what

you people are doing? I think we need not only set the guidelines, we ought to know what is expected of them. If we just account for dollars we could save a lot of money. If all they are going to do under the present law is say Travelers is supposed to do a lot more than they actually did, maybe we ought to file a suit against them for negligence, but, first, I would like to have some good analysis. What is expected of auditors? I ask the committee staff to give us that so we can make some comparison.

Representative GIBBONS [presiding]. Mr. Pickle, I will do that.

Mr. Gary Macomber, director, Department of Social Services, State Department of Health, State of California.

We will hear you now, Mr. Macomber.

STATEMENT OF GARY MACOMBER, DIRECTOR, DEPARTMENT OF SOCIAL SERVICES, CALIFORNIA STATE DEPARTMENT OF HEALTH

Mr. MACOMBER. Thank you.

This division supervises the administration of 23 separate social service programs in the State of California which are principally county administered so our role is not as a direct provider but as a supervisory agency.

I didn't come prepared to rebut the auditor general's comments, but a few of them I feel I have to speak to.

Our view of the auditor general——

Senator CHURCH. Excuse me. I apologize for interrupting but it is 5 minutes after 12 and it is my understanding that you will move us deeper into the case of Peter C. Gottheiner and we won't be able to really question you before having to adjourn for lunch.

I would like to have the whole case presented at one time rather than to try to break it into two pieces. So I would suggest if the members don't object that we adjourn now for lunch and come back at 1:30.

Does that present any problem for you?

Mr. WILLIAMS. We can work it out.

Senator CHURCH. I believe we best recess.

The committee is recessed for lunch; we will return to this room at 1:30 this afternoon.

[Whereupon, at 12:08 p.m. the committee recessed, to reconvene at 1:30 p.m., the same day.]

AFTERNOON SESSION

[The committee reconvened at 1:30 p.m., Hon. Frank Church, chairman, presiding.]

Senator CHURCH. The hearing will come to order.

When we recessed this morning Gary Macomber was about to give his testimony and we will turn to him at this time.

STATEMENT OF GARY MACOMBER—Resumed

Mr. MACOMBER. Thank you, Mr. Chairman.

I was not prepared to respond to the auditor general's report, but I feel I should make some comment. There are some errors in the report.

Before I go into the testimony—I don't think we ever object to objective criticism when it is founded in fact, but such was not the case in this instance. I think one of the recommendations that was referred to was that we were not maximizing our Federal reimbursement regarding the homemaker/chore program in terms of title XIX. This is a lowering of State costs to the program. To do such would cost the taxpayers $24 million a year; therefore we have not chosen to do that.

I think we should point out that counties do not determine eligibility on an individual county-by-county standard basis for the programs determined according to State standards that are governed by Federal law and regulations.

Contrary to the testimony that was already given, regulations have been filed specifying allowable costs and procedures that bidders must go through before securing a contract, the experience that is required in financial statements, and I will provide these to the committee.[1]

The audit referred to what the auditor general accomplished in June 1975. I think you will find there is a close resemblance to the audit we did in March and April 1975 and I will provide a copy of that to the committee.[2]

Senator CHURCH. Very well.

Mr. MACOMBER. Just to put the matter in perspective, in California we serve about 70,000 aged and disabled folks in the homemaker/chore programs to permit them to remain in their homes as a result instead of an institution.

Some 70 or 80 percent are noncontractor services; they are services provided by another individual who is the employee of the recipient of services.

Related to the question of whether they are employees of the county, this is a matter that the legislature has been aware of in California and they may make that clear in some hearings on workers' compensation, but the bulk of the people providing the services are individuals.

The State code requires that the first preference be given to former or current recipients of public assistance to enable them to be self-sufficient and to enable them to function as a homemaker or chore service worker.

The State Welfare Institution Code mandates that we allow counties to exercise as many as three options in providing services; that is, through a contract or through an individual as I just described or through county employees on a per-hour basis. Far and away the most expensive basis is county employees. That runs in the neighborhood of $20 per hour compared to $2 or $3 an hour for an individual provider and $3 to $5 for a contract provider.

I would like to now go into the circumstances of visiting home services and home health, the things that the committee has asked me to speak to.

At the time of the bankruptcy of the firms in August 1976 the two companies held nine contracts in California counties for the delivery of homemaker/chore services.

[1] See appendix 4, p. 1197.
[2] See appendix 5, p. 1228.

Senator CHURCH. Who owned the two companies?

Mr. MACOMBER. The ownership was divided at the time. I have it in the audit report. I will get into it later.

At the time of the bankruptcy Mr. Peter Gottheiner was no longer officially associated with the firm having divested himself of his interest in June of 1976. I can lead up to that.

Senator CHURCH. All right.

Mr. MACOMBER. The statewide total value of the contracts for the fiscal year in question was in excess of $4 million. All of these contracts with the exception of the one in San Francisco County, which is the one we were hearing about this morning, we have 59 counties in California and all counties other than San Francisco County have complied with competitive bidding requirements. The State now has San Francisco County, and has had for several months, in formal compliance proceedings to force that county to go into competitive bidding. They have in fact issued an invitation for bid and bids have been received and they will be responding to those bids very shortly.

Each county in California administers its own purchase of service arrangements under policies and guidelines established by the State department of health in accordance with State and Federal laws and regulations. State staff in the department of health review for approval or disapproval the county's bidding process, including invitations for bids, the complete bid package received by the county and the county's award of contract.

Under the State's requirements, each bidder must submit to the county along with his bid a current financial statement to help the county in its assessment of the bidder's qualifications and ability to fulfill the obligations of the anticipated contract, if awarded to him. Without evidence to the contrary, such financial statements have been in practice accepted on general face value, since neither the State nor the counties had the staff capacity for auditing or other verification of the statements.

The major concern of both State and county agencies in being alert to the activities of the two firms centered on continuous delivery of service to the recipients of services, without interruption, at a cost that may be termed to be reasonable.

Senator CHURCH. How do you determine it to be reasonable if you have no idea of the actual measure of profit being realized?

Mr. MACOMBER. We subject all the counties, with the exception of San Francisco, where the profits that Mr. Witt and others were referring to this morning, to go through a competitive bid process on each bid package. The rate is broken down at our office and broken out to assure that the individuals providing the service are receiving the minimum wage or appropriate higher wage depending upon the specific salary structure of that particular firm. The regulations that we filed also specify allowable cost. We have picked up the same allowable cost the Federal Government uses and that is our requirement now as to what can be charged against the contract cost.

Senator CHURCH. When did you do this?

Mr. MACOMBER. The regulations were developed last fall and were filed on December 30 with the secretary of state in California.

Senator CHURCH. So you completed this reform in your administrative controls a couple of months ago?

Mr. MACOMBER. Yes, sir.

The first solid evidence that we had that the delivery of services was threatened came when payroll checks issued by Visiting Home Services, Inc., or VHS began to bounce in two California counties. This information came to us in August 1976 and we immediately advised them to examine the contractor and the program carefully to determine the solvency and performance.

With the assistance and support from the State department of health staff, all counties concerned began to make arrangements for alternate methods of service delivery. Payroll checks in other counties were not being honored for payment by the firm's bank. As soon as each county felt its contract was being breached, its service delivery was picked up and operated through an alternate method with the county welfare departments working through county counsel in close coordination with our State agency and State counsel.

Arrangements were made for a State audit team to investigate the fiscal solvency of Visiting Home Services, Inc., and a meeting was held between State representatives and VHS representatives to set up an audit schedule. Auditors found that the lack of sufficient record and bookkeeping practices made it nearly impossible to discover specific details of the firm's internal operations.

Although Peter Gottheiner himself had previously, in June 1976, stepped out of official connection with the firm, he did in fact attend all of these meetings and participated as if the firm were still under his control. The audit team's findings disclosed many questionable circumstances in the handling of funds in the firm generally and in withdrawals of cash from the firm's account without adequate explanation, some withdrawals continuing to go to Peter Gottheiner after his "disassociation" from the firm.

Examples of extraordinary amounts of money disbursed to Peter Gottheiner from the accounts of Visiting Home Services and Home Health firms totaled some $236,000 during the year prior to the fiscal collapse and were listed under such items, including salary, as take-out moneys for unidentified consultants and repayments of unidentified loans, excessive travel and promotion expenses, nonprogram-related personal expenses, and payroll salary for ex-wife with no evidence of her employment.

Audit findings were turned over to other governmental agencies as appropriate including the State attorney general, the State employment development department, the State franchise tax board and the Intelligence Unit of the Federal Internal Revenue Service, and this occurs in the early fall.

Senator CHURCH. This is 1975?

Mr. MACOMBER. 1976.

Senator CHURCH. What happened to your 1975 audit?

Mr. MACOMBER. Following the 1975 audit a letter was prepared and guidelines presented at each county office in June 1975 setting forth the requirement for competitive bidding in each individual county and specifying the contents of what the invitation for bid must contain. As I said, all counties with the exception of San Francisco complied with that directive.

Senator CHURCH. But your 1975 audit, we are talking now about this particular firm.

Mr. MACOMBER. Yes, sir. The 1975 audit covered this firm and two others.

Senator CHURCH. All right, this firm and two others, and it showed, according to the résumé that I have, a considerable number of charges being made for entertainment, business expenses and travel, including out-of-State and foreign expense reimbursements not adequately supported, out-of-pocket expenses of $26,000 and $49,098 in 1974 which were totally unsupported by bills or receipts, reimbursements to the president, Mr. Gottheiner, of $45,430. The audit indicated that there was no basis for determining what these expenditures were and so on and so forth, and go on down through a whole number of findings in your audit. That must have signaled that something was very wrong with the corporation.

Mr. MACOMBER. I think one of the gentlemen this morning made a good point of the question whether it is a questionable activity or whether it is an illegal activity or contrary to a contract. The contracts that San Francisco County entered into at that time with their providers at that point were not subject to State approval and they have not been forwarded. The activities of the contractor were not such that could be disallowed under the existing contracts between San Francisco County and their contractor. Therefore, we began the work and in June 1975, as I mentioned, distributed the requirement of going to competitive bid.

Senator CHURCH. Well, you are avoiding my question, I think. You did an audit of this firm which suggested that the firm was being milked.

Mr. MACOMBER. Was being what, sir?

Senator CHURCH. Milked.

Mr. MACOMBER. Yes.

Senator CHURCH. And yet you didn't alert the counties to this, you didn't suggest that your audit raised grave questions about this agency and its fiscal management and its ability to continue to render services at a reasonable rate to the counties?

Mr. MACOMBER. This was one instance out of eight or nine counties that the contractor was providing services in. In all other counties program reviews indicated the services were being delivered, the counties felt the services rendered were of very adequate quality; they were paying a reasonable price for those services.

Senator CHURCH. Did you conduct an audit in those other counties?

Mr. MACOMBER. We did an audit in not all of the counties. We had 4 evaluators for all 23 programs to be administered.

Senator CHURCH. Well, in your audit, you had no basis upon which to assume that a man who would operate one company in this way in San Francisco County would operate any differently in other places, did you?

Mr. MACOMBER. I was not in the department at that time, I can only guess what the thinking was at that time and it was that they were satisfied that the competitive bidding process would be adequate as a control measure. I am not that satisfied that it is adequate as a control measure.

Senator CHURCH. So in any case, the answer to my question is no, having made the audit, a warning did not go out to all the counties.

Mr. MACOMBER. A directive went out to San Francisco.

Senator CHURCH. I understand that, but did a warning about the way this company was being managed go to the counties?

Mr. MACOMBER. I think it was general information at that time. It was not officially transmitted to each county welfare department.

Senator CHURCH. So the answer to my question is no, the warning did not go out.

Mr. MACOMBER. I believe so.

Senator CHURCH. Thank you.

Mr. MACOMBER. Going back to the period of August 1976 when the firm entered their bankruptcy proceedings, for a 10-day period, while the special auditing was acting on a full-time assignment, the firm's books were closed and the trustee was installed.

Immediately after ending his association with the California-based firms in June of 1976, Mr. Peter Gottheiner had incorporated a new firm in the State of Illinois under the name of National Home Care, Inc. This new firm has entered bids in some California counties to provide homemaker/chore services but with no success. No contracts in California have been awarded to this new firm. It is the State's present position that while our counties are free to accept bids from this firm, they are also free to disqualify the bids at this point on grounds of fiscal instability due to the history of Mr. Gottheiner's operation in this State while associated here with other firms.

Currently in San Diego County new bids have been received and reviewed by the county for the purpose of recommending an award of contract. Of the bids received in San Diego, the lowest bid was submitted by the new Gottheiner firm out of Illinois.

County authorities have recommended to the county board of supervisors that the Gottheiner bid be disqualified on the basis of financial instability. The State will support the recommendation to disqualify. State investigators have reason to believe that the new Illinois firm's fiscal operations are presently paralleling some of the operations that led up to the bankruptcy of the California firm.

For example, the new firm, National Home Care, included in its financial statement accompanying the San Diego bid an item claiming $206,400 assets in the form of "subscriptions receivable." A letter dated August 5, 1976, from certified public accountant Victor Harvey, an employee of National Home Care, written to the San Diego County supervisors attests to the firm's "stability, solvency, and fiscal responsibility" through fiscal investment pledges as needed for new contracts and supposedly from individuals but they were not named.

I have this material for the committee.

This closely resembles a statement signed by Victor Harvey dated May 7, 1976, when he was employed by Visiting Home Services in California, written in support of that firm's fiscal solvency through a promise of investments based on new contract awards, which later proved false. The promissory note from Ralph Gomez promising to provide capital to Visiting Home Services in the amount of $250,000 is dated January 15, 1976, but it was not notarized until June 21, 1976. It was submitted in support of a bid in California to indicate fiscal solvency. The note was never honored and the VHS firm failed and went bankrupt.

Such similarities between the California operation when Peter Gottheiner was associated with it and the current National Home Care operation in Illinois would preclude us from approving awards of contracts to the latter firm at this time due to the potential risk of failure in contract performance and subsequent disruption of vital services to recipients of in-home supportive services.

Shortly after the bankruptcy of Visiting Home Services, Inc., in California the State department of health drafted and implemented regulations designed to prevent recurrence of such a situation through tighter controls over the contract bidding process. Proposals for legislative changes and further regulatory changes are now under development and drafting that will give controlling governmental agencies protection against the procurement of service contracts in this program by unstable vendors in the future so as to assure effective use of tax dollars and continuation of needed services to recipients.

Thank you.

Senator CHURCH. As I understand this case, back in February of 1971, the Assistant Regional Director of HEW forwarded the Gottheiner file to the U.S. Attorney James Browning for criminal prosecution and it was alleged that Gottheiner billed Medi-Cal for services not rendered in violation of section 208 of the Social Security Act.

In the same month Gottheiner moved into title XX social services, set up a new corporation and was awarded a contract by the city and county of San Francisco.

Then in March, the next month, the corporation that had been doing the business with the medicaid and medicare programs was dissolved and claims against it were never collected. Then doing business now with the social services in a new corporation, Gottheiner proceeded to handle the corporate affairs in such a way that in March of 1975 Thomas Tierney, the director of the bureau of health insurance, claimed that the corporation owed to the government $804,655. Then Mr. Gottheiner resigned from the corporation. Then the corporation filed bankruptcy. Now, the $804,655 is lost to the Government.

Then Mr. Gottheiner forms a new corporation and applies for doing business in Illinois and some other States. He apparently takes on and sheds corporations the way a snake sheds his skin leaving the unpaid bills behind and yet continues to do business as he forms the next corporation with one of these programs or another.

Now, the record in California suggests that there ought to have been some way to have alerted the county governments as to the previous experience that the State had had with this particular person. Unfortunately, there does not seem to have been any kind of coordination that would have prevented the second loss following on the first. We are talking about quite a lot of money.

Mr. MACOMBER. I think the counties were aware although they had not gone through a formal notification but that the law that governs our State, welfare and institutions code, requires that bids go to the lowest responsible bidder bidding in that particular county and there is no authority in the code, and this is something we are trying to get legislated into the code, for the State to certify providers of services but as long as it is in current State code there was the ability to provide the services and the amount charged was the lowest responsible bid. There was not a great deal of discretion.

Senator CHURCH. Well, we know now that the lowest responsible bid does not prevent corruption on the very broad scale as was illustrated in our investigation of the Souza case yesterday. Did you ever conduct an audit for Souza's Unicare?

Mr. MACOMBER. We conducted an audit of Unicare and Mr. Halamandaris requested it. I have a copy of the audit with me. I just received it Monday and will make all the workpapers available to the committee.[1]

Senator CHURCH. When did you conduct that audit?

Mr. MACOMBER. It has been going for 2 or 3 months, to the best of my recollection.

Senator CHURCH. Would it be fair to say you commenced the audit once you learned of the investigation of our committees into the Souza matter?

Mr. MACOMBER. No, sir. We commenced the audit when we received our audit capability which was in December. From the 1st of July we had the audit capability of 2 man-years of audit staff for a $468 million program. In December we received an augmentation of 14 which enabled us to do the kind of audits we wanted to do.

Senator CHURCH. Were you satisfied with what you were able to find by the audit you conducted?

Mr. MACOMBER. I think we would like to look at the companion companies involved. We would very much like, I think, to do some additional joint audits together with the Federal Government. The audit of Unicare that we accomplished showed apparently no illegal charges to the title XX program but leaves us questioning whether some overhead was passed on to other Government programs.

Senator CHURCH. And by being aware of the audit of the corporation you are really not able to know whether that corporation is in fact being subsidized by the taxpayers in order that it can make the lowest bid?

Mr. MACOMBER. Very much so.

Senator CHURCH. Does Mrs. Souza now have some of the contracts that Mr. Gottheiner had before the company declared bankruptcy?

Mr. MACOMBER. I believe she does, yes.

Senator CHURCH. How was she able to get them so quickly, do you know?

Mr. MACOMBER. The counties that had services severed by the bankruptcy of VHS, we authorized them so that the recipients could continue to receive services, to purchase them from private agencies pending going to a competitive bid process. They had that option or the option of going to the next lowest responsible bidder when the rates were bid in late last spring; so in some instances they would have been the selected lowest bidder or they would have gone through a competitive bid process once again. All the counties in which VHS failed to provide services did not go to the agency, some picked up where done by employees, some were other providers.

Senator CHURCH. Mr. Halamandaris, do you have questions?

Mr. HALAMANDARIS. No, thank you.

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[1] See appendix 4, item 2, p. 1211.

Representative GIBBONS. I don't really understand the relationship of Mr. Macomber, to Mr. Williams. You don't work for him, I assume.

Mr. MACOMBER. No, sir.

Representative GIBBONS. You work for the department of social services of the State of California, which I would assume is an agency of the executive branch of the government.

Mr. MACOMBER. Yes, sir. It is part of Mr. Obledo's agency.

Representative GIBBONS. And those 2 man-years of audit power you talk about, what program does that support?

Mr. MACOMBER. It supported our entire social service program from the contractor's prospective. We do have a capability within the State controller's office that——

Representative GIBBONS. The program you are essentially talking about is title XX of the Social Security Act; is that correct?

Mr. MACOMBER. Yes, sir.

Representative GIBBONS. And I don't know what part California gets. I usually do.

Mr. MACOMBER. $245 million.

Representative Gibbons. $245 million, but that is about all we put up, $245 million. What year was that?

Mr. MACOMBER. We have been frozen in our allocation for the past 3 years. The national appropriation is $2.5 billion per year.

Senator CHURCH. That is for all social services under title XX?

Mr. MACOMBER. Yes, sir.

Representative GIBBONS. Why were you frozen at that amount?

Mr. MACOMBER. Congress.

Representative GIBBONS. Is it because you had so much that nobody else had anything?

Mr. MACOMBER. I think all States are experiencing the same thing we are experiencing.

Representative GIBBONS. Why did you have only two auditors? I am not criticizing you. I ask why did California, with $245 million of money only have two auditors? Do we prohibit you from having anymore in the Federal law?

Mr. MACOMBER. I think there is a dual crunch when you have a closed-in allocation, and your financing is really less each year because of the impact of inflation, so you are in a situation of laying off staff rather than bringing new staff on and there is not the additional funds available for these administrative expenses.

Representative GIBBONS. Mr. Williams wanted to interrupt.

Mr. WILLIAMS. I was not going to interrupt.

One point, there are 3,550 auditors within the executive branch and the department of finance is one of the largest organizations within the executive branch that has the capability of performing that audit.

Representative GIBBONS. But he said they had 2 man-years, I guess that is two people, to audit this $245 million program. What happened? Did you just decide or California decided to close their eyes on this?

Mr. MACOMBER. No. I think the bulk of the responsibility rests at the county level with some State supervision. Contract monitoring

and auditing is a county requirement. The counties work in the same fiscal bind, even more so than the State government, with the decreasing Federal revenue source.

Senator CHURCH. Would the gentleman yield?

Representative GIBBONS. Yes.

Senator CHURCH. This is just another illustration of the pass-the-buck syndrome. We have a $2.7 billion social service program under title XX of the Social Security Act. The Federal Government does not monitor nor audit nor police the program because that is left up to the States. Clearly California had a capability, with 3,550 auditors, to allocate more than two to a program that in the State alone amounted to a quarter of a billion dollars, but the State failed to do it. The excuse that is given is that that was a responsibility to counties and the counties didn't have any particular interest in the program. I am sure the county commissioners would assure us that they do not have the resources to police the program because none of their funds were involved in the program anyway. I can't imagine a system that is better designed to invite the kind of fraud that we have than this pass-the-buck arrangement. Please don't misunderstand; I am not blaming you for this.

Mr. MACOMBER. Thank you.

Senator CHURCH. But I think you really helped make it clear just what the situation is and that we have to find some way to come to grips with it.

Mr. MACOMBER. I think, Senator, since the buck has stopped and with the augmentation that we have received, that we have the ability now. It is unfortunate that it took 2 years to clamp down on these activities. We are in the process of going through every one of the homemaker/chore providers on a priority basis. We have in our title XX program 1,300 individual contracts with providers of one type of service or another so it is a heavy job to carry out, even with the 16, sir.

Senator CHURCH. Mr. Halamandaris, do you have any further questions?

Mr. HALAMANDARIS. No further questions.

Senator CHURCH. Thank you very much for your testimony.

Frederick Keeley will come forward and take the witness chair.

Mr. Keeley, would you raise your hand and take the oath.

Do you solemnly swear that the testimony you will give will be the truth, the whole truth, and nothing but the truth, so help you God?

Mr. KEELEY. I do.

STATEMENT OF FREDERICK KEELEY, FORMER EMPLOYEE OF HOME CARE, INC., SAN JOSE, CALIF.

Senator CHURCH. Mr. Keeley, you appear here under subpena, do you not?

Mr. KEELEY. Yes, I do, Senator.

Senator CHURCH. Do you understand that you are protected by the immunity that is extended to congressional witnesses who appear under subpena insofar as it relates to answers you give to questions put to you?

Mr. KEELEY. I understand that, Senator.

Senator CHURCH. Very well.

Mr. HALAMANDARIS. Mr. Keeley, I would appreciate it very much if you would tell this committee the circumstances surrounding the awarding of a contract to Mr. Gottheiner in the State of Illinois. If you know the amount of the contract, the circumstances under which it was let, we would appreciate hearing about it.

Mr. KEELEY. In approximately February of 1976 I was employed by Visiting Home Services, Inc., of San Francisco in the capacity of special assistant to the president, and the president of the corporation at that time was Peter Gottheiner. On or about February 10, 1976, that corporation held a board of directors meeting in San Francisco at which time, among other items contained in the pack of materials presented to me was a memo to the board of directors from Ronald B. Gottheiner, executive vice president of the corporation, regarding the State of Illinois.

I believe that Mr. Halamandaris has a copy of that memo.

[The memorandum referred to follows:]

To: Members of the board of directors of Visiting Home Services, Inc.
From: Ron B. Gottheiner, executive vice president.
Date: February 10, 1976.
Re: The State of Illinois.

Mr. President, members of the board, ladies and gentlemen: On January 12, 13, and 14, 1976, my father and myself went to Springfield and Chicago, Illinois for various prearranged meetings in reference to a contract for the delivery of in-home supportive services to the State of Illinois. We have been in contact with them for more than 3 years, and we had two meetings prior to this one with the assistant director and the chief of services, Department of Public Aid, State of Illinois. There was also extensive correspondence in the way of very detailed proposals requested by the Department of Public Aid.

Our proposal, which originally was designed for a pilot program to involve about 300 recipients in Cook County, was very carefully evaluated, and we received word that our concept, offer and rates were above expectations and that they desired to contract with us for the entire State. A formal recommendation from Jesse B. Harris, assistant director, Department of Public Aid, was made to James L. Trainor, director, for approval of a contract.

However, in the meantime, political developments of considerable magnitude brought their entire services program, as well as the award of new contracts, to a standstill. One of the main reasons for that state of affairs was a power play between the two major gubernatorial candidates, the incumbent, Gov. Daniel Walker, and the present secretary of state, Mr. Michael Howlett. Although both of the major candidates are Democrats, the social services program is unfortunately being utilized as a political football; but we were assured that after the primaries, which will be held on March 16, everything will go back to normal with either candidate. We expect to provide services to this State not later than July 1, 1976.

Through some excellent connections and friends in Chicago, we were invited to meet not only with Director James Trainor, Assistant Director Jesse Harris, and Mrs. Margaret Washnitzer, chief, bureau of self-support, but we were also most fortunate to have a lengthy and most successful talk with Hon. Don A. Moore, Senator, State of Illinois, and chairman of a 12-man legislative advisory committee on social services. Senator Moore is a Republican, and the committee consists of six senators and six assemblymen, one-half being Republican and one-half being Democrat. Senator Moore is very highly regarded among the other committee members, and likewise highly respected by the Governor and the other candidates. His executive director, Joel Edelman, was an administrator and executive vice president to Michael Reese Hospital in

Chicago, and member of the board of trustees for 3 years. Thereafter, he was the director of public aid, State of Illinois, and is now the executive director and close friend of Senator Don A. Moore, the chairman of the legislative committee making all the decisions on social services, including contracts.

During our short stay, we developed a genuine friendship and close relationship not only with Senator Moore and Mr. Edelman, but with other legislators whom we met, and their staffs.

We were asked to submit immediately a proposal which would provide full-time employment, with all benefits, for 500 present welfare recipients as a pilot program, and which would likewise require the delivery of services to about 2,500 recipients, at an average of 30 hours per month. This would mean almost 1 million service hours per year on a demonstration program only; after our services would be implemented statewide, the contract could well reach between 7 to 10 million hours per year.

Our proposal will be submitted within the next week, since all the groundwork has been completed, and we expect a favorable response shortly after their primaries.

Needless to say, you will be advised of all new developments individually.

Thank you very much.

Respectfully submitted,

RON B. GOTTHEINER,
Executive Vice President.

Mr. HALAMANDARIS. Yes; what I would like to do at this point is send this memo down to you and have you take a look and identify this document for authenticity and then have it returned to me.

[The witness acknowledged the document as a true copy.]

Mr. HALAMANDARIS. Thank you, Mr. Keeley. We have a copy of that memorandum from Ronald B. Gottheiner in front of us which you have identified. Can you then tell us what the gist of this memorandum is, please?

Mr. KEELEY. The gist of the memorandum is that Ronald B. Gottheiner, Peter Gottheiner visited the State of Illinois for the purpose of exploring the possibility of contracting that State for homemaker/chore services. It indicates that they met with certain State officials and a member of the State senate and that they developed a close personal relationship. The memo seems to indicate that they felt positively that they would be able to obtain at least a demonstration project grant for homemaker/chore services in that State.

Mr. HALAMANDARIS. What further action was suggested in the memo? What route were they to take to secure the contract?

Mr. KEELEY. It was suggested that the corporation continue to be in contact with those State officials and that an arrangement be made between a particular law firm in that State and the corporation.

Mr. HALAMANDARIS. Is this a copy of the contract[1] to which you refer?

Mr. KEELEY. Yes, it is.

Mr. HALAMANDARIS. That is a contract between the law firm and Mr. Gottheiner, is it not?

Mr. KEELEY. Yes.

Mr. HALAMANDARIS. Would you tell us, please, what the compensation is for the law firm in that contract?

Mr. KEELEY. It is an attorney's contract between the Visiting Home Services and the law firm of Moriarty, Rose & Hultquist, Ltd. Under

[1] See p. 1029.

section 2 regarding retainer and contingent fees it indicates that the clients shall pay the attorneys a retainer fee of $7,000 in the following installments and it lists A through D and the installments. Later in that same document it indicates that on behalf of Visiting Home Services the attorneys will attempt to successfully negotiate contracts with the State of Illinois on behalf of the client and the compensation therefor will be 4.8 percent of the first million dollars in contracts and 1.2 percent of all sums in excess of $1 million.

Senator CHURCH. The law firm's fee was to be based upon a percentage of the take?

Mr. KEELEY. As it were.

Senator CHURCH. As it were. The bigger the contract, the bigger the fee. Since they are talking about millions of dollars, that would come to a mighty tidy fee, wouldn't it?

Mr. KEELEY. I imagine that it would, Senator.

[The contract and related material follow:]

MORIARTY, ROSE & HULTQUIST, LTD.,
ATTORNEYS & COUNSELORS,
Chicago, Ill. May 11, 1976.

Re Visiting Home Services, Inc.

Hon. FRANK M. CZINGA,
Czinga & Lepore,
Evergreen Park, Ill.

DEAR FRANK: At the time I appeared before the Committee on Public Aid, you asked about the volume of business that our client, Visting Home Services, Inc. does in the State of California. I have just received these figures from the President of the company and herewith forward a copy of his letter of May 8, 1976.

These figures have been supplied to you and are available to the members of the Committee in strictest confidence. We have not asked for nor do we believe that we would be entitled to receive the information concerning sales of Upjohn. We respect the confidentiality of our competitor in this regard.

Yours very truly,

MAURICE JAMES MORIARTY.

Enclosures.

VISITING HOME SERVICES, INC.
May 8, 1976

M. J. MORIARTY, Esq.,
Moriarty, Rose & Hultquist,
Chicago, Ill.

DEAR MR. MORIARTY: Following our telephone conversation in which I acknowledged receipt of your letter dated April 28, 1976, I want to express to you once more our sincere thanks for having won the first round.

In reply to your letter, I am still not sure whether or not to operate under Visiting Home Services, Inc. or if we should form an Illinois corporation. However, probably prior to your receipt of this letter, I will be in touch with you by telephone.

In reply to your memo on Page 2, Paragraph 6, we attach under separate cover the dollar amounts for contracts in the State of California and other areas.

As mentioned before, I will be talking to you; and we can discuss everything further by telephone.

Warmest personal regards to you and friends.

Very sincerely,

PETER GOTTHEINER, RPT,
President.

VISITING HOME SERVICES, INC.
May 8, 1976.

M. J. MORIARTY, Esq.,
Moriarty, Rose & Hultquist,
Chicago, Ill.

DEAR MR. MORIARTY: Following are the dollar amounts of contracts for delivery of in-home supportive services.

State of California:	
County of Fresno	$725,000
County of Imperial	375,000
County of Madera	175,000
County of Merced	350,000
County of Plumas	75,000
City and County of San Francisco	840,000
County of Santa Barbara	600,000
County of Tehama	200,000
Entire State of Utah	1,000,000
Minnesota: Ramsey and Hennepin Counties	250,000
Missouri: Nine small rural counties	480,000
Washington, D.C.	650,000

Respectfully submitted,

PETER GOTTHEINER, RPT,
President.

[Western Union Mailgram]

M. J. MORIARTY,
Chicago, Ill., May 5, 1976.

PETER GOTTHEINER,
Visiting Homes Services, Inc.,
San Francisco Calif.

We anticipate contract between Visiting Homes and State of Illinois to be executed prior to July 1976.

M. J. MORIARTY,
Attorney.

MORIARTY, ROSE & HULTQUIST, LTD.,
ATTORNEYS & COUNSELORS,
Chicago, Ill., April 28, 1976.

Mr. PETER GOTTHEINER, R.P.T.,
President, Visiting Home Services, Inc.,
San Francisco, Calif.

DEAR PETER: I am returning an executed copy of the Attorneys' Contract and a very brief summary of the proceedings in Springfield. Also included is a statement of the costs advanced and expenses incurred in conjunction with our negotiations for the Illinois contracts.

If you wish to form an Illinois corporation under the name "Visiting Home Services of Illinois, Inc.", let us know. We should have this accomplished prior to the execution of a formal agreement with the State.

As I reported to you by telephone, we are pleased with the progress and look forward to a profitable venture for you in Illinois. At the conclusion of the first year's contract, I feel quite confident that we will be able to demonstrate to the State the savings that have resulted from your services.

Yours very truly,

MORIARTY, ROSE & HULTQUIST, LTD.
MAURICE JAMES MORIARTY.

Enclosures.

ATTORNEYS' CONTRACT

This agreement, made and entered into this 23rd day of April, A.D. 1976, by and between VISITING HOME SERVICES, INC., a California corporation, with its principal place of business at 450 Sutter in the City and County of San Francisco, California (hereinafter referred to as "Client") and

MORIARTY, ROSE & HULTQUIST, LTD., a Professional Corporation organized and existing by virtue of the laws of the State of Illinois with its principal place of business at 150 N. Wacker Drive in the City of Chicago, County of Cook and State of Illinois (hereinafter called "Attorneys").

1. SCOPE OF EMPLOYMENT

The client hereby employs the Attorneys to represent the Client as local counsel in the State of Illinois. The Attorneys shall negotiate on behalf of the Client and prepare legal documents for the Client, at the Client's request, relating to contracts for the employment of the Client's services in the private and public sectors in the State of Illinois.

2. RETAINER AND CONTINGENT FEES

The Client shall pay the Attorneys a retainer fee of Seven Thousand Dollars ($7,000) in the following installments: (*a*) April 15, 1976, $2,000; (*b*) May 15, 1976. $2,000; (*c*) June 15, 1976, $2,000; and (*d*) June 30, 1976, $1,000.

In the event that no contracts are in effect in Illinois on July 1, 1976, the Attorneys' retainer fee shall be reduced to One Thousand Dollars ($1,000) per month from July 1, 1976, to December 31, 1976, or until the first contract shall be in force in Illinois, whichever event shall occur first.

The parties acknowledge that the retainer fees will be insufficient to cover the time required to service the Client's business in the State of Illinois. The parties therefore agree that the Attorneys' retainer fee will be substituted for the following contingent percentages on all contracts in the State of Illinois successfully negotiated by the Attorneys for the Client: (*a*) 4.8% on the first million dollars in contracts; and (*b*) 1.2% on all sums in excess of one million dollars.

3. TERM OF CONTRACT

The retainer fees and contingent fees specified in paragraph 2 hereof shall continue to be paid so long as the Client shall have contracts in force and effect in the State of Illinois.

4. COST AND EXPENSES

All costs and expenses involved in travel and long distance telephone shall be paid by the Client upon invoice from the Attorneys.

5. ATTORNEYS' LIEN

The Attorneys are given a lien for the recovery of any payments due pursuant to this Contract. The Attorneys shall have all general, possessory, or retaining liens, and all special or charging liens, known to the common law against the Client's property including the Client's receivables from services rendered in the State of Illinois.

6. NOTICE

All notices required under this Contract shall be in writing and shall be deemed to have been duly served if delivered to the party for whom it is intended or sent by registered or certified mail to the business address of the parties as specified in this agreement.

7. GOVERNING LAW

This Contract shall be accepted when signed by the Attorneys at Chicago, Illinois. The laws of the State of Illinois shall govern the construction and interpretation of the Contract.

In witness whereof, Attorneys and Client have executed this Contract at Chicago, Illinois, the day and year first above written.

VISITING HOME SERVICES, INC., *"Client"*.
MORIARTY, ROSE & HULTQUIST, LTD., *"Attorneys"*.

MAYER AND O'BRIEN, INC.
Chicago, Ill., April 15, 1976.

MR. PETER GOTTHEINER,
Visiting Home Services, Inc.
San Francisco, Calif.

DEAR MR. GOTTHEINER: I was wondering if you had had any response to your letter of February 28, 1976, in which you proposed a limited program for the Visiting Home Services, Inc. to Mr. James L. Trainor, director of public aid to the State of Illinois.

While public aid is underfire from many directions presently it would seem that they ought to be exploring ways and means of saving money and improving the service, and that your proposal would be most timely. On the other hand, I also feel that it is well to keep the matter alive even in a low pressure manner since, as you undoubtedly know, there will be a change in the governors office as of next January. In the meantime, it seems well to keep the pressure low as it is most advisable that this matter not become a political football (as we have discussed in the past).

I hope all goes well with you and Ron, and I hope that we will be seeing you in Chicago one of these days.

My best,

HOWARD G. MAYER.

MORIARTY, ROSE & HULTQUIST, LTD.,
ATTORNEYS & COUNSELORS,
Chicago, Ill., April 13, 1976.

PETER GOTTHEINER, R.P.T.,
President, Visiting Home Services, Inc.
San Francisco, Calif.

DEAR PETER: Enclosed is the original and copy of our retainer and contingent fee agreement. Please have this reviewed by your counsel and return with the initial monthly retainer of $2,000 on or before April 23. As indicated to you by telephone today, I will be leaving for Springfield on the 25th and will return the evening of the 26th.

The documents that I have promised should be in the mail by the 19th. After you have had an opportunity to review these, give me a call. Even if I am absent from the office, you may dictate your notes to my secretary.

The contingent fee amounts to $4,000 per month for the first million dollars in contracts with an additional $1,000 per month per million dollars over that sum. I believe this to be in keeping with your letter to me of March 20, 1976. We anticipate that we will have your first contract by July 1, 1976.

If you will return the signed original and copy, we will accept the agreement and sign it here and return a complete executed copy for your records.

Best regards.

Sincerely,

MAURICE JAMES MORIARTY.

DOBBS, DOYLE & NIELSEN,
ATTORNEYS AND COUNSELORS AT LAW,
San Francisco, Calif., March 18, 1976.

MORRIS JAMES MORIARTY, Esq.,
Chicago, Ill.

DEAR MR. MORIARTY: As General Counsel for Visiting Home Services, Inc., I am responding to the instructions of Peter Gottheiner, its President, in acknowledging that this office is prepared to assist you in providing any information you may require in your capacity as Counsel for Visiting Home Services, Inc. in Illinois.

I look forward to meeting you at some future time, either here or in your area.

Sincerely,

HAROLD S. DOBBS.

VISITING HOME SERVICES, INC., STATE OF ILLINOIS, GRANT FOR A RECIPIENT OF PUBLIC AID

$6,000 per annum equals $500 per month.

If this person works 35 hours per week for the same $500 per month, his/her wages would be $3.30 per hour.

210 hours fringes on $3.30 equals $693 divided by 12 months equals $57.75 per month.

Following are the fringe benefits our company offers to full-time employees:

Paid holidays	8
Paid vacation days	10
Paid sick days	12
Total	30

Thirty paid days times 7 hours per day equals 210 hours per annum, multiplied by $3.30 per hour equals $693 per annum, or $57.75 per month.

	Per month
Basic wages	$500.00
Fringes	57.75
9.75 percent employer's share of Federal and State taxes	54.38
3 percent worker's compensation insurance	16.73
Health insurance (medical and dental)	45.00
Payrolling expenses	1.50
Liability insurance	.10
Travel expenses	42.00
Total	717.46

Each worker employed for 40 hours per week in total could work in the client's home only approximately 35 hours per week, because 5 hours a week, or approximately 1 hour per day, would be used up in traveling time.

Thirty-five hours of work per week totals 151.5 hours per month.

In order to provide work for 500 present recipients of public aid who would be requested to work full time, our agency would require 75,750 hours per month to keep these 500 people occupied for 151.5 service hours and 22 traveling hours per month.

Based on our experience and track record, the average number of in-home supportive service hours per month per recipient will be 30.

75,750 hours divided by 30 hours per month would require 2,525 clients for this demonstration program. In order to safeguard you, as well as us, with the average number of clients, we would say that a minimum of 2,500 and a maximum of 3,000 clients per month could be serviced.

At wages of $717.46 per month, including all fringe benefits as listed, the employer's share of taxes, worker's compensation insurance, a comprehensive health insurance plan (medical and dental), payrolling expenses, liability insurance and traveling expenses, 500 employees would receive $358,730 per month. This amount, divided by 75,750 hours of service per month, represents an hourly rate of $4.74 per month.

At a ratio of one supervisor for the equivalent of every 15 full-time homemakers, 500 homemakers would require 30 supervisors. A supervisor's wage would be 30 percent higher (or $650 per month) than the wages for homemakers.

Working the same number of hours and receiving the same fringe benefits of 30 paid days, or 210 paid hours, per annum, would give them a rate of $4.79 per hour.

Thirty paid days times 7 hours a day equals 210 hours per annum, mutiplied by $4.29 per hour equals $900.90 per annum, or $75.08 per month.

	Per month
Basic wages	$650.00
Fringes	75.08
9.75 percent employer's share of Federal and State taxes	70.70
Worker's compensation	21.75
Health insurance	45.00
Payrolling expenses	1.50
Liability insurance	.10
Travel expenses	42.00
Total	906.13

$906.13 multiplied by 30 people equals $27,183.90, divided by 75,750 hours equals $.36 per hour.

Administrative, clerical and accounting personnel, including the above identical fringe benefits, equals $24,097.50 per month, divided by 75,750 hours equals $.33 per hour.

Orientation training for each employee at a minimum of 50 hours and on-going training sessions for 500 unskilled workers would cost about $4,545 per month, or an equivalent of $.06 per hour.

Consulting fees equal $7,575, divided by 75,750 hours equals $.10 per hour (Illinois consultant).

General expenses of rent for several offices, telephone including answering service, computer billing, various insurance start-up expenses, equipment and supplies, printing, advertising, miscellaneous, equals $15,150, divided by 75,750 hours equals $.20 per hour.

Home office expenses, including home office supervision (administrative and service) and including legal and accounting fees, equals $9,090, divided by 75,750 hours equals $.12 per hour.

Administrative reserve and profit (5%) equals $22,725, divided by 75,750 hours equals $.30 per hour.

Summary:	*Per hour*
A. Homemaker wages, taxes, and fringes	$4.74
B. Field supervisor wages, taxes, and fringes	.36
C. Administrative/clerical, taxes, and fringes	.33
D. Training	.06
E. Consultant	.10
F. General expenses	.20
G. Home office expenses	.12
H. Administrative research (profit) at 5 percent	.30
Total	6.21

75,750 hours multiplied by $6.21 is $470,407.50 per month, or $5,644,890 per annum.

500 recipients of public aid receiving $6,000 per annum in grants equals $3,000,000.

If you divide $3,000,000 by 500 recipients, you would arrive at a total expenditure of $6,000 per recipient per annum (including medical and dental insurance). $3,000,000 divided by 909,000 hours (75,750 hours multiplied by 12 months) of homemaker services amount to $3.30 per hour, which you would be obliged to pay for these 500 welfare recipients in any case, even if they are not working.

	Per annum
Cost for services, including all items	$5,644,890
Deduct welfare grants, including insurance	3,000,000
Total	2,644,890

75,750 hours per month equals 909,000 hours per annum.

A cost of $2,644,890 equals $2.91 per hour.

On $2,644,890 per annum:

The Federal Government pays 75 percent	$1,983,667.50
The State of Illinois pays 25 percent	661,222.50

On the remaining welfare grant of $3,000,000, to the best of our knowledge:

The Federal Government pays 50 percent, or	$1,500,000
The State of Illinois pays 25 percent, or	750,000
The county pays 25 percent, or	750,000
Total	3,000,000

On the other hand, the breakdown on funding for $5,644,890 would be paid out as follows:

Federal Government (75 percent)	$4,233,667.50
State of Illinois (25 percent)	1,411,222.50
County (0 percent)	0

In addition, the Federal Government and the State of Illinois would derive revenues from Federal and State income taxes. The welfare rolls and the unemployment rate would be reduced by 500 persons.

This proposal would cost the program only $2.91 per hour in-home supportive services if the grants for public aid are deducted from the recipients.

Since recipients of public aid do not receive fringe benefits such as paid holidays, paid vacation days, and paid sick days, the amounts for these fringe benefits of $57.75 per month per worker plus $5.63 for employer's share of Federal and State taxes, or a total of $63.38 per worker per month, are optional and could be saved.

The figure of $63.38 per worker per month multiplied by 500 workers equals $31,690 per month. This figure, divided by 75,750 hours per month, would reduce the rate by approximately $.42 to $5.79 per hour. It would likewise reduce the above-listed figure of $2.91 per hour to $2.49 per hour.

VISITING HOME SERVICES, INC.,
February 28, 1976.

Mr. JAMES L. TRAINOR,
Director of Public Aid,
State of Illinois
Springfield, Ill.

DEAR MR. TRAINOR: This proposal is submitted to you following at least two (2) years of corresponding and negotiating with your staff.

We hope that you are fully aware of our previous correspondence submitted, our qualifications and ability to deliver a high level of care, our past performance record and our expertise and reputation in home care.

Visiting Home Services, Inc. was incorporated March 15, 1971, and is registered as a corporation with the California Corporation Commission and the Secretary of State.

Since that time, Visiting Home Services, Inc. has provided in-home supportive services and is presently under contract with the following states:

CALIFORNIA

Fresno County	San Francisco County
Imperial County	Santa Barbara County
Madera County	Plumas County
Merced County	Tehama County

MINNESOTA

Hennepin County	Ramsey County

MISSOURI

Nodaway County	Johnson County
Adair County	Pettis County
Buchanan County	Saline County
Platte County	Randolph County
Clay County	Boone County

THE ENTIRE STATE OF UTAH

Ogden District	Blanding District
Salt Lake City District	Richfield District
Provo District	Vernal District
Logan District	Cedar City District
Price District	

WASHINGTON, D.C.

In all of the above areas combined, we provide approximately 1,250,000 hours per year.

Our working force is very reliable, and our supervisory and administrative staff are professional and fully dedicated to assisting the aged, blind and disabled.

Our concept of in-home care is as follows:
Maintenance or improvement of physical health
Modification of personal functioning or mental health.
Family acceptance and support of limitations requiring special treatment.
Protection from abuse, neglect and exploitation.
Individuals returned to their own home.
Modification of client skills.
Social contact and reduction of isolation.
Modification of hindering cultural and language factors.
Maintenance of individual families in their own home.
Modification of household management skills.
Development of skill and personal growth.
Modification of money management skills.

Our homemakers will help consumers by providing a variety of direct services under the direction of your social services staff. Services from our homemaker staff include, but are not limited to, the following: housekeeping; meal planning and preparation; personal service; financial management and/or budgeting; shopping; transportation; support and training for self-care (non-medical) and independence.

When awarded a contract for homemaker services, our agency agrees to meet all the standards and contract specifications required by you. We exceed standards set by the state and federal governments and the National Council of Homemakers and Home Health Aides.

Due to our years of expertise in this field, we were successful in many cases in reducing some of the hours *without* depriving the recipient of any needed services, to the psychological benefit of the client and the economic advantage of the paying agency. We have accomplished this sufficiently in other counties and states for the following reasons:

(1) Utilization of more qualified, experienced and better trained personnel.
(2) Closer supervision.
(3) More frequent evaluation visits.
(4) More careful assessment of the individual's physical, psychological and environmental condition.
(5) By taking appropriate action when observing their progress or problems.
(6) By utilization of the client's rehabilitative potential in activities of daily living. We train, guide and encourage the aged and disabled to assist in their own rehabilitation, making them more independent and developing a greater sense of self-support and self-respect.

However, we wish to emphasize that our supervisors will merely recommend changes to your Department after careful evaluation and assessment of the client. The final decision to decrease or increase hours will always remain solely the responsibility of your department.

We wish to mention that Visiting Home Services, Inc. is exclusively a professional homemaker/chore service agency.

Personalized and professional services will be available 365 days a year, not only to clients of your program, but also to the private, self-paying sector in your community.

We wish to assure you of professional and personalized service at the highest quality.

Sincerely,

PETER GOTTHEINER, R.P.T.,
President.

VISITING HOME SERVICES, INC.,
February 28, 1976.

MR. JAMES L. TRAINOR,
Director of Public Aid,
State of Illinois
Springfield, Ill.

DEAR MR. TRAINOR: The enclosed proposal for a demonstration program of in-home supportive services to eligible recipients of Public Aid in the State of Illinois was prepared after our meeting with you and Mr. Harris; as well as with the Hon. Don A. Moore, Senator State of Illinois, Chairman, Legislative Advisor Committee; Joel Edelman, Executive Director, Legislative Advisory Committee on Public Aid.

Our proposal is based on full-time employment including all fringe benefits of 500 recipients of Public Aid. According to information received, the annual grant per recipient is approximately $6,000, which includes food stamps, Medicaid and all other benefits.

You will note in our enclosure that we calculated the total grant (including the above benefits) in the amount of $6,000 per annum.

In order to provide full-time employment for 500 welfare recipients, the demonstration program would require about 2,500 to 3,000 clients per month averaging approximately 30 hours or less of service per client, per month.

You will note on Page Three of our enclosure, that the total cost per hour is $6.21.

However, you will further note on Page One of our enclosure the comprehensive package of fringe benefits for homemakers and on Page Two of our enclosure the comprehensive package for field supervisors.

We realize that a person on Public Aid does not get paid for sick leave, vacation and holidays. These fringe benefits total about 12% for homemakers and almost 18% for field supervisors. After evaluating these figures, you may recommend omission of fringe benefits which would then reduce the hourly rate proportionally to $5.79.

In conclusion, we wish to refer to Page Four of our enclosure which shows that after deducting the grant, including all benefits for the recipients of Public Aid, that the total additional cost for one (1) hour of homemaker services, including training, supervision, administrative, etc., would only cost you $2.91 per hour, including holidays, vacations and sick leave. This figure is based on a demonstration program of 2,500 to 3,000 clients requiring a total of approximately 75,750 hours per month.

Please be advised that the less cases and service hours in this program would slightly increase the hourly cost, while more cases and service hours would decrease the hourly cost.

This concept would not only provide full-time employment and fiscal independency for welfare recipients but guarantee the delivery of professional and personalized in-home supportive services at the highest quality.

We would consider it a great privilege to be given the opportunity to demonstrate our ability and expertise in the State of Illinois.

Visiting Home Services, Inc. would be ready, willing and able to commence services thirty (30) days after notification of award of contract.

We hope to hear from you at your earliest convenience. Should you have any further questions, please do not hesitate to call us collect (415-989-4455).

Furthermore, please be advised that we will be in Chicago on March 15 and 16 and would be pleased to meet with you and your staff either there or in Springfield.

Thank you kindly.

Respectfully submitted,

PETER GOTTHEINER, R.P.T.,
President.

Enclosure.

See December 1975 explanation

1.	Trader Vic's: Robert Whittaker and assistant—Peter	$133.00
2.	Vanessi's: Henning, Griffin, Bowers, Twomey: Peter	102.80
3.	Rubens: Fresno director, assistant director, Ron, Lory, Peter	55.00
4.	Marin Joe's: Ron (Jeannie), Lory (Hank), Peter (Virginia)	101.00
5.	All office staff (Santa Barbara)—Lory, Peter	106.71
6.	American Express:	
	Forum—Springfield Hotel bill	196.35
	Southern Air Rest—Springfield	55.99
	Southern Air Rest—Springfield (legislators and staff)	156.73
	Templebar: Griffin, Twomey—Peter	18.68
	Sir Francis Drake Hotel—Millie, Judy	45.00
	Sid and Jim: Fred Keeley, wife, Peter	65.00
	Hyatt: Barrett, Friend—Peter	34.15
	Charthouse—Santa Barbara director, assistant director—Lory, Peter	40.00
	Santa Barbara Inn—Hotel bill	69.15
	Villa Chartier: Jack Stewart, Fred Keeley, Lory, Ron, Peter	19.40
	Sheraton Inn, Fresno—Fresno staff, Lory, Peter	41.91

7. None
8. None
9. Red Lion Motel—Sacramento: Hotel bill, including entertainment of welfare directors: Lory, Fred, Ron, Peter 406.97
10. Fresno Hilton: Fresno staff, Lory, Peter .....
11. Benaderets: Griffin, Chinn, Wada 56.77
12. Benaderets: Dobbs, Wada 87.89
13. John Walker: as per list, Griffin 227.78

Mr. HALAMANDARIS. Mr. Keeley, were they successful in getting an Illinois contract for Mr. Gottheiner and, if so, do you know the amount of that contract?

Mr. KEELEY. To the best of my knowledge, events took place which precluded more than prevented Visiting Home Services, Inc., from obtaining a contract in that State and I believe that those events went something like this: That Mr. Peter Gottheiner was at one point in time no longer president of the corporation and was separated therefrom. To my knowledge, he immediately went to the State of Illinois. When he returned I was in a meeting at which time, to the best of my recollection, he stated that the attorney's contract to which I made reference earlier was no longer valid and that notwithstanding any corporate affiliation that the law firm and the State of Illinois were doing business with Peter Gottheiner and not with any particular corporation.

Mr. HALAMANDARIS. Let me jump in at that point. Do I understand it, a preliminary commitment had been made by the State of Illinois to Visiting Home Services that Mr. Gottheiner declared bankruptcy, went to Illinois, returned and somehow the contract which had been executed between the State of Illinois and Mr. Gottheiner's VHS suddenly had been translated into an instrument and agreement between the State of Illinois and Mr. Gottheiner as an individual; is that essentially correct?

Mr. KEELEY. Not essentially correct. The attorney's contract between Visiting Home Services and the law firm of Moriarty, Rose & Hultquist was the document in question, not a contract with the State of Illinois, but it is the attorney's contract wherein they are being paid to obtain contracts in the State of Illinois.

During that meeting I was told that the law firm was in an arrangement with Mr. Gottheiner notwithstanding his corporate affiliation so as a practical matter what you have is an attorney's contract which has Visiting Home Services' name on it although it is signed by Peter Gottheiner as president for the corporation and when he is no longer president of the corporation and forms a new one Visiting Home Services, Inc., was told that that attorney's contract is void.

Senator CHURCH. Do you know whether in one form or another, doing business as one corporation or another or individually, he did in fact succeed in getting a contract from the State of Illinois?

Mr. KEELEY. When I was still employed by Visiting Home Services I was told by an officer of the corporation that Mr. Gottheiner's new corporation, National Home Care, Inc., I believe, which is an Illinois corporation, I believe, the secretary of which is Mr. Moriarty was, I

believe, one of the senior partners in the law firm named in the contract, that they had been successful in negotiating a contract on his behalf in that State. I don't know of my own knowledge. I was told that.

Senator CHURCH. You were told that.

Mr. KEELEY. Yes.

Senator CHURCH. And the new corporation has the law firm or a member of the law firm involved in the corporation itself?

Mr. KEELEY. To the best of my knowledge.

Senator CHURCH. Well, we have seen in the course of this investigation instances were medicare mills have been built and the facilities have been made available to doctors who then pay a percentage of the fees charged to the Government to the owner of the property and we have seen cases where physicians have been paid on the basis of the same percentage arrangement of the bills that are submitted to the Government and now we see a case where the law firms are moving in to adjust their fees in proportion to the amount charged the Government. So wherever you look you find the same tendencies at work, all of which constitute an inducement and incentive to maximize the costs to the Government and thus to the people of the country for these programs.

Mr. HALAMANDARIS. Mr. Keeley, I would like to ask you to identify for the record Mr. Ralph Gomez. Can you tell us if you were ever physically threatened by Mr. Gomez and, if so, why?

Mr. KEELEY. Ralph Gomez was formerly a vice president of Visiting Home Services in San Francisco. During a discussion I had with Mr. Gomez I felt that he had threatened me with respect to a statement that he had made regarding the Illinois contract.

Mr. HALAMANDARIS. Do you remember his exact words and manner? You say that you felt he threatened you. Do you have some doubt? Why did he threaten you?

Mr. KEELEY. I have no doubt about it.

Representative GIBBONS. Would you identify Mr. Gomez a little more completely for the record. I am not sure I know who he is.

Mr. KEELEY. He was formerly vice president of Visiting Home Services in San Francisco which is the corporation and prior to National Home Care of which Peter Gottheiner was president.

Representative GIBBONS. How long have you known Mr. Gomez?

Mr. KEELEY. I knew him from February 4, 1976, until I departed the corporation in August of 1976.

Representative GIBBONS. About 9 months then; is that right?

Mr. KEELEY. All right.

Representative GIBBONS. Where did this threat take place?

Mr. KEELEY. In the Visiting Home Services corporate headquarters office at 450 Sutter Street, San Francisco during a meeting.

Representative GIBBONS. Do you remember the date and time?

Mr. KEELEY. I can't recall the date and time.

Representative GIBBONS. Do you know what month it was?

Mr. KEELEY. Approximately August of 1976.

Representative GIBBONS. Could you tell us the nature of this threat?

Mr. KEELEY. Yes, I can. I want to make sure I understand your question properly, Mr. Gibbons.

Representative GIBBONS. I want to know what he said or what he did.

Mr. KEELEY. You are asking me what he said?

Representative GIBBONS. You just go ahead and tell me what he said and what he did.

Mr. KEELEY. At the end of a meeting between Mr. Gottheiner and Mr. Ralph Gomez and myself he indicated that if I disclosed the nature of that conversation to anyone that the world would not be big enough for me to hide from him.

Representative GIBBONS. Did he do anything other than say that to you?

Mr. KEELEY. No, he didn't but I think that in a business context, in a professional environment, when a person looks you in the eye and says that kind of thing that it is unmistakable what they mean to say.

Representative GIBBONS. Thank you.

Senator CHURCH. Any further questions?

Representative GIBBONS. We are talking now about title XX money: is that right?

Mr. KEELEY. That is right.

Representative GIBBONS. This is Mr. Gottheiner—he has already withdrawn either forcibly or voluntarily from titles XVIII and XIX and he has gotten over to title XX now; is that right?

Mr. KEELEY. Correct.

Representative GIBBONS. How many more titles have we got? [Laughter.]

Senator CHURCH. I think from what we have learned so far that we would be well advised to look at the use of contingency fees based upon a percentage of the charge to the Government whether it be by law firms or by physicians or by real estate owners with an eye toward prohibiting such fees as a matter of good public policy. I can see no reason why a law firm could not charge a set fee for a given service and I can see lots of reasons why it is against the public interest to permit a law firm to collect a fee based upon the size of the charge to the Government for medical services that may be procured.

I think in this particular case there is also an illustration of how corporations can be used as shells. A corporation is formed and the money that flows into it is diverted to personal uses by the officers of the corporation. Then if in the auditing process these costs are disallowed and the corporation is faced with a large demand on the part of the Government for a return of money improperly paid, the corporation declares bankruptcy, the money is never recovered, a new corporation is then formed by the same people and they move from title XVIII to title XIX and the same process is repeated. And when they are finally driven from the State, after the local agencies finally catch on, they form new corporations under new names and begin doing business in the same fashion in other States.

Always the persons concerned are protected in their personal assets by the limited liability of the corporation and thus claims against these persons cannot be pressed for the corporations form a legal shield that can't be penetrated and behind that shield this kind of thing goes on.

I don't know how we would deal with that problem legislatively but it is certainly one we have to also consider.

No more questions.

I want to thank you for your testimony again today, it has been very helpful to the committee.

Mr. KEELEY. Could I ask for just a moment of time, Senator?

Senator CHURCH. Surely.

Mr. KEELEY. It seems to me that the committee's interest is basically of a fiscal financial nature. I would like to tell you that I think one of the real tragedies of this entire program, title XX, homemaker/chore programs, is that when corporations are allowed to get into the situation where they default on contracts or otherwise are suspended from the program there are two groups of persons who are seriously disadvantaged: Obviously the recipients of the program—the aged and blind and disabled people are the least able to fight for their own interests. The second group of people who are adversely affected by it are the actual workers who provide the services.

I think the problem here is really at the State level. The contract requires the contractor to hire or give preference in hiring to former, potential and current recipients of public assistance. Generally speaking, it is women—it is poorly educated women, it is minority women. I think that maybe not this committee but some entity of the Government ought to take a look at the fairly racist, fairly sexist program that they are perpetuating by allowing corporations to engage in these kinds of practices.

Thank you very much.

Senator CHURCH. Thank you very much, Mr. Keeley.

Our next witness is Peter C. Gottheiner.

Mr. Gottheiner, will you please take the oath?

Do you swear that all the testimony that you will give in this proceeding will be the truth, the whole truth and nothing but the truth, so help you God?

STATEMENT OF PETER GOTTHEINER, NATIONAL HOME CARE, INC., SAN FRANCISCO, CALIF.

Mr. GOTTHEINER. I do.

Senator CHURCH. Mr. Gottheiner, you have a lengthy statement that you prepared.[1] I am wondering if you would be willing to put that statement in the record considering your own problems of time and those of the committee so that we could proceed directly to questions.

Mr. GOTTHEINER. Yes, Mr. Chairman, with the exception of some minor changes of which I was not aware.

Senator CHURCH. Very well. Would you indicate those changes.

Mr. GOTTHEINER. Yes. On page 4 I mentioned $3.6 billion after I had talked with Mr. Halamandaris but I found out yesterday that the figure for the homemaker program was only $340 million. I think $3.6 billion was a title XX program.

Senator CHURCH. You are correct.

Mr. GOTTHEINER. Therefore, I would like to correct that figure.

[1] See p. 1058.

On page 6 in the second paragraph I wish to add what was brought out by Mr. Macomber and which is in the records of the report of the Auditor General, Mr. Hawes, that the cost of the program as administered by the county is up to $24 an hour.

We then go to page 12.

Mr. HALAMANDARIS. Excuse me, Mr. Gottheiner. Would you repeat the last one on page 6.

Mr. GOTTHEINER. That the services provided by the county might be up to $24 an hour. That is according to the report.

Mr. HALAMANDARIS. What page are you reading, sir?

Mr. GOTTHEINER. I believe it was 4. No, sorry. Four was the first one.

Page 6.

With your permission, would you mind going back to page 2?

The paragraph before the last where it says, "The two existing non-hospital-based home health agencies in San Francisco, Visiting Nurses Association and San Francisco Home Health Services, did not like competition, since they were used to monopolizing the program; and they did a good job of this," I wish to add "and I think it would be important for your committee to know that the Visiting Nurses Association had about 90 percent of the hospitals in San Francisco staffed with their own discharged coordinators. They are on the Visiting Nurses' payroll and work in the hospital for the hospital as well as the Visiting Nurses' pay undoubtedly goes to the medicare program, the funds which came out of title XVIII and XIX."

I think I would appreciate if that would go in the record.

I also forgot to mention when you swore me in I don't have the initial "C"—I don't know what it stands for. It could stand for crook, I guess, for chiseling, for charisma, but I don't have an initial.

Senator CHURCH. We will strike it from the record.

Mr. GOTTHEINER. Thank you.

Okay, on page 12 where I mention the example with the words "football game,"—after having read the Washington Post this morning—and I read about it before it was introduced for the legislatures and I am sure that that bill is all not retroactive. That bill takes effect when it is signed by the President and not a year before like the other things.

I would like to add in the next paragraph the words "innocent wrongdoings."

On the same page in the paragraph beginning, "In general, let me tell you that the percentage of profit which Health Help, Inc., has been accused of making"—and that figure was mentioned this morning, which was 38 percent for the Visiting Home Services profit margin, and I am sure the State of California, the department of health, can verify it because on the line item budget the profit is mentioned and all you have to do is divide it by the total number of the costs between 2 to 4 percent and the profit in health was somehow higher, but I come to that later.

On page 15 my secretary made an error. It is the year 1975–76. That was nationwide by about 5 percent, the lowest cost provider in in-home supportive services.

On page 16 in the last paragraph; the "by nonprofit agencies"-that was a Fresno County economic commission in the county of Fresno which was $3.55 for homemaker, and I would like to add for the record, even though it is in the testimony, that is the highest rate in the State. It is likewise by a nonprofit organization at $7.75.

On page 17 the dates in the second line are 1974 to 1975 and in the first line of paragraph 2, 1975 to 1976.

On page 19 I wish to add that some of those additions, Mr. Chairman, are based on the various things I heard since yesterday morning, that it was me who several times recommended to the State department of health, of not only California but in other areas, instead of an hourly bid to ask for a bid per month. We have 2,000 cases. For how many would you do the program. I think it would be much more of an incentive and much more economical.

On page 23 if I may read the first sentence on that page. "If that was the case, I would certainly have hoped, in the interest of justice, that two proprietary agencies and one nonprofit agency would have been audited instead of no nonprofit agency and three for-profit agencies," for the reason brought out that it was again the so-called nonprofit agency which charged 11 percent more than the company I was president of and which supposedly ripped the program off. If we make 38 percent profit with no profit restrictions, and we didn't by far make any—I will bring that out later—then how come under the same identical program, the same identical specification another company which calls itself nonprofit, charges $7.75 and has never been audited?

On page 25 after the word "reluctantly" I would like to add "often we were not approved when we were the low bidder and were not approved when we were the high bidder." There seems to be, for a while in counties and in the State, a dislike for a low rate which I cannot understand at the sterling cost of the program which was brought out.

On page 25 in the first paragraph where it says "(3), the lowest cost for services," I would like to add "per hour and/or decline per months."

On page 26 we have to change the figures to 300. That is because I want to tell you something afterwards. Instead of 340 million that is 360 million, it is easier to divide by 12. In other words, all the figures you see, if you would strike one 0 instead of 300 million per month, 30 million per month. On the next page instead of 60 million service hours, 6 million service hours, and the number of recipients instead of 500,000, 50,000.

That was again in the Washington Post today and I heard it over the news yesterday, that Secretary Califano intends to save $2 billion annually. This program, if it is operated properly, can save $200 million in 2 years which would be $150 million Federal money and $50 million State money.

With your permission, Mr. Chairman, it is just very brief, that was the basis on our proposal to the State of Illinois, which goes way back.

Then if you use welfare recipients exclusively and you figure an average of that decline needs 30 hours per month, and that is the

good average, and if you pay those welfare recipients little better than what you get on welfare grants, deduct what they would get from welfare grants and deduct that from medicaid or medicare in California, food stamps and so on and so forth, give them an income they can live on, give them fringe benefits as others have, you could get 50,000 off the welfare roles. You could get 50,000 people in the main stream of employment who could pay taxes and who would go to the stores in the economy and the Federal Government would save $150 million in 2 years and the State would save $50 million in 2 years.

That is all the additions I have there.

Mr. Chairman, if I may ask you something. I took some notes, as I mentioned, during the hearings yesterday and today and there are some discrepancies. There were some statements made which are not factual and if I may just run them down, I think we could save some time.

Senator CHURCH. Surely.

Mr. GOTTHEINER. Mr. Martin in his testimony said yesterday—and I presume he meant Visiting Home Services—and I want to say, all I hear, all I read, this is an organization, this was a corporation, there it was Visting Home Services and National Home Care. I did not operate as an individual before California other than as a registered physical therapist.

"We were kicked out of the medicare program," that statement is false. We were never kicked out of the medicare program. You have in your exhibits several letters, one letter written by me to the representative of Blue Shield who was a fiscal intermediary, that when I noticed that and I had to say the company from whom I hired to service where those things occurred. All I can give you is the location. It was in the summary earlier and you can figure it out yourselves.

I also heard that Unicare underbid title XX and that the Visiting Nursing Association——

Senator CHURCH. Excuse me, Mr. Gottheiner. I don't mean to interrupt your pattern of thought but our record shows that you received a letter from the Medi-Cal agency on September 28, 1967, signed by Carol E. H. Mulder, suspending your corporation.

Mr. GOTTHEINER. I never saw that letter, and the corporation was never suspended. There is a letter from me dated June 30 to the gentleman from Blue Shield, and anybody who knows Mr. Mulder would assume Mulder served as chairman of the board of Visiting Home Services several years later and as a consultant thereafter and——

Senator CHURCH. He later came to work for your corporation.

Mr. GOTTHEINER. He did not work for us. He got paid as a consultant in Sacramento a very conservative fee of $15 an hour. Mr. Mulder is one of the most honest persons. If he put 5 cents in the parking meter, he told us he had to charge for 5 cents. The letter you are referring to—it was said if the money was not paid back or something, but when I went out about it there is a copy of a letter to Blue Shield advising I regretted what happened.

I had at that time six or seven physical therapists working for me in the radius of about 100 miles one way or the other, 50 miles one way, 50 miles the other way, and I did note that.

What the therapist did do was the following: He provided th services. Let's say he took four patients or three patients and e treated them simultaneously with exercising only. He billed each individual for the time instead of prorating. When I found out about it I called and then followed it up by letter to Blue Shield and prevented the flow of money to Medi-Cal, but nothing, not even my driver's license, was ever revoked.

Senator CHURCH. Was one of these therapists Flora Souza?

Mr. GOTTHEINER. That is right, sir.

Senator CHURCH. She worked for you?

Mr. GOTTHEINER. She did not work for me. I subcontracted with her.

Senator CHURCH. You subcontracted with her.

Mr. GOTTHEINER. Yes. I got paid for whatever she billed us, but I was the one that returned the money and I returned it gladly because she did it a long time. She had received his check already. We received our payment of it before I found out about it and there was no way to recover it.

Senator CHURCH. How did it happen that the director of the Medi-Cal program in California became a consultant for both of your corporations?

Mr. GOTTHEINER. I would be happy to tell you that, Senator.

Senator CHURCH. Later served as chairman of the board of the national corporation.

Mr. GOTTHEINER. Mr. Mulder resigned as director of Health Care Services—or let me put the things in reverse. I met Mr. Mulder many years ago in Sacramento when he was chief of the medical services and the Medi-Cal program and he liked my ideas I brought forward to him and then came to Washington, D.C., I think it was, for President Kennedy and was one of the head persons under the medicare program.

I stayed in contact with him. Then he came back to California and maybe 2 years later I asked him, since he lived in Sacramento close to where all the legislation was going on, whether he would agree to be chairman of the board and serve as consultant because I had the highest respect—I still do, I always will—for Mr. Mulder and he accepted it.

Senator CHURCH. Was this after he had left his post as Director?

Mr. GOTTHEINER. That was maybe 2 years later.

Senator CHURCH. About 2 years after he left his post. He was director of Medi-Cal?

Mr. GOTTHEINER. Yes.

Senator CHURCH. Please go ahead. I apologize for the interruption.

Mr. GOTTHEINER. No, that is all right.

I heard yesterday that Unicare underbid title XX. I knew for a long time that the VNA provided more quality care. I have serious doubts about it. That is a number of visits from the proprietary agencies, 70 percent higher. Now, I had the Home Health Agency, as you are aware of, and as it was brought out this morning these are prescribed by a physician. Unless somebody cheats there is no way that once you have your personal physician, your physician wants you to have certain things. The girl who is filing or the claims clerk writes

the physician. We had—and I speak out of experience—the worst intermediary which was Blue Cross. We picked six doctors as a utilization of your committee, all or most of them from members of the Medical Society in San Francisco under the Committee on Aging and Utilization. Those gentlemen got $50 an hour. We paid 1 day $900 to a few claims and when the claims were reviewed the Blue Cross said, "We are not accepting it."

You asked for improvement of the medicare program and I think from what I heard from Mrs. Fox things have improved but then you have a physical therapist or a nurse or a home care agency and the doctor prescribes a number of services. You are supposed to render those services. The Home Health Agency got caught in the middle. They provided the services, they had to pay their staff and at the end of it lost $200,000 in the medicare program, but we will get into that later.

Senator Church, you said that in California the decision to void a contract is up to the counties. That is correct, but the State department of health has the veto power to approve or disapprove a contract.

It was also brought out that the State of California did not control and wholeheartedly underwrite that. In February 1971 the city and county of San Francisco was the first county who wanted a contract for homemaker services. It was not until 1974 that Mr. Elich made an audit here.

Then, Senator, you mentioned yesterday, I believe, that two agencies provide title XX services and more or less monopolize California. For your information, I presume you meant Unicare and Visiting Home Services, but for your information and again to set the record straight, some economic opportunity outfits—the Visiting Nurses Association, San Francisco Home Health Service, Sojourners, Homemaker For Northern California, the Medicare Work Shop and then various attendant care cases which are much higher than the contracts.

I think Mr. Keeley mentioned yesterday the merry-go-round for titles XVIII and XIX and XX. I precisely say the same thing in my testimony, that under a home health agency they can provide 100 home health visits a year.

Now, it has happened, it happens all the time, when one company does both things. They provide the 100 with it. Then the 100 with it run out and they cannot bill medicaid or medicare any more. Then they go to the department of social services because there is hardly any difference between Home Health Services or Homemaker/Chore. They get homemaker service until the next calendar year starts and start all over again. So my suggestion to you is that the House agency who provides title XVIII and XIX service should not be on title XX and vice versa and that can be cleaned up.

Representative GIBBONS. Mr. Chairman.

Senator CHURCH. Yes.

Representative GIBBONS. Mr. Rostenkowski and I are going to have to start voting pretty soon and I certainly don't want to cut him off, but I want to ask him some questions.

Mr. Gottheiner, in 1973 through your home—did you charge $1,691 for pipe and tobacco costs?

Mr. GOTTHEINER. No, sir. I can explain.

Representative GIBBONS. How did I get told you did if you didn't?

Mr. GOTTHEINER. All right; I made one mistake. Since I was the sole owner of the company, I had those checks made out on the company account, but they were debited to my income. In other words, I was the sole incorporator at that time of Health Help, Inc., and I figured—and apparently it was wrong because that is what started the ball rolling.

Representative GIBBONS. Don't present title XVIII, XIX, or XX.

Mr. GOTTHEINER. Title XX. Now, there are no profit restrictions; there were none.

Representative GIBBONS. How about the liquor charge?

Mr. GOTTHEINER. That is the same thing.

Representative GIBBONS. Same thing.

Mr. GOTTHEINER. That is the same thing, Mr. Gibbons.

Representative GIBBONS. And that home office you had for $1,498, that was the same thing?

Mr. GOTTHEINER. Well, what I said, it had nothing to do with. What I should have done is taken it out of the profit, put it in my bank account and made out my own check.

Representative GIBBONS. How about the inaugural expense? Whose inauguration was that?

Mr. GOTTHEINER. President Nixon and it was not an inaugural expense.

Representative GIBBONS. $925. He was not inaugurated in 1975, was he?

Mr. GOTTHEINER. That was not 1975. The audit is 1973.

Representative GIBBONS. Did you seek reimbursement?

Mr. GOTTHEINER. No, it was the same thing. I don't recall whether it was Congressman Burton. I met with someone but anyway that was strictly my own business and I should have taken all the profit out and then paid it on my own, but it did not affect this in one way or the other.

Senator CHURCH. What you are saying is you should have paid these personal expenses from your personal account.

Mr. GOTTHEINER. Correct.

Senator CHURCH. And not billed the company.

Mr. GOTTHEINER. I made that mistake and I was unaware of it because I figured whatever the profit is left, whether it is paid out of this account or that account——

Representative GIBBONS. Advancing you $80,000 in 1973.

Mr. GOTTHEINER. Pardon?

Representative GIBBONS. In 1973 the records indicate that Health Help advanced you more than $80,000.

Mr. GOTTHEINER. It is part of my compensation I presume.

Representative GIBBONS. You presume it was part of your compensation?

Mr. GOTTHEINER. Yes, Mr. Gibbons.

Representative GIBBONS. I don't know. Was it a loan or was it compensation?

Mr. GOTTHEINER. It was probably compensation.

Representative GIBBONS. You don't know? You filed an income tax return, I understand.

Mr. GOTTHEINER. Yes.

Representative GIBBONS. I don't know, I guess you did.

Mr. GOTTHEINER. I certainly did. The CPA did it and I don't know whether the whole amount was compensation or part of it was compensation and part of it was a loan.

Representative GIBBONS. That was also charged to title XX. Is that right, or you got an advance?

Was it compensation in title XX,—$80,000?

Mr. GOTTHEINER. Yes.

Representative GIBBONS. In fiscal 1973.

Mr. GOTTHEINER. Like I said, it was probably half and half and part compensation. It was charged to title XX unless it was a loan and then a loan was——

Representative GIBBONS. How about cash disbursements in 1973 for entertainment, $50,000.

Mr. GOTTHEINER. In 1973?

Representative GIBBONS. Yes, sir.

Mr. GOTTHEINER. For which company? [Laughter.]

Representative GIBBONS. You got me confused. I guess it is——

Mr. GOTTHEINER. No, I didn't ask the——

Representative GIBBONS. It looks like $50,000.

Mr. GOTTHEINER. I did not ask the question to be funny.

Representative GIBBONS. I understand.

Mr. GOTTHEINER. I wanted to tell you before I answer the question. In 1971 Visiting Home Services was formed and Visiting Home Services until 1973 had no contract, so probably the major part of it, because Visiting Home Services had no income, was charged, was regularly reimbursed by Home Services.

Representative GIBBONS. But you sought reimbursement.

Mr. GOTTHEINER. Yes, Health Help was the only company who had a contract that was in business and they advanced money at many occasions, or I did, or the company for Visiting Home Services, until they got on their feet and for as long as I could keep it up.

Representative GIBBONS. Do you really need to entertain anybody that much?

Mr. GOTTHEINER. No, it was not entertaining, Mr. Gibbons.

Representative GIBBONS. What was it.

Mr. GOTTHEINER. All right. We attempted to get contracts since 1972. There were a lot of travel expenses during the entire time of the existence of Visiting Home Services. Almost everything was billed on my credit card. When I went on a trip I then got that reimbursed. Both companies used my credit card regardless whether I traveled, whether other people traveled or whether I stayed at the motel or whether other people stayed at the motel.

Representative GIBBONS. The staff writes this question that cash disbursements for entertainment according to the audit exceeded $50,000 for the period 1973. Either the audit is wrong or the staff is wrong. Now, who is wrong?

Mr. GOTTHEINER. If the audit picked it up as entertainment, then this staff was wrong. The staff was unfortunately wrong in a lot of things in the accounting department but there was no way there was that entertainment. There was a lot of travel.

Representative GIBBONS. They were all reported as traveling expenses, is that right?

Mr. GOTTHEINER. Most of them unless there was some entertaining which was very, very minor.

Representative GIBBONS. What do you mean by "very, very minor"?

Mr. GOTTHEINER. Well, I would say 80-percent traveling and maybe 20-percent entertainment.

Senator CHURCH. Would the gentleman yield?

Representative GIBBONS. Yes.

Senator CHURCH. This audit was done by the State of California.

Mr. GOTTHEINER. I am not objecting to the audit.

Senator CHURCH. You are not objecting to the audit?

Mr. GOTTHEINER. No.

Senator CHURCH. You are not suggesting that the audit is inaccurate are you?

Mr. GOTTHEINER. The auditor picked it up from the check stubs but our personnel in the accounting department, which we will probably get into later, did a lot of entries which should have been entered a different way.

Senator CHURCH. Why?

Mr. GOTTHEINER. Because they entered it the wrong way.

Senator CHURCH. Why? Why did they enter $50,000 under entertainment for 1973? Who told them to do that? That certainly would not have occurred to them.

Mr. GOTTHEINER. It should have been travel and entertainment.

Senator CHURCH. They didn't write travel down?

Mr. GOTTHEINER. No.

Senator CHURCH. So in 1973 there was $50,000 worth of expenses which were charged ultimately to the Government.

Mr. GOTTHEINER. That is correct.

Senator CHURCH. For entertainment and travel, what does that have to do with medicare, home visits?

Mr. GOTTHEINER. It was travel to obtain contracts.

Senator CHURCH. And you think that is a legitimate charge?

Mr. GOTTHEINER. I thought that was a legitimate charge as it is now.

Senator CHURCH. Can you explain how HEW concluded, after auditing your books, that you owe the Government over $800,000 in reimbursements for overpayment.

Mr. GOTTHEINER. I will be happy to give you the answer to that afterwards. I mean any time.

Senator CHURCH. Well, given the $80,000 you charged for 1 year's entertainment and travel, the $840,000 figure does not surprise me too much.

Mr. GOTTHEINER. No, Senator. Are you talking about title XVIII or XIX now?

Senator CHURCH. Yes.

Mr. GOTTHEINER. That was not entertainment and travel.

Senator CHURCH. What was it?

Mr. GOTTHEINER. What was it?

Senator CHURCH. Yes.

Mr. GOTTHEINER. OK. Several years later—I don't know as of what year the audit is—the fiscal intermediary Blue Cross said that my salary was only supposed to be $4,000 a year. They readjusted things afterwards. We provided physical therapist services on the open market and they said to further conserve the services, instead of $15 for a home visit it should be only $5. They threw out the legal fees, the accounting fee. They threw those out, not taking into consideration that every time we were supposed to get paid the group cost the computer broke down and we had to wait and in order to pay the personnel they came to us 3 years later, again what they mentioned before. We had a meeting with them and the gentleman from HEW said they finally realized it was there, the CPA was there, let's forget it. They cannot come afterwards and say there was a fee from Blue Cross.

He had a big book and he said "It is in the book, you cannot charge further physical therapy, the open market rate." Our attorney asked to see the book and they said, "No, sorry, you can't see the book." If you can show us the book after the fact, how can we know before the fact that they readjusted? Senator Church, the balance of it is that in the final few months after the company was dissolved I personally had to pay the withholding taxes and all the bills.

Like I said, I lost over $200,000. No one was fired and we were told by HEW, by Mr. Fox and by the other gentlemen that as long as no tax report is filed that that will be open forever.

Senator CHURCH. Any way, Mr. Gottheiner, the record shows that in 1975 with respect to the services to be rendered under title XVIII the Government computed an overpayment to you of $804,655.06.

Mr. GOTTHEINER. Yes, but that was not in 1974.

Senator CHURCH. On March 24.

Mr. GOTTHEINER. That is when the letter and the company went out of business in 1971.

Senator CHURCH. Well, the letter in any case.

Mr. GOTTHEINER. We had——

Senator CHURCH. Your business may have already been closed but on March 24, 1975, the Government computed an overpayment of $804,655 and made that claim against you.

Mr. GOTTHEINER. They made that claim several years after. That was only a repeat letter. They made it before, as I mentioned.

Senator CHURCH. Was any part of that sum repaid to the Government?

Mr. GOTTHEINER. It was not because we met with them and they disposed of the case at that time.

Senator CHURCH. They just said "We won't pressure you for it"?

Mr. GOTTHEINER. That is correct.

Senator CHURCH. All right. Then you went into title XX of the program for home services?

Mr. GOTTHEINER. In 1971.

Senator CHURCH. In 1971, and on October 29, 1976, the Department of Benefit Payments for the State of California released their audit of your title XX operations.

Mr. GOTTHEINER. Which one was it?

Senator CHURCH. On October 29, 1976, the Department of Benefit Payments for the State of California released their audit[1] on your title XX operations for the period of July 1, 1975 through June 30, 1976. The Department reported that funds were shifted back and forth between Health Help and Visiting Home Services and payments were made through available resources. Accordingly, they wrote, "Our review treats the two organizations as a single entity." The audit reported further that Health Help held the only lucrative contract and funds from this revenue source were generally used indiscriminately to finance both business and criminal expenses of both expenses of both corporations.

Among the major findings of this audit was the following: Gottheiner received $58,815 as expense advances and reimbursements during the audit period. These included purchases of liquor and tobacco and personal expenses at local restaurants and hotels. There may have been duplicate and triplicate payments of some of these expenses.

That is the first major finding in the audit.

Mr. GOTTHEINER. May I ask you, Senator, is that the memorandum signed by Mr. Stewart and Mr. Embly? No?

Senator CHURCH. Do you have a copy of this?

Mr. GOTTHEINER. Is that the audit, Mr. McFarley?

Senator CHURCH. Yes.

Mr. GOTTHEINER. There was a——

Senator CHURCH. Among the major findings was finding 5: Reimbursements included the purchase of liquor and tobacco, personal expenses in local restaurants and hotels. The further finding in the audit was that there have been duplicate and triplicate payments of some of these expenses. Do you have anything to say about that?

Mr. GOTTHEINER. Would you be kind enough to tell me what page that is?

Senator CHURCH. If you have the audit before you.

Mr. GOTTHEINER. I don't know if that is the one.

Mr. HALAMANDARIS. Excuse me. This is the audit conducted by the State of California. Do you have it in front of you?

Mr. GOTTHEINER. No; I have the audit by Mr. McCullough and I have the audit by Mr. Manley and Mr.——

Mr. HALAMANDARIS. So you have not seen a copy of the Macomber audit?

Mr. GOTTHEINER. Are you talking about the audit made by Mr. Elich?

Mr. HALAMANDARIS. No; the one that Mr. Macomber reported on this morning.

Mr. GOTTHEINER. I do not have a copy of it.

Senator CHURCH. Let me just mention the charges and then I would like to hear what your explanation may be.

Gottheiner received $43,100 in consultant fees during the period even though he was also receiving a salary for his services. Is that true or false.

Mr. GOTTHEINER. During which period?

[1] See appendix 4, item 1, p. 1197.

Senator CHURCH. From July 1, 1975 to June 30, 1976. That is what the audit shows. Is it true or false?

Mr. GOTTHEINER. What was the sheet, sir?

Senator CHURCH. $43,100 in consulting fees plus additional total salary you received.

Mr. GOTTHEINER. Yes; that agrees with the late audit.

Senator CHURCH. That is true?

Mr. GOTTHEINER. That is right.

Senator CHURCH. What justification was there for drawing a salary for services and then adding on top of them $43,100 for consulting fees?

Mr. GOTTHEINER. The reason for it was that I added it all up and it comes to $23 an hour, that I worked a minimum of an 80- to 100-hour week. I had a special office at home. I worked the weekends and as I said I worked the double shift.

Senator CHURCH. I don't want to quarrel with how much work was involved, you would be the best judge of that, but you received rather healthy salaries from the two corporations, $24,000 from Visiting Home Services and $29,000 from Health Help for a total of $53,000, but the additional $43,100 for consulting fees I find——

Mr. GOTTHEINER. $96,000.

Senator CHURCH. $96,100.

Mr. GOTTHEINER. Yes, a month.

Senator CHURCH. Then the audit finds that you were paid $91,168 in loan repayments during the period. The department could find no evidence of any loans.

Mr. GOTTHEINER. The loan repayments are correct and if the department can't find any evidence of the loans, as I mentioned before when Health Help was the only money earning, bread earning organization, Health Help subsidized and it was the same like they said they considered it as one entity. Health Help was my company and I advanced funds in the neighborhod of $200,000 and those were repayments of those funds.

Senator CHURCH. One corporation advanced money according to your testimony.

Mr. GOTTHEINER. Health Help advanced money to Visiting Home Services.

Senator CHURCH. And the audit shows that you personally received loan repayments but your own testimony does not square. Why should you receive this health reimbursement?

Mr. GOTTHEINER. Senator, when Health Help had the surplus over the years of whatever you wish to call it. I could have pocketed the difference. I gave the money for the operation of Visting Home Services and when Visiting Home Services was in business and had a lot of contracts then Visiting Home Services started to repay some of the money.

Senator CHURCH. Aren't you really saying these two corporations were just fictitious, you were actually operating your finances as an individual entrepreneur?

Mr. GOTTHEINER. No, sir, they weren't fictitious, they were both corporations.

Senator CHURCH. Then why should you get the $91,000 in loan

repayments for a loan which you say a corporation made to another corporation?

Mr. GOTTHEINER. The corporation Health Help was a corporation where I owned 100 percent of the stock.

Senator CHURCH. Yes.

Mr. GOTTHEINER. Visiting Home Services, I never was a stockholder there. So one corporation was mine; the other was not. My profit was in the owner company and it was later partially repaid. I did not operate them as an individual entrepreneur. Minutes are available. The attorneys, I am sure, still have all the minutes and that was one of the matters I took issue with because it said I operated them as a sole proprietorship. If that would have been the case I would not have been asked to resign.

Representative BAFALIS. Are you saying you drew the money out of that corporation and loaned it to another corporation? I am confused?

Mr. GOTTHEINER. I did it, out of one into the other.

Representative BAFALIS. Then why did that corporation pay the other corporation back instead of paying you? Would that not have been the way to transfer it? In other words, if they paid the loan back, why didn't they pay it back to the other company instead of paying it back to you?

Mr. GOTTHEINER. That is the arrangement the CPA told the girl who was handling the accounts payable to make.

Representative BAFALIS. Am I correct then they did not go back to the lending corporation, they went back to you instead?

Mr. GOTTHEINER. I believe so, yes.

Senator CHURCH. Well, in this particular audit our study shows that payments from the county agency for services billed for calendar year 1973 totaled $683,326. Reimbursement costs under the contract total $505,234 resulting in a net profit before taxes of $178,092 or 35 percent of the total costs.

Mr. GOTTHEINER. No; I believe you must be referring to the HEW audit.

Senator CHURCH. Yes; to the HEW audit.

Mr. GOTTHEINER. In the HEW audit I had met afterwards with the gentlemen here today. First of all, that audit was only a draft and I wish to tell you a few things about the audit. No. 1, that audit and their figures are considerably incorrect. Their audit was based on the assumption that the company delivered 10,000 hours of services to homes. The record will show, if you get it from the city and county of San Francisco, that it provided a little less than 8,000 hours of services.

Senator CHURCH. This audit has been finalized. The final figures show 97,658 hours of work. If I divide that into the profit it comes to $1.82-per-hour profit or 35 percent of costs which by any standard is a very fat profit indeed.

Mr. GOTTHEINER. It is correct. If it would have been that, then you are 100 percent correct, but it was not. I don't know whether it is final or in draft form, but I would like to tell you a few points which will make it clearer.

No. 1: The audit says that the general manager said we should get only $6.50. Three pages later it said that he said between $6.60 and $6.70. I don't know on what figures that audit is based.

It is also not taken into consideration that there is a limit of $350, I believe it was at that time, per recipient to get services for. We had many who exceeded 70 hours a month, we had many cases where the agency, the Department of Social Services, City and County of San Francisco requested 60, 70 hours and so on. We only billed for 50 hours. That means we had a loss, what we called a writeoff. Those writeoffs averaged between $3,000 to $4,000 a month multiplied by 12 is between $36,000 and $48,000 a year.

No. 2: In that year later we had a ministrike. None of the recipients ever went without any service. We had either carpools or cabs which was a very expensive venture.

No. 3: We had a woman working for us who was very dedicated. She came to the office and the doctor said she had terminal cancer. Fortunately by miracles the lady is still alive but I paid her for 9 months $750 a month without doing any work because I felt morally obligated.

The next thing is we were the only company who gave the employees cash bonuses at Christmas as well as sent little food parcels to the recipients.

Senator CHURCH. You say all of this is being paid for by the Government?

Mr. GOTTHEINER. That is right.

Senator CHURCH. And you are testifying yourself that you paid the cash benefits at Christmas and kept people on the payroll?

Mr. GOTTHEINER. Correct.

Senator CHURCH. While they were sick.

I know that you may have been motivated out of a spirit of concern, Christmas spirit, but you know this money is coming from all of us.

Mr. GOTTHEINER. Yes, Senator.

Senator CHURCH. And we are trying to get the costs of this program under control.

Let me just go to another statement from the audit.

Mr. GOTTHEINER. All right.

Senator CHURCH. The HEW audit, the statement of income and expenses included $57,566 of expenses which were not related to the San Francisco contract for calendar 1973. Certain costs reported by the contractor were not subject to Federal reimbursement. Under this criteria we have classified $13,691 of expenses as nonreimbursable. This amount included $4,092 for Federal income taxes, $3,915 for payment of tax penalty, $5,504 of interest on the expenses and $185 for expense.

You were charging us for your income taxes plus the penalties for not paying them properly, plus the interest and expenses that you accrued.

Mr. GOTTHEINER. May I explain?

Senator CHURCH. Yes, explain that.

Mr. GOTTHEINER. I can give an explanation. [Laughter.]

We had a certified public accountant. We had an accounting department and then at the end we had the genius of Mr. Gomez as a so-called financial consultant.

Now, I have taken the oath. I have never lied, I will never lie, and I am telling you that I had almost nothing to do with the accounting department at any time because, as you see, with the various contracts, the proposals, the bidding, the implementation, the supervision of services which came out today was all right. That was my job responsibility and assignment. It was not until I read the audit I was as shocked as you were. I have never known that the $4,000 income taxes or the $3,000 penalty were charged back to the program. I was totally unaware of it.

Representative GIBBONS. Good. I want to direct a question regarding California Coordinated Health Care Services. I believe you were the principal in that corporation.

Mr. GOTTHEINER. A physician and myself.

Representative GIBBONS. A physician and yourself. What percent of the corporation did you own?

Mr. GOTTHEINER. Sixty and the physician 40.

Representative GIBBONS. Now, did the California Coordinated Health Care Services dissolve in 1975?

Mr. GOTTHEINER. No; it dissolved in 1971.

Representative GIBBONS. At that time it had $800,000 in an unresolved audit pending against it.

Mr. GOTTHEINER. I went through that before. I would be happy to go through it again.

Representative GIBBONS. Who was the intermediary?

Mr. GOTTHEINER. Blue Cross.

Representative GIBBONS. Blue Cross.

Mr. GOTTHEINER. The Government owes me probably in excess of $200,000. [Laughter.]

Representative GIBBONS. If we owe you, sir, we want to be sure we pay you.

Did these exceptions include personal telephone bills like the telephone expenses paid by Peter Gottheiner as an individual?

Mr. GOTTHEINER. Do they include personal telephone calls?

Representative GIBBONS. Yes.

Mr. GOTTHEINER. Which expenses?

Representative GIBBONS. The ones on Home Health Care.

Mr. GOTTHEINER. No.

Representative GIBBONS. How about California Coordinated?

Mr. GOTTHEINER. I made my own phone bills and I am sure you are aware, sir, that I was given $200 toward the office at home and I had two telephones, one exclusively for business and one personal, and that can be verified.

Representative GIBBONS. How about the next item? Apparently you paid the Fairmont Hotel for an orchestra and a photographer that was charged as expenses and is the subject of this 1971 audit that HEW made of your California Coordinated in 1968 and 1969.

Mr. GOTTHEINER. Yes.

Representative GIBBONS. Did you believe that the orchestra and a photographer were related to anything connected with medicare?

Mr. GOTTHEINER. I don't think it was much of an orchestra. [Laughter.]

I don't think that——

Representative GIBBONS. That is not exactly being responsive to my question, Mr. Gottheiner.

Mr. GOTTHEINER. I didn't mean it that way. I mean the charges for the orchestra were not mine. That was the second anniversary Christmas party we had for the medical profession, for other people in the hospital and medical related fields. That subject came up at the meeting with the intermediary that I referred to. The attorney was there and the CPA was there and again during that meeting it was brought out that we were unaware that you cannot have once a year, for the people who you are doing business with, a Christmas party. That, unfortunately, is the problem in most governmental programs, that the Government comes out with the program and some are good and some are not so good, but I wish they would only come out with a program after the regulations are written so the people know what they are doing.

Representative GIBBONS. Let's concentrate on this question because this goes right to the heart of the issue. This is not the homemaker service.

Mr. GOTTHEINER. I know.

Representative GIBBONS. Is this medicaid?

Mr. GOTTHEINER. It is titles XVIII and XIX.

Representative GIBBONS. These are the titles that deal with medicare and medicaid?

Mr. GOTTHEINER. Right.

Representative GIBBONS. Pursuant to these titles the old and poor go to the hospital, although sometimes you cannot get fully reimbursed for the visit, or the doctor examines you in his office and you get reimbursed for that but you charged an orchestra—not a very good orchestra—and photographers to medicare. Now, just explain to me how in the world did you ever think that had anything to do with medicare?

Mr. GOTTHEINER. It had nothing to do with medicare. It had to do with the business relationship with the people we were associated with.

Representative GIBBONS. Yes; I understand that. But do you mean to tell me that you got money from Blue Cross for that?

Mr. GOTTHEINER. If the truth be known, like I said, we did not get the money. There were many more services rendered than there were paid for and the employees got paid——

Representative GIBBONS. Did you bill Blue Cross for the orchestra and the photographers?

Mr. GOTTHEINER. I think it was not included in the cost statement.

Representative GIBBONS. Did Blue Cross pay it?

Mr. GOTTHEINER. I don't think they paid it. Blue Cross ordered a lot of money when the company went out of business.

Representative GIBBONS. But did they claim that back or did they pay it and then claim it back?

Mr. GOTTHEINER. I don't believe they paid it.

Representative GIBBONS. You are not sure whether they paid it or not?

Mr. GOTTHEINER. No; this is about 6 years ago. All I know is that Blue Cross—and I have some correspondence here which I would be more than happy to give you for the records. At that time Senator Murphy wrote to Commissioner Ball that every time we had to meet a payroll and we were expecting a check from Blue Cross, as I mentioned before, the computer broke down and that is why we eventually—but it was too late then—changed directly reimbursement with Mr. Fox's office.

Representative GIBBONS. What I am really trying to find out, did Blue Cross honor a bill for you for an orchestra and a photographer?

Mr. GOTTHEINER. To the best of my knowledge, no.

Representative GIBBONS. They never paid you any money for it?

Mr. GOTTHEINER. To the best of my knowledge, no.

Representative GIBBONS. But you billed them for it?

Mr. GOTTHEINER. Sir, I did not do any billing. I was the administrator and I was in charge of the physical therapy. We had a billing department. Unfortunately, I am being made responsible for the entire operation of——

Representative GIBBONS. You own 60 percent of it.

Mr. GOTTHEINER. That is correct. That is correct, but the billing part was never my responsibility. It is not in any of the companies.

Representative GIBBONS. Did the company go bankrupt?

Mr. GOTTHEINER. I beg pardon?

Representative GIBBONS. Did the company go bankrupt?

Mr. GOTTHEINER. Well, you can call it that, yes.

Representative GIBBONS. Thank you.

Mr. GOTTHEINER. It was also brought out this morning that Visiting Home Services had in Illinois a contract. They have never.

In Mr. Keeley's testimony today it was brought out that Visiting Home Services paid the law firm *x* amount of dollars. I want to have it on the record that National Home Care has reimbursed Visiting Home Services for all the money or a little money they paid to the law firm, and for your information the law firm has got a lot of money because, talking about the Illinois contract, the contract was supposed to be for 3 months for $126,000. The actual contract, the actual billing, the actual services was $13,800 and that attorney's agreement, the attorney could have gotten $162,000. I will regretfully tell you that National Home Care lost $28,000. A contract like that we can do without.

Senator CHURCH. Well, on that volume of business, yes.

Mr. GOTTHEINER. No; National Home Care has no business at this time. I would like to make——

Senator CHURCH. How many corporations of yours have gone bankrupt?

Mr. GOTTHEINER. None; I would like to point that out. Thank you, Senator, for asking the question; none. California Coordinated Health Care Service went out of business because Blue Cross stopped paying us and I paid whatever was owed, never had bankruptcy.

No. 2: Visiting Home Services held out until June 15, no check ever bounced. The service was good, the employees were satisfied.

While I was there they did not go bankrupt. They went bankrupt 2½ months later. I personally was not involved in any of the bankruptcy and I wish you could have stayed, then it would not have happened.

Senator CHURCH. I just have one further question.

Who in the Bureau of Health Insurance told you that they would not pursue the recovery of over $800,000 in overpayments?

Mr. GOTTHEINER. I believe there were three gentlemen who were present at the meeting. I can dig up the date and maybe through Blue Cross we can find out the former attorney from whom we interceded, Mr. Gomez, and he can tell us who is the gentleman.

Senator CHURCH. Well, I have no further questions.

Mr. GOTTHEINER. May I just make a couple more comments?

On the other audit here for Mr. Manly, again for the record, on the last page I am referring to the audit of October 29, 1976, where, Senator, you have the compensation out of the other audit, but the figures as far as I am concerned are correct. I just would like to go briefly through the others because it is on my conscience to tell you.

Mr. Gomez for the $49,000 he got, first of all, that was only for a 9-month period prorated over 1 or 2 hours a day where he made personal telephone calls. His hourly rate was $200 an hour. My daughter, Vivian, is listed with $1,875.

Senator CHURCH. Mr. Gomez, what was he doing making telephone calls and getting $200 an hour for?

Mr. GOTTHEINER. What was he doing?

Senator CHURCH. Yes.

Mr. GOTTHEINER. That is a question I asked myself a long time ago. [Laughter.]

Senator CHURCH. The auditor indicates he didn't do anything.

Mr. GOTTHEINER. I think Mr. Gomez, if I may be very candid with you, should not be a case for the auditors.

Senator CHURCH. Should not be what?

Mr. GOTTHEINER. Should not be a case for the auditors.

Senator CHURCH. Should not be a case for the auditor?

Mr. GOTTHEINER. No; I think the category higher. I worked that hard for the company 4 years ago, I had a heart attack in a welfare office and to me, not even talking about financially, it was morally the worst blow when Mr. Gomez came in about 1 month later and I knew what was going to happen. I had, and I admit it, frankly, the worst crying spell and I tried to get drunk and get it over with, drink myself to death. I mean, I didn't do it, but I knew that Mr. Gomez was a wing of the company and that is not the first company.

But getting back to my daughter, $1,875; $375, the last check bounced. That made it $1,500 and that was charged to me.

My son was a full-time worker for the company and he deserved his income. The $8,300 from loan repayment he had to borrow once and somebody gave him cash and wanted cash back and that was the transaction. There will be entries, there should have been entries, and I am sure there were entries for that money for the $8,300. My ex-wife did some secretarial service, the rest I charged. It was charged on me.

Furthermore, she loaned the company $10,000 which she never got back or she got back and Jennie got hers, my son's wife. She was a service coordinator and she worked full time, not as a family member. She worked, she did her job like any outsider.

However, that financial business, Mr. Gomez's son, whom we all inherited and he worked for it, but he got paid.

And last, but not least, I would like to mention one more thing. Mr. Clean, Mr. Keeley, talked yesterday about Unicare and today about Visiting Home Services. I think it is sour grapes. He lost one job, he lost the other job. If the company, Visiting Home Services, would have stayed on, but Mr. Keeley says, this should not be charged to medicare. When his girlfriend went to Connecticut for about 6 weeks he came to the office even on Saturdays and Sundays until my son finally had to change the lock to call her for an hour or more. So I would like to put that in the record so that Mr. Clean is not as clean as he sounds.

Senator CHURCH. I think we have our work cut out for us. [Laughter.]

Thank you very much for your testimony.

Mr. GOTTHEINER. You are welcome, Senator.

[The prepared statement of Mr. Gottheiner follows:]

[Testimony resumes on p. 1069.]

PREPARED STATEMENT OF PETER GOTTHEINER

Mr. Chairman, honorable members of your committee, ladies and gentlemen: May I take this opportunity to express my sincere gratitude for inviting me and for giving me the opportunity to submit my testimony and answer your questions.

The Committee on Aging under the Chairmanship of former Senator Frank Moss from Utah held hearings approximately more than a year ago, and it was at that time my name specifically and the names of the companies of which I was president were mentioned. Extremely negative statements and allegations were made by some witnesses, particularly by two competitors.

While reading these front page stories in the newspapers, I also read that former Senator Moss will give me an opportunity to submit my testimony.

As a matter of fact, I met former Senator Moss at a small campaign gathering in San Francisco, California; and I introduced myself and told him that I was the person against whom many false allegations were made during his Committee Hearings, and that I was pleased to learn that I would be given an opportunity to reply. He seemed to have only a vague memory of the Hearing and of my involvement; however, he promised to invite me to appear before his Committee. Unfortunately, this never happened during his tenure as Chairman; and for that reason, I do appreciate it very much that I, Peter Gottheiner, can address you, read you my own statements and give you my own answers candidly and honestly.

Until now, almost everything I heard about myself and about the companies which I headed was distorted, taken completely out of context, and based on information which was somehow supplied by some malicious individuals who were unable to compete with me professionally and ethically, but whose reigning success drove them to a nationwide campaign of slanderous and anonymous letters to welfare directors, newspapers, etc.

Fortunately, I survived and carried on business, answering every question I was asked and attempting to put the false allegations in their proper prospective. Gentlemen, without a perfectly clear conscience, belief in myself and the faith that justice would prevail, I could not have survived this continuous nightmare.

Jealous competitors haunted me since 1960 when the first contract was awarded to me on sealed bids to provide physical therapeutic and rehabilita-

tive services to employees of the City and County of San Francisco who sustained industrial injuries in their line of duty.

When I started a certified and licensed home health agency in 1968, I received many referrals from satisfied and loyal physicians who had referred patients to me for physical therapy since my arrival in the United States in 1949.

The two existing non-hospital based home health agencies in San Francisco, Visiting Nurses Association and San Francisco Home Health Services, did not like competition, since they were used to monopolizing the program; and they did a good job of this.

The Visiting Nurses Association had discharge nurses stationed in 90 percent of San Francisco's hospitals, those nurses being on the hospital staff but paid by the Visiting Nurses Association, and, consequently, charged to titles XVIII or XIX.

Charges were made, perjury was committed by individuals, including staff of the Department of Health, State of California, accusing me and the company of wrong-doing. The investigation took over a year, and the case was submitted to the U.S. Attorney, who in turn likewise investigated all charges carefully.

The letter from the U.S. Attorney is attached to my testimony and speaks for itself. There was not a single instance of wrong-doing on the part of the company or me.

I anticipate questions on this subject, as well as on all the other stories told primarily about me and about the various organizations with which I was connected. Since I do not know the content of your questions and do not wish to second-guess, I will respond to them as they are asked. For that reason, they are not included in the written testimony. If I feel that some relevant questions were not asked, I would very much like, with the permission of the Chairman, to advise you of them and, at the same time, to reply to them.

Every member of your Committee is a Lawmaker; and it is for that reason that I have included in my testimony some constructive criticism and my reasons for it, as well as some constructive suggestions and recommendations from which the entire nation could benefit, such as: Compassionate care of the indigent and unfortunate homebound individuals eligible for this program, which would prevent and substitute for institutionalized care in nursing homes; Reduction in welfare recipients; Job opportunities; Savings of millions of dollars.

I would be pleased, after you evaluate the merits of my suggestions, to offer my knowledge and expertise or to serve on any Advisory Board which you may intend to create and which, in turn, could provide you with additional constructive imput for introduction of legislation that would make this program one of the most popular, humanitarian and economic programs ever sponsored by the Federal Government.

Home care is, without a doubt, one of the most valuable programs in the nation.

With the continued spiraling cost of institutionalized care, the cost for home care has a great bilateral advantage:

One: For the individual, whether he/she is aged, infirmed or blind, or is eligible under another category of social, services to receive adequate help and assistance in order to stay in his/her own home represents a tremendous psychological value for the homebound or bedridden;

Two: The total expenditure, which is being paid 75% by the Federal Government and 25% by the respective State and, in very few cases, split up 12½% by the State and 12½% by the County, is only a small fraction of institutionalized care.

It was in 1964, when extended care facilities mushroomed all over the country, that I began to realize and appreciate the immeasurable value and advantages of retaining a person at home instead of transplanting him/her to a nursing home facility, often fifty or more miles away from his/her nearest relative.

The concept of in-home supportive services and its increasing popularity is proven by the fact that approximately over $3.4 million is spent annually on homemaker chore worker services and attendent care.

The cost for the same number of recipients in extended care facilities or nursing homes would be five to eight times more, while the chances of convalescence and rehabilitation in a nursing home compared to home care has been proven many times to be less.

It is most unfortunate that in-home supportive services, until now, have neither been adequately or properly controlled by the respective government agency nor has advantage been taken of during this program of the vast source of employment for recipients of public assistance. It is further regrettable that many counties or states still operate this program as a formerly known "attendent care" program, which means that the recipient of services is at the same time the employer of his/her attendent. This, to me, is not only a conflict of interest but a most inefficient arrangement, because nobody can or should be judge and jury at the same time.

I know as a matter of fact from statistics of the State of California, which surely do not differ from any other state, that there is a large overutilization of services for reasons such as: (a) the recipient requests more hours than necessary; (b) the worker is an employee of the recipient and, therefore, has to comply with his/her requests; (c) the worker is untrained and underqualified; (d) there is no supervision or monitoring of the services.

The recipients of services are allotted a lump sum by the respective Department of Social Services, which he or she is requested to pay to the provider of services. It has happened in many instances that either the attendent did not receive his/her full pay or, since many of these attendents are either relatives, close friends or neighbors of the recipient, "arrangements" are being made and fees are split.

For that reason, it is much more advantageous, economical, businesslike and efficient if the provider of services is employed by someone other than the recipient. Costs are considerably lower and quality of service is considerably higher. One of the best examples in California is the largest county, Los Angeles, which years ago had the intention of contracting for services but reneged on this; and the second largest county, San Diego, has recently invited proposals and bids to replace the old program.

Another way of providing these services is that some counties and states have their own "in-house" program, utilizing civil service employees. Not only is the cost for services considerably higher, but I am a firm believer that the government . . . federal, state or county . . . should *not* engage in domestic or personalized services.

If the county administers their own homemaker/chore program, the cost is up to $24 per hour, according to the report by the Auditor General, State of California.

This program started out as what it was originally designed for, which in brief is home maintenance, home management and personal service. There is *absolutely no* necessity for the utilization of medical or paramedical personnel.

For you gentlemen on this Committee who are married, your wife is a homemaker; and for those of you who are not married, your mother was and is a homemaker. I seriously doubt that neither your wife nor your mother needed a public health nurse, or registered nurse, or licensed vocational nurse to teach her to be a homemaker.

These domestic services are provided primarily by females and, at times, by widowers or unmarried men who learned to take care of these duties and chores from their parents.

I am the first one to admit and fully agree that the in-home supportive services program is becoming one of the largest industries in the nation, is becoming very commercialized and competitive. Since it is paid for by public funds, it should be operated as efficiently and economically as possible. A more qualified, better trained and supervised homemaker/chore worker will complete his/her chores and duties assigned in a shorter time than a less qualified, less trained and less supervised person. Therefore, the training program of about 50-60 hours is essential; and proper supervision at a certain sensible ratio is very important.

Supervisors not only assess the quality of services provided by the homemaker/chore worker, but simultaneously evaluate the physical, psychological and environmental condition of the client. They should also be trained to make every effort to utilize to the fullest any rehabilitative potential of the individual receiving services. Guidance, encouragement and proper training will in many instances not only reduce hours and cost of service but, more importantly, restore the recipient to independency in activities of daily living, self-respect and self-help.

Several of the homemaker/chore service agencies are also licensed under Titles XVIII and XIX—Medicaid and Medicare. It was these agencies who suddenly and strongly pushed and supported utilization of paramedical personnel in the in-home suportive services program. A home health agency is required to provide home health services under the direction of a medical director who is a licensed physician and surgeon, a public health nurse and other registered nurses, a medical social worker, registered physical, occupational and speech therapists, a dietician, and other paramedical personnel.

Almost the identical services which are rendered under Title XX by homemakers and chore workers are rendered under Titles XVIII and XIX by certified home health aides. Home health aides are required to complete a training course of 120 hours; and most are supervised by registered nurses again, if you pardon me, providing almost the identical services as homemakers/chore workers.

The only differences are that Titles XVIII and XIX require supervision by registered nurses, medical social workers, registered physical therapists, etc., while Title XX does not require such supervision.

For that reason, the cost of one hour of service rendered by a home health aide with all his/her professional supervision compared to one hour of homemaker/chore worker service costs approximately three times as much.

It is my belief that it was the precise reason to provide these domestic services under Title XX without the unnecessary "window dressing" and, hence, the increased costs.

I invite your comparison of hourly rates between home health aides versus homemaker and chore workers. The advantage for a home health agency to operate simultaneously as a homemaker/chore service agency is proration and utilization of the professional staff. However, these agencies claim that their quality of service is better, which in my opinion is an extremely poor excuse. One does not need nursing supervision to go shopping, prepare meals, bathe the client, do light housecleaning, etc.

Almost every company who is trying to have legislation on Title XVIII and XIX introduced whether on a federal, state or county level, to go the route of high class and high priced, yet unnecessary, supervision calls itself "non-profit". These so-called "non-profit" agencies have proven nationwide, almost without exception, that they are unable and unqualified to compete with free enterprise. In almost every area where bids for homemaker/chore services with an hourly rate were submitted, these so-called "non-profit" agencies' bids were considerably higher than the ones submitted by proprietary, for-profit agencies.

If Mr. Gerald Hawes of the Auditor General's Office, State of California, is in the audience, he will attest to this fact; because it was his office that published statistics and, at the same time, was unable to explain the fact that companies who claim to make no profit had to charge more than other companies who admittedly make a profit. Their only continued excuse is that they claim to provide a better service, which has been proven *not* to be the case anywhere. If these so-called "non-profit" agencies would have their way and be able to regulate the Title XX program, the cost would be at least 50% higher, while the quality of service would not be one per cent better.

For these reasons, I totally disagree with some of the conclusions, recommendations and benefits in Appendix 3, particularly with:

THE CONCLUSION

"In spite of statutory authorization to provide for a full range of in-home supportive services, the Department of Health has not done so. This has resulted in either the provision of medically-related service by unqualified providers or medically-related services which are not being provided at all."

THE RECOMMENDATION

"We recommend that the Department of Health attempt regulations which would permit the use of the full range of in-home medically-related social services so that homemaker and chore worker clients will not have to depend on unqualified providers for medically-related services."

"We also recommend that the Department require the use of medical social review teams or their equivalent, where indicated, to assure provision of appropriate levels of services to clients."

"Implementation of these recommendations will permit the provision of the optimum levels of services at the minimum cost."

I believe that the above conclusions, recommendations and benefits probably have certain merits but would make the program too cumbersome, complicated and confusing, and too costly.

I have personally had many years of experience in home health services and in in-home supportive services. Judging from that experience, it appears to me that although both programs were designed to retain the aged, infirmed or blind in his/her own surroundings, these two types of services should be totally separate in delivery and billing, but yet coordinated in programmatics. Home health services require paramedical personnel, while in-home supportive services are described as home maintenance, home management and personnel services.

I am in full support of each individual having their own physician, which they usually do, and quite frankly it should be left up to the physician to decide whether his patient requires home health services, such as skilled nursing, physical therapy, etc., or plain domestic services with a personal touch.

All funding comes from either the Federal Government, the State or the Counties. The description of percentage between Titles XVIII and XIX varies to Title XX. In reality, it is all allocated from public funds out of the taxpayers' money; and I strongly feel that these services should neither be shifted around nor be combined.

If a *client* receives homemaker and/or chore services in order to remain at home instead of being placed in a nursing home facility, and this *client's* physical condition deteriorates, then this very same *client* should become a *patient* of a certified home health agency and receive home health services as prescribed by his/her physician from qualified paramedical personnel.

On the other hand, if a *patient* receives home health services, as prescribed by his/her physician, and this *patient's* physical condition improves to the point where home health services are no longer required but domestic services are, then this very same *patient* should become a *client* of an agency providing homemaker and chore services. Almost every profession in the United States and especially the medical profession has many, many specialties within it. A specialist in his own field is much more qualified and experienced to do a better job at a lesser cost than in a specialty in which he/she has had no training. I am sure that any person with a heart condition would not see a dermatologist to care for his heart problem. I believe in the same principle and differential for home health services versus in-home supportive services. The Report with the conclusions, recommendations and benefits with which I disagree does not take into consideration the much higher cost of training, wages and supervision, if the programs were combined.

Figures speak for themselves in that the hourly rate for a certified home health aide who actually performs almost identical services as a homemaker is three times higher, as said previously. For that reason, I see no merits in trying to combine both types of services.

The Report by the Office of the Auditor General of California entitled "A Management Review of the Homemaker/Chore Services Program" dated June 11, 1975, submitted by Gerald A. Hawes, deals mainly with the many deficiencies in the program caused and created almost exclusively by the Department of Health, State of California.

It is as difficult as risky for any provider of services to participate in a governmental program with no specific laws, regulations, guidelines and directions. For that reason, it was the easiest way for the Department of Health to point their finger at the provider of services who delivered the largest volume in the State of California, which was Visiting Home Services, Inc., a company which I founded and of which I was president until June 16, 1976.

No agency should be accused of administrative, management, accounting or program deficiencies in the absence of laws, regulations, guidelines and directions.

If a referee in a football game throws his handkerchief, both teams know that a penalty will be imposed on either of the two teams. The penalty is based on the rules under which football is played. The referee then tells the teams

and demonstrates to the audience the type of error or wrong-doing the player has committed. The team is being penalized according to these rules. However, no football game could be played without rules where the referee would throw his handkerchief indicating a penalty and telling the players and the audience that it is for an error or wrong-doing for which rules will be published in two years.

Let me give you another example, gentlemen. A new bill for a code of ethics pertaining to outside income was introduced. This bill does not become law until after the President of the United States signs it. For that reason, it is also not retroactive; and income of legislators, which could not be earned after this legislation, but was earned prior to this legislation, would not have to be refunded.

The Department of Health, State of California, finally drafted some regulations in the beginning of January, 1977; and I think it is totally unjust to accuse people, innocent of wrong-doings, when they were never told what was right and what was wrong. As far as Visiting Home Services, Inc. and its subsidiary, Health Help, Inc. and myself are concerned, I acted in good faith, professionally and ethically.

In general, let me tell you that the percentage of profit which Health Help, Inc. has been accused of making is in actuality extremely lower than stated in the various reports and is based on many distorted, erroneous figures and imput. For that and other reasons, I consider the Audit Report on Health Help, Inc. to be inaccurate.

The profit for which Health Help, Inc., has been accused of making was 38 percent as per the audit report. Although there is no limit in profit, this figure is very wrong, due to numerous deductions which were not accounted for in the audit. The average profit margin of contracts provided by Visiting Home Services, Inc., was between 2 percent and 4 percent; otherwise, Visiting Home Services, Inc., could never have been the lowest bidder in most cases.

As far as the Audit Report dated October 29, 1976, on Visiting Home Services, Inc. and Health Help, Inc., which was done after the filing of bankruptcy, is concerned, I will attempt to answer your questions to the best of my ability, as long as you realize that I was asked to resign three months prior to the filing of the bankruptcy.

However, I wish to take issue with and deeply resent a comment on Page 6, Paragraph 2, in this report; and I quote, "Peter Gottheiner held no stock interest in Visiting Home Services, Inc. However, as President of both organizations and ostensibly only an employee of Visiting Home Services, Inc., he operated both Health Help, Inc. and Visiting Home Service, Inc. as sole proprietorship".

This is an assumption of the author of this report and the assumption is untrue and is merely the personal opinion of the author.

I also wish to take issue with and resent the comments on Page 15, Paragraph 2, in this report; and I quote, "This is the second time within five years that an organization headed by Peter Gottheiner, and heavily involved in providing medical or social benefits under governmental programs, has sought refuge in bankruptcy action. Some $39,000 in audited overpayments is still due the State of California from California Coordinated Healthcare Services, Inc. for services provided under Title XIX. Other amounts are due the Medicare (Federal) program from the same organization".

I never sought refuge in bankruptcy, not within five years nor in the 57½ years of my life; and if anyone is owed money, it is California Coordinated Health Care Services, Inc., the defunct but never bankrupt home health agency, and not Medi-Cal nor the Medicare programs.

I will be pleased to go into further detail when responding to your questions.

In order not to take up additional time, I am enclosing in my written testimony a news release dated November 4, 1976, from the Department of Health, State of California, by Gary Macomber, Deputy Director, Social Services Division. I am also enclosing my reply dated November 30, 1976, to Mr. Macomber in which I pointed out the various false statements made in the Press Release. Again, if you have any questions, it will be my pleasure to respond.

I read with great interest the report by the Office of the Auditor General of the State of California entitled "A Management Review of the Homemaker/Chore Services Program", dated June 11, 1975, submitted by Gerald A. Hawes, addressed to the California Legislature, which was requested by Senator George

Moscone, presently Mayor of the City and County of San Francisco, and Assemblyman Willie Brown. Both legislators were representing the San Francisco constituency.

Mr. Hawe's findings were that the Department of Health has neither adequate regulations nor appropriate management tools to effectively supervise the County's administration of the Homemaker/Chore Service Program. As a result, the administration of the Homemaker/Chore Service Program, as well as the cost of the Program, varies significantly from county to county.

As far as the cost factor is concerned, hourly rate ranges by providers were included in the report. According to the heading, these hourly rates were as of December 31, 1974.

It might interest you very much to note the decrease in costs for the fiscal years 1975-1976 and 1976-1977.

When I speak of decrease, I am speaking only of decrease in cost for in-home supportive services delivered by proprietary agencies. For some strange reason, there is an increase in cost for so-called "non-profit" agencies.

For your information, I listed seventeen counties in California, which to the best of my knowledge are all the counties who were contracting with agencies. The following figures were taken from bids submitted to counties for the fiscal year 1975-76 with the exception of the City and County of San Francisco, which as you are probably aware invited bids but rejected them, and is presently in the process of evaluating new bids.

County	Visiting Home Services, Inc.		Unicare, Inc.		Homemakers Inc., Upjohn		Nonprofit	
	Homemaker	Chore	Homemaker	Chore	Homemaker	Chore	Homemaker	Chore
Fresno	3.24	3.23	3.54	3.39	3.63	3.53	3.44	3.40
Humboldt	3.42	3.29	3.80	3.19	4.51	3.40	4.11	3.65
Imperial	4.04	4.04	4.23	4.03	4.23	3.85	4.83	4.03½
Mendocino	3.22	3.22	3.85	3.32	4.29	3.37	4.75	3.46
Madera	4.12	4.12	3.79	3.79	4.09	4.03	----	----
Merced	3.56	3.56	3.46	3.21	3.42	3.37	3.70	3.60
Plumas	4.34	4.34	4.50	4.45	----	----	----	----
Riverside	3.19	3.17	3.30	3.25	3.62	3.55	4.18	4.09
San Joaquin	3.98	3.98	4.60	4.25	4.37	4.24	4.70	4.11
San Luis Obispo	4.10	4.10	4.33	4.27	4.78	4.51	5.14	4.80
Santa Barbara	3.22	3.22	3.32	3.32	3.39	3.38	3.59	3.59
Santa Clara	5.17	----	5.19	----	5.91	----	5.10	----
Santa Cruz	4.93	----	4.85	----	4.67	----	6.00	----
Tehama	4.08	4.08	4.50	4.20	4.75	4.27	4.75	3.96
Tulare	3.24	3.24	3.37	3.37	3.70	3.57	----	----
Ventura	3.42	3.40	3.51	3.38	3.60	3.60	4.68	4.36

By computing the above figures which can be verified by the various counties, excluding San Francisco, the average homemaker rates for all counties were as follows: Visiting Home Services, Inc., the lowest cost— $3.81 per hour; Unicare, Inc.—$4.02 per hour; Homemakers, Inc., Upjohn—$4.20 per hour; and Nonprofit—$4.55 per hour.

The average Chore Worker rates for all counties were as follows: Visiting Home Services, Inc., the lowest cost—$3.61 per hour; Unicare, Inc.—$3.66 per hour; Homemakers, Inc., Upjohn—$3.72 per hour; and Nonprofit—$3.92 per hour.

Most counties, with the exception of San Francisco, who contracted for homemaker services exclusively, utilized almost exclusively chore services. The only counties other than San Francisco who had a sizable amount of homemaker hours was the county of Santa Clara.

The lowest rate for homemaker services was submitted by Visiting Home Services, Inc. in the county of Riverside at $3.19 per hour and the lowest bid for chore services was likewise submitted by Visiting Home Services, Inc. in the county of Riverside for $3.17 per hour. The lowest bid submitted by Unicare, Inc., was in the county of Riverside at $3.30 per hour for homemaker services and $3.35 per hour for chore services.

The lowest bid submitted by Upjohn was in the county of Merced at $3.42 per hour for homemaker services and $3.37 per hour for chore services.

The lowest bid submitted by nonprofit agencies (Fresno County Economic Opportunity Commission) was in the county of Fresno at $3.55 per hour for homemaker services and $3.50 per hour for chore services.

The highest rate statewide is presently $7.75 per hour charged by San Francisco Home Health Services, one of the so-called nonprofit organizations.

At this point, I would like to draw your attention to the fact that while sealed bids were required during the year 1974-75, the Counties of Tulare, Riverside, Humboldt, Ventura, Santa Cruz, San Joaquin, all in the State of California; the State of Kansas; the State of Missouri and the District of Columbia did not award the contract to the lowest, responsible and qualified bidder.

During the fiscal year 1975-76, the Counties of Riverside, San Bernardino, Mendocino, Merced, San Joaquin; all in the State of California; the State of Kansas; the State of Missouri; the District of Columbia and the County of Allegheny, Pennsylvania, did not award the contract to the lowest, responsible and qualified bidder.

Furthermore, during the first bidding procedure in the City and County of San Francisco, as well as in the County of San Diego, the contract was not awarded to the lowest, responsible and qualified bidder, but both counties went for rebidding.

I cannot comprehend the request for sealed bids and the disregard for the cost when contracts were awarded in the specific instances listed above.

For example, in the County of Riverside, which requires almost a million hours, they accepted a bid at $.92 per hour more, or 29% higher than the lowest, qualified and responsible bidder for the award of the contract. The annual difference is $92,000, but that is only one county. Multiply that by the number listed and by the other counties or states of which I am unaware, and you are seeing very sizable amounts being needlessly spent. If sealed bids are required and sent out to qualified and responsible providers, the lowest bidder should be awarded the contract, provided the line item budget and the budget narrative are correct, and the company does not take any shortcuts by not budgeting for enough administrative staff or supervisory personnel or pays the employees less than called for in the specifications by employing them primarily as casual workers who are only entitled to statutory benefits. Furthermore, according to the summary also included in Mr. Hawe's report, the following larger counties are likewise wasting money with their in-house program, which again, according to Mr. Hawe's report, is the most expensive one. To cite a few, the County of Marin in California is $50 per client per month above the average figure; the County of Monterey in California is $8 per client per month above the average figure; the County of Sacramento in California is $35 per client per month above the average figure; the County of San Diego in California is $49 per month per client above the average figure; and the County of Yolo in California is $45 per client per month above the average figure.

In addition, I wish to add that the figures quoted in Appendix B show that the average cost per client per month during the second quarter of 1974-75 was $119.69, in the State of California.

I have definite proof that in most counties where Visiting Home Services, Inc. had contracts, the cost per client per month was considerably lower than quoted in the Summary.

The Department of Health, State of California, received from me correspondence on two separate occasions where we offered to provide services at a savings of $12 million annually to the State. The County of Los Angeles, who still provides most of their services under the old Attendent Care Program, carrying the individual provider contracts, could save a considerable amount of money by contracting for services, as could the other counties mentioned previously. Until this day, I have never received a written response from the Department of Health in Sacramento, which clearly confirms Mr. Hawe's findings of lack of adequate regulations to effectively control the cost of service delivery and lack of management information system or adequate staff capable of enforcing existing regulations and detecting potential problems in the program by the Department of Health, State of California. I also recommended to the Department of Health, State of California, that bids should be submitted on a cost per client per month, instead of an hourly rate.

During the last several years, I have made numerous requests to the Department of Health to issue clearer guidelines and more definitive regulations, obviously without success. Most of the gentlemen at the Department of Health whom I tried to contact were hardly ever available to speak with me because they were tied up in meetings day after day, month after month, year after year.

Gentlemen, there are a couple of proven examples in the State of California which I want to mention by name.

(1) The Fresno County Economic Opportunity Commission, one of the so-called "non-profit" organizations, charged $4.50 per hour a few years ago for homemaker services in the County of Fresno. When competitive bids became compulsory, their rate changed between June 30 and July 1 from $4.50 per hour to $3.75 per hour. I brought this matter to the attention of the county and state, telling them that either the Fresno County Economic Opportunity Commission made a profit at $4.50 per hour, which was not allowed under OASC-5, or they were losing money at $3.75 per hour. If they charged more than their cost, they were either supposed to refund the overpayment, which was the case in the County of Fresno in the sum of $75,000, or they utilized and commingled other funds which were not designated for the in-home supportive services program to substitute for their loss, which is likewise illegal.

(2) Another example is San Francisco Home Health Services, who was under contract with the City and County of San Francisco, and for years was charging the rate of $7.35 per hour compared to proprietary companies who charged $7.00 and $6.00 per hour. San Francisco Home Health Services' volume was almost fifty percent higher than that of the other agencies charging $.75 or $1.75 less. It is the same in this program as in any other business that wholesale is cheaper than retail, or that the cost for more hours should not be as much as the cost for less hours of service.

Bids were submitted for the City and County of San Francisco on January 21, 1977. San Francisco Home Health Services submitted a bid of $8.03 per hour, while our company submitted a bid of $5.82 per hour. This is a difference of $2.31 or forty percent higher than a proprietary company who admittedly included a profit in their line item budget.

As a matter of fact, every proprietary company who submitted bids in San Francisco were lower than San Francisco Home Health Services.

(3) The identical situation happened in San Diego where Allied Home Health Services and the Visiting Nurses Association in a joint venture submitted a bid averaging $4.46 per hour versus the bid of our company at $3.80 per hour, which again included a profit. This difference was seventeen percent.

In addition to the income from the City and County of San Francisco, San Francisco Home Health Services received for years $100,000 in subsidies from the United Way and additional funds from other voluntary organizations as well as a one-time federal grant for almost $1 million for a demonstration program. Allied Home Health Services and the Visiting Nurses Association alike surely received subsidies from the United Way.

It is incomprehensible to me that despite the subsidies, grants, and the fact that they supposedly not only make no profit, but are also tax-exempt, they continuously bid higher and, in most cases, get away with it; while proprietary agencies who deliver the same quality of services in a more business-like, efficient and streamlined way with less administrative overhead and less unnecessary window dressing, at the same time accomplishing the same goals which are retaining the aged, disabled, ill or blind comfortably in their own homes, are continually under criticism.

I sincerely hope that this comparison, which can easily be documented by facts and figures, will make you gentlemen realize that it would be unfair and unwise to surrender to the prejudiced, untrue and unsubstantiated allegation that proprietary agencies take advantage of this program. I am pleased to say that it is just the opposite; besides, the United States of America depends upon free enterprise, and I am proud to be a part of it.

I believe we all agree that institutionalized care is too costly and that the unemployment figure in our country is too high, as is the number of persons who depend on public assistance.

In order to reduce program costs and to make the purchase of in-home supportive services more competitive, counties and states are now required to invite proposals and bids from potential providers of services.

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Being in full agreement with this procedure, I cannot understand that in many instances counties or states who invite competitive bidding totally disregard the actual bid, which is the hourly rate for the delivery of homemaker and chore services, including all supervision, administrative, training and program expenses. Those counties and states who have the habit of disregarding the lowest bid perpetuate that concept, which means that the goal of the procedure—to obtain the best service for the lowest cost—is not accomplished. Millions of dollars are being spent unnecessarily, often for unjust priorities given to one contractor or another. According to Invitations For Bids, awards of contracts are to be made to the lowest, responsible and qualified bidder.

If a bid is submitted, most every governmental agency has it evaluated by a department-appointed advisory or review board. The composition of such a review board is predominantly from members of local volunteer organizations who are in most cases brainwashed in favor of so-called "non-profit" home town organizations and are totally adverse to proprietary agencies and totally disregarding the cost factor. Again, statistics support my statement anywhere that so-called "non-profit" organizations have never submitted a lower bid than a proprietary company which included profits in their line item budgets and, consequently, in their bids. I believe that a lot of lobbying was done favoring non-profit organizations and discrediting proprietary agencies. A typical example was the HEW Audit for the City and County of San Francisco.

The contract in that county was split between four companies, one of them supposedly non-profit, and three of them for-profit. In addition, the Visiting Nurses Association, another non-profit group, was also referred some cases under contract. The HEW Audit, for strange and unknown reasons, was made exclusively on the three proprietary agencies. Although San Francisco Home Health Services, headed by Hadley Hall, received 11% and 29% respectively more per hour than did these three for-profit agencies, and their caseload was about 50% higher than any of the proprietary agencies, no audit was ever conducted; and it it was conducted, it was never published.

When we inquired with the auditors why the fourth company was omitted in the audit, we were given, in my opinion, an unjustifiable excuse that they did not have the time nor the manpower to audit all four companies. If that was the case, I would certainly have hoped, in the interest of justice, that two proprietary agencies and one non-profit agency receiving the highest hourly rate would have been audited instead of no non-profit agency and three for-profit agencies.

The publications of that audit made it appear that all three proprietary companies did bad things, one more than the other. while the actual audit was, and to the best of my knowledge still is, in draft form.

In the particular case of Health Help, Inc., the company I founded and of which I was president, the conclusive figures published were based on assumptions and not facts. I am sure that some of you gentlemen will ask questions about the audit; and since I do not know how you will phrase these questions, I cannot pre-write the answers. However, I will be more than happy to reply to your questions candidly and honestly in a detailed fashion and to the best of my ability.

For about three years, the rate for homemaker services provided by San Francisco Home Health Services was $7.75 per hour compared to $7.00 and $6.00 for profit-making agencies.

During the three years, an increase supposedly based on cost to $8.21 was requested but disapproved. It makes one wonder how the company was able to continue their operation at a $.46 per hour loss . . . that is if their actual cost was $8.21, while others performed the same or better services for $7.00 or $6.00 respectively.

On January 21, 1977, San Francisco Home Health Services submitted a bid for the new homemaker contract for $8.03 per hour compared to other bids of proprietary agencies which were all below $6.00 per hour for the identical services provided by personnel with wages, benefits and seniority under the identical union worker contract.

On February 24, Mr. Hall, the Executive Director of San Francisco Home Health Services, requested an increase on his old rate of $7.75 per hour to $9.20 per hour for the two or three months of the remainder of the old contract.

How can this organization presently provide services for $7.75 while their cost is supposedly $9.20 in February, 1977, and then submit a bid on a new contract with higher wages and benefits for $8.03 on January 21, 1977.

I sincerely hope that this example will make you realize that all the nice fairy tales published about non-profit companies are nothing but a "perpetuated myth", and favoritism toward them should end right here and now.

On the other hand, the fact remains that a lot of allegations have been made against Health Help, Inc. and Visiting Home Services, Inc., both proprietary companies, and that these allegations could have been extremely harmful and destructive to those two companies, which I am afraid was the purpose; because Visiting Home Services, Inc., was the most successful and progressive company in the delivery of in-home supportive services in the United States. The company was also the easiest target for any deficiencies in the program as well as in the administration of the program, be it state or county. When somebody had to be blamed, it was the easiest to blame the successful company with derogatory remarks and accusations, whether they were factual or not. However, despite the tremendous publicity, and I mean bad publicity, against Health Help, Inc., Visiting Home Services, Inc. and me, in most of the newspapers in the country, nobody has ever bothered to listen to my side of the story. Despite all the bad publicity and allegations, Visiting Home Services, Inc. continued to be awarded new contracts which were approved by the State of California, and in many cases reluctantly. Often we were not approved when we were the low bidder, and often we were not approved when we were not the low bidder. It appeared that a company in California and some other States is being penalized for being the low bidder. Counties in California or other states would not have awarded contracts to Visiting Home Services, Inc. disregarding all the publicity if Visiting Home Services, Inc., would not have lived up to the three major goals in the program: 1) the highest quality services, 2) well-compensated employees, and 3) the lowest cost for services. I feel that this speaks for itself and should be seriously taken into consideration when evaluating my testimony.

Despite the demise of Health Help, Inc. and Visiting Home Services, Inc. and the fact that I was asked to resign three months before the companies declared bankruptcy, the witchhunt on me personally continues, which in my opinion is just as unfair as it was in the beginning when I was singled out as far as bad publicity was concerned.

I have been professionally involved in home care since 1964, much, much longer than any one of my competitors. I provided physical therapy and rehabilitative services since my arrival in the United States in 1949 in a professional, ethical and dedicated manner by medical prescription exclusively. I retained my source of referrals from the medical profession, was well-supported by the insurance industry and was the first one who provided physical therapy and rehabilitative services under contract to the City and County of San Francisco in 1960 to 25,000 city employees who sustained industrial injuries in the line of duty.

Despite a statement made by Mr. Hall some time ago, I never had my physical therapy license, nor any other license, including my driver's license, revoked. When I entered the in-home supportive services field I not only did my very best to render services at the highest standard, but at the same time to show compassion for our workers as well as for the recipients of services. I considered myself advanced and creative and submitted numerous constructive and logical suggestions to the various governmental agencies. Some of them have been adopted, even if it took a long time in doing so. I consider myself extremely involved in the home care industry, and I fully intend to continue my involvement regardless of all the negative publicity in the past and with the hope that this testimony before you will make my side of the coin known to you and to the public and will gradually make justice prevail and clear the air once and forever.

The in-home supportive services program would give this nation the perfect opportunity to accomplish great psychological improvement of the indigent and homebound, job opportunities for welfare recipients and economic savings in all aspects by: (1) encouraging and increasing home care versus institutionalized care; (2) training and hiring as exclusively as possible recipients of public assistance and minorities to provide in-home supportive services.

This can only be done if a recipient of public assistance's wages are a little higher than their welfare grants, if they are covered by health insurance at least equal to Medicaid, and if they receive the modest fringe benefits as do most other employees.

I wish to submit to you some rough figures. It takes an average of thirty hours per month per client to keep this individual well cared for at home. Some will need two or three times the number of hours, and many of them will require less hours. If a person works an average of thirty hours per week, he or she can provide service for approximately four clients. $340 million annually nationwide is $30 million per month. At an average of $5.00 per hour, which is a higher hourly rate than under contract, 6 million service hours per month could be rendered nationwide.

At an average of thirty hours per month, more than 2 million persons could be serviced at a ratio of one homemaker/chore worker to every four clients, and approximately 50,000 recipients of public assistance could be removed from welfare rolls. They could be returned to the mainstream of gainful employment, regaining their independence and self-respect, improving the economy, and paying taxes. If you deducted the savings in welfare payments from the cost of the program, you would be purchasing the service for an unbelievably low cost.

In addition to and in order to simplify and uniform the program, I suggest the Federal Government and the State to perform some kind of "Dun & Bradstreet" rating for in-home supportive services agencies. Let them fill in a questionnaire which would require disclosure of anything about the company that the Federal Government or State wishes to know. Give the agency a rating or even disqualify some of them from providing services for valid reasons. If a county or state then invites bids with the criteria of awarding the bid to the lowest, responsible and qualified bidder, they can easily obtain their rating for quality and responsibility; and all they have to do is look at the dollar figure when they make an award. It would make it much easier for everyone concerned, and a lot of money could be saved in repetitious bureaucratic procedures on the county and state level as well as unnecessary and repetitious costs of submitting and re-submitting bids, continuance of appearances before boards of supervisors, involvement with legal counsel, etc. on the part of the providers. These costs will sooner or later have to be added to the program, while the cost for duplicating personnel, either on the county or state level, is likewise unnecessary and could be saved, which, on a nationwide basis, would amount to quite a bit of savings.

In conclusion, government, be it Federal, State or county, should realize that any program will be only as successful as they want it to be and as good as they make it.

I believe that it would certainly be worth exploring the validity of these recommendations. Thus, you would experience a pleasant surprise in making more people happy by letting them stay in their own surroundings, in making more people happy by removing them from welfare rolls and training them for gainful employment, and in making more people happy by considerably reducing the budget allocated for the in-home supportive services program and welfare payments by combining the two into one project, from which every American would benefit.

Again, thank you very much for having me honored with the opportunity to testify before you.

Respectfully submitted,

PETER GOTTHEINER, R.P.T.

Senator CHURCH. Our next witness is Mr. Thomas Tierney, director, Bureau of Health Insurance. I understand, Mr. James B. Cardwell, Commissioner of the Social Security Administration, was to be here but, due to a conflicting engagement at the White House, will be unable to attend. That was explained to the committee earlier and he was excused.

Mr. Tierney, we will look to you for the wrap-up testimony this afternoon.

Do you solemnly swear that the testimony you will give will be the truth, the whole truth, and nothing but the truth, so help you God?

STATEMENT OF THOMAS TIERNEY, DIRECTOR, BUREAU OF HEALTH INSURANCE, U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Mr. TIERNEY. I do.

I would like to introduce Mr. Mike Piazza of the San Francisco region who has been closely connected with some of your investigators in these matters.

As you said, Mr. Cardwell intended to be here but then got into a schedule conflict and could not come back this afternoon. He didn't have a prepared statement; we went down to his office and wrote a few points that he wanted to make and I have copies of it here, at least enough for the members of the committee.

Senator CHURCH. Yes.

Mr. TIERNEY. It is very brief. I don't know whether you want it read or not.

Senator CHURCH. We will include it in the record.

Are these recommendations for changes in the law?

Mr. TIERNEY. Yes, specific legislative and administrative changes.

Senator CHURCH. We will enter it in the record at this time.

Mr. TIERNEY. All right.

[The statement follows:]

PREPARED STATEMENT OF HON. JAMES B. CARDWELL, COMMISSIONER, SOCIAL SECURITY ADMINISTRATION

My comments are directed to lessons that we have learned not just as a result of the individual cases that have come under review by the House and Senate committees but also from our broader experience with home health care generally.

POSSIBLE LEGISLATIVE CHANGES

Several changes in the basic structure of the medicare financing of home health activities seem to be in order. The following might prove to be particularly useful at this time.

(1) The right of home health care agencies to nominate their own carrier and/or intermediary has produced a number of anomalies that should not be allowed to continue. For example, out of the more than 200 providers of home health care in the State of California, one of the cases under review by this joint hearing involves an agency that elected a given medicare intermediary that processes claims for no other home health provider within the State of California. (Other kinds of providers within the State and home health care providers outside of the State are, of course, dealt with by this particular intermediary/carrier.) One-on-one relationships between carriers/intermediaries and providers are not acceptable. Most in doubt about such a relationship is the lack of incentive on the part of the carrier or intermediary to develop a full-scale and efficient system for screening and processing claims and, for that matter, for reviewing and auditing the general activities of the provider. There just isn't enough activity to generate the need for the necessary range of reviews and audits.

To deal with this anomaly, the Congress should consider the granting of authority to the Secretary wherein he can make exceptions to the nomination procedure that is the inherent right of all providers under the existing statute without having to go through a hearing or without having to carry the burden of proving that the exception is warranted. To be more specific, I would rec-

ommend that the Bureau of Health Insurance be allowed to set up either a single national intermediary to deal with home health care providers or a series of regional intermediaries. In other words, establish an arrangement where the volume of activity would generate a full range of reviews and audits.

(2) Stiffen criminal penalties for fraud and abuse. Those proposed in H.R. 3 and the Talmadge bill would probably be satisfactory.

(3) Provide the Bureau of Health Insurance and agents and others at interest at the Federal level with full authority to gain access to not just the records of the provider itself but the records of any interlocking activities of the provider. This could be done by the granting of subpena power or a specific right of access to be spelled out in the statute.

(4) Although I think it would take some additional time and effort, steps should be taken to develop legislation which would better define those services that can properly constitute home health care and be reimbursed as a part of the medicare program. Today home health care seems to be in the eyes of the beholder. Almost any service or activity provided by an agency can be argued to justify reimbursement. Most important is the need to separate and identify medical and health-related services from custodial and homemaker services. The medical delivery system does not now have an established concept or criterion for defining home health care or for the participation of professional and paraprofessional medical personnel in the furnishing of such care. In short, as soon as possible, the Federal Government needs to decide what should be covered under home health care versus what should be covered under social and other services financed either directly or indirectly by the Government. Until this is done, providers, reimbursers and beneficiaries alike will continue to be confused. This confusion invites fraud and abuse.

ADMINISTRATIVE CHANGES

(1) The program integrity staff of the Bureau of Health Insurance, particularly as it functions in the field, has had a need for a procedure to screen and process initial complaints. Action to do this has already been taken by the Bureau of Health Insurance in that specific staff is now designated within each regional office for this purpose and a system has been designed to link up any complaint with any previous history involving the same provider.

(2) A system is needed to automatically refer cases to the intermediary or to the office of the inspector general, recently established as you know, wherever a pattern of previous complaints exists. This is not now handled in an efficient, systematic way. The Bureau of Health Insurance and the office of the inspector general should work to develop such criteria.

(3) Again involving the office of the inspector general is the need to establish a systematic and routine audit of intermediaries on a predetermined cycle, not just for fiscal purposes but, more importantly, to assess the effectiveness of the claims processing practices and procedures employed by the intermediary. This is an established requirement for most Medicare activities. It seems to be weak at the moment with respect to home health care agencies again, I believe, because of a lack of volume relative to other medicare services. The establishment of a limited number of intermediaries would help solve this particular problem.

(4) One of the problems facing medicare in the home health care area is that many of the providers have been newly created and are without prior experience in the delivery of health care. They lack adequate organizational and business practices and thus represent a source of both unintended errors and deliberate fraud and abuse. Moreover, medicare and, where applicable, medicaid constitute the only course of their income. This invites them to maximize their claims against the Government.

Steps should be taken to develop minimum requirements for participation in the program such as proof of minimum acceptable and customary business practices and capacities. In cases where a prospective provider lacks experience and adequate business acumen, he should be subjected to a special arm's length review and audit by, perhaps, a CPA in order to qualify for participation. This idea needs to be perfected and probably would require legislation.

(5) Steps should be taken to review and evaluate the existing medicare provider reimbursement manual to determine whether special revisions might be needed to deal with the special problems of home health care agencies.

Mr. TIERNEY. Senator, I think in fairness I should say that in recommending the concept of either a single organization intermediary to do this job on a national basis or at least a limited number on regional basis it is not meant to criticize the intermediary in this particular case. I think the problems our California intermediary experienced permeate the entire field. We have other situations in which a single intermediary, while it may be expending literally hundreds of millions of dollars in hospital care, is dealing with only a few home health agencies and quite frankly that does not, as the Commissioner says, generate enough volume to keep them as alert to problems as they would be otherwise. We think if one organization were doing all of them it might be much better.

Senator CHURCH. Thank you.

Do you have any further testimony you would like to give?

Mr. TIERNEY. No, sir.

Senator CHURCH. I have no questions.

Mr. Bafalis.

Representative BAFALIS. Thank you, Mr. Chairman.

Has there been any consideration given to requiring a bond on the part of the people providing the service so that when you find several hundred thousand dollars have been misappropriated the firm does not go out of business and we have a chance of recovering these funds?

Mr. TIERNEY. Yes; that has certainly been considered. There are lots of problems in it and again I don't want to minimize what have been very substantial amounts of money but nevertheless are relatively small in given situations. It is very difficult to get such a solution. We are paying, as I said, hundreds of millions of dollars to hospitals and if we were to ask somebody to bond a hospital against giving unnecessary services or having unnecessary costs, I think it would be impossible. Here we are asking a bonding company to come in and in effect bond not only the integrity but also the fiscal capacity of a relatively small agency. In our inquiries to date that seems to be virtually impossible.

Representative BAFALIS. Are there any guidelines regarding the administrative expenses as to what is and is not allowed? We just heard a witness while you were sitting here that charged off a band, charged off liquor and a number of other items as the cost of obtaining business. Do we publish guidelines for the small operator so that he fully understands what he can and cannot charge off as part of his rate, and don't we have the responsibility to do so?

Mr. TIERNEY. If I may, the second greatest criticism of the medicare program—this may be the first at the moment—is the fact we put out monumental amounts of paper. There are provider manuals as well as intermediary manuals and carrier manuals that we try to keep up to date and do go into elaborate detail as to what expense medicare will reimburse and what it won't. The problem is that no matter how detailed our guidelines, we cannot anticipate every contingency and circumstance. Moreover, the review of a provider's costs is not done as expenses are incurred but ex post facto, after an accounting has ended.

At the end of the year a provider compiles its costs and assembles them into a cost report, which is uniform for everybody, and submits

it. The intermediary desk reviews all cost reports and in those instances where it seems appropriate, audits them. Often it is only when you get into an audit that you discover certain kinds of nonallowable expenses, included under the general and administrative expenses section of the cost report. So it is not a case of sending in a bill for a band or a photographer.

Senator CHURCH. It is a case of sending in the form that does not mean anything unless you have an audit.

Mr. TIERNEY. You are right, Senator. In face of the fact that it is pretty clear in the provider reimbursement manuals that liquor is not allowed at all, promotional activity is not allowed at all, advertising is not allowed at all, if somebody wants to include expenses of that kind in a cost report it can be discovered and disallowed, but usually by audit after the fact.

Representative BAFALIS. The concern I have is that the gentleman says he never has gone into bankruptcy, he just stopped operating his businesses. Obviously there are not any assets. Now he says he believes he has a $200,000 reimbursement coming, but let's presume that we find that we have overpaid him by $300,000 or $400,000. Under the system of payment where an individual can set up a series of companies as we have seen, establish a rate that is possibly predicated on items which he would not get reimbursed for, and when the audit starts, close down that business and open another business. Eventually when we find that he does owe money there is nothing in that corporation to pay it with. It seems that there ought to be some way to protect the taxpayer. If we are going to talk about national health insurance, which will be much larger than what we are doing in home health care—if we cannot administer this program, I don't know how we can begin to think about national health insurance.

Mr. TIERNEY. That is exactly the problem. Mr. Bafalis and I think, one that the Commissioner was trying to address. This is not to criticize home health agencies but the fact remains that a home health agency need have no assets, it need have no building, it need have no cash. It need only organize and get a registered nurse or a physical therapist or both on the payroll and convince a State agency that these are qualified people and that they are qualified therefore to render care in somebody's home and then the operation can be off and running. Now that is what is so difficult. If you get a hospital that goes bankrupt or a nursing home or something, you have some assets to grab hold of. In the case of a home health agency there usually is nothing.

Representative BAFALIS. It seems to me that the Congress should establish programs and that we then ought to take the responsibility when this kind of thing is allowed to happen. We ought to establish the kind of a program with requirements greater than the requirements you have just outlined.

Mr. TIERNEY. Yes, sir; let me just state the opposite side of that coin because it is said so often and has been said to the Congress in other committees looking at the positives of home health care, and that is the government ought to be encouraging the use of home health care; it ought to be begging people to go out and establish agencies providing such services. On the other hand, we now come

along and say to these agencies, by gosh, you have to furnish bonds, you have to do this, you have to do that. I guess it is a case of measuring to the best of your ability where the greater risk is. If you get absolute assertions that it is all going to be swell, you will not run into situations such as we're examining today, but then you won't have very many home health agencies either.

Representative BAFALIS. No, sir, but if you are chartering a bank or if you are chartering an insurance company, or in Florida you are going to operate a perpetual care cemetery, you are required by the State to give guarantees that people who are making investments in those particular institutions are going to be able to be guaranteed for a period of time that their funds are safe or the investment they made is going to be protected. Now it seems to me at the Federal level could do the very same thing. We have to accept the responsibility for not having done it and I think there is enough intelligence within the Congress and the bureaucracy so that we can design programs to protect the taxpayer and at the same time give the type of service we have to give.

Mr. TIERNEY. I don't disagree and I don't want to be arguing against that point of view. However, there is one, Mr. Bafalis, a unique phenomenon in the home health care situation that is very basic both to our understanding of the problem and how we deal with it. For the most part, as the Commissioner said in his remarks, there is no source of revenue other than medicare and whatever pays for most of these agencies. Medicaid, Blue Cross and other organizations still don't cover home health care. Home health care had never been a part of the whole spectrum of health services until medicare came along so if you go too far saying you have got to show experience, you have to show business acumen, you have to show bond, and then you say, well, if that is not possible, you cannot do business until you can, the likely result would be the destruction of many of these agencies.

Representative BAFALIS. I have to disagree with that. Quite frankly I have been in other businesses all my life and after listening to what I did today I think I missed the boat somewhere along the way [laughter].

Senator CHURCH. You chose the wrong business.

Representative BAFALIS. This is the greatest opportunity to get wealthy there is.

Mr. TIERNEY. Well, that is certainly a point of view I would not argue with.

What you heard today is certainly discouraging. However, that does not mean that all of them operate in that way and even new ones need some opportunity to at least get started.

Senator CHURCH. Mr. Rostenkowski.

Representative ROSTENKOWSKI. Thank you, Mr. Chairman.

Mr. Tierney, what worries me is that this operation can become so contagious that the legitimate operator, the person that really wants to deliver home health care, can't compete and I really have been under the impression for as long as I have been working on the Ways and Means Committee that the Bureau of Health Insurance had an obligation with respect to watching how accounts were flowing. I am wondering whether some of the people that are

employed as administrators in this area are doing their job when we can send an auditor in from the Ways and Means Committee and discover, in a very short while, some of the most unpalatable fraud and abuses to a program that I should think you and your department would be so familiar with that it should never have happened. It is really a shame, Mr. Tierney, that the ingenuity of man works in the direction of abusing his Government more than in helping it. I am really disappointed that we are at this juncture principally because I think we are on the threshold of trying to write a national health insurance program. I think Mr. Bafalis' point is well taken. How can we manage something as large as a health insurance program, when we cannot manage something as small as this? How do we keep faith with the American people? How can we legislate and have the support of the taxpayer whose money these people have been using and really defrauding?

Mr. TIERNEY. I think this certainly raises a question, Mr. Rostenkowski, and we have to try our best to make it clear to the American people that this is not characteristic of a government health program. Let me say, if I may——

Representative ROSTENKOWSKI. You know the ordinary operation of the program does not make news but this does make news. Given that it is going to be, and has been, over a period of a year on the front page of all of the newspapers, I can very well understand that the American public loses faith not only in their legislature but in the administrative offices as well.

Mr. TIERNEY. I agree with you, and as you say, it does make the headlines. But again, let me give it a little perspective, Mr. Rostenkowski, and this is not said in defense of any given case. Medicare is dealing with over 4,000 nursing institutions, it is dealing with independent laboratories, it is dealing with 250,000 physicians, the carriers are processing about 94 million claims a year. This is a big operation. Now we could try to audit every case down to the final penny and this sort of thing would not happen, or you try to do what seems to be reasonable and this sort of thing will happen, somebody will sneak through.

Representative ROSTENKOWSKI. I hope, Mr. Tierney, this is the one that snuck through but the evidence shows us that there is a pretty big hole in it.

Mr. TIERNEY. I don't know which one we are talking about.

Representative ROSTENKOWSKI. Yes; it is a shame, isn't it?

Mr. TIERNEY. Well, I think we have had two of them to talk about. The only point I was trying to make is that you cannot hire enough inspectors or enough evaluators to go out and do a job. Our program integrity operation in the California region consists of only 16 people; yet they have got 10 percent of the medicare business in the country.

We have tried to develop a system where we have not just inspectors going out but most of the people we have working in medicare scrutinizing the process from the time a claim arrives at the front door until it is finally audited out at the end. At the end you are still going to lose a couple. This is the perspective from which these problems should be viewed, and I have tried to get

this into the newspaper but never succeeded. If this can ever be gotten across I think it should be encouraging to the American people.

I don't mean to suggest that our business is out to indict health professionals but I think it is noteworthy that 10 years of its existence has referred more cases to the Justice Department and secured more indictments and more convictions than all of the health insurance programs in the country combined—all the Blue Cross and Blue Shield plans combined and all the commercial contracts. Although we cannot get that message across very well I think this kind of thing shows we do have a system, one that works rather well.

I think some of the things the Commissioner suggests, particularly in this area, make sense and I would hope we might move ahead with them. We now have 84 different intermediaries, I think, dealing with these home health facilities—big, little, small, urban, rural. That just does not generate in any one area or in any one operation enough activity and I guess you might even say enough interest to do everything that could be done.

Representative ROSTENKOWSKI. Mr. Tierney, when were you aware that this operation was in effect? When did the Bureau of Health Insurance become aware that Flora Souza was running a corporation that was involved in something equal to carrying on a fraudulent operation?

Mr. TIERNEY. I have been looking back through the record. I was not aware of it at any time but in reviewing our reports it appears that a complaint was filed in our regional office back in 1970, 1971. I ask Mr. Piazza to please correct me or to fill in anything I miss.

The first complaint about the mismanagement of things was filed by a former employee, someone who had worked there a very short time, someone who again in the views of the people who were doing the job at that time really didn't seem to be too reliable. They nevertheless said, OK, we have a complaint and turned it over to the intermediary. The intermediary, not finding anything in its records to indicate wrongdoing, dropped it.

Then we got more complaints not in that area, but regarding services. Some people claimed they were receiving solicitations at their homes to provide services they had not even asked for. Again we looked into it and asked the intermediary to look into it. We were lulled to sleep a little bit, Mr. Rostenkowski, by the fact that their costs seemed quite reasonable. When the committee staff got interested in the whole field and asked us to give a list of organizations, I think it was becoming very clear we may have some problems. This was one of them, and they have done an excellent job since that time of zeroing in on this.

Representative ROSTENKOWSKI. So your original complaint came in 1970, 1971. Have there been other complaints about mismanagement between 1970 and now?

Mr. TIERNEY. I recall one other.

Mr. PIAZZA. There has been a series of complaints over the years, all dealing with somewhat different areas of the operation of Home Care. There was a complaint in 1971 or 1972, as Mr. Tierney said,

regarding the areas of costs that were charged to medicare by Home Care. I think that is a particular episode that Mr. Tierney was referring to.

Mr. TIERNEY. I know better than to try to just kiss off any poor performance with you, Mr. Rostenkowski; I tried to do that once before. Sitting and looking at that record now and having had five or six auditors spend months pouring through the thing, it looks very bad. But I must tell you that at that time looking at this situation in the whole context of this field it didn't look like much of a problem.

Representative ROSTENKOWSKI. Mr. Tierney, I agree that it looks bad. It is horrible.

Mr. TIERNEY. Yes, sir.

Representative ROSTENKOWSKI. You know the responsibility that we are going to be charged with and we are going to have to walk down that avenue together—you the administrator and we the legislators. I just become very concerned with the attitude that people are going to have toward their government with respect to a massive program that we are on the threshold of trying to write. I am disappointed because this is just not the best way to start on a health insurance program for the people in this country that I think they deserve.

I am disappointed because I don't know that we can develop in the next 2 or 3 years the confidence that is necessary for us to write good legislation. It may take more administrative acumen or it may take more investigators in order for us to ultimately provide the health services that are necessary. I think that we are going to have to hire more people but I think, Mr. Tierney, we are going to have to hire people that are willing to work, that are willing to watch the program, that are willing to make decisions and to charge people with falsely documenting applications or documents that they are issuing to the Federal Government.

I have no further questions.

Senator CHURCH. Mr. Martin.

Representative MARTIN. I yield.

Senator CHURCH. I promised Mr. Vanik that I would yield to him next.

Representative VANIK. Having been, as you know, Senator, chairman of the Oversight Committee last year I requested your office to let the staff have access to some audit papers on home health care. Mr. Cardwell wrote me back a two-page letter telling me why the Social Security Administration could not give me these audit papers. Then yesterday I heard the Senator say that the law you cited to me was not intended to apply to Congress. Then I discovered that the documents that I wanted were given to Mrs. Souza's lawyers under the freedom of information proceeding [laughter]. The violators seem to have more access to the records than the investigators and I feel like I am stonewalled. I feel this was kept from us because we were on the trail, as you know, and we wanted to see the important documents.

What have you got to say about that? Did you change your mind about the letter I got from Mr. Cardwell, that two-page letter that

explained to me why my committee staff could not have access to these working papers?

Mr. TIERNEY. Not at all. I would like to explain, Mr. Vanik, a lot of things happened yesterday but we didn't change our mind. HEW I mean.

I would hope that Mr. Vaughan, Mr. Martin, and Mr. Halamandaris would agree that the Bureau of Health Insurance did everything it could to cooperate in every way in providing everything it could in this case. When we finally got down to the question of the working paper backing up the audit done by the intermediary, for better or worse, our HEW General Counsel said that under the law we cannot disclose the names in those workpapers. So the letter was written to you, Mr. Vanik, saying first of all we would be glad to turn over the papers with the names deleted; second, that this was general counsel's opinion and if the committee's counsel wanted to sit down with them and fight it out, that would certainly be appropriate; and third, that if the committee, as a result of its own investigation had developed the names so that it was not a case of our disclosing, which our attorney said we could not do, that would be fine, but nothing came of that.

Now when these people filed their demand for these documents under the Freedom of Information Act——

Representative VANIK. I want to recall that I have had some bad experience on that with the Administration because I had a situation where the Internal Revenue Service Director would not give us records under the Freedom of Information Act but gave the whole Government's case to a person who was indicted for tax evasion. I am wondering, who does the agency work for? It seems to be a defendant's agency and that was my problem with IRS and apparently that has been my problem with your agency. What about the plaintiffs, the people? What is our right to access? We do it in their name. They do it to protect their resources. I think the stretch should be made in behalf and in support of the investigation.

Mr. TIERNEY. I just have no argument with you. When the Social Security Act was enacted, as you well know, there was great concern about the privacy of people, beneficiaries and their earnings records. The Congress wisely wrote into the law provisions that would protect the privacy of information in Social Security files. Now 40 years later the situation has changed and we have all kinds of different people—doctors, lawyers, and others, certainly never intended to be protected by those provisions but there stands the law.

Now I know that the regulation which interprets section 1106 is being reviewed by the Department right now and I am quite sure it is going to be liberalized. While the decision in this situation sounds, I am sure, bureaucratic, it nevertheless represents the General Counsel's considered interpretation of the law.

Representative VANIK. You know, what puzzles me is that these discretions, this is what we are talking about, the discretion to act or not to act to provide the information or to hold it, if you are going to have a doubt it seems to me it should be resolved in the public's interest and I don't know that you have to worry too much

if we have that sort of an approach. I want the public's access to really be equal, not less than anyone else's but equal.

I have one other question, Mr. Chairman.

Do you believe that BHI officials should moonlight or be permitted to take consulting fees from anyone who is a provider or working for providers under the medicare/medicaid program? Have you encountered any BHI officials taking such consulting fees or having their expenses picked up by providers?

Mr. TIERNEY. Well, the answer to that first question is no. I agree that that is not acceptable. As to your second question I am not aware of any such situation.

Representative VANIK. You don't know.

Mr. TIERNEY. Wait a minute. You have clipped me enough, Mr. Vanik.

There may have been situations in which people in the Bureau of Health Insurance, maybe people in the Social Security Administration or in the Department of Health, Education, and Welfare who may have had their transportation costs paid for addressing a national association meeting or something of that kind. You can always argue about is that good or bad. I don't think it is very good since these usually are private organizations. If it is a big national association you can still argue about that but it may be less questionable than other situations. I never have known of anybody in BHI to ever accept any kind of a fee for moonlighting or to do more than perhaps make a mistake in letting somebody pick up a dinner check or something of the sort.

Representative VANIK. I am talking about a specific provider. You don't know of any cases in which this would have been done for a special single provider?

Mr. TIERNEY. I know that in the record in this situation, Mr. Vanik, that there is a gentleman who works with BHI who was on government business from Baltimore to Colorado Springs and who as I recall it, on a weekend was offered a position by this organization. So without claiming any per diem and by taking annual leave and doing all those things appropriately he did fly from Colorado Springs out to California, had the interview according to the gentleman, quickly decided he was not interested, flew back to Colorado Springs, got on the plane and flew home to Baltimore. That is one.

Now there are a couple of other allegations I am told about people's names appearing on luncheon checks and one thing or another. I know that the one individual whose name was brought to my attention was not even in California when it was alleged he was there.

Now if there were any BHI people involved in what the last witness was talking about, I would plead with this committee to let us know. I don't want to sound like a Simon Pure but I think one thing we hopefully have convinced the American people about, Mr. Vanik, is that there is no crook in the Bureau of Health Insurance and if there ever is I hope we will all disclose it very quickly.

Representative VANIK. Well, I just want to report to you that

I understand that our staff has picked up at least two other situations in this one case so——

Mr. TIERNEY. I might ask you if it is possible for your staff to tell us about those and I will be very happy to give you a total investigation.

Representative VANIK. Well, I am certain that that will be disclosed during the course of the progress of this hearing.

Thank you very much.

Senator CHURCH. You will be so informed.

What is the present annual cost of medicare?

Mr. TIERNEY. You mean benefit, total program?

Senator CHURCH. Yes.

Mr. TIERNEY. I think we estimate for fiscal 1977 close to $22 billion, Senator. I would like to give you the exact figure.

Senator CHURCH. Do you have any figures as to the number of annual patients that the program now covers?

Mr. TIERNEY. Now I get a little——

Senator CHURCH. You know what I am getting at. How many people?

Mr. TIERNEY. There are around 8.5 million inpatient hospital admissions under the institutional part A expenditures. As I said before, there are over 94 million services performed under part B. Now that does not mean there are that many claims; five or six might be submitted in one claim. If I may, I would like to give you the exact figure.

Senator CHURCH. Our figure here is about 24 million beneficiaries, all services considered.

Mr. TIERNEY. You mean that is the number of people who get some benefit?

Senator CHURCH. No.

Mr. TIERNEY. I am surprised at that.

Senator CHURCH. No, no. The 24 million people is the number covered and entitled to benefits. You say that about 8.5 million are hospitalized in the course of a year.

Mr. TIERNEY. Yes, sir. Again I would like to give you the exact figures. You have to remember that under part B there is a deductible.

Senator CHURCH. Yes.

Mr. TIERNEY. So that there are or were, and I think I could estimate, 10 million people who exceed the deductible and get medicare payments. Of course all of them are covered.

Senator CHURCH. Yes. So with 9 to 10 million receiving benefits in a year's time in a program that is costing $22 billion a year, medicare has referred, according to our statistics, about 741 cases to the Justice Department since 1969.

Mr. TIERNEY. That is right. I might say, Senator, that is the result of over 40,000 investigations of allegations of fraud and abuse since the program started. That means there are a lot of things that some old lady or some person comes into a district office and says, "I don't think this bill is right," but nevertheless we run that down.

Senator CHURCH. I think the point is that with a program as mammoth as this you are quite right when you say that there will

be no way that it can be policed to the point where all of these frauds will ever be detected. Therefore, I think we must find a method for administering this program that puts the incentive on the side of honesty and which somehow gets us away from the present dilemma which has been described several times over in the past 2 days where the Government pays on a kind of cost plus basis and where every incentive is to maximize the cost.

Now we just have to find some other way of doing it and I don't know what it will be but I do know that the legislation that is presently being proposed as a remedial falls so far short of this problem that we ought not to get up our hopes that much will be accomplished with it. I think it does not begin to address the magnitude of the problem that faces us.

At this point I would like to have the statement of Representative Pepper put in the record.

[The statement of Representative Pepper follows:]

STATEMENT OF REPRESENTATIVE CLAUDE PEPPER, CHAIRMAN, HOUSE SELECT COMMITTEE ON AGING

As chairman of the House Select Committee on Aging, I am pleased to have the opportunity to express my views on the timely and important topic of fraud and abuse among home health agencies.

The integrity of the health care system in America is dependent to a great degree on our efforts in Congress to eliminate even the appearance of fraudulent or abusive activity in federally supported or endorsed health care programs. American taxpayers and all who benefit from Federal or federally assisted health programs deserve to know that these programs are the best we can provide in our effort to insure every American of good health care at a decent cost. I commend the efforts of my colleagues on these two important committees of Congress who are endeavoring to address the important and complex issue of fraud and abuse in home health programs.

I continue to believe that home health care must be a vital component of our American health care system, providing services which are at the same time more personal and individual and cost efficient, as well. Experts are in agreement that home health care will be less costly than institutional care at lower levels of impairment. Care for those with low disability is significantly less expensive in their homes than in even the lowest level of institutional care.

The area of home health care has been studied for many years. In 1974, the General Accounting Office reported to the Congress that home health care—while not a substitute for appropriate institutional care—is generally a less expensive alternative when such care would meet the patient's needs. The GAO reported that several studies focusing on savings realized by early transfer of patients from hospitals to home care programs have pointed out that such care can be less expensive than institutional care.

The Department of Health, Education and Welfare has recognized the need for alternatives to institutional care and has funded projects to study this area. In 1975, the General Accounting Office reported in its review of twenty studies dealing with the cost of home care that nineteen presented data which supported the proposition that home health care can be less expensive under some circumstances than alternative institutional care. I firmly believe that expanding the availability of home health care is important to the well-being of older Americans, and for that reason I have introduced a number of proposals whose aim it is to make home health care more generally available so that institutionalization of the elderly can be the exception, rather than the rule it has become. Implicit in my proposals is acknowledgement of the fact that any health service which is financed in whole or in part by the Federal Government must be financially sound.

I am gratified that the authors of H.R. 3, the Medicare-Medicaid Anti-Fraud and Abuse Amendments, Congressmen Rogers and Rostenkowski, have included in this important legislation two proposals I have advanced. The first is the requirement that providers and suppliers under both Medicare and Medicaid

disclose, upon request, ownership interest of 5 percent or more. Congressman Edward Koch and I proposed disclosure in H. R. 453, which has 68 additional cosponsors. It also was recommended by the Subcommittee on Health and Long-Term Care, which I also chair, and by the full Committee on Aging last year. It is imperative that operations which involve Federal funds be carried out in the broad daylight.

Second, the authors of H.R. 3 included my proposal for a requirement reaffirming the clear intent of Congress that Medicaid be the payor of last resort where third parties such as insurance companies and auto no-fault insurance programs have an obligation to pay. This in the intent of my bill, H.R. 1128, which has been cosponsored by 64 of our colleagues.

The Social Security Act requires each State to take all reasonable measures to determine the legal liabilities of third parties to pay for covered medical services. The Department of Health, Education and Welfare estimates that between $200 and $500 million could be saved each year through a vigorous program of collecting from liable third parties. Yet HEW State audit agency reports have proved that recovery programs by the States are sadly lacking. And several States have enacted laws, primarily automobile no-fault insurance programs, which serve to make Medicaid the primary payor, rather than the payor of last resort as intended by Congress.

Medicaid costs the States—not just the Federal government—a great deal of money. The States should recognize that it is in their own interest to seek out other parties which have responsibility to pay for medical services that otherwise deplete State budgets. I have urged, and will continue to urge, that HEW emphasize the necessity that States comply with this important legal requirement.

It is my expectation, and my hope, that this legislation will be enacted with the greatest possible speed.

H.R. 1116, which I introduced on January 4, 1977, and which is cosponsored by 73 of my colleagues in the House, includes a number of provisions which would assure the integrity of home health agencies and prevent opportunities for abuse or fraud. Means of achieving control over the quality of performance of home health service providers would be improved by amending the definition of "home health agency" in section 1861 of the Social Security Act to require home health service providers to have in effect a utilization review plan along the same lines as those now required of hospitals and skilled nursing facilities. This would assure that periodic assessment of need is carried out to provide for the most efficient use of scare resources. The Secretary would be given authority to make appropriate changes in regulations that would take into consideration the non-institutional character of home health service providers.

Another change proposed by my bill, H.R. 1116, would require an annual audit of the financial statements of home health service agencies by a certified public accountant as a basis for cost-related reimbursement. The auditor's opinion would state that expenses of the agency are in conformance with allowable expenditures as authorized in HEW regulations and guidelines. This would ensure that the financial statements are accurate, but even more importantly, that the costs claimed in the financial report are legitimate, honest costs invovled with providing health services. This is an important concept and one which deserves the careful consideration of the Committees of the Congress.

To conform other sections of the Act affected by the proposed changes, provisions in the Social Security Act dealing with duties and functions of Professional Standards Review Organizations would be amended to make it clear that nursing homes, intermediate care facilities and home health agencies, as well as medical institutions, are to be routinely subject to review by such professional organizations. Moreover, another provision of this bill would require the inclusion in Professional Standards Review Organizations of nurses, social workers, guidance counselors, and other health professionals as well as physicians

Further, my bill proposes to supplement that section of the medicare law which defines reasonable cost by adding a provision that "payment with respect to services provided by hospitals, skilled nursing facilities and home health agencies shall to the maximum extent practicable be on a reasonable cost-related basis". A similar provision is included in H.R. 1126, which I also introduced on January 4, 1977, and it provides that the Federal requirement for State medical plans that makes it necessary for States to pay "for skilled nursing facility and intermediate care facility services provided under the plan on

a reasonable cost-related basis," after July 1, 1976, shall also apply to "nursing homes, health agencies and other long-term care providers".

I believe we should encourage the concept of cost-related payment to all health care institutions under both medicare and medicaid. In the 92nd Congress, the Senate Finance Committee expressed concern that in the absence of statutory requirements, some long-term care facilities were being under-paid by Medicaid while others were over-paid. Section 249 of Public Law 92-603, requiring reimbursement on a reasonable cost-related basis, resulted from that concern. I believe that we should expand this concept. Not only will it save money, but it will also give the assurance that adequate funds are provided to support a high quality of patient care in health care institutions. I believe we must emphasize this goal in all our future deliberations.

I believe that proposals such as those I have outlined are central to our efforts to assure the integrity not only of home health care providers but indeed of all sectors of our health care system.

Congress and the Administration must let it be known that we will not tolerate fraudulent or abusive activity by those who are fortunate enough to participate in federally financed health care programs. We must act, in the ways I have described, and in others deemed to be necessary, to tighten applicable laws and regulations and to maintain adequate oversight so that opportunities for such activity are not available.

However, I strongly believe that we must guard against giving the impression that we are less than supportive of the concept of home health care as an essential, indeed the most natural, component of health care delivery. The Subcommittee on Health and Long-Term Care has given a great deal of study and attention to both the philosophy and the practice of providing health services in the home for those who do not require the full-time attention of skilled health professionals. A Subcommittee report of January, 1976 entitled "New Perspectives in Health Care for Older Americans: Recommendations and Policy Directions" revealed some of our findings on this subject. For example, a January 1975 study contracted by the Department of Health, Education, and Welfare cited figures indicating that between 144,000 and 260,000 persons, or between 14 to 25 percent of the approximately one million elderly persons in skilled and intermediate nursing homes, may be "unnecessarily maintained in an institutional environment." As further evidence of the extent of over-institutionalization the Subcommittee heard from Dr. Robert Morris who testified in behalf of the Levinson Gerontological Policy Institute of Brandeis University that depending on the area of the country which was examined, unnecessary institutionalization ranges from 10 percent to 40 percent. These figures represent persons who have been placed in long-term care institutions because there were no alternatives available to them.

In addition, my Subcommittee has collected evidence that there are from two to three million non-institutionalized aged persons who are bedfast, homebound, or have difficulty in getting outdoors without help. Moreover, the National Council of Senior Citizens estimates that one out of six older Americans who do not reside in institutions need help in social services if they are to be able to remain in their homes. These facts tell us that we need to take a long and hard look at how Federal policies may contribute to what has become the national rule, rather than exception, of placing older people in institutions whether or not it is actually necessary.

I quote from this Subcommittee report: "It is a tragedy of our times that we as a nation should find ourselves in the position of thinking of home health care for the elderly as an alternative to institutionalization. Somehow, it shocks the conscience and goes against the grain to deal with the subject in that context. It only stands to reason that in the natural order of things it should be just the reverse. Institutionalization should be an alternative to home health care.

While there will always be highly disabled patients who require full-time institutionalization in nursing homes, persons capable of remaining in their own homes should have the right to choose.

That is why I have proposed legislation to expand coverage of home health care under the medicare and medicaid programs. Essentially my proposals would strike the requirement for prior hospitalization under Part A and eliminate the limit currently in the law of 100 home health visits following discharge from the hospital or skilled nursing facility. My proposed legislation would also amend Part B of medicare to broaden home health coverage. Part

B would be amended to strike out language that limits coverage to 100 home health visits and provide instead that home health coverage is available under Part B to the extent that it is not available under Part A without limit. Limitations in Part B that restrict home health coverage to not more than 100 visits a year would be repealed.

H.R. 1126 would amend Title XIX of the Social Security Act (medicaid) to include an expanded definition of home health services that would qualify for medicaid coverage. This expanded definition of home health services would make medicaid funding available for nutritional counseling, professional guidance and personal counseling, periodic chore service, and hospital outreach services.

There merely are general descriptions of the proposals I have introduced, and which I believe merit the careful consideration of the legislative committees of the Congress. The provisions I have described are but a small portion of the proposals I have introduced to address what I believe to be the serious needs of older Americans.

But I hope that my remarks have indicated clearly my deep concern that our efforts here not jeopardize in any way the work that currently is underway to expand vitally needed home health services for the benefit of all Americans.

In summary, I commend my colleagues for undertaking this most valuable effort to detect and address fraudulent activities which could in the future impair our ability to deliver home health services to those who desperately need them. At the same time, I urge that you give equally needed emphasis to the priority of expanding home health services to address the vast unmet need which exists.

Senator CHURCH. I would also like to include in the record and then I am going to have to leave and other members may have questions to ask—I will turn the remainder of the hearing over to others who want to ask you further questions—we have a letter here addressed to Herman Talmadge written by H. Eugene McNease of the Regional Commissioner's Office of External Affairs in Atlanta, making a further complaint that when cases are turned over to the Justice Department there is a great reluctance to prosecute such cases.

I think one of our real afflictions in the series of hearings we are now conducting brings it out it is a white collar fraud in this country, white collar embezzlement, involving business people and professional people. Since it is quite a different thing than ordinary street crime and frequently prestigous people in the community are involved there seems to be not only a failure to adequately police the system against their transgressions but also to prosecute once cases are finally referred to the Justice Department.

So without objection I will include this letter in the record together with the investigative memorandum pertaining to the case of Peter Gottheiner.

[The letter follows; the investigative memorandum appears in appendix 1, p. 1105.]

REGIONAL COMMISSIONER'S OFFICE
OF EXTERNAL AFFAIRS,
Atlanta, Ga., February 2, 1977.

HON. HERMAN TALMADGE,
Russell Senate Office Building,
Washington, D.C.
(Attention of Russell King).

DEAR SENATOR TALMADGE: I was a Program Integrity Specialist for the Bureau of Health Insurance, Social Security Administration, for four years until July 1976 when I asked to be transferred. I am currently working in the Congressional Inquiry section of the Atlanta Regional Commissioner's Office.

I asked to be transferred because I became indignant and dismayed with the Justice Department and frustrated with the Bureau of Health Insurance. In case after case U.S. Attorneys failed to prosecute violators of Medicare laws vigorously while the Bureau of Health Insurance stood idly by. Allow me to briefly review four cases that illustrate my point.

I investigated a case in Asheville, North Carolina in which three related doctors cheated Medicare out of at least $34,000.00. I presented the case to the U.S. Attorney in Asheville who delayed the case and finally refused to present the case. They referred the case to Washington who sent it back with a recommendation to prosecute civilly. Upon the recommendation of the Bureau of Health Insurance Atlanta Regional Program Officer a settlement for one quarter of the $34,000.00 was agreed upon.

I investigated Dr. O. B. Crocker, M.D. and Calhoun County Hospital of Bruce, Mississippi. Dr. Crocker and his family owned and operated the hospital through a non-profit corporation. In filing the annual hospital cost reports Dr. Crocker included family and personal expenses for reimbursement by Medicare. One significant cost item was the remodeling of Dr. Crocker's son's law office. The family and personal expenses included as hospital expenses reimbursed by Medicare totalled $66,000.00 for four years. The U.S. Attorney's office in Oxford held my investigative report over six months until Dr. Crocker died. Although three other persons were implicated, the U.S. Attorney declined to prosecute anyone. He never even presented the evidence to a Federal grand jury for their consideration.

My investigation of Dr. William J. Wheeler of Wilmington, North Carolina revealed 30-40 counts of filing false Medicare claims. The Raleigh U.S. Attorney's office brought a ten-count indictment against Dr. Wheeler but did not pursue the prosecution of the case for almost a year. Meanwhile the witnesses because of pressure from Dr. Wheeler and advanced age became incompetent. The U.S. Attorney's office finally agreed to a plea of nolo contendre to five misdemeanor counts. The judge fined Dr. Wheeler a small sum and suspended his sentence. He is continuing to practice in spite of recommendations that his license be revoked.

I conducted an investigation in Tampa, Florida disclosing the following: a kickback scheme between Feegle & Howard Doctors Lab and numerous medical doctors, osteopaths and chiropractors in four counties; a kickback scheme between Feegle & Winkle Respiratory Services and South Florida Baptist Hospital; and the filing of false Medicare claims for X-rays, lab tests, and pulmonary function studies by Medicare in Motion, Feegle & Howard Lab and F&W Respiratory Services respectively.

Upon my direction a Federal grand jury heard testimony covering all these violations. However, due to delay in the U.S. Attorney's office, this grand jury disbanded without handing down any indictments.

I was allowed thirty minutes to present the case to a new grand jury in April 1976, ten months after my investigation began in July 1975. Upon the recommendation of the U.S. Attorney's office four individuals were indicted—three of whom were insignificant participants, while none of at least twenty doctors implicated were touched. Particularly significant is the fact that Dr. John R. Feegle, the one person who was most significant in all these schemes, was not prosecuted, indicted, nor subpoenaed for questioning. I objected to this obvious special treatment. I was accused of misconduct and thrown off the case by the U.S. Attorney's office. I was subjected to unfounded accusations and harassment. My career as an investigator was destroyed. But most significant, the case was not prosecuted properly.

As a government agent investigating white collar crime, I have come to expect name calling and mud throwing from defense attorneys. This is part of the game. But I was shocked when the U.S. Attorney's office used this tactic against me. This does not speak well of anyone but its use by the Justice Department against a Federal agent is frightening.

It is important to realize that stronger penalties will not solve the problem. There must be a strong resolve to investigate and vigorously prosecute all violators whoever they are.

The protection of the integrity of these health programs is not the only problem. Health care is already the Nation's second largest industry and growing as fast as any segment of our economy. National health insurance in some form is certain to become a reality. Therefore, it is paramount we develop better means of conveying health care and particularly medical care to the public.

I believe this can only be accomplished through cooperation between government entities and the medical community. In fact leaders of the medical community should take the initiative in solving problems of conveying medical care to the public and reimbursement for these services. If they do not, the government must.

The most significant problem we face is cost. Health care in general and medical care in particular demand an ever increasing share of our consumer dollar. Today's costs after Medicare exceed the entire cost of health care prior to Medicare in 1965. Therefore, the impact of spiraling health care costs is obvious. The impact is sharpest on senior citizens who need health care more but can afford it less. More significantly, spiraling health care costs make it mandatory to have third party payers for all segments of our population. This inevitability must be met with expertise to assure quality care for the patient and to prevent abuse and fraud by providers.

Another problem is a growing disparity between health care available for the affluent citizen and that available to the poor citizen. Young doctors looking for medical practices are drawn to areas where the people are younger, healthier and more affluent. They find medical practice in these areas is less demanding and more rewarding monetarily than practice in urban ghettos or depressed rural areas. Therefore, the gap continues to grow broader as medical expertise becomes less accessible to those who need it most. We must change our system to make it more desirable for doctors and hospitals in depressed areas. A system that will convey equitable medical care to all segments of our population must be developed and implemented.

These are some of the problems we face. There are many others! The question of the hour is—who is going to take the initiative? I hope the medical community will act on its own volition but experience has shown this is not likely.

Therefore, the government must provide the leadership. I propose the following: a government-funded research and training program. This program should have two purposes: to train doctors and medical support personnel at government expense who will serve in depressed areas, and to search for new management techniques, new technology, and better utilization of medical facilities and expertise in order to provide quality health care to all while controlling costs and eliminating wastes.

I believe such a program would show the way. It would enable us to take an objective look at our present systems of delivering health care and reimbursing providers of these services. We must place the incentive on getting the patient well as opposed to keeping him sick. We must develop minimum and maximum standards of treatments according to valid diagnoses. We must find a system to prevent the tremendous duplication of tests and services now accepted as routine in the medical community.

In conclusion let me say, bigger government cannot solve the problems without the cooperation of the medical community. It must show an intensified concern to seek solutions and greater willingness to implement these in the day-to-day care of patients. The time has come for doctors to come down off their individual pedestals and work together. It is time the science of medicine was exposed to the scrutiny of independent research. It is time the practice of medicine was exposed to independent investigations. Realizing this is a new and drastic step, we must have patience but perseverance.

Respectfully yours,

H. EUGENE MCNEASE.

Senator CHURCH. I turn the hearing over to Members of the House who have further questions to ask.

Mr. TIERNEY. Sir, may I——

Senator CHURCH. I apologize for having to leave.

Before I leave, what is it you would like to say?

Mr. TIERNEY. I knew of this letter. I think in fairness to the individuals and to the Justice Department I should say that there is a written statement about that letter, and I would like to have it submitted.

Senator CHURCH. Yes. If you have any statement or if there is a

statement on the part of the Justice Department in reply to the letter, that statement, too, will be included in the record.

[The statement referred to follows:]

[Testimony resumes on p. 1091.]

REPORT TO THE DIRECTOR, BUREAU OF HEALTH INSURANCE, SSA, FROM THE REGIONAL MEDICARE DIRECTOR, ATLANTA

Subject: Senator Talmadge's letter dated February 15, 1977, re allegations of Mr. H. Eugene McNease, former program integrity specialist, BHI, Atlanta.

We appreciate the opportunity to comment on Mr. McNease's letter of February 7, 1977, to Senator Talmadge. Mr. McNease's comments are for the most part unfounded and biased. We are extremely pleased with the cooperation of the Justice Department in this region, and with their prosecution efforts on medicare cases in the majority of instances. We disagree with most of Mr. McNease's comments on the four cases which he cites, and categorically disagree with his allegations about inappropriate handling of cases by Justice.

We characterize Mr. McNease as a sincere but misguided, disgruntled former employee who is somewhat bitter over his lack of success as an investigator. His inadequate performance apparently stemmed from an inability to perceive true facts and make judgments on the establishment of evidence in complicated medicare cases. Mr. McNease implies in his second paragraph that his transfer request was wholly on his own initiative based on dissatisfaction with Justice and BHI. In part, at least, his transfer request was in response to our dissatisfaction with his performance and conduct.

With reference to the case in Asheville, N.C. (Appalachian Hall Hospital and Doctors William R., Mark and Robert A. Griffin) Mr. McNease's statements are either misleading or incorrect. Mr. McNease did investigate this case, and his work did establish fairly conclusively that false claims had been filled out by personnel employed by the doctors and the hospital. The disputed services on the claims were services rendered by medical social workers, but billed as physicians' services. However, the claims were submitted on an unassigned basis; i.e., the suspects did not file the claims and did not receive the medicare payments. The claims were submitted by the patients and medicare reimbursement went directly to the patients. The doctors and the hospital filed no claims and received no payments. This was the most significant weakening factor in the criminal case. The U.S. attorney gave every consideration to prosecuting this case, but the Justice Department in Washington ultimately made the judgment that the case lacked prosecution merit due to weakening factors. We agree with Justice's judgment that this case is not worthy of criminal prosecution.

The $34,000 figure Mr. McNease uses is incorrect. A recent onsite audit established that the incorrect payments were approximately $23,000. However, offsetting to this to some extent is the allegation by the doctors that they did not bill for services which they rendered personally to medicare beneficiaries. They would have been entitled to such medicare reimbursement if they had filed claims. We believe that the appropriate amount of offset is approximately $5,000 which would make the overpayment approximately $18,000.

Nobody in this office has recommended a settlement of this case, and no settlement has been agreed upon to our knowledge. Justice is considering an offer in compromise from the suspects of $9,276. Additional information has been requested before a decision on acceptance or rejection is made.

In his comment about the O. B. Crocker, M.D., case, Mr. McNease insinuates that the U.S. attorney "held" his investigation report over 6 months until Dr. Crocker died. This is patently ridiculous. No one anticipated Dr. Crocker's death. The fact is, Mr. McNease and his supervisor met with the U.S. attorney and the U.S. attorney indicated he would seek an indictment. The case was dropped only because of Dr. Crocker's death. Three other persons were implicated, but their culpability was not established, and could not have been, in our opinion. We satisfactorily resolved the case administratively. Mr. McNease participated in this resolution.

We are very pleased with the outcome of the William J. Wheeler, M.D., case. The U.S. attorney did not intentionally delay the case as Mr. McNease implies. The reason the U.S. attorney brought a 10-count indictment, according to the assistant in charge, is that when he and Mr. McNease interviewed the poten-

tial witnesses Mr. McNease had developed, many of them did not recognize Mr. McNease. In many of our cases our aged beneficiaries deteriorate as witnesses, and were particularly weak in this case. Under these circumstances we believe plea bargaining was appropriate. Dr. Wheeler was fined $5,000, not "a small sum" to us.

The fourth case (Winkle) was not properly developed by Mr. McNease. He would have you believe that "upon my direction" testimony was presented to a grand jury. Of course, the Justice Department directs such activity. The grand jury term did end without an indictment, but only because it did not hear sufficient evidence to indict. This was not due to intentional delays as Mr. McNease asserts.

The individuals indicted were not "insignificant participants" as Mr. McNease asserts. The doctors implicated were not sufficiently culpable to sustain an indictment. Mr. McNease failed to develop sufficient evidence against them during his investigation.

Dr. John R. Feegle was not indicted because there was no viable evidence against him. Mr. McNease never has understood the inadequacy of his investigation in this respect.

There was absolutely no casual relationship between Dr. Feegle and Mr. McNease's dismissal from the case as he has implied, but there were several reasons why we removed him from this case. In general, the situation had become untenable because the U.S. attorney no longer had confidence in his work and requested his removal. The U.S. attorney found that he could not rely on Mr. McNease's investigative findings. Mr. McNease failed to investigate areas requested by the U.S. attorney. Secret grand jury information found its way to the press and Mr. McNease was suspected of being the source. Many potential witnesses were not interviewed, and they should have been.

Mr. McNease befriended a primary witness and potential suspect beyond reasonable bounds. He confided in this witness and socialized with him. This situation created the defense argument that the witness was prejudiced, and almost destroyed his effectiveness. Mr. McNease depended on this witness to the exclusion of other potential witnesses and to the detriment of the case. His personal conduct became an additional point of contention; he dated the defense attorney's secretary, thereby creating a question of impropriety by the Government.

In the final analysis Mr. McNease was discharged from the case about 3 weeks before trial because of his inadequate performance and misconduct. Because of this, serious consideration had to be given to dropping the indictment. However, two other BHI investigators did a 3-week crash job of completely reinvestigating the case, and after a 2½-week trial, Ernest Winkle, the primary suspect, was found guilty of 19 felony counts and was later sentenced to 5 years in prison. We and the U.S. attorney's office worked long hours to achieve this success in spite of the poor job done by Mr. McNease.

As you know, as of December 31, 1976, the Atlanta region has achieved 50 convictions out of 220 nationally and leads the Nation in convictions. The record speaks well for the overall cooperation and prosecutive efforts by the Justice Department.

The Tampa U.S. attorney's office is the focal point of Mr. McNease's displeasure. That office has accomplished 11 of Atlanta's 50 convictions. On another case involving home health care, an assistant U.S. attorney has devoted a substantial portion of his time for almost a year. Office space and secretarial help have been provided our two investigators on the case. We enjoy especially good relations with the Tampa office and are justly proud of our joint accomplishments there.

Our personnel frequently receive complimentary letters from U.S. attorneys after successful prosecutions. The attached letter from Bernard Dempsey, a former assistant U.S. attorney (who, incidentally, prosecuted two medicare cases), marks the first time we've received such a letter from a defense attorney. His comments about Mr. McNease are appropriate to this situation.

Of course, we can do nothing about sentences as Mr. McNease implies in his comments on Dr. Wheeler, but the attached list of Atlanta convictions illustrates that, with experience in these cases, the courts are giving more meaningful sentences.

So, our final assertion is that neither we nor the Justice Department stand "idly by" as Mr. McNease suggests.

If you need further details or additional information, please let me know.

TABLE VI.—STATUS OF SUSPECTS RECOMMENDED FOR PROSECUTION AND DEFENDANTS AS OF DEC. 31, 1976

Regional offices	Submitted to Justice Department			Prosecution declined			Decision pending U.S. attorney		Prosecution undertaken			Convictions			Acquittals			No pros and dismissals			Pending trial	
	C	Y	Q	C	Y	Q	Total	0/6	C	Y	Q	C	Y	Q	C	Y	Q	C	Y	Q	Total	0/6
Boston	54	20	[1] 19	12	2	[2] 2	26	7	16	14	[3] 7	4	3	1	0	0	0	3	2	[2] 2	[1] 9	5
New York	122	44	[1] 23	32	7	3	46	18	44	19	11	24	12	7	3	0	0	4	0	0	13	0
Philadelphia	99	21	4	30	2	2	14	9	55	14	3	42	7	0	3	1	1	4	0	0	6	0
Atlanta	103	25	[1] 9	11	0	0	26	12	66	17	[3] 6	50	18	[1] 7	10	5	2	6	2	0	0	0
Chicago	[3] 99	40	2	7	0	0	51	51	41	20	5	32	19	13	3	1	0	4	2	2	2	0
Dallas	67	9	[1] 2	21	6	0	9	6	37	5	4	25	3	1	3	0	0	5	0	0	4	0
Kansas City	35	14	2	19	7	2	10	7	6	0	0	5	0	0	0	0	0	1	0	0	0	0
Denver	12	1	1	5	0	0	2	1	5	0	[3] 1	5	1	1	0	0	0	0	0	0	0	0
San Francisco	24	42	32	40	4	0	33	7	51	17	12	29	6	0	5	0	0	4	4	0	13	0
Seattle	31	21	[4] 2	7	1	[3] 1	18	5	6	3	1	4	2	1	0	0	0	0	0	0	2	0
National	[3] 746	237	[1] 96	184	29	[1] 10	235	123	327	109	[1] 50	220	71	[1] 31	27	7	3	31	10	[1] 4	[1] 49	5

C=Cumulative total.
Y=Total in calendar year.
Q=Total in report quarter.
0/6=Total pending more than 6 mos.
[1] Includes suspects/defendants not reported/recorded in prior quarters. (See table IV, full scale investigations, prosecution recommendation column for number of referrals this quarter.)
[2] Consists totally of suspects not reported/recorded in prior quarters.
[3] Reduced by 5; adjustment in chain organization referral figures.
[4] One referral incorrectly reported last quarter as synopsis.

REGION IV—ATLANTA—CONVICTION LIST

Defendant	Date convicted	Sentence	State
1. Conway, John W., M.D	Aug. 18, 1969	3 yr probation; fine: $1,000	Mississippi.
2. Cunningham, Roy P., M.D	Dec. 18, 1969	8 yr imprisonment, all but 90 d suspended; 5 yr probation.	South Carolina.
3. Chakmakis, Apostolos, D.O	Oct. 22, 1970	120 d in jail	Florida.
4. Evans, Frank E., D.S.C	Jan. 25, 1971	2 yr probation; fine: $1,000	Do.
5. Strong, Odis, M.D	Feb. 10, 1971	2 yr prison; fine: $16,150	Tennessee.
6. Katz, Harry, M.D	Apr. 23, 1971	2 yr prison; fine: $2,000	Florida.
7. Armadio, Alex, M.D	do	3 yr suspended; fine: $1,000	Do.
8. Katz, Allen D.O	June 3, 1971	60 d suspended; fine: $2,000	Do.
9. Israel Armand, D.P.M	Oct. 2, 1971	6 yr suspended; fine: $6,000	Do.
10. Frisby, Noble, M.D	Nov. 1, 1971	2 yr probation; fine: $2,000	Mississippi.
11. Corum, Paul E., M.D	Nov. 5, 1971	2 yr suspended	Kentucky.
12. Shelnut, Mary	Aug. 8, 1972	4 yr suspended; fine: $5,000	South Carolina.
13. Waddel, Florence	do	do	Do.
14. Hubbard, R. C., D.P.M	Jan. 2, 1973	do	Florida.
15. Anderson, Donald P., M.D	May 17, 1973	5 yr probation	Do.
16. Statham, John F., D.D	July 18, 1973	1 yr suspended; fine: $2,000	Do.
17. King, Weil S., N.D	do	1 yr suspended; fine: $1,000	Do.
18. Mekjian, Jack, D.O	Oct. 10, 1973	15 d imprisonment—2 yr probation; fine: $5,000.	Do.
19. Korach, Shlomo	Nov. 28, 1973	30 d in jail; fine: $10,000	Do.
20. Ricks, R. L., M.D	Nov. 19, 1973	2 yr probation; fine: $2,000	Georgia.
21. Follette, L. S., M.D	do	do	Do.
22. Belcher, Pat E., D.C	do	do	Do.
23. Adamson, Charles L., D.C	do	do	Do.
24. Bateson, Edward M., D.C	do	do	Do.
25. Daum, Delmar, D.C	do	do	Do.
26. Bateson, Robert G., D.C	do	do	Do.
27. Smith, Oakley	Feb. 25, 1974	75 d in prison; fine: $7,500	Florida.
28. Chasin, I. S., D.P.M	Mar. 1, 1974	2 yr probation; fine: $5,000	Georgia.
29. Brown, W. E., M.D	Aug. 26, 1974	3 yr probation; fine: $5,000	Mississippi.
30. Holt, George F., D.P.M	Nov. 8, 1974	30 month suspended; fine: $10,000	North Carolina.
31. Jones, Bobby E	Jan. 3, 1975	30 mo imprisonment	Tennessee.
32. Rousseau, Ronald, D.P.M	Mar. 21, 1975	19 mo imprisonment	Mississippi.
33. Austin, Duff, M.D	May 15, 1975	1 yr probation; fine: $2,000	Do.
34. Patrick, Robert, M.D	Jan. 19, 1976	2 yr imprisonment; fine: $6,625.50	Tennessee.
35. English, Grace	Feb. 12, 1976	1 yr probation	Florida.
36. Evans, Lois A	Mar. 3, 1976	4 mo imprisonment; fine: $5,000	Do.
37. Evans, William B	do	3 yr suspended; fine: $5,000	Do.
38. Bernstain, Harold N., D.P.M	Apr. 4, 1976	60 d imprisonment; 3 yr probation	Do.
39. Wheeler, William J., M.D	Apr. 5, 1976	5 yr suspended; fine: $5,000	North Carolina.
40. Evans, Boyd D	May 7, 1976	4 mo imprisonment; fine: $10,000	Florida.
41. Campbell, Roy L	May 17, 1976	4 mo imprisonment	North Carolina.
42. Mekjian, Jack, D.O	June 21, 1976	Fine: $5,000	Florida.
43. Colmar, Alan	July 23, 1976	2 yr probation	Do.
44. Winkle, Ernest A	Aug. 17, 1976	5 yr imprisonment	Do.
45. Levin, Harold, M.D	Oct. 15, 1976	20 yr suspended; fine: $4,000	Georgia.
46. Alvin H. Servita (Flagler)	Oct. 18, 1976	1 yr, all but 30 d suspended	Florida.
47. Nelson Regnet (Flagler)	Oct. 28, 1976	1 yr, all but 45 d suspended	Do.
48. Kenneth Burdick	Nov. 12, 1976	2 yr imprisonment; fine: $45,000	Do.
49. Paul Dudley	Dec. 10, 1976	2 yr imprisonment	Do.
50. Nancy Dudley	do	6 mo imprisonment; 18 mo suspended; 3 yr probation.	Do.
51. Inrique Callmano, Jr	Feb. 10, 1977		Do.

DEMPSEY & KELLY,
ATTORNEYS AT LAW,
Tampa, Fla., August 24, 1976.

Mr. CHRIS C. MULHOLLAND III,
Social Security Administration, Atlanta, Ga.

DEAR CHRIS: Just a brief note to let you know how much I enjoyed seeing you and speaking with you during the *Winkle* trial. Although I was disappointed with the result from a personal viewpoint as an attorney, I want to sincerely congratulate you and Doug Wright for the splendid job you did in putting the case together. I know that you were faced with an extremely hodgepodge situation and you two men performed a yeoman's task in preserving and presenting the evidence.

Many things came to my attention concerning the behavior of Mr. McNease which are, to me, disgraceful and embarrassing as a former Federal employee and as a citizen. I don't wish to cause Mr. McNease any personal problems which are not of his creation, but I would strongly suggest, for the benefit of your fine organization, that he not be given responsibility to act on his own as a representative of the Government in the future. Everyone who came in

contact with him was appalled at some of the things he did and said. I hope you will believe me when I say that I have no ill will toward Mr. McNease, but I do not approve of his actions while representing my Government.

Once again, please accept my expression of admiration and congratulations for a job well done. You and Doug Wright are indeed a credit to the Social Security Administration.

Please give my regards to Bill Mote. When I am next in Atlanta and have a few hours to kill in the evening, I'll give you a call and maybe the three of us can get together for a few drinks.

With warm regards, I remain

Very truly yours,

BERNARD H. DEMPSEY, JR.

Senator CHURCH. Mr. Martin, do you have questions?

Representative MARTIN. Yes, I do. I thank the chairman.

It is good to have you back testifying before this committee. You were here just this past September 13, 1976, and according to the testimony that you gave us then you were aware of the problem that has been highlighted in these hearings not only of the fraudulent false claims, but also of the unnecessary profiting by the use of high volume business; that is, the excessive utilization of services, making far more calls than the nonproprietary company might be giving.

It strikes me that in your recommendation for legislative and administrative changes, that there is nothing that deals with that, yet that seems to be the most expensive abuse as far as Federal programs are concerned. Is it not legislatively or administratively possible to correct that?

Mr. TIERNEY. Mr. Martin, I wish I could be more helpful to the committee in this area. I don't mean to be evasive. This is an unusual and, well, it is a unique aspect of medicare. It is a great idea, home health care—don't put these people in hospitals, take care of them in their own homes. Now who can argue against that principle; it is wonderful. In a hospital there is a medical staff, utilization review, PSRO review, and other mechanisms for reviewing the quality of and need for services in the home health area, such review is a nebulous thing. I would not know how to suggest review of a home health service. I think, Mr. Martin, that some of the suggestions that the Commissioner made in his statement to the committee hold the greatest promise and that is specialization in this area by a limited number of organizations so that something eminates that really answers these problems. But it is a tough problem.

Representative MARTIN. Isn't there something in the records available to you that would raise a warning signal, that would raise an alert that one provider is providing far more house calls than is normal?

Mr. TIERNEY. Oh, sure. That really is relatively easy, if you have an aberrant situation to detect.

Representative MARTIN. No, but all you have to do is have something to alert you that there is excessive abuse and then you can examine that, you can focus, you can home in on that one provider to find out what the justification for all those calls is. It seems to me that you could do that.

Mr. TIERNEY. You are right.

Representative MARTIN. And you are aware of that problem.

Mr. TIERNEY. It is being done in all the other aspects of the medicare program and it is being done in home health care but I put

qualifications here for it is not very much. Here is a doctor that says that this man requires home care and ought to have a nurse come by once a week and that he also needs help with his catheter and this and that. Who can argue? Another doctor says he does not need that. It is tough.

Representative MARTIN. Mr. Tierney, I am sure it is. I am sure it is very tough, and certainly where you have a provider that has a small number of cases it would be difficult to base anything on statistics because there would be no statistical reference, there would be no validity to the particular numbers, but where you have the largest provider of home health care services in the entire State of California which, as we have learned yesterday and today, has made many more house calls than is normal for the industry and where it is indicated to us that from appearances that is the way in which this company can underbid competitors and yet make more money i. profit with a smaller margin bloated into a large profit by high volume use, surely when your largest providers have an excessive number of calls in total that ought to alert you to something but apparently it has not.

Mr. TIERNEY. Mr. Martin, if I could only respond to that quickly in defense of the program.

Representative MARTIN. Yes, sir.

Mr. TIERNEY. We don't contract with any agency to pay $3.50 a visit or anything. The State does that. So there is not that same factor in this situation. Out of medicare theoretically, and I won't tell you that it cannot happen, it does not do any particular good to do twice as many visits—all you get is the cost. It is not so much a visit, in other words, is all I am trying to say for the record. The State of California contracts with some of these people on a fee per visit basis.

Representative MARTIN. I beg your pardon. If there is a profit-making entity that is providing services, what is the basis of the profit? Is it not a percentage of cost?

Mr. TIERNEY. No, sir, we don't recognize in the cost formula that kind of a profit motive; we do in proprietary institutions.

Representative MARTIN. You gave them the same profit no matter how many calls they make?

Mr. TIERNEY. For the proprietary institutions generally, Mr. Martin, the law specifies that in addition to their costs they get a return on their net equity investments equal to one and a half times the return on the Social Security fund investments. Now that is a truly——

Representative MARTIN. You make 10 calls or 2, no matter how many.

Mr. TIERNEY. All the same.

Representative MARTIN. Mr. Tierney, in response to Mr. Rostenkowski's question you indicated that the first complaint against Home Kare, Inc., had come in 1970 which is about 7 years ago. At that time I believe the complaint was from a former employee, a nurse who was a former employee, that she had been offered kickbacks. In 1972 there was a charge of fraudulent costs and in reply to Mr. Rostenkowski you expressed the opinion that based on what was then available the costs seemed reasonable to you on the basis of the cost per visit.

Mr. TIERNEY. Yes, sir. I mean on the basis of a comparison between what this organization was receiving in totality, which is of course broken down to a visit or a service they were providing, they were quite reasonable.

Representative MARTIN. You would not have examined the reasonableness of those costs in terms of the large number of visits per patient. There is no reason to even look at that?

Mr. TIERNEY. Yes, and it does go on, Mr. Martin. The intermediaries have got this job of determining the reasonableness of costs and the medical necessity for services provided and many cases are turned down. As a matter of fact, in part B of the program we have got a rather horrific problem. About 78 percent of all part B bills submitted are reduced. So it is not just a case of paying everything that comes in.

I don't want to be guilty of trying to appear to be assuring you, Mr. Martin, that everything is going fine in the home health business because it is not. Among the most effective things that the Congress has done and committees like this do is to have these hearings just to call to the attention of the public the fact that here is a problem which demands attention.

Every home health agency in the country now knows there is vast concern about this. I know it is not your job to do it but I would hope that the spotlight would continue to be turned on every facet of the program which has an element of abuse in it. I really think that the deterrent effect is probably better than any effect our investigations may have.

Representative MARTIN. Is it true that in addition to the case of the complaint which first came to your attention in 1970 and another one in 1972 that there have been four additional complaints against Home Kare, Inc., for a total of six?

Mr. TIERNEY. Yes, sir.

Representative MARTIN. Is that typical of the industry to have six complaints?

Mr. TIERNEY. It is not atypical, Mr. Martin, over a period of 6 years to have that many complaints from beneficiaries about the services of an organization.

Representative MARTIN. Is that all these were?

Mr. TIERNEY. No.

Representative MARTIN. No complaint about kickbacks and fraud?

Mr. TIERNEY. No. That is not usual, no.

Representative MARTIN. So that in itself is unusual.

Mr. TIERNEY. That is unusual.

Representative MARTIN. And there should have been a key that said, aha, there is something to look at a little closer here. As a matter of fact, you had the same informants that our investigator has had access to.

Mr. TIERNEY. Right, and it was a key. We did raise the question and the intermediary involved told us that there was nothing that they had in their records to substantiate such a charge and we dropped it. Looking back now I sure wish we had not.

Representative MARTIN. We have heard in testimony here that at times it seemed that the entrepreneur, the principal of Home Kare, Inc., learned immediately of some of the complaints and some of

the evidence that was given by a previous witness in confidence to employees of the Bureau of Health Insurance. Was that the first time you had heard of that?

Mr. TIERNEY. Mr. Martin, we have heard this complaint from the staff members of the committee and have been as perplexed as they have been. Apparently they do have evidence that she seems to have known about what was going on and we both have been perplexed about how. We didn't know how, but it did seem like somebody must be doing it.

Representative MARTIN. They didn't know the informants.

Mr. TIERNEY. Pardon?

Representative MARTIN. You said they didn't know and we didn't know.

Mr. TIERNEY. Your committee staff members.

Representative MARTIN. Well, at least you were here when Mr. Keeley testified under oath. Although he was not cross examined, he testified yesterday that someone had violated the pledge of confidentiality.

Mr. TIERNEY. No, sir, I was not here but whatever evidence of this there is we should follow to the very end.

Representative MARTIN. You might be confused on one thing, Mr. Tierney. Did Mr. Martin, on October 29, give you a memo relating to Mr. Keith Olsen of your San Francisco office?

Mr. TIERNEY. If Mr. Martin says he did, I would have to check the records. I have no memory of hearing about this memo before and we have had discussions with Mr. Markin and Mr. Halamandaris as recently as 10 days, 2 weeks ago, and I still have no memory of hearing that assertion. Now if he gave me a note, I don't know what happened to it. I would like to see it.

Representative MARTIN. Well, I am sure that you would be willing to assure us that you will pursue that particular testimony.

Mr. TIERNEY. I certainly will.

Representative MARTIN. Thoroughly.

Mr. TIERNEY. I certainly will for his sake, too.

Representative MARTIN. Certainly. We also have some information that we will try to pursue as to who the leak was in the Travelers Co.

Mr. TIERNEY. Well, if you have any such information, I am sure that the Travelers Insurance Co. would be very much interested in it. I am sure it is not their policy to have their employees leaking.

Representative MARTIN. We also had testimony that indicates that three employees of the Bureau of Health Insurance have from time to time gotten consulting fees from, I believe, Home Kare, Inc.

Mr. TIERNEY. No, sir. I missed that testimony. I heard the last witness testify that three BHI people were at a meeting with him and gave him reason to believe that the costs were all right. It is difficult to understand in view of the record which shows that the Bureau of Health Insurance then, and since, tried very hard to get the Justice Department to prosecute the case.

Mr. PIAZZA. If I can add one thing, too. I think the record should reflect that the Federal Government has not dropped the medical claim against Peter Gottheiner. In California the complaint has been filed for collection, $800,000 plus amount, and it is currently in litigation.

Representative MARTIN. I will give you a copy of the memorandum Mr. Markin referred to so you will have that. I am not suggesting Mr. Olsen did anything improper, lest anyone misinterpret this record.

Mr. PIAZZA. I appreciate that.

Representative MARTIN. It is not a problem but I think it is something that you just neglected to recall.

Let me ask you a final question which I guess is the profound question of this whole series of hearings and that is, is this program really unmanageable?

Mr. TIERNEY. Beg pardon?

Representative MARTIN. Is this program really unmanageable?

Mr. TIERNEY. Are you talking about the home health aspect of it?

Representative MARTIN. Yes.

Mr. TIERNEY. No, I don't think it is unmanageable. I do think one of the greatest problems with it from the very beginning, Mr. Martin, was the one I referred to in answering Senator Church—one of the two things. There is no outside financing for this service, it is not like hospitals or doctors that also get their money from other third parties and other sources. For home health services, although there may be some instances in which some organizations now pay for such services, for the most part, medicare is still their primary source of funding. In that fact lies a basic part of the problem because obviously anybody in that business tries to maximize their cost allocation to medicare.

The second part of it, I think, is maybe even more disturbing over the long term and that is the medical necessity question. I have testified before Senator Muskie's committee and other committees which want to see home health care blossom, want to see it become a really major part of the medical system. At the moment it is only about 1.7 percent of benefit payments even in medicare, but the problem with all that is that since it is the only train going through the station every attempt is made to tie to it everything that needs to be done to answer aged people's historical social needs. These are problems which certainly need to be addressed, but I wonder whether medicare should be the vehicle for their solution.

I hope that some day we will face up to the problem that older people have tremendous social living needs that don't have much of anything to do with health care and to address those problems separately. As long as we try to pretend that this is a health business and that health insurance coverage is needed, the attempted solution is always going to be unsatisfactory. At the moment, I think that is the gist of the whole home health care problem.

That is not to say, as I have often been quoted as saying, that home health care is not a good thing. Home health care is a good thing but to try to provide for 25 million aged people all custodial, homemaker-chore type services under the guise of a health program I think will always be unsatisfactory.

Representative MARTIN. Thank you. I have no further questions.

Representative GIBBONS (presiding). Excuse me. Before you begin, Mr. Gephardt, let me say there is one more witness after you, Mr. Tierney, so I hope that you would keep your answers as concise as pos-

sible. I would say you may want to stay around because if you want to respond to this witness, I will give you the opportunity.

Mr. Gephardt.

Representative GEPHARDT. Mr. Tierney, could BHI suspend payments now to Home Kare, Inc.?

Mr. TIERNEY. Well, the answer, I think is, yes, we could. We have had some experience in the past where, without terminating an organization and without having any hearings, we have terminated payment. Now we are talking about a home health organization that is totally dependent on medicare payments, and in such cases, I think the courts have held we must give them due process. We have to give them a hearing before terminating payment. The courts might hold that way in the future.

Representative GEPHARDT. My understanding is they are on PIP today, is that correct? If so, in fact we had testimony yesterday from Travelers that they didn't think that it could be justified that they would be on PIP. Can you take them off PIP today or tomorrow?

Mr. TIERNEY. Yes.

Representative GEPHARDT. Do you think that is going to happen?

Mr. TIERNEY. I don't mean to argue with Travelers but the ultimate responsibility for making that decision under our contracts and under our regulations lies with the intermediary to put them on in the first place and to take them off when they no longer qualify.

Representative GEPHARDT. All right. That leads me to the next point and that is you have testified today that these may be isolated instances. Most of the testimony I have heard in the last 2 days would indicate that the fraud and abuse is wide and deep, at least in this program. Your recommendations which you made today are an attempt to construct the system that will solve some of these problems. Let me ask you some specific questions about the proposals you made.

First you talk about the incentive problem and that really leads you to intermediaries. What you are proposing, I take it, is that we get rid of all these different intermediaries and go to either one nationally or a few in the regions. Is that what you are saying?

Mr. TIERNEY. Yes, Mr. Gephardt. That is not because I am criticizing individual intermediaries. It is simply that this is a very small spectrum, a very small, indeed miniscule, part of medicare and yet we have 83 different organizations handling their claims. Some have got one, some have got three, some have got four. The point I was trying to make is that I don't think that that kind of a volume generates in anyone enough interest to establish a system to do the job. Hopefully if you have one outfit doing it all, it might do better.

Representative GEPHARDT. Are we going in the right direction? I read stories that say that Ross Bros. & Co. are going to run the whole thing.

Mr. TIERNEY. No; there is nothing to believe that we are going in the wrong direction. We do now have a study going on pursuant to the recommendations of the so-called Perkins committee which recommended to the Secretary that we examine the efficiencies and economies of regional processing areas as opposed to the present arrangement. On the physician side, we have 48 carriers and now there are some people who say that we could be better off if we had four. There are others who say exactly the opposite, of course.

Representative GEPHARDT. Do some suggest that we would be better off if we had none, do it ourselves?

Mr. TIERNEY. I have heard that suggestion.

Representative GEPHARDT. The point is made in the proposals that we need standards with regard to home health care. Who should promulgate these standards? The proposal really does not go to that point. It says as soon as possible the Federal Government needs to decide this, that, and the other thing about home health care. Whose responsibility is it to promulgate those standards?

Mr. TIERNEY. It is ours.

Representative GEPHARDT. Your bureau?

Mr. TIERNEY. Yes, sir.

Representative GEPHARDT. Can you tell me why they have not been put together now?

Mr. TIERNEY. I am afraid I am going to be repeating myself. I won't do it long, Mr. Gibbons.

We have gotten a lot of people together. We have had groups of physicians come in. We have had groups of medical directors of carriers come in. The Congress at one time suggested, why don't we have a diagnostic category, an assumed proper length of stay, or frequency of visits. The profession tells us that there is no way to do this, no way to set a standard. You are talking about an 86-year-old woman with a broken hip who lives in a tenament. What kind of standard do you apply to her situation compared to that of the 66-year-old who has a lovely home?

Representative GEPHARDT. Aren't you then saying that home health care is not administrable?

Mr. TIERNEY. I think it is administrable, Mr. Gephardt. I think if we were not concerned with the type of thing that you have been concerned about here and if we were not concerned about this homemaker-type service, if we really could zero in on health needs and satisfy them, I think it is administrable.

Representative GEPHARDT. But it is my understanding that your portion of the program is health care as opposed to the title XX which it is my understanding is the homemaker-chore business.

Mr. TIERNEY. That is true but in the home health care service which we do provide, the law specifies that it must be related to a health condition, that the doctor must lay out a plan of care and whatnot and that once that happens, the people are also entitled to homemaker service, home chore service, whatever seems appropriate.

Representative GEPHARDT. Under title XX or title XVIII?

Mr. TIERNEY. Title XVIII.

Under title XX it is much more direct. We go through the rigmarole, if that is a proper term, of having a doctor certification of need, a doctor laying out a health plan, the requirement of meeting a defined level of care, the requirement of professional services indicating what things can be done only by a professional nurse and which can be done by a nurse's aide and whatnot. I just have the general feeling, Mr. Gephardt, when we get all through with that that we are kidding ourselves. We actually are paying for a lot of service of tremendous value to these old people and which they need but which really are not health.

Representative GEPHARDT. But until you do that I see no way to

administer the program because unless you make those policy determinations there is no way to evaluate what someone is doing and what their costs are and what their costs should be so that what you recommend later with regard to administrative changes to bring enforcement to the program can never be achieved. I think what you are finally concluding is that you cannot administer this kind of a program as worthy as it may be.

Mr. TIERNEY. I don't want to argue semantics with you. I would not use the word "can't." I would use the words that no matter how well we finally did it if we try to do it all under the guise of home health care, we will still be doing things requiring a lot of unnecessary paperwork, requiring in a lot of cases that some professionals render opinions that they may not totally believe in and getting into questionable situations. I don't want to bore you but back in 1969 the big thing the Senate Finance Committee was concerned about in home health care was lack of medical necessity. At that time there didn't seem to be much fraud or abuse or anything but there was tremendous evidence that in fact the people receiving home health benefits were not sick. Because they had been in the hospital and needed some help, home health care was assumed to be the way to provide that help, even though there was no medical need.

I am not articulating this very well but that is the problem I am talking about. I don't think it means you can't solve it, but it is always going to be difficult.

Representative GEPHARDT. Do you think it is a lot easier to administer the rest of the medicare program because of the more easily defined standards that can be applied?

Mr. TIERNEY. I think more easily defined standards help. It also helps to have institutions obviously with assets and value. In addition, there have been about 50 years of third-party experience in paying for the services these institutions provide. We don't have any of that in home health services.

Representative GEPHARDT. We make policy decision when we decide that is what we have to do to administer the program. It is really against what I think are the important new trends in health care which is to take it to the home to get people out of the hospital to do preventive health care. Really what you are saying is that when you get out of the hospital where we have tried and true perimeters that we run into trouble in administering the program and that is going to be a difficult problem.

Representative GIBBONS. Will the gentleman from Missouri yield?

Representative GEPHARDT. Yes.

Representative GIBBONS. Let me say the witness is overweight and has smoked constantly since he has been here and I don't know whether we are going to get much more out of him. I think we can drop this pretty soon and go on to something that I think is going to be more productive than his testimony.

Representative GEPHARDT. I am finished.

Representative GIBBONS. Go right ahead.

Representative GEPHARDT. No; I yield back my time.

Representative GIBBONS. Thank you.

Mr. TIERNEY. I am going to quit smoking next Monday.

Representative GIBBONS. Fine.

Our next witness is Mr. H. Eugene McNease.

Mr. McNease, would you come forward.

Do you solemnly swear that the testimony you will give will be the truth, the whole truth, and nothing but the truth, so help you God?

STATEMENT OF H. EUGENE McNEASE, REGIONAL COMMISSIONERS OFFICE, SOCIAL SECURITY ADMINISTRATION, ATLANTA, GA.

Mr. McNEASE. I do.

Representative GIBBONS. What is your occupation and where do you live?

Mr. McNEASE. I am currently working in the congressional inquiry section of the regional commissioner's office of the Social Security Administration in Atlanta, Ga. I live in Decatur, Ga.

Representative GIBBONS. Mr. McNease, I think the letter that you wrote to Senator Herman Talmadge dated February 7, 1977, has already been placed in the record. Am I correct about that?

Mr. McNEASE. Yes; you are.

Representative GIBBONS. Were the contents of it made public at the time the letter was placed in the record?

Mr. McNEASE. Senator Church made a brief statement.

Representative GIBBONS. He did.

I think it would be helpful if you ran through that letter. I don't know whether you need to read it verbatim but it is concise and perhaps it would help focus your testimony.

Mr. McNEASE. All right, sir.

The nature of it consists of four cases that I investigated while I was employed as program integrity specialist for the Bureau of Health Insurance.

Representative GIBBONS. In other words, the gentleman that just testified was your boss, is that right?

Mr. McNEASE. Yes, sir.

Representative GIBBONS. All right. Go ahead.

Mr. McNEASE. The four cases consist of two in North Carolina, one in Mississippi, and one in the State of Florida. The first case I will talk about is in Asheville, N.C. It involved three related doctors, two brothers, and one first cousin, who at the very minimum cheated medicare out of at least $34,000. I presented this case to the U.S. attorney's office in Asheville. I met with him three times and was under the impression that he was going to pursue prosecution of the case but ultimately he did not. He held it for several months and then referred it to the Justice Department in Washington who subsequently sent it back to him with a recommendation that civil prosecution be pursued. I understand now that the regional office in Atlanta has agreed with the U.S. attorney's office in Asheville to recommend an agreed settlement for one-quarter of that $34,000. I also have heard lately that the Justice Department in Washington refused to accept that recommendation so I don't know what the final outcome of that case is.

Representative GIBBONS. When did your investigation begin?

Mr. McNEASE. This case began in early 1975 along about February or March.

Representative GIBBONS. Let's go next to the *Mississippi* case then.

Mr. McNEASE. The *Mississippi* case involves Dr. O. B. Crocker who along with close members of his family owned a hospital in Calhoun County, Miss., in the county seat of Bruce. Dr. Crocker and his family owned this hospital through a nonprofit corporation and in filing the annual cost reports about which we have heard testimony previously, included in his cost reports, family and personal expenses for reimbursement by medicare totaling approximately $66,000. One significant cost included in the cost reports was the remodeling of his son's law office.

I referred this case to the U.S. attorney's office in the northern district of Mississippi, worked with him as closely as possible but he held it for several months. His story was that IRS was interested in the same case and he wanted to wait until IRS had done an investigation or completed an investigation, I am not sure which. Ultimately nothing was done about the case.

Representative GIBBONS. Let me interrupt you. At the same time you were making these recommendations to the Justice Department were you also making a recommendation to your own agency about action on these?

Mr. McNEASE. Oh, Yes. There was correspondence back and forth between our office and the U.S. attorney's office in Oxford.

Representative GIBBONS. Did they ever tell you not to push these cases or to push them or what?

Mr. McNEASE. No, sir, there was never any instructions like that. Most of our work was done more or less on our own judgment because naturally we were all busy in different areas and there was not a great deal of input from the regional office at all on individual cases.

Representative GIBBONS. Let me ask you whatever happened to the *Crocker* case?

Mr. McNEASE. Well, ultimately Dr. Crocker died and although there were three to four other persons directly implicated in the case the Justice Department and the U.S. attorney's office in Oxford refused to indict anyone, refused prosecution because of the situation—Dr. Crocker's death—and we ultimately negotiated a settlement to get the money back as best we could.

Representative GIBBONS. Let's go to the *Wilmington, N.C.* case.

Mr. McNEASE. This involved Dr. William J. Wheeler of Wilmington. I investigated this case and found just numerous counts. We could have gotten as many counts as we wanted. I referred the case to the U.S. attorney's office in Raleigh who seemed to be motivated and really charged up about prosecuting this case when last I saw them. They assigned one of their top prosecutors, I was told, to the case and soon afterwards we got an indictment, a 10-count felony indictment. However, after that nothing happened.

I understand, after the fact, that this prosecutor who was assigned to the case just kind of forgot it and eventually was taken off the case and it was assigned to another assistant who was 3 months away from retirement and was essentially trying to finish out his term.

Meanwhile the potential witnesses due to their age and their condition and the pressure of continuing to see the same doctor because they were black and the doctor was black and he was the only black one in the community; so they essentially had no one else to go to—so being under the pressure, plus age and sickness, some became virtually incompetent as witnesses. The final outcome of the case was that the U.S. attorney's office finally agreed to a plea of nolo contendere to five misdemeanors. The doctor was fined $5,000, given 5 year's probation and is still practicing medicine, and as far as I know he is still billing medicare and medicaid. I don't know whether he is being reimbursed for those or not.

Representative GIBBONS. Let's go next to the *Tampa, Fla.* case. As you know, Tampa is my congressional district. While I have never had the opportunity to meet you, I am aware of that case because I read about it in the newspaper. Would you explain, please, what happened there?

Mr. MCNEASE. Yes, sir. This case began as a result of informants who came, I guess, for a number of reasons and volunteered their information. It came to me just like a shot out of the dark with a phone call one day. Getting into the case I found that there was not one, not two, but three corporations involved and all of them were centered in the Tampa Bay area.

The names of the three corporations were Feegle and Howard Doctors Lab, Inc.; Medicine in Motion, Inc.; and Feegle and Winkle Respiratory, Inc. All three of these corporations instigated and carried out schemes to defraud the medicare program. The chief of these schemes was the kickback scheme between Feegle and Howard Doctors Laboratory and medical doctors, osteopaths, and chiropractors in four surrounding counties; and a kickback scheme between Feegle and Winkle Respiratory Services and South Florida Baptist Hospital in Plant City.

This is interesting so I will go into that since it is not a common kickback scheme. What was involved was Feegle and Winkle Respiratory was not a certified medicare provider whatsoever—they had no license, no authorization, nothing. They went out to nursing homes, tested patients and rendered treatment to the patients and then prepared their own bills, submitted their bills to Blue Cross-blue Shield under the provider number of South Florida Baptist Hospital. South Florida Baptist Hospital in turn received payment from Blue Cross-Blue Shield and then wrote a check to Feegle and Winkle Respiratory for 90 percent of the gross and retained 10 percent of the gross for themselves without rendering any service, without rendering any supervision, without being involved, period.

After I got involved in this I quickly saw that it was a tremendous task particularly for one person, one investigator, so I requested and got the cooperation from the U.S. attorney's office to have a Federal grand jury convened to hear testimony covering all these violations which was done. However, the delays in the U.S. attorney's office were such that this grand jury after hearing all this testimony disbanded before any indictments were handed down and when a new grand jury was convened I was allotted just 30 minutes to present the entire case to a new grand jury in April of 1976, 10 months after the investigation had begun.

Upon the recommendation of the U.S. attorney's office there were four individuals indicted. Three of these individuals were more or less insignificant in the entire operation while none of at least 21 doctors who had received kickbacks were touched. Particularly significant is the fact that Dr. John R. Feegle, the one person who is most significant in all of these schemes and stood to profit more from all the operations than any other person, was not tried, he was not indicted, he was not even subpenaed for questioning. Of course I objected to this obvious show of partiality and special treatment.

I understood that Dr. Feegle had a special position in the community; he is the Hillsborough County medical examiner and in addition to being an M.D. he is a lawyer and a writer. He is widely known for his practice of forensic medicine. Even so, I thought his involvement in these schemes certainly merited questioning and I protested the treatment he was receiving from the Justice Department and particularly the U.S. attorney's Office in Tampa.

Representative GIBBONS. Did you proceed with him to the BHI?

Mr. MCNEASE. You know, in our conversations and reports to our superiors of course it was divulged and talked about. But what could you do? This is a rhetorical question, asked to emphasize the helplessness I felt. I could do nothing. BHI could do nothing but come out against the office as I did. They chose not to do that.

Representative GIBBONS. I don't know. What you are saying is news to me. I never heard it before. In all of these what was the attitude of BHI towards your investigations?

Mr. MCNEASE. Well, the BHI is the new man on the block, Congressman Gibbons, as you may know and the investigative function of BHI is even newer on the block. There are a lot of shall I say, doubts in the minds of U.S. attorneys and prosecutors as to the expertise of investigations conducted by BHI since they don't have a reputation, they don't have the sophisticated surveillance techniques that other agents have with whom they are accustomed to dealing.

All of these do not induce a U.S. attorney to take up a case. You are an attorney yourself, I believe, and most of you are. I understand that no one wants to take on a case that he is likely to lose or if he stands a chance to lose even if he is employed by the Federal Government. He wants a case that is strong, show a good public image, and one that is going to be an easy case to prosecute, and I put easy in quotes. There are no easy ones, I understand.

The answer is that we walked very softly when we dealt with U.S. attorney's offices since we were new. We were new and it was very easy to offend and tear down any rapport that may have already been developed with the U.S. attorney's offices. One of the keys in getting a reputation established is being patient, being diplomatic and trying to be understanding but there is only so far that a person can go and keep justice with himself and his own conscience.

Representative GIBBONS. How much experience have you had as an investigator?

Mr. MCNEASE. Approximately 4 years. I began in November 1972 and continued through July 1976.

Representative GIBBONS. With BHI?

Mr. MCNEASE. Yes, sir.

Representative GIBBONS. And you still work with Social Security?

Mr. MCNEASE. Yes, sir.

Representative GIBBONS. And you expect to get the C-5A treatment after this testimony today. You know what happened to that fellow at the Pentagon.

Mr. MCNEASE. Well, Congressman, needless to say I have suffered traumatic experience as a result of my coming out against the U.S. attorney's office and speaking out and I expect it will continue. I don't expect anyone to admit that they have done wrong, that is not a very easy thing to do. I don't expect that they will admit or anyone else will admit that there is a gap in prosecution of cases when they have themselves been handling them. Persons don't do that, they defend themselves.

Obviously there are some things involved in these cases that they were not pleased with and they thought could have been done better. Of course I am pretty sure they are right, but still that does not excuse them for not prosecuting the cases vigorously and seeing that the program was protected. It is unfortunate but it is true. And it is seemingly overlooked. The real crime is not so much that the tax money is being wasted, that it is being outright stolen, but the real crime is that the people for whom these funds were made available, the sick, the afflicted, the old, the aged—those are the people who are suffering as a result of it and that is the crime.

Representative GEPHARDT. Would the gentleman yield?

Representative GIBBONS. Glad to yield.

Representative GEPHARDT. To your knowledge, was any action taken by Social Security with regard to these cases you talked about? Were the payments cut off? Were counter-actions taken?

Mr. MCNEASE. Oh, yes. When I got involved in these cases I immediately notified the carriers and the intermediaries of the need to withhold payment until we could make some sort of determination.

Representative GEPHARDT. Have they all been cut off?

Mr. MCNEASE. As far as I know. Now, I have not had close contact with those for some months.

Representative GEPHARDT. From what your testimony is today and from experience you have had it would appear that perhaps U.S. attorneys are not the best equipped to deal with white collar crime cases like this, perhaps the interest they have is not the greatest in this kind of crime. Do we need a special prosecutor, a task force in different districts to handle cases like this?

Mr. MCNEASE. Congressman Vanik has proposed a plan which I find very stimulating, not only to have special prosecutors to deal with this program, or these programs I should say, but also a special system of courts to handle all HEW problems. That would probably be a real expensive process and it would take a great deal of machinery to conduct it, but I noticed you were raising questions, Mr. Gephardt, about whether or not these programs were manageable. Well, this may be the only answer. If we plan to maintain these programs, we have to go in there and enforce the regulations, and we have to make some central objectives and we have to work toward those, whatever the cost, if we are going to maintain the programs.

Representative GEPHARDT. I agree. Thank you.

Mr. MCNEASE. I might say the major problem as I see it in national health care management is the lack of leadership. We have gone too long following the mule rather than leading. We have a runaway mule on our hands now and there seems to be little anybody is able to do.

If you will pardon a personal reference, one of the early lessons I learned growing up on a small peanut farm in south Georgia was how to lay off a straight row. The first thing you have to do is to establish a clear marker at the other end of the field and then you cannot drive the mule toward that marker, you have to lead him because he cannot see the marker, he is looking straight down. You have to continually lead that mule toward the marker so you have a straight row. After you get a straight row the remainder of the field can be planted without a great deal of effort, because you have a guide to go by.

This program and these other programs that we have talked about, medicaid and medicare, they were put into operation without the necessary controls, and without a correct assessment of resources necessary to meet the demand and to carry them out. That is essentially it. We have got the horse and the team ahead of the driver and there seems to be no way to direct them in the correct passage they should be going.

Let me say this. It is really time to act and stop delaying and giving lip service to a lot of problems that we already know exist.

Representative GEPHARDT. That is all I have, Mr. Chairman.

Representative GIBBONS. Thank you.

Mr. Martin.

Representative MARTIN. I have no questions, Mr. Chairman.

I move that we go over and write a part of our record available for other agencies of the Government.

Representative GIBBONS. Do you have any other documents you wish to submit other than this letter?

Mr. MCNEASE. No, sir, I have nothing else.

Representative GIBBONS. Thank you for coming, sir. We appreciate your testimony.

Mr. MCNEASE. I appreciate the opportunity.

Representative GIBBONS. This concludes the presentation of evidence and testimony in this hearing. I am going to direct the staff to prepare this record and to send it to the Justice Department among other people for any possible inclusion in any criminal prosecution that is made that may result from all of this and to the Internal Revenue Service for their investigation.

I am also instructing the staff to follow through on this and to come up with a set of proposed recommendations as to legislation and corrective action that can be taken administratively to straighten this out. I would put a deadline of one month from today on all of this.

Unless there are further questions or further comments, the meeting is adjourned.

[Whereupon, at 5:37 p.m., the hearing was adjourned.]

APPENDIXES

Appendix 1

INVESTIGATIVE MEMORANDUM[1]

Re Peter C. Gottheiner.

To: Senators Frank Church and Pete V. Domenici, Senate Committee on Aging, and Representatives Dan Rostenkowski and Sam Gibbons, House Ways and Means Committee,

From: Tom Cline, investigator, and Val J. Halamandaris, associate counsel, Senate Committee on Aging.

I. Summary

Peter Gottheiner has been a provider of home health services for more than a decade. He has participated in and was suspended from Medicaid (called Medi-Cal in California). He withdrew from Medicare one month after the Department of Justice was asked to prosecute him. To this day, Medicare claims he owes the program $804,655.06 in unresolved audit exceptions. Even though he was investigated by Santa Clara County District Attorney, State of California Department of Health (several times), Blue Cross, the Bureau of Health Insurance (several times), California Franchise Tax Board as well as the Department of Justice, the audit exceptions still stand and he continues to operate, reportedly receiving public funds now under Title XX of the Social Security Act.

Title XX is a block grant program with 75 percent Federal matching funds to help the States provide social services for indigents. One of the most frequently offered services is called homemaker/chore services. About 10 percent of Title XX funds or about $340 million are paid for such services nationwide. Gottheiner's pattern of operation has been the same whether in Title XX or Title XVIII (Medicare) or XIX (Medicaid). His first corporation providing home health services in Medicare went into "bankruptcy" when faced by possible Justice Department action. Similarly, his first venture into the Title XX business ended in bankruptcy. Gottheiner himself claims he left two months before the fall. Once again he left behind audit exceptions pertaining to excessive profits, luxury automobiles, excessive salaries, placing relatives on the payroll who did no work, charging liquor and tobacco and other expenses unrelated to patient care.

Gottheiner is a highly political figure. There is abundant evidence that his political contacts have helped him to not only continue to operate but to expand his services. Gottheiner has a history of hiring employees of State Health and Welfare Departments who were in a position to grant him favors or contracts.

Despite the outstanding audit exceptions under Medicare and now under Title XX, Gottheiner now operates under a new corporate name. His latest corporation, National Home Health Care, Inc., reportedly obtained an Illinois contract to provide homemaker/chore services to some welfare clients in that State.

II. Background

On October 28, 1975, Senator Moss' Subcommittee on Long-Term Care conducted hearings on proposed HEW regulations which would allow for-profit home health agencies to participate in the Medicaid program. During the hearing, substantial evidence was received concerning fraud and abuse in existing home health programs including Title XVIII (Medicare), Title XIX (Medicaid), and Title XX of the Social Security Act. (Some 47 States

[1] Senator Church, on page 1084, made this memorandum a part of the official record.

are using Title XX money in part to provide homemaker/chore services or other in-home services.)

At these hearings, the Committee became aware of Mr. Gottheiner and his activities as the result of testimony presented by a California State official and both proprietary and non-proprietary business competitors of Mr. Gottheiner's. Among those who testified was Fred J. Keeley, at that time working for Flora M. Souza and Home Kare. Keeley, who made serious charges against Gottheiner, later went to work for Gottheiner and still later provided the Committee with detailed evidence relating to the operations of both Souza and Gottheiner.

III. Parties Involved

1. *Peter Gottheiner:* The central figure in this study.
2. *Ron Gottheiner:* Peter Gottheiner's son. He was formally Vice President of both Visiting Home Services (in which he held an original 50% interest, later reduced to 30%) and of Health Help. He became President of the former upon his father's resignation in June 1976.
3. *Vivian Gottheiner:* Peter Gottheiner's daughter. She was listed on the books as a VHS consultant.
4. *Eva Gottheiner:* Peter Gottheiner's ex-wife. She was also on the VHS payroll.
5. *Jeanie Gottheiner:* Ron Gottheiner's wife. Like the rest of the family, she was paid by the organization.
6. *Salvatore Marconi:* A San Francisco restauranteur, Marconi was a principal financial backer of VHS from November 1972 through November 1973, and lent money on a cash "as-needed basis." He owned 40% of VHS stock.
7. *Ralph Gomez:* Another of the corporation's chief financial supporters (from August 1975 through August 1976).
8. *William Bagley:* A former California State Assemblyman and a close personal friend of Gottheiner. Bagley wrote letters on Gottheiner's behalf when the latter was suspended from the California Medical Assistance Program (Medi-Cal).
9. *Carel B. H. Mulder:* As Director of the Office of Health Care Services in California, Mulder signed the letter suspending Gottheiner from Medi-Cal. Mulder later became a consultant to Health Help, Inc. and Chairman of the Board of Visiting Home Services, Inc.
10. *Jay Wimmer:* Wimmer was a Programs Specialist in the State of Utah, and seems to have played a major role in the awarding of the Utah Title XX contract to Gottheiner's firm. Wimmer reportedly tried to solicit business for Gottheiner in other States while still employed by the Utah Division of Family Services. In 1975, Wimmer went to work for Gottheiner a few months after the Utah contract was awarded.
11. *Hadley Hall:* Executive Director of San Francisco Home Health Services, a non-proprietary provider of homemaker/chore services. Hall is perhaps Gottheiner's most vehement critic, and is the defendant in a $12 million law suit filed on behalf of Gottheiner and his corporations.
12. *Fred Keeley:* Like Hall, Keeley was a witness at the Committee's October 1975 hearings. He was, at various times, employed by Gottheiner's chief competitor, Flora Souza, and by Gottheiner himself
13. *Harold Dobbs:* A San Francisco lawyer who handled Gottheiner's defense in the case referred to the Justice Department in February 1971. Dobbs was an ex-mayoral candidate in San Francisco and represented Gottheiner against criminal charges brought by the local U.S. attorney.
14. *Janet Aitken:* The Assistant United States Attorney in San Francisco who handled the case against Gottheiner. Aitken admitted to a Committee investigator that she sat on the case for more than six months. Although originally convinced of Gottheiner's guilt, Aitken apparently changed her mind after a meeting with Harold Dobbs, Gottheiner's lawyer.
15. *Conrad Sadowski:* An investigator with the Division of Administrative Appraisal and Planning in the Office of Administration (SSA). Sadowski produced the report that served as the basis for BHI's (Bureau of Health Insurance) referral of the Gottheiner matter to the Justice Department.
16. *Richard Reisman:* HEW Assistant Regional Attorney in San Francisco who handled the Gottheiner case.
17. *Kathryn Stewart:* Former Director of Nursing for California Coordinated. She told Sadowski that Gottheiner knowingly continued fraudulent billing practices, even though she advised him that certain procedures were in violation of Medicare law.

IV. The Entities and a Chronology

Gottheiner was born in Breslau, Germany. During the War, he emigrated to Shanghai, China, where he managed Class 1 subsistence for the USA Quartermaster Corps. In 1949 he emigrated to the United States.

In July of 1949, he obtained a California license as a physical therapist and opened an office in San Francisco. He maintained a private practice until 1960 when he obtained an exclusive contract through 1964 with the City and County of San Francisco for the treatment of employees injured in the line of duty. During this time, the first in a series of allegations charging program abuse arose. He was accused of misrepresenting services offered to the Workman's Compensation Board. A restitution was ordered.

1966

In 1966, Gottheiner founded the *California Coordinated Health Care Service*, a proprietary home health agency certified for both Federal and State participation in January of 1967. He was the corporation's administrator and president. *By April, records of the California Department of Health show he was under investigation by the Medical Services Bureau for excessive billing, treatment of a duration shorter than claimed and altering prescriptions.*

Specifically, the investigators charged Mr. Gottheiner's agency billed for a full hour treatment for each recipient of physical therapy and treatment of less than half that and, in many cases, treatment in group and billing as though treated separately.

Additionally, the evidence indicated that someone, "possibly Mr. Gottheiner, altered the Rx Form 165 in question." The prescription forms were all pretyped and prepared and "smacked of wholesale prescribing of physical therapy by Gottheiner, not the doctor," the investigators said. The charge was that Gottheiner was giving physiotherapy without a physician's authorization. In a letter to John Fourt, Office of Health Care Services, Harvey E. Haslett, one of the investigators, spelled it out: "We have learned Gottheiner makes out the form MC 165. Some of the doctors have balked at being dictated to as to the length of treatment and who gives treatment." Also under investigation was a charge of unethical solicitation.

A summary of the conclusion of the investigation is taken from the health department records:

"Our investigation was initiated as the result of a letter from Robert Monlux, M.D., deputy director, Santa Clara Department of Public Health. The therapist stated to our investigators and the Santa Clara County DA investigator, Mr. Bernard P. Blackmore, that he did not give more than half-hour treatments. Gottheiner billed Medi-Cal for a full hour of treatment in each instance.

"Also noted was a prescription for therapy in which the dates were altered and the period of treatment raised.

"Our investigator then approached the district attorney's office in Santa Clara County without evidence. The district attorney agreed that the evidence was sufficient enough to ask the grand jury for an indictment for fraud.

"Mr. Gottheiner, knowing he was under investigation, returned $4,292 to the fiscal intermediary claiming that clerical errors caused the overpayment. The restitution made the district attorney change his mind and he has dropped his plans to go to the grand jury.

"In our opinion, Mr. Peter Gottheiner should be suspended from participation in the Medi-Cal program effective immediately."

September 1967: Suspended From Medi-Cal (Medicaid)

By letter, September 28, 1967, signed by Carel E. H. Mulder, Gottheiner was suspended from Medi-Cal.[1] He was informed he might request a hearing. He did not.

The letter follows:

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[1] In one of the continuing ironies of the evolving Gottheiner case, Carel E. H. Mulder turns up with Gottheiner's Health Help agency, being listed as a consultant in corporate stationery in 1973 and later as chairman of the board of Gottheiner's national corporation, Visiting Home Services.

SEPTEMBER 28, 1967.

[Certified Mail—Return Receipt Requested]

Re suspension from California medical assistance program.
PETER GOTTHEINER, R.P.T.
San Francisco, Calif.

DEAR MR. GOTTHEINER: Please take notice that pursuant to the provisions of section 51455 of title 22 of the California Administrative Code, you are hereby suspended from receiving further payments under the California medical assistance program. This suspension is effective immediately, and billings rendered by you for services under the California medical assistance program on or after _____ will not be accepted for payment.

The legal basis for this suspension is your repeated violation of section 51455(b) of title 22 of the California Administrative Code. This section provides in material part:

"Causes for suspension shall consist of the following or substantially equivalent actions under this program or the previous public assistance medical care program or the medical assistance for the aged program.

"(1) Billing for visits not made or services not rendered."

The factual basis for this suspension consists of the following violation:

Subdivision (1) was violated by continuous billings to the State of California for 1 full hour of physical therapy when in fact half hour or less of physical therapy was given.

You may request a hearing to present any defenses to the above charge, should you so desire. Your written request for hearing must be received at the Office of the Health and Welfare Agency, State capitol, Sacramento, Calif., within thirty (30) days after service of this notice or suspension. Such request should state your business name and address, if any, and list all current licenses and permits issued to you by any State or Federal agency. Any request for hearing must state which of the facts or circumstances set forth in the order of suspension are admitted or denied, and the nature of the relief sought.

Very truly yours,

CAREL E. H. MULDER,
Director.

Curiously, there is some doubt if the suspension ever went into force. A letter dated October 19, 1967 from Carel E. H. Mulder, Director of the Office of Health Care Services (OHCS), California Department of Health, to Charles Stewart reads in part as follows:

"You will recall Assemblyman Bagley (now Chairman of the Futures Commodity Market) had suggested my meeting with him and Mr. Gottheiner to compromise whatever action OHCS might be contemplating with respect to suspension. . . .

"Mr. Bagley called me again today to inquire as to the status of this case. I informed Mr. Bagley that OHCS has decided on the following course of action.

"A demand letter for approximately $3,000 still due will be sent to Mr. Gottheiner, having to be complied with within 60 days. If Mr. Gottheiner can submit proof of payment, the demand will have been satisfied. In the same letter he will be notified that Blue Shield has been requested to audit his billings with particular care (a future action). If Mr. Gottheiner does not comply with demand for repayment or if subsequent review by Blue Shield or investigation by the County or this office discloses further irregularities, he will be served a notice of suspension subject, of course, to his right to request a hearing.

"Mr. Bagley deemed this an excellent solution and requested that he be furnished a confidential copy of our letter to Mr. Gottheiner."

[The letter and related correspondence follow:]

Memorandum

To: Charles W. Stewart.

OCTOBER 19, 1967.

From: Office of Health Care Services.
Subject: PETER GOTTHEINER, R.P.T.

You will recall Assemblyman Bagley had suggested my meeting with him and Mr. Gottheiner to compromise whatever action OHCS might be contemplating

with respect to suspension. I told him that I could not agree to such a meeting until our investigation was completed.

Mr. Bagley called me again today to inquire as to the status of this case. I informed him that our investigation has been completed, and it has been established that Mr. Gottheiner had submitted billings for an excessive amount of more than $7,000, of which more than $4,000 has been repaid to CPS. Although Mr. Bagley's letter of September 25 reports that Mr. Gottheiner has paid an additional $3,000 to CPS, no verification of this alleged payment has been possible through CPS. I informed Mr. Bagley that OHCS has decided on the following course of action.

A demand letter for the approximately $3,000 still due will be sent to Mr. Gottheiner, having to be complied with within 60 days. If Mr. Gottheiner can submit proof of payment (e.g., canceled checks), the demand will have been satisfied. In the same letter he will be notified that Blue Shield has been requested to audit his billings with particular care. If Mr. Gottheiner does not comply with demand for repayment or if subsequent review by Blue Shield or investigation by the county or this office discloses further irregularities, he will be served a notice of suspension subject, of course, to his right to request a hearing.

Mr. Bagley deemed this an excellent solution and requested that he be furnished a confidential copy of our letter to Mr. Gottheiner.

Please have staff proceed in accordance with the above decision.

CAREL E. H. MULDER.

ASSEMBLY, CALIFORNIA LEGISLATURE,
WILLIAM T. BAGLEY, MEMBER OF ASSEMBLY,
Marin-Sonoma Counties, Calif., September 25, 1967.

Re Peter Gottheiner, Medi-Cal services.
Mr. CAREL H. MULDER,
Director, Health Care Services,
Sacramento, Calif.

DEAR CAREL: As you may recall, I am a longtime acquaintance, and friend, of Peter Gottheiner, a physical therapist in San Francisco. He has brought to my attention a situation which may have been called to your attention. I am writing, and sending enclosures, to help clarify the situation, if need be. Basically, my request is that your office, or the appropriate office, contact me for any further information or for any further discussion if these are considered necessary.

The enclosed correspondence should be self-explanatory.

You will note a copy of a letter of July 26 to the Santa Clara County district attorney's office from Mr. Gottheiner's attorney. This letter reviews an error in billing, and reviews the circumstances thereof. The district attorney's office, apparently at the behest of the local welfare department, had conducted something of an investigation, and, upon receipt of the July 26 explanation, closed their file. Our concern now is that the file has not yet been closed, but may still be active, in your office.

Peter Gottheiner has explained to me the background of the error in billing and also given me a copy, enclosed, of his letters of June 30 and July 24. You will note from the former that he first learned of the overbilling just prior to his June 30 letter. He, himself, then informed California Physicians' Service of this error and has since made correction and reimbursement. The July 24 letter shows his reimbursement of $4,292, and subsequently he has made reimbursement as he has received checks, totaling almost $3,000 additional.

As stated, Peter Gottheiner called this matter to my attention and I volunteered to forward this material to your office. He is simply concerned that someone in your office will not have the full facts and will not know of the explanation contained in the enclosures. I am fully confident, after speaking with Mr. Gottheiner, that the situation arose because of an honest error on his part. The treatments given were at five extended care facilities, four in Contra Costa County and one in Santa Clara County. These were new contractual arrangements made by Gottheiner with these facilities starting in February or March. He simply billed for them as he bills for services that he renders in his San Francisco office. These services, as rendered in San Francisco, apparently are in a different category than services actually rendered at the extended

care facilities. When he learned of the difference in treatment being given, he wrote the June 30 letter.

As stated, I will be happy to participate in any further discussions necessary on this. I did want to alert you of my interest, and give you the backgroun of the facts which have come to my attention. I would request that if the file is active in your office and if further discussion is necessary, or if any action is contemplated, that you please contact me prior to any further action. I would not like to see Mr. Gottheiner's good name prejudiced, and do want to bring the various facts to your attention.

Sincerely yours,

WILLIAM T. BAGLEY.

Enclosures.

AUGUST 11, 1967.

Re Possible suspension of Peter Gottheiner, R.P.T.
CAREL E. H. MULDER, *Director*

We have investigated the activities of Mr. Peter Gottheiner, a registered physical therapist, pertinent to his physical therapy treatment billings submitted to and paid by the fiscal intermediary for services rendered to Medi-Cal recipients. The investigation was initiated as the result of a letter from Robert Monlux, M.D., deputy director of the Santa Clara Department of Public Health.

Our investigation included interviews with the administrator and the head nurse of the Forest Avenue Convalescent Hospital in San Jose; the physical therapist who performed the services in the above hospital; and his employer who billed Peter Gottheiner for the services rendered.

We determined that Peter Gottheiner subcontracted with the Physical Therapy Center, owned by Flora Souza, to service his clients at the Forest Avenue Convalescent Hospital for $3 per treatment. The employee of Flora Souza who actually gave the therapy treatments stated to our investigator and the Santa Clara County district attorney's investigator, Mr. Bernard P. Blackmore, that he did not give more than half-hour treatments to clients at the above hospital. Mr. Gottheiner billed the Medi-Cal program for a full hour of treatment in each instance. We reviewed billings for the months of February through June 1967, and found that Mr. Gottheiner had billed and was paid a total of $3,645 for services not rendered.

Also noted was a prescription for therapy in which the dates were altered and the period of treatment was raised. A copy was given to an investigator from the Department of Professional and Vocation Standards who investigated the circumstances surrounding the alteration.

Our investigator then approached the district attorney's office in Santa Clara County with our evidence. The district attorney agreed that the evidence was sufficient enough to ask the grand jury for an indictment for fraud.

Mr. Gottheiner, knowing he was under investigation, returned $4,292 to the fiscal intermediary claiming that clerical errors caused the overpayment. This restitution made the district attorney change his mind and he has dropped his plans to go to the grand jury.

In our opinion, Mr. Peter Gottheiner should be suspended from participating in the Medi-Cal program effective immediately. Although we are fairly sure that an additional recovery of money could be made by a 100-percent audit we recommend that such an audit not be made based on manpower and budget limitations.

HARVEY E. HASLETT,
Chief, Vendor Investigation Bureau.

ASSEMBLY, CALIFORNIA LEGISLATURE.
WILLIAM T. BAGLEY, MEMBER OF ASSEMBLY,
Marin-Sonoma Counties, Calif., December 30, 1971

Mr. HAROLD S. DOBBS,
Dobbs & Doty, Attorneys at Law,
San Francisco, Calif.

DEAR HAROLD: I have just spoken with your client and my friend Peter Gottheiner regarding some help which I gave him when, in October of 1967, the Department of Health Care Services had claimed an overcharge by him, acting as a physiotherapist in the bay area. This letter is simply to state the facts as they existed and as they were found to be by the then director of Health Care Services, Mr. Carel Mulder. I met with Peter, and Mr. Mulder in Sacra-

mento and reviewed the circumstances involved. They were these: Peter Gottheiner was not giving treatments personally but supervising a staff of physiotherapists. The staff, on occasions where groups of patients were treated, would name individual patients treated, and the office bookkeeping staff, in transcribing the treatment record to the billing record would include these patients as if they were individually treated, and therefore treated on an hourly basis as individuals.

These circumstances were explained to Mr. Mulder and, also explained, was the fact that prior to any claim of the Department of Health Care Services Peter Gottheiner had discovered the mistake, had corresponded with the California Physicians' Service (on June 30, 1967) and had alerted them to the mistake and to claims which would call for overpayment.

Mr. Mulder at that time, and upon review of all of the records concerned, was totally satisfied that the circumstances amounted to a simple mechanical mistake within Peter Gottheiner's organization. There was never any charge of anything other than a simple mistake which Mr. Gottheiner himself caught, which he acknowledged, and for which refund payments were made to the State. The matter was closed without any adverse consequences and without any formalities of the like.

This simple administrative error, made by erroneous billing transcriptions, certainly should not be in any way held out as an incident adverse to Mr. Gottheiner's professional status. I should add, on a personal note, that I have known Peter for more than 10 years as a friend here in Marin County where he lives and as a practitioner in the fields of physiotherapy and home health care services. His professional standing in the community is high and is respected by me and by those around him.

Sincerely yours,

WILLIAM T. BAGLEY.

In May 1969, the San Francisco Regional Office of the Social Security Administration's Bureau of Health Insurance became aware of complaints concerning the operations of *California Coordinated Health Care Services*, Incorporated (CCHCS).

On November 26, 1969, an administrative assistant of Blue Cross who was formerly in charge of the home health agencies claims reported to BHI that early in the months of the program, *California Coordinated* submitted a substantial number of duplicate claims. When Gottheiner realized that Blue Cross was starting to check on duplicates, he began noting on some bills: "Please do not pay, this is a duplicate." At the same time, he began noting on other bills, "Please do not pay; this patient did not receive these services."

In or about December of 1969, two *California Coordinated* clients reported to BHI that they had been charged for two visits rather than one. In December of 1969, BHI asked Blue Cross to resolve the discrepancy. In January of 1970, Carol Ford, *California Coordinated's* Director of Nurses, admitted to Blue Cross that prior to March 1969, it had been her agency's practice to double bill for the initial nursing visit made to each patient due to the additional time involved in assessing the patient's total condition and the services needed. Blue Cross asked for an accounting of the double billing charges because this practice had been specifically forbidden by regulation promulgated by BHI and Blue Cross in June of 1968.

1970

In January, 1970 the Regional Representative of BHI in San Francisco forwarded to the central office in Baltimore reports of irregularities in the billing practices of CCHCS. There were indications of criminal violation. As a result, the Office of Administration was requested to provide investigative assistance. Mr. Conrad Sadowski, an investigator with the Division of Administrative Appraisal and Planning in OA, was assigned to the Gottheiner case.

In his background work, Mr. Sadowski talked with Dr. Lois Lillick, Assistant Chief of the Bureau of Adult Health and Chronic Diseases. Sadowski reported that supervision of HHA's had been removed from Dr. Lillick's section of the Bureau because, as she explained it, Gottheiner had objected to her department's supervision and had used his political connections to force the move.

HEALTH HELP, INC., FORMED

In March of 1970, Gottheiner forms *Health Help, Inc.* which was incorporated the following month. The corporation is to provide Homemaker and Chore Services within the State of California. The funds for this purpose came from Titles I, VI, and XVI of the Social Security Act, the predecessor programs of Title XX.

August 10, 1970, Lilly Toney, Manager, Federal Medicare Claims Department, Hospital Service of California (Blue Cross) informed BHI that California Coordinated admitted double billing on the account of 215 beneficiaries. The reported amount of overpayment was $2,924.

On or about this same time, BHI received a statement from Kathryn A. Stewart, former Director of Nursing for California Coordinated, reporting that Gottheiner was aware of his fraudulent billing practices. In a bulletin issued June 27, 1968, Blue Cross notified Home Health Agencies that the cost of a visit to establish a plan of treatment was to be considered an overhead expense and was not chargeable as a visit. This fact was supported by the June 1968 issue of the Home Health Agency Manual. However, Stewart, who was Director from August 1, 1968, through February 1969, said that it came to her attention in January, 1969, that Peter Gottheiner was double billing for initial evaluation visits. She also stated he was double billing for physical therapy visits because one hour's treatment was billed as two visits. (N.B. It was on this charge that Mulder wrote the September 1967 letter suspending Gottheiner from Medi-Cal. Gottheiner maintained he had been unaware of the fact that his therapists had been rendering an hours treatment in group therapy sessions). Ms. Stewart reported that she advised Mr. Gottheiner that these practices were in violation of Medicare law, but he continued them nonetheless.

On November 24, 1970, the Social Security Division of the HEW Office of the General Counsel transmitted the Peter Gottheiner case to the San Francisco Regional Attorney's Office of BHI.

1971

On January 4, 1971, the BHI Program Integrity Staff in Baltimore forwards, to the HEW Regional Attorney, material necessary to process the Gottheiner case. January 7, the regional representative notifies the home office of BHI that they are forwarding an additional case of billing for services not rendered.

January 14, 1971, Blue Cross notifies Gottheiner that a review of his costs in 1968 and 1969 has been made which revealed $44,961 in financial discrepancies. Gottheiner was asked to repay this amount.

REFERRED TO JUSTICE: CRIMINAL VIOLATION ALLEGED

February 3, 1971, the Assistant Regional Director for HEW forwarded the Gottheiner file to U.S. Attorney James Browning for criminal prosecution. It was alleged that Gottheiner billed Medicare for services not rendered in violation of Section 208 of the Social Security Act and Sections 287 and 1001 of Title 18 (criminal violations) of the U.S. Code.

GOTTHEINER RECEIVES S. F. CONTRACT

In February of 1971, Gottheiner's Health Help, Inc. was awarded the homemaker/chore services contract with the City and County of San Francisco. According to a later 1976 HEW audit, the initial rate of $5 per hour was not justified by supportive cost data.

MARCH 1971: CALIFORNIA COORDINATED HEALTH CARE SERVICES DISSOLVED

California Coordinated Health Care Service, Inc. is said to have been voluntarily dissolved in March of 1971. There is an indication this dissolution flowed from a decision to avoid recapture of funds. The staff of the Regional Office of the Bureau of Health Insurance stated: "There were overpayments, through audit exceptions, in the amount of $364,192 for cost reporting periods ending December 1967. No cost reports were submitted for 1970 and 1971, although interim Medicare payments in the amount of $481,309 were made to CCHCS, Inc."

MARCH 21, CIVIL SUIT DISMISSED BY CIVIL DIVISION, U.S. DEPARTMENT OF JUSTICE

In a letter to HEW's General Counsel, L. Stanley Paige, Chief of the Fraud Section of the Department of Justice Civil Division, said that after a preliminary review "available evidence of fraud appears insufficient to warrant institution of such a suit. Accordingly, we are closing our files."

MARCH 15, GOTTHEINER FORMS VISITING HOME SERVICES

Gottheiner forms Visiting Home Services (VHS), another corporation to offer homemaker/chore services in California and throughout the nation.

On August 12, 1971, U.S. Attorney James Browing notifies HEW that in the opinion of the Civil Division there is insufficient evidence of fraud and added, "It has been our experience in fraud cases that if the evidence is insufficient for purposes of a civil suit, the likelihood of a successful criminal prosecution is remote."

September 27, 1971, Florence Lee of Blue Cross wrote to Phyllis Stanton of BHI recommending that the Gottheiner case be transferred to GAO for collection.

In October and again in December, BHI wrote to the Justice Department asking about the status of the Gottheiner matter.

1972

January 25, 1972, Assistant United States Attorney Janet Aiken informs BHI that after consulting with Gottheiner's attorney and reviewing Gottheiner's file, she had come to the conclusion that Gottheiner was not guilty. Aiken notified Gottheiner's Attorney Harold Dobbs on March 3, 1972 that she could find no breach of criminal law. Investigation of this matter by the Committee staff reveals that this case might have been dropped for reasons other than lack of evidence. See below.

1973

In 1973, Gottheiner was negotiating for contracts for Health Help in California and for Visiting Homes Services (VHS) in other States. By Mid 1973 Carel E. H. Mulder is listed as a consultant for Health Help and as Chairman of the Board of Visiting Home Services.

1974

As of January 1974, Gottheiner had contracts in 9 California counties and the States of Utah and Missouri.

1975

On March 24, 1975, Mr. Thomas Tierney, Director of the Bureau of Health Insurance, wrote to the General Counsel of HEW indicating BHI's computation of audit exceptions and moneys owed to Medicare by Gottheiner's California Coordinated Health Care Service as follows:

Year—explanation:	*Overpayment*
1967—audited cost report	$6,304.00
1968—audited cost report	76,320.00
1969—audited cost report	213,338.00
1970—failure to file cost report	449,522.00
1971—failure to file cost report	31,787.38
1971—current financing payments	69,000.00
Subtotal	846,271.38
Less claims held in escrow	41,616.32
Total indebtedness	804,655.06

[The complete text of the letter follows:]

[Memorandum]

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL SECURITY ADMINISTRATION,
March 24, 1975.

To: Office of the General Counsel.
From: Bureau of Health Insurance.
Subject: Title XVIII: Overpayment Litigation Case: California Coordinated Health Care Services, Inc., provider No. 057085.

On August 26, 1974, the General Accounting Office informed us that they were closing their file on the subject case because the debt was uncollectable. We wrote to GAO on February 6, 1975, requesting that GAO refer this case to the Department of Justice so that a judgment may be awarded against the provider. We explained to GAO that there is considerable interest in the local health care community regarding our efforts to collect this overpayment and suggested that even if the corporation is presently without substantial assets, the awarding of a judgment would place our claim on record should their status change sometime in the future.

On February 26, 1975, GAO informed us that they communicated with the Department of Justice and were informed that the Department of Justice would be agreeable to obtaining a judgment provided that information could be furnished which would indicate that such action would be productive.

The stock of the subject provider is owned by Peter Gottheiner, RPT—60 percent—and Dr. Robert S. Sitken—40 percent. Our records indicate that the provider and the shareholders have sufficient assets to satisfy the overpayment.

The provider was incorporated in the State of California for the purpose of participating in the medicare program as a home health agency. The provider was certified on January 20, 1967, and continued in the program through March 10, 1971, when it voluntarily terminated its participation in the program. Blue Cross Hospital Service of California was nominated by the provider to serve as its fiscal intermediary through December 31, 1970. Thereafter, the provider requested to change its intermediary to the Social Security Administration. This request was granted and became effective January 1, 1971. At the time the provider terminated its participation from the program, it was indebted to the Medicare Trust Fund in the amount of $804,655.06. We have information from the California secretary of state's office that the provider is not dissolved but was suspended by the California Franchise Tax Board effective February 1, 1973.

Pursuant to the provisions of sections 1814(b), 1815, 1833(a)(2), and 1861(v) of the Social Security Act, as amended (42 U.S.C. 1395f(b), 1395g, 1395*l*(a)(2), and 1395(x)(v)), the amounts of $155,283, $366,839, and $555,678 have been determined to be the reasonable cost of services furnished to medicare beneficiaries by the provider, during the periods ended December 31, 1967, December 31, 1968, and December 31, 1969 respectively, and that the amounts of $161,597, $443,159, and $769,016 respectively, were actually paid to the provider for such services during the above-cited periods resulting in overpayments of $6,304, $76,320, and $213,338, respectively.

The provider filed cost reports for the cost reporting periods ending December 31, 1967, December 31, 1968, and December 31, 1969. The overpayment for the 3-year period was calculated as follows:

Period ending Dec. 31, 1967

Part A:	
Total cost incurred	$98,504
Interim payments made to provider	99,987
Amount of overpayment	(1,483)
Part B:	
Total cost incurred	72,177
Less: Deductibles chargeable to patients	1,203
Net cost	70,974
80 percent of net cost applicable to HIP	56,779
Less: Payments made by intermediary	61,600
Amount of overpayment	(4,821)
Total amount of indebtedness per final settlement	(6,304)

Period ending Dec. 31, 1968

Part A:	
Total cost incurred	$265,000
Interim payments	322,750
Amount of overpayment	(57,750)
Part B:	
Total cost incurred	132,738
Less: Deductibles chargeable to patients	5,439
Net cost	127,299
80 percent of net cost applicable to HIP	101,839
Less: Payments made by intermediary	120,409
Amount of overpayment	(18,570)
Total amount of indebtedness per final settlement	(76,320)

Period ending Dec. 31, 1969

Part A:	
Total cost incurred	$392,450
Interim payments	482,120
Amount of overpayment	(89,670)
Part B:	
Total cost incurred	212,401
Less: Deductibles chargeable to patients	8,366
Net cost	204,035
80 percent of net cost applicable to HIP	163,228
Less: Payments made by intermediary	201,896
Amount of overpayment	(38,668)
Initial settlement paid to provider	(85,000)
Amount of indebtedness per final settlement	(213,338)

The provider failed to furnish cost report information for the periods ended December 31, 1970 and March 31, 1971. Therefore, the entire amount paid to the provider for such periods is deemed to be an overpayment. The amount of the interim payments received by the provider during the aforesaid periods was $449,522 and $31,787.38 respectively.

In addition to the overpayments paid to the provider due to excessive interim payments, the provider also received current financing payments of $69,000. Effective May 29, 1973, all current financing payments were eliminated to all participating providers and any such payments outstanding after that date constituted an overpayment.

The provider has continued to present claims to its intermediary for payment. The intermediary calculated $41,616.32 as the estimated amount due the provider on behalf of such claims and placed this amount in escrow.

In view of the foregoing, the provider is indebted to the Medicare Trust Fund in the amount of $804,655.06. The overpayments can be summarized as follows:

Year—explanation:	*Overpayment*
1967—Audited cost report	$6,304.00
1968—Audited cost report	76,320.00
1969—Audited cost report	213,338.00
1970—Failure to file cost report	449,522.00
1971—Failure to file cost report	31,787.38
Current financing payments	69,000.00
Total	846,271.38
Less claims held in escrow	41,616.32
Total indebtedness	804,655.06

Please request the Department of Justice to initiate suit against the subject provider and its two shareholders. If necessary, the Department of Justice could obtain a certificate of indebtedness from GAO. We will secure a certified administrative file and affidavit, in accordance with our established procedure, when requested by the Department of Justice through your office.

THOMAS TIERNEY,
Director.

1975 STATE AUDIT

On or about this same time the Department of Justice notified BHI that they will take the case only if BHI could demonstrate evidence of collectability.

In August 1975, a California Department of Health audit indicated the following concerns about the operation and management of Health Help:

A considerable number of charges were made for entertainment, business expenses, and travel (including out of State and foreign).

Expense reimbursements were not adequately supported.

Out-of-pocket expenses of $26,000 and $4,998 in 1974 were totally unsupported by bills or receipts.

Reimbursements to the President totaled $45,430.97 for 1974 exclusive of March and $31,954.72 for 1973 exclusive of May. The audit indicated that there was no basis for determining that these expenditures were related to provision of service in San Francisco County and that for a smaller portion of these items, there was no assurance that these were not personal expenses.

Reported expenses included political contributions to both political systems. Title VI funds were, in effect, used for political contributions.

Since these political contributions were not consistently recorded in the same place, all may not have been identified. The identifiable total was $2,200, not including a $57.50 contribution to the police officer association.

A number of entries were not supported:

(1) An American Express invoice mailed November 17, 1973, for $1,059.32 (most of this payment was for a prior balance with no detail as to what the balance was for).

(2) A Carte Blanche invoice for $363.68 mailed October 25, 1973, had receipts enclosed totaling only $169.68.

(3) A Diner's Club bill mailed October 18, 1973, for $626.03 was supported by receipts totaling only $88.85.

The contractor included income taxes and tax penalties for late payment of payroll taxes as a reimbursable cost.

Other questionable charges include the following:

	1973	1974
Prorated home office	$1,498.00	$1,900.00
Benardarets (pipe and tobacco store)	1,690.97	2,389.53
John Walker (liquor store)	2,580.91	2,083.67
Out-of-pocket expenses	2,600.00	4,998.58
Washington, D.C. (inaugural)	925.00	
Alfred Dunhill (men's boutique)		254.00
Honolulu expenses		405.00

THE HEW AUDIT

On May 18, 1976, the HEW Audit Agency in San Francisco released the findings of an audit conducted on three California homemaker chore service providers. One of these was Gottheiner's Health Help, which received a contract with the city and county of San Francisco in February 1971. With respect to Health Help the audit concluded:

(1) The initial rate of $5 an hour was not justified by supportive cost data.

(2) Health Help received a rate increase to $6 an hour effective July, 1971, without submitting required financial information. Health Help asked for a rate increase to $7.30 an hour in July of 1972. The social services commission approved a rate of $7 an hour which allowed a monthly profit of $9,900 (or about $118,800 for the year). Again rates were not based on actual cost data.

(3) "Unaudited financial statements prepared on behalf of Health Help did not fairly present reimbursable contract costs and substantially understated profits made by the individual contractors * * *"

(4) The compensation paid to officers of Health Help was for distribution of profits rather than for actual services rendered.

(5) When Gottheiner claimed that he was making 12 cents an hour profit, the auditors noted the accounting records were not designed to clearly identify and report costs. "The financial statements, while presented as a basis for justifying the $7 per hour contract rate, are misleading primarily because they reflect corporate expense account balances that included the costs of an affiliated corporation." These costs were in no way connected with the San Francisco contract, and totaled $91,276. This amount, said the audit, "represents a material overstatement of actual contract costs and substantially understates actual profit under the contract by $0.93 per hour ($91,276 divided by 97,658 hours)."

(6) The HEW audit said further "Our audit showed that payments from the county agency for services billed for calendar year 1973 total $683,326. Reimbursable costs under the contract totaled $505,234, resulting in a net profit before taxes of $178,092 or 35 percent of total costs. On this basis, the net profit before taxes was $1.82 per hour ($178,092 divided by 97,658 hours)."

(7) Then added: "The statement of income and expenses included $57,566 of expenses which were not related to the San Francisco contract for calendar year 1973. Certain costs reported by the contractor were not subject to Federal reimbursement under 41 CFR, subpart 1-15.2. Under this criteria we have classified $13,691 of expenses as nonreimbursable. This amount included $4,092 for Federal income taxes, $3,915 for payment of a tax penalty, $5,504 of interest expenses and $180 of organization expense."

JUNE 12, 1976: GOTTHEINER RESIGNS FROM VISITING HOME SERVICES

On the following day, his son, Ron Gottheiner assumed the presidency of the corporation. Gottheiner reportedly received $25,000 in loan severance pay, plus about $8,000 in what were termed "loan repayments."

VISITING HOME SERVICE AND HEALTH HELP FILE BANKRUPTCY

On or about August 1, both corporations filed a petition of bankruptcy.

THE STATE AUDIT: DEPARTMENT OF BENEFITS PAYMENTS

On October 20, 1976, the Department of Benefit Payments for the State of California released their audit of Gottheiner's corporations for the period July 1, 1975, through June 30, 1976. The department reported that "Funds were shifted back and forth (between Health Help and Visiting Home Services) and payments were made from available resources. Accordingly, our review treats the two organizations as a single entity." The audit reported further that "Health Help held the only lucrative contract (San Francisco), and funds from this revenue source were generally used indiscriminately to finance both personal and business expenses of both corporations."

Among the major findings of this audit were the following:

(1) Gottheiner received $58,815 as expense advances and reimbursements during the audit period. These included purchases at liquor and tobacco stores and personal expenses at local restaurants and hotels. There may have been duplicate and triplicate payments of some of these expenses.

(2) Gottheiner received $43,100 in consultant fees during the period even though he was also receiving a salary for his services.

(3) Gottheiner was paid salaries of $24,000 by Visiting Home Services and $20,000 by Health Help for a total of $53,000 during the period.

(4) Gottheiner was paid $81,168 in loan repayments during the period, though the department could find no evidence of any loans from Gottheiner to either corporation.

(5) Gottheiner's son, Ron, received a salary of $25,875 from Visiting Home Services and $2,500 from Health Help. He was also paid $8,300 in loan repayments, though auditors found no evidence of loans from Ron Gottheiner to either corporation.

(6) Gottheiner's daughter, Vivian, was paid $1,875 in consultant fees. There was no documentation of her work.

(7) Gottheiner's ex-wife, Eva, received $11,000 in salaries for the period. It appears that these payments were a personal benefit to Gottheiner.

(8) Gottheiner's daughter-in-law, Jeanie, was paid a salary of $10,400 for the period The auditors could not determine the extent of her corporate activities.

1077

Gottheiner is currently operating in the State of Illinois. He obtained contract (duration and amount unknown). The name of his new corporation National Home Health, Inc.

V. ALLEGATIONS

As noted from the above chronology, several areas of concern have been raised by Gottheiner's operations. These areas are highlighted below:

A. ALLEGATION: COSTS REPORTED BY GOTTHEINER ARE INFLATED AND ARE NOT REASONABLY RELATED TO THE QUALITY OF CARE

This point is discussed in detail by the State and HEW audits reported above.

B. ALLEGATION: THE QUALITY OF SERVICES OFFERED BY GOTTHEINER'S CORPORATIONS LEAVE MUCH TO BE DESIRED

Evidence

(1) The Tri-Counties Commission for Senior Citizens tried to prevent the awarding of the Santa Barbara County Contract to Visiting Home Services last July. The organization claimed that VHS allowed the quality of service to deteriorate to the point where some clients went unattended. The Visiting Nurses Association supported the charge, stating that it had 16 documented cases of severely disabled clients who received little or no home care service from VHS.

(2) The newspaper carrying the above story contacted 22 clients of VHS, 20 of whom agreed to discuss quality of care. Fourteen said there were periods where VHS homemakers repeatedly failed to make their scheduled visits. The 72-year-old wife of a 92-year-old stroke victim had cared for her husband for 6 weeks without homemaker care, although they were entitled to 9½ hours of service per week. Other findings:

A 61-year-old woman, entitled to 4 hours per week, hadn't seen the homemaker for almost two months.

One man who signed a petition protesting VHS' firing of a codirector was apparently penalized by a complete loss of service.

Clients who called VHS to complain said their efforts resulted in promises, rudeness, or cold indifference.

Although the VHS/Santa Barbara contract specified 50 hours of required employee training, Codirector Evangelina Diaz, who was fired, told the county board that homemaker attendants received no training from Visiting Home Services. When she tried to organize the training program, Diaz said he was told by VHS that any training program had to be done in the office by volunteers at no cost to the company.

Another charge against VHS was that personal services such as bathing, done only by nurse's aides according to VHS, were actually assigned to employees with no previous experience or training. Diaz claimed that "People were hired as they walked in through the front door. We never had time to look at their references because of the need to cover clients. If an attendant was willing to take on bathing, then he or she was sent out on it."

C. GOTTHEINER USES POLITICAL INFLUENCE TO GAIN FAVORABLE TREATMENT

Utah

In the State of Utah, program specialist, Jay Wimmer, was instrumental in getting Gottheiner a statewide contract to provide homemaker services. While employed by the State's division of family services, Wimmer wrote letters on Gottheiner's behalf to appropriate officials in Kansas and Minnesota. These letters touted the capabilities of Gottheiner and his VHS corporation. The letters were sent March 14 and March 20, 1975.

A copy of Mr. Wimmer's letter to the State of Minnesota follows:

UTAH DEPARTMENT OF SOCIAL SERVICES,
DIVISION OF FAMILY SERVICES,
March 20, 1975

MS. JANIS HILLIARD,
Homemaker Supervisor, Department of Public Welfare, County of St. Louis, State of Minnesota, Duluth, Minn.

DEAR MS. HILLIARD: Mr. Peter Gottheiner of Visiting Home Services, Inc., asked that I write to you concerning Utah's homemaker/chore service program which is under contract with his company.

The State of Utah currently has eight counties under contract with Visiting Home Services, Inc., which accounts for 90 percent of the State's population.

Prior to selecting Visiting Home Services, Inc., an extensive 6-week evaluation of their services in nine counties in California took place. The reference letters we received from all nine counties were excellent with no negative responses.

In Utah, Visiting Home Services was able to set up offices, recruit and train homemakers and start delivering a quality service within 60 days. His staff has been able to handle difficult situations as well as 24-hour care, weekend work, and 1-hour emergency call kinds of requests.

I would recommend consideration of Visiting Home Services, Inc., for your homemaker/chore service program.

If further information is desired, please contact me. Please find enclosed a packet describing our homemaker programs.

Sincerely,

J. S. WIMMER, M.S.W.,
Program Specialist.

At the time he wrote such letters on Gottheiner's behalf, Wimmer had specific information as to the problems with Gottheiner's past performance in California. One example of what Wimmer knew was the June 24, 1974, letter to Wimmer from Hadley Hall, president of San Francisco Home Health Services, questioning the quality of care and the reported costs. Hall said in part, "There seems to be a pattern of hiring well known political figures to advocate Mr. Gottheiner's position."

In May 1975, the Utah contract was in force and in June 1975, Wimmer went to work for Gottheiner.

California

The possibility of strong political influence on the local level was raised by the awarding of the San Luis Obispo County homemaker chore service contract 2 years ago. A May 21, 1975, newspaper article announced that San Luis Obispo's Board of Supervisors awarded their home care contract to Visiting Home Services, even though it was the highest of three bidders. Director Thomas Ganoe said that he felt the low bidder could do the job just as well as VHS and for less money. At the time of the award, Visiting Home Services had had the home contract with the county for the previous 17 months. The difference between high and low bid was approximately $63,000. In June 1975, the Board voted to rescind its contract award, and on November 1, services were taken over by Unicare, Inc.

Illinois

According to Fred Keeley, a former employee of Gottheiner's, Gottheiner was having trouble obtaining the Illinois contract for homemaker chore services. He was directed to a State Senator, who met with Gottheiner several times and allegedly rendered assistance. Gottheiner did receive a limited contract after he hired the law firm suggested by the State Senator. This charge has not been verified beyond the sworn statement of the employee.

Missouri

In this State, the contract was awarded Statewide without bid. One of the State's contracting officers, who asked that we respect his confidentiality, informed us that it had been a political decision and that the contract had been let in unseemly haste. He also stated that although Gottheiner had promised that he would serve the entire State, only one office had been opened and that in the most lucrative area, St. Joseph, Mo.

D. ALLEGATION: THE PROSECUTION AGAINST GOTTHEINER BY THE DEPARTMENT OF JUSTICE IN 1971–72 MIGHT HAVE BEEN DROPPED FOR REASONS OTHER THAN LACK OF EVIDENCE

Investigator Halamandaris interviewed Janet Aiken, Assistant U.S. Attorney who handled the Gottheiner case. Here are his notes:

"She was friendly and forthcoming and remembered the case quite well. She indicated it had been a matter of almost seasonal recurrence. At her invitation I viewed 'the whole file'. I also was allowed to duplicate at will. Throughout our interview she made rather frequent protestations of good faith, possibility of a mistake honestly made, rather more frequent than necessary I thought. She stated the Gottheiner case had been one of her first cases after coming into the U.S. Attorney's Office out of private practice.

"She admitted sitting on the case for 6 months despite a number of letters from BHI. (Didn't know quite how to handle it. Had other 'more interesting' less 'taxing' more 'rewarding cases' was her reasoning.) She admitted she thought it was so strong that when she went to lunch with Dobbs (Gottheiner's attorney and a former political force in San Francisco she rubbed it in a bit and told him there was little he could do but plea for a misdemeanor. She admitted she was talked out of the prosecution by Dobbs subsequently. 'I didn't really see it until he explained it to me,' she said. 'I began to question it more closely. If you look at it in that way it begins to become clear the investigator had it in for Gottheiner. The man is widely disliked,' she said. 'It is very easy for anyone with a grudge to make a case and find witnesses to testify against him.' She admitted as well giving Gottheiner particular consideration because of the reputation of her counsel, who, she said, was a friend, former mayoral candidate and attorney of outstanding reputation and ability but denied political influence.

"The case was resolved, she said, when Dobbs brought in Gottheiner's Cal Coordinated Files ('obviously still in the packing crate'—the corporation had at this time been dissolved) and laid them out on her table. Two billings were pulled out of the box for examination. She is uncertain who pulled the billings. Off the top, she says, she thinks she must have, he might have. She plainly does not recall or perhaps does not want to recall. On the basis of examining these two vouchers she stated she lost faith in her case and the investigator who compiled it for HEW. 'Once you find something wrong in one area, you tend to doubt it all,' she said. Out of fairness, HEW was told of the existence of the file and invited to view and evaluate it if they wished to prepare a counter-argument (considering the original cause of action sprang from 1967 and it was now 1973, there is a considerable question of reasonableness).

"Conclusion: More than probably the U.S. Attorney was influenced, sugared more likely than bribed. I think she had a strong disinclination going in, found the case technical, unpromising, unrewarding. I think additionally she has more than sufficient respect quotient for Mr. Dobbs."

ADDITIONAL CORRESPONDENCE RELATING TO MR. WIMMER

SAN FRANCISCO HOME HEALTH SERVICE,
San Francisco, Calif., June 24, 1974.

Mr. JAY WIMMER,
State Program Specialist, Division of Family Services, Salt Lake City, Utah.

DEAR MR. WIMMER: Enclosed are materials related to Mr. Peter Gottheiner, and information available about him in San Francisco. As you can tell from the material, a wide variety of individuals have had dealings with Mr. Gottheiner. For instance, Mr. Carel E. H. Mulder, who signed the letter suspending Mr. Gottheiner from the California medical assistance program (medicaid), is the same gentleman who is now listed as one of Mr. Gottheiner's consultants. Assemblyman Bagley was chairman of the California Assembly's Welfare Committee, and is an attorney in private practice. Mr. Harold Dobbs was an unsuccessful candidate for mayor of the city and county of San Francisco, and was also a paid attorney for Mr. Gottheiner.

There seems to be a pattern of employing well-known political figures to advocate Mr. Gottheiner's position. Since there has never been a conviction for criminal involvement, Mr. Gottheiner has every right, and the rest of us have a responsibility to ensure that right, of appropriate representation. It would appear that Mr. Gottheiner has the resources to secure a proper defense.

The testimony to the Social Services Commission outlines some of the issues related to unit cost (charging what is paid for but not necessarily providing what is needed) and total monthly cost. You may find this testimony of interest.

It seems to me that, since the Federal regulations require that agencies meet the standards of the national council, any prospective contractor that does not have national council approval should be rejected. In essence, these standards only require that patients be evaluated before a homemaker is assigned and at regular intervals so that overutilization will not occur. In addition, the national council standards require that the homemaker have initial training, as well as ongoing training and supervision. Supervision cannot be by phone, and one or two professionals on a staff for 200 clients is not evidence of appropriate client assessment or supervision.

If we can be of further assistance, please let us know.

Cordially,

H. D. HALL,
Executive Director.

UTAH DEPARTMENT OF SOCIAL SERVICES,
DIVISION OF FAMILY SERVICES,
September 19, 1974.

To: Lloyd H. Nelsen, deputy director.
From: Jay Wimmer, program specialist.
Subject: Permission to amend homemaker contract.

It has come to my attention that under the old housekeeping policy, we were allowing individuals to live 24 hours with consumers, and we were compensating them at the rate of $1.60 per hour times 100 hours maximum.

Under our current 24-hour contractual arrangements with Visiting Home Services, this would run into an unreasonable amount of money. The intent of the 24-hour care is really for intermediate kinds of situations and was not intended to be a 24-hour ongoing arrangement at the higher cost.

For this reason, I am asking for permission to amend the contract to pay these individuals a minimum standard wage which is $2 per hour times 100 hours per month. In addition to this, we would pay the contractor, Visiting Home Services, a 15.7 percent management fee which breaks down into the following: 10.7 percent of that will go toward Visiting Home Service's share of taxes resulting in a 5 percent management fee profit.

This seems reasonable to me and with your permission, I will draw up the amendments with Jay Oldroyd and submit them for division and departmental approval.

[Memorandum]

UTAH DEPARTMENT OF SOCIAL SERVICES,
DIVISION OF FAMILY SERVICES,
November 25, 1974.

To: Heber G. Mehr, assistant director.
From: Jay S. Wimmer, program specialist.
Subject: Comparison by district of the homemaker program.

DISTRICT I

[In hours per week]

	Homemaker	Chore services	Total
October 18	271	82	
November 18	170	149	
Total for month	736	645	

They have been allowed 1,700 general homemaker services by the contract and 300 chore service hours a month per contract. This would show District I far short in the homemaking projections and exceeding chore service expectations.

DISTRICT II

[In hours per week]

	Homemaker	Chore services
October 18	346	100
November 18	231	104
Total for month	1,001	450

They have been allocated 2,400 per month homemaker and 840 chore services per month. They have used no 24-hour care.

DISTRICT II-B

For the month of November, they have used 528 homemaker hours and 253 chore service hours and no 24-hour care. They have been allocated 1,333 homemaker and 933 chore service hours.

DISTRICT III

[In hours per week]

	Homemaker	Chore services
November, 1974	338	652

They have used no 24-hour care. They have been allocated 1,263 homemaker hours and 1,010 chore service hours.

This gives a grant total for the State of 2,603 homemaker hours used at a cost of $11,192.90 for the month of November.

2,000 chore service hours at a cost of $7,700 and 24-hour care is 0.

Grand total of compensation for the provider in the amount of $18,892.90.

If you compare this with what in essence we projected, the projected amount would be as follows:

7,151 homemaker hr	$30,749.30
3,183 chore service hr	12,254.55
2,560 24-hr care	3,328.00
Total	46,331.85

When you subtract the $18,892.90 you can see that the provider took a loss of $27,408.95. When you add the $26,000 he lost last month you can see that his total loss for the program so far is $53,408.95.

Based on this information the provider is requesting that we consider a similar arrangement as provided in California where they prorate the homemaker program and pay him a monthly amount based on the projections and then make any corrections one way or the other during the last 3 months of the contract. The provider has indicated the problem of obtaining long range financing due to the tightness of money and is hopeful that a solution can be arrived at.

[Memorandum]

UTAH DEPARTMENT OF SOCIAL SERVICES,
DIVISION OF FAMILY SERVICES,
December 10, 1974.

To: Evan E. Jones, Jr., director.

From: Jay S. Wimmer, program specialist.

Subject: Visiting Home Services, Inc.

After reviewing the proposal sent to you from Peter Gottheiner asking for an advance on the contract in the amount of $50,000 and knowing how you feel about this request, I would like for you to consider the following recommendation which could very well work out to be a workable solution for all concerned.

My recommendation is that we allow the provider to charge us more on a hourly rate for the services being rendered during the next 3 months and then subtract this amount during the last 3 months from the amount of the contract so that in actuality, the dollar amount ends up the same, An example of this proposal would be to allow him to charge us $5.35 instead of $4.35 an hour for homemaker services during the months January through March and during the last 3 months, pay the provider $3.35 an hour instead of the $4.35, or whatever it works out in order to balance out the contract.

In talking with Jay Oldroyd, he indicates that this arrangement would necessitate amending the contracts unless an arrangement can be worked out with Finance.

If you were to authorize such an arrangement, we would closely supervise the amount of money going to the provider so that we would not exceed the original contract amount.

I have also assured Mr. Gottheiner of our intentions to accelerate our program after the first of the year by tripling what we are doing now.

I have enclosed the total billing for the month of November for the following districts: 1, 2A, 2B, 3, and 6. All of the rural districts except District 5 are participating in the program as of December 1; Cedar City should be on board by January 1.

Let me hear from you immediately concerning your decision on this recommendation.

[Memorandum]

DEPARTMENT OF SOCIAL SERVICES,
DIVISION OF FAMILY SERVICES,
January 17, 1975.

To: Lloyd H. Nelson, deputy director.

From: Jay S. Wimmer, program specialist.

Subject: Emergency contract with visiting Home Services, Inc.

After studying the proposed sliding scale fee submitted by Visiting Home Services, Inc., and evaluating what I feel his actual costs are to maintain his program here in Utah, I propose the following:

(1) Reduce Visiting Home Services' requested rate per hour by approximately 7½ percent starting at $5 per hour for homemaker services and $4.25 per hour for chore services, and going to approximately $4.30 per hour for homemaker services and $3.85 per hour for chore services, which was his price under our present contract.

	Division of Family Services rates	Visiting Home Services rates
Total monthly number of homemaker service hours in all districts presently under contract:		
11,200	$4.30	$4.30
11,000	4.30	4.30
10,800	4.30	4.30
10,600	4.30	4.35
10,400	4.35	4.40
10,200	4.35	4.45
10,000	4.35	4.50
9,800	4.35	4.55
9,600	4.40	4.60
9,400	4.40	4.65
9,200	4.40	4.70
9,000	4.40	4.75
8,800	4.45	4.80
8,600	4.50	4.85
8,400	4.55	4.90
8,200	4.60	4.95
8,000	4.65	5.00
7,800	4.65	5.00
7,600	4.65	5.00
7,400	4.65	5.10
7,200	4.70	5.10
7,000	4.70	5.10
6,800	4.75	5.20
6,600	4.75	5.30
6,400	4.95	5.40
6,200	5.00	5.50
6,000	5.00	5.60

	Division of Family Services rates	Visiting Home Services rates
Total monthly number of chore service hours in all districts presently under Contract:		
6,000	$3.85	$3.85
6,400	3.90	4.00
6,200	3.95	4.15
6,000	4.00	4.30
5,800	4.05	4.45
5,600	4.10	4.60
5,400	4.15	4.75
5,200	4.20	4.85
5,000	4.25	4.95

Five dollars would be the highest amount he could charge us for homemaker services and $4.25 would be the highest rate for chore services.

The current rate of $1.30 per hour for 24-hour intermediate care would remain as well as $2.31 per hour for long term 24-hour care.

(2) We will write one contract to cover the emergency period covering all districts. This would avoid developing a sliding scale for each area. Provider will have to absorb the cost or loss of operating in unproductive areas until hours can be brought up.

(3) The $5 figure is still under the bid proposal submitted by Upjohn which was $5.26 per hour for homemaker services and $4.10 per hour for chore services, and $1.56 per hour for 24-hour care. (See attached.)

(4) If the division were to set up this program, my estimation of the cost would be as follows:

	Per hour average
Hourly wage	$2.75
Taxes and social security	.27
Administrative and supervisory costs	1.75
Total	4.77

Some of my concerns of running our own program are as follows:

(a) Time factor involved in recruiting and maintaining staff.

(b) Program will become a maintenance program instead of expansion.

(c) Our cost will go up administratively as the program grows requiring more supervision and other administrative considerations.

CONCLUSION

Offer emergency contract to Visiting Home Service, Inc. as to recommendations and give him 5 days to indicate acceptance.

UTAH DEPARTMENT OF SOCIAL SERVICES,
DIVISION OF FAMILY SERVICES,
Salt Lake City, Utah, January 31, 1975.

Mr. C. SALAZAR, JR.
Associate Regional Commissioner for Management,
Department of Health, Education, and Welfare, Denver, Colo.

DEAR MR. SALAZAR: I have been asked to respond to three questions directed to Mr. Paul S. Rose in your letter dated January 6, 1975, as it pertains to the homemaker program and specifically with the Division of Family Services' contract with Visiting Home Services, Inc.

Your first question deals with long-term, live-in care with a caution to exercise discretion in approving these services: We have established guidelines with our workers when determining approval for long-term, live-in care. The guideline is from 1 to 15 days. If a case requires long-term care on an ongoing basis, we then convert the case over to a long-term program with a $231.40 maximum payment per month.

Your second question asked the method of basis of how the $4 per hour rate for chore services and $4.25 per hour rate for homemaker services was established as being reasonable. The homemaker contract was put out for bid. [illegible] to this process, many State's programs were surveyed as to reasonable costs

and actual cost of their programs. We found the rate that we accepted through the bid process was extremely competitive and, in most cases, lower than programs being conducted in other States. The provider is also required to submit a form 515 showing the actual cost of his service.

Your third question deals with the four amendments to the original contract where we refer to a management service fee. We have deleted this terminology. The actual cost of $231.40 per month is the total cost of services for 24-hour, long-term care and the contract terminology will be changed to reflect this and reference to management service fee will be deleted.

Sincerely,

JAY S. WIMMER, MSW,
Program Specialist.

VISITING HOME SERVICES, INC.,

MR. EVAN E. JONES, Jr.,
ACSW, Director, Division of Family Services,
State of Utah, Salt Lake City, Utah.

DEAR MR. JONES: Complying with your request and pursuant to our letter of January 28, 1975, we herewith enclose the required financial data prepared and certified by our certified public accountant.

Should you have any questions, please do not hesitate to contact Victor L. Harvey, 1280 Columbus Ave., San Francisco, Calif. 94133, 415-441-8882.

Warmest personal regards.

Very sincerely,

PETER GOTTHEINER, R.P.T.,
President.

CREATIVE LEISURE BUILDING,
San Francisco, Calif., February 10, 1975

VISITING HOME SERVICES, INC.
San Francisco, Calif.

I have examined the accompanying statement of loss for the year ended December 31, 1974, of Visiting Home Services, Inc.—Utah Division. My examination was made in accordance with generally accepted auditing standards and, accordingly, included such tests of the accounting records and such other auditing procedures as I considered necessary in the circumstances.

In my opinion, the accompanying financial statement presents fairly the results of the operations of Visiting Home Services, Inc.—Utah Division—for the year ended December 31, 1974. In conformity with generally accepted accounting principals.

V. L. HARVEY.

Visiting Home Services, Inc., statement of loss for the year ended Dec. 31, 1974
(Utah Division)

Operating loss before general and administrative expenses	$(8,414)
General and administrative expenses:	
Officers' salaries	13,500
Office salaries	6,473
Payroll taxes and compensation insurance	1,010
Auto and travel	11,484
Bank charges	833
Depreciation	135
Equipment rental	169
Insurance	2,219
Interest	1,147
Professional fees	3,760
Office supplies and postage	1,667
Rent	1,250
Consulting fees	1,544
Telephone	1,914
Advertising and promotion	743
Total general and administrative expenses	47,848
Net loss	(56,262)

VISITING HOME SERVICES, INC., STATEMENT OF LOSS FOR THE YEAR ENDED DEC. 31, 1974 (UTAH DIVISION)

	Salt Lake City	Provo	Ogden	Logan	Vernal	Richfield	Price	Blanding	Total Utah locations
Sales—Social Services	$28,933	$ 16,137	$22,465	$18,569	$5,339	$2,145	$1,278	$390	$95,256
Cost of sales:									
Salaries—Homemakers and live ins	19,450	9,051	11,836	9,517	3,518	1,218	617	128	55,335
Salaries—Administrative and clerical	7,036	4,775	5,710	4,200	1,862	978	0	0	24,561
Payroll taxes	2,402	1,251	1,588	1,242	487	191	56	11	7,228
Workmens' compensation insurance	595	314	442	305	108	40	15	3	1,822
Transportation costs	740	280	412	249	221	158	16	46	2,122
Total costs of sales	30,223	15,671	19,988	15,513	6,196	2,585	704	188	91,068
Gross profit from sales	(1,290)	466	2,477	3,056	(857)	(440)	574	202	4,188
Direct operating expenses:									
Automobile and travel	65	128	0	0	0	77	165	150	585
Computer payroll charges	264	155	142	156	56	47	30	85	935
Office supplies and postage	1,231	756	710	451	513	383	213	0	4,257
Rent	1,000	608	431	400	315	140	0	0	2,894
Telephone	1,582	682	1,056	344	150	75	23	19	3,931
Total operating direct expenses	4,142	2,329	2,339	1,351	1,034	722	431	254	12,602
Operating income (loss) before general and administrative expenses	(5,432)	(1,863)	138	1,705	(1,891)	(1,162)	143	(52)	(8,414)
Statistics (percent):									
Cost of sales	104.5	97.1	88.5	83.5	116.1	120.5	55.1	48.2	95.6
Operating income (loss) before general and administrative expenses	(18.8)	(11.5)	.6	9.2	(35.4)	(54.2)	11.2	(13.6)	(8.8)

UTAH DEPARTMENT OF SOCIAL SERVICES,
DIVISION OF FAMILY SERVICES,
Salt Lake City, Utah, March 11, 1975.

MR. LANCE GRAHAM,
Director, Department of Social Services, State of Missouri, Broadway Office Building, Jefferson, Mo.

DEAR MR. GRAHAM: Mr. Peter Gottheiner, of Visiting Home Services, Inc., asked that I write to you concerning Utah's homemaker/chore service program which is under contract with his company.

The State of Utah currently has eight counties under contract with Visiting Home Services, Inc., which accounts for 90 percent of the State's population.

Prior to selecting Visiting Home Services, Inc., an extensive 6-week evaluation of their services in nine counties in California took place. The reference letters we received from all nine counties were excellent with no negative responses.

In Utah, Visiting Home Services was able to set up offices, recruit and train homemakers and start delivering a quality service within 60 days. His staff has been able to handle difficult situations as well as 24-hour care, weekend work, and 1-hour emergency call kinds of requests.

I would recommend consideration of Visiting Home Services, Inc., for your homemaker/chore service program.

If further information is desired, please contact me. Please find enclosed a packet describing our homemaker programs.

Sincerely,

JAY S. WIMMER, M.S.W.,
Program Specialist.

UTAH DEPARTMENT OF SOCIAL SERVICES,
DIVISION OF FAMILY SERVICES,
Salt Lake City, Utah, March 14, 1975.

Mr. CURTIS HARTENBERGER,
Coordinator of Special Services, State Department of Social Services and Rehabilitation, State Office Building, Topeka, Kans.

DEAR MR. HARTENBERGER: Mr. Peter Gottheiner of Visiting Home Services, asked that I write to you concerning Utah's homemaker/chore service program which is under contract with his company.

The State of Utah currently has eight counties under contract with Visiting Home Services, Inc., which accounts for 90 percent of the State's population.

Prior to selecting Visiting Home Services, Inc., an extensive 6-week evaluation of their services in nine counties in California took place. The reference letters we received from all nine counties were excellent with no negative responses.

In Utah, Visiting Home Services was able to set up offices, recruit and train homemakers and start delivering a quality service within 60 days. His staff has been able to handle difficult situations as well as 24-hour care, weekend work, and 1-hour emergency call kinds of requests.

Implementing a homemaker program in Kansas would have some similarities to Utah's program since there are both rural and urban kinds of problems which require special kinds of services and considerations.

I would recommend consideration of Visiting Home Services, Inc., for your homemaker/chore service program.

If further information is desired, please contact me. Please find enclosed a packet describing our homemaker programs.

Sincerely,

JAY S. WIMMER, M.S.W.,
Program Specialist.

UTAH DEPARTMENT OF SOCIAL SERVICES,
DIVISION OF FAMILY SERVICES,
Salt Lake City, Utah, May 20, 1975.

Mr. PETER GOTTHEINER,
President, Visiting Home Services, Inc., San Francisco, Calif.

DEAR PETER: Enclosed is the letter prepared for the Salt Lake County Commission. All other district offices will be writing a similar letter in support of homemaker services through title XX.

Sincerely,

JAY S. WIMMER, M.S.W.,
Program Specialist.

VISITING HOME SERVICES, INC.
May 19, 1975.

Commissioner RALPH MCCLURE,
Salt Lake County Commission, c/o Salt Lake County Social Services, City and County Building, Salt Lake City, Utah.

DEAR COMMISSIONER MCCLURE: Homemaker/chore services are multiplying rapidly through Salt Lake County because of the direct and practical help given to people in need.

Much of the present demand for the creation and expansion of homemaker/chore service programs is due to the growing conviction throughout Utah and the United States that generally, people of various ages and personal problems are happiest in their own homes if safeguards in necessary services are offered to them.

What is the essence of homemaker service? Its true purpose has remained constant, although demands for it have resulted in an increasingly wide variation in groups served.

Homemaker service is provided to maintain, strengthen, improve and safeguard the home and family life for individuals and family groups when such service is appropriate.

We have found that in Salt Lake County many families and individuals need a broad range of services from the homemaker program in order to offset a family or individual breakdown. A homemaker program contributes to families and individuals in many ways:

One: It enables children to remain at home, if the environment is favorable, when the usual homemaker, generally the natural mother, is incapacitated by illness or when death, desertion or other reasons deprive them of her help.

Two: It is increasingly used to help teach young inexperienced, migrant, or irresponsible mothers improved methods of household management and child care and to lighten the burden of those mothers unable to cope with home management needs of a large family.

Three: It provides, in conjunction with protective social agencies and the courts, protective care to children in their home during a diagnostic period and until an optimum on-going plan is developed.

Four: It frees the employed adult, responsible for the economic support of the family, from the direct care of children, older or chronically ill members of the family so that he can maintain his job responsibilities during periods of home crises.

Five: It provides, through assignment of a homemaker, a professional supervised, trained person to give attention to an individual family member requiring simple personal care and thus enables other family members to fulfill their usual responsibilities in the household and toward each other.

Six: It enables family members, who must provide continuing personal care to an elderly, blind or chronically ill family member, to have temporary periods of rest or relief on a planned basis, either through daily assignment of a homemaker or through a block assignment for away-from-home purposes.

Seven: It allows individuals to remain in familiar home surroundings and so helps them avoid unnecessary placement in a hospital or other institution of foster home.

Eight: It supplements the professional service of social agencies necessary in protective care programs for appropriate older or mentally incapacitated individuals.

Homemaker/chore service is sound economy:

It provides a service that reduces the time people spend in hospitals or nursing homes.

It provides a service that prevents hospitalization.

It provides a service that prevents premature placement and over extensions of a nursing home stay.

It provides a service that makes it unnecessary to place children and the aged in institutions and foster homes.

It provides a service that keeps the family wage earner on the job when there is illness or a crisis at home.

It provides a service which brings intelligent, trained and capable homemakers into the homes of the disadvantaged to help them improve their standards of living and move toward breaking the poverty cycle.

Visiting Home Services, Inc. has been pleased to demonstrate through its contract with the Division of Family Services, that we can maintain an individual or family in their own home through professional service at a cost way under alternative types of care such as nursing homes, hospitalization, or other types of institutional care.

Also along with serving eligible Division of Family Service consumers we are providing in-home supportive services to the private self-paying sector of our community thus affording them the same opportunities to receive needed homemaker services in their home.

In conclusion we support the continuation of this service under title XX and strongly recommend that this supportive program be maintained under the Division of Family Services. We ask that you support the Division of Family Service District 2B budget allocation in the amount of $162,000.

Thank you.

Sincerely,

VIRGINIA SUGIHARA,
Acting State Coordinator.

VISITING HOME SERVICES, INC.
June 9, 1975.

Mr. EVAN E. JONES, JR., ACSW,
Director, Division of Family Services, Department of Social Services, Salt Lake City, Utah.

DEAR MR. JONES: We are pleased to announce that as of June 10, 1975, Mr. Jay S. Wimmer of Salt Lake City, Utah, will become an employee of Visiting Home Services, Inc.

Mr. Wimmer's position will be vice president in charge of operations and development. He will also be in charge of our operation for the State of Utah.

His office will be located at 57 West 700 South, Salt Lake City, Utah. Phone: 801-531-6040.

Warmest personal regards.

Very sincerely,

PETER GOTTHEINER, R.P.T.,
President.

DESCRIPTION OF HOMEMAKER/CHORE SERVICES CONTRACT

This contract will cover Homemaking/Chore Services for the entire State of Utah. The State is now divided up into nine districts, with district offices located in the following cities: Logan (district I), Ogden (district II-A), Salt Lake City (district II-B), Provo (district III), Richfield (district VI), Cedar City (district V), Vernal (district VI), Price (district VII-A), and Blanding (district VII-B).

Those eligible to receive homemaker service will be current recipients of aid to families with dependent children (AFDC), supplemental security income (SSI), and child welfare protective service cases, along with potential recipients, as determined by the Division of Family Services. Those eligible to receive chore services are limited to adults.

Now, therefore: The providers will need to consider the following provisions prior to making their bids:

1. Providers program must meet national standards for homemaker service as published by National Council for Homemaker Service.
2. Provider will need the staff and expertise to provide a wide range of homemaker services to include:
   a. Twenty-four-hour live-in service.
   b. Work with mentally retarded.
   c. Work with consumers who require protective services.
   d. Assist disabled adults.
   e. Working with the aged to keep them in their own home.
3. Providers homemaker services will include, but are not limited to the following:
   a. Encouraging self-care and independence.
   b. Performing routine housekeeping duties.
   c. Helping consumers to have nutritious, well-prepared meals.
   d. Helping to work out the family financial budget.
   e. Seeing that adequate suitable clothing is available for each member of the family.
   f. Helping in planning family activities. —
   g. Performing simple personal care when supervised by a qualified public health nurse.
   h. Helping families reach or maintain at least minimum standards of living and home safety .
   i. Giving services to the aging, the disabled, and families with children.
4. Provider chore services will include, but are not limited to the following:
   a. Basic housekeeping.
   b. Shopping.
   c. Household maintenance.
5. The initial 40-hour training for Homemaking Service is to be arranged by the Division and all continuing inservice training to be rendered by the provider. Initial chore service training not to exceed 16 hours will also be provided by the Division.
6. The provider shall make its records available to the Division, Department of Social Services or appropriate Federal agency in order to meet the Division's monitoring requirements. The provider's bid should include a 5 percent adjustment which the Division will subtract from the gross for purposes of monitoring, evaluating, and technical assistance.
7. Provider will protect the Division of Family Services under the indemnity contract provision by keeping in force a liability insurance policy, issued by a company authorized to do business in the State of Utah and licensed by the insurance department thereof, with liability coverage provided for therein of at least $25,000 for property damage sustained by any one person, $100,000 for injury and/or damages to any one person, and $300,000 for total injuries and/or damages arising from any one accident.

8. The contract will expire automatically on June 30, 1975. The contract may also be terminated in advance of the expiration date specified upon 30 days prior written notice of either party given to the other party.

9. The number of hours to be bid on are as follows:

1. Twenty-four-hour care: 2,400 hours per month. Maximum hours for the entire period of this contract for 24-hour care is 28,800.

2. General homemaker services: 8,500 hours per month. Maximum hours for the period of this contract for general services is 102,000.

3. Chore services: 5,000 hours. Maximum hours for the entire period of this contract for chore services is 60,000.

VISITING HOME SERVICES, INC.
November 19, 1975.

Dr. ROBERT C. HARDER,
Secretary, Kansas Department of Social and Rehabilitation Services, State Office Building, Topeka, Kans.

DEAR DR. HARDER: We understand that our competition supplied you with an article which appeared in the Deseret News on November 1, 1975. This article was a result of our competition meeting with Senator Moss, at which time many untruths were perpetrated about our company. The Division of Family Services, in the enclosed letter, completely exonerates any wrong doings in the State of Utah in regards to the bid process and my involvement.

The Governor of the State of Utah, as well as the Division of Family Services and our attorneys, have been in touch with Senator Moss's office and to our knowledge, these accusations have been refuted. We would encourage you, if you have any further questions concerning this matter, to contact Evan Jones, Director, Division of Family Services.

We are certainly unhappy that you have had to be exposed to the lengths our competition is taking to try to discredit our company. I am sure as you check out our references that our professional services will speak for themselves.

Sincerely,

J. S. WIMMER, M.S.W.,
Vice President of Operations and Development.

Enclosure.

UTAH DEPARTMENT OF SOCIAL SERVICES,
DIVISION OF FAMILY SERVICES,
Salt Lake City, Utah, November 5, 1975.

Mr. PAUL S. ROSE,
EXECUTIVE DIRECTOR,
Department of Social Services, Salt Lake City, Utah.

DEAR MR. ROSE: Following an article in the Deseret News last Saturday evening, the Division of Family Services has received a number of questions in relation to the contract for homemaker services with the firm, Visiting Home Services, Inc.

From a conversation with a staff member of Senator Moss's office, I was informed that all allegations were leveled against Visiting Home Services and a former employee of the Division of Family Services, Mr. Jay Wimmer, during a hearing conducted by staff of the Senator's office. It was unfortunate that the article was printed without an opportunity to discuss with the committee the facts and sequence of events in relation to Visiting Home Services, Inc.

The Division of Family Services was authorized by the 1974 legislature an appropriation for the purposes of providing homemaker services. This program was in response to a Federal requirement that agencies must have homemaker services statewide no later than April 1974. The Division was authorized $793,100 for this program.

Several firms contacted the Division regarding these services. It should be pointed out that the Division was not authorized administrative expenses and permission to employ staff in order to provide the services directly. Four firms were invited to submit bids in relation to the program through the State Purchasing Agency. Based on the sealed bid process, the Division awarded the contract to Visiting Home Services, Inc., in July 1974. It should be noted that the Visiting Home Services, Inc., was the low bidder for the contract.

In January 1975, Visiting Home Services, Inc., notified the Division of Family Services that they would need to cancel the contract and were giving us

30-days advance notice. Their reason for the cancellation was that the Division was not providing the number of hours anticipated at the time the contracts were bid and consequently, the Visiting Home Services was losing money. Following several liaison visits and exchanges of correspondence, it was agreed that the Visiting Home Services, Inc., would provide the homemaker services on an emergency contract for up to 60 days while the contracts were re-bid.

In March, the State Purchasing Agent again announced bids for the homemaker services statewide. In April, I notified Visiting Home Service, Inc., that they had been awarded the contract for 14 months, May 1975, through June 1976, on the basis of the low bid.

Mr. Jay Wimmer of my staff did have responsibilities in relation to the homemaker program. Under supervision, he had been involved in the clarification of references of the bidders in the first contract series and had evaluated the delivery of homemaker services by Visiting Home Services, Inc. It should be noted that Mr. Wimmer was not the only staff member involved, however, and I relied upon his immediate supervisor, Mr. Sam Anton on the first bid award, and Mr. Heber Mehr on the second bid award for the data on which the decision to award the bid was made. Mr. Wimmer was a valued employee of the Division and resigned effective May 30, 1975. It is my understanding that since that time, he has been employed by Visiting Home Services, Inc.

I think it is important to emphasize that the firms who desired to bid for homemaker services responded to the specifications of the regular bidding process through an established State process relating to such items. I see no way that an individual staff member could have individually, materially influenced the awarding of the contract to an agency. If the State had awarded the contract to other than the lowest bidder, or if the bids had been significantly close, perhaps an allegation of inappropriate action could be substantiated. However, I do not believe that the facts in the process outlined by the Division of Family Services in selecting and implementing the contract with Visiting Home Services, Inc., could reflect on other than a sound principle of competitive bidding for services in order to provide the greatest amount of services at the least amount of cost to beneficiaries of that service.

If you desire to have copies of correspondence or documentation in relation to this material, I will be glad to furnish it upon your request.

Sincerely,

EVAN E. JONES, JR., ACSW,
Director.

Appendix 2

REPORT BY THE OFFICE OF THE AUDITOR GENERAL OF CALIFORNIA ENTITLED "A MANAGEMENT REVIEW OF THE HOMEMAKER-CHORE SERVICES PROGRAM," DATED JUNE 11, 1975; SUBMITTED BY JOHN WILLIAMS[1]

HON. SPEAKER OF THE ASSEMBLY,
HON. PRESIDENT PRO TEMPORE OF THE SENATE,
HON. MEMBERS OF THE SENATE AND THE ASSEMBLY OF THE LEGISLATURE OF CALIFORNIA.

MEMBERS OF THE LEGISLATURE: I am today releasing the report of the auditor general on a management review of the homemaker-chore services program requested by Senator George Moscone and Assemblyman Willie Brown.

The homemaker-chore services program, which is administered by county welfare departments under the supervision of the State Department of Health, was implemented in December 1973. The purpose of the homemaker-chore services program, which is currently funded by the State and Federal Governments, is to provide in-home supportive services to certain infirm adult welfare recipients who are either aged, blind, or disabled. These services, including household cleaning, essential shopping, cooking, laundry, and nonmedical personal care such as bowel and bladder care, enable the recipients to remain in their own homes.

For fiscal year 1974–75, the State had allocated $65 million to the counties for the homemaker-chore services program, consisting of $48.75 million in Federal funds and $16.25 million in State funds. In March 1975, the Governor transferred an additional $12.4 million into the program and in April legislation was enacted appropriating another $2.7 million, making an estimated total program cost of $80.1 million in 1974-75.

The auditor general's report has cited the following deficiencies:

—The department of health has not developed the management capability, including a management information system, to effectively supervise county welfare departments in their administration of the homemaker-chore services program.

—The department has not specified which services are to be made available to homemaker recipients versus which services are to be made available to chore recipients. As a result, the counties have no systematic method for classifying the type of services needed or the proper rate of payment for the services rendered to the recipients otherwise referred to as clients.

—The department has not established adequate regulations to effectively control the cost of the services rendered. For example, in one county a client was receiving "chore" services at a cost of $2.50 per hour, and in another county a client was receiving essentially the same services, called "homemaker" services, at a cost of $6 per hour, or a 140 percent increase in cost.

—Approximately 72 percent of the clients receive services from providers employed directly by the clients at salary rates ranging from $1.65 to $2.51 per hour. The balance of services is provided by both profitmaking and nonprofit agencies under contract with the counties and by county staff themselves with hourly rates ranging from $3.39 to $7.75. Agency-employed providers receive a wage approximately 21 percent to 46 percent higher than the client-employed providers. In addition to paying higher wage rates, contract agencies incur administrative expenses and make profits. Therefore, the counties pay between 105 percent and 209 percent more to contract agencies than they pay to client-employed providers. There is no requirement that the agency contracts be competitively bid.

—The department of health has not been monitoring the county contracts with agencies, and has not enforced the limited regulations it has adopted

[1] See statement, p. 999.

to control contract agency costs. As a result, San Francisco County overpaid three agency contractors $271,000 in fiscal year 1974-75.

—The payments made to providers who are relatives of clients receiving homemaker and chore services are inconsistent. For example, in some counties a wife is paid for cooking, cleaning, and washing accomplished as a part of her daily routine, while in other counties she is paid for only those tasks which are extraordinary to the normal household routine or if she has quit a job to care for the client.

—Funds to provide homemaker and chore services have not been appropriated in a way to promote fiscal responsibility in the administration of the homemaker-chore services program. The homemaker-chore services program funds have been separated in the State budget in a manner which has led to the belief that the State has full fiscal responsibility for the program. There has been minimal effort by the counties to control program costs based on the assumption that any cost overruns had to be borne by the State.

—The department of health does not provide the full range of in-home supportive services authorized by law. As a result, certain in-home medically-related services are either being furnished by unqualified providers or are not being provided at all. Some homemakers were providing medically-related services such as renal dialysis and blood pressure readings. One welfare department administrator recognized that such unauthorized medically-related services were being provided by homemakers when he said, "I shudder at the idea that some providers go from waxing the floor to irrigating a catheter or giving an insulin shot". However, he pointed out that because the clients ask the providers to perform these tasks, the counties have virtually no control or means to prevent it.

—The department of health relies exclusively on a single source of funds to finance homemaker and chore services. Continuation of this practice will result in an estimated annual loss of $11.3 million in Federal matching Medi-Cal moneys which could be used to finance personal care services currently provided to clients under the homemaker-chore services program.

The auditor general makes the following recommendations for action by the department of health:

—Implement a management information system for the purpose of effectively supervising the county administration of the homemaker-chore services program.

—Establish a listing of those services which would be available to clients eligible to receive "homemaker services" and to clients eligible to receive "chore services".

—Establish a range of provider payment rates to be paid by counties to client-employed providers and to provider agencies under contract with the counties.

—Establish regulations requiring the periodic monitoring of agency contracts awarded by counties.

—Establish regulations to allow homemakers or chore service payments to relatives only if they are from low-income households or if they are providing other than normal household duties.

—Adopt regulations which would permit the use of the full range of in-home medical-social services in order that the homemaker and chore clients will not receive medically-related services from unqualified providers.

—Exercise its existing authority to change the regulations which would permit the use of Medi-Cal funds to finance personal care services. In the absence of such action by the department of health, the legislature should amend section 12301.5 of the welfare and institutions code to require the department of health to grant counties the authority to fund from Medi-Cal moneys the personal care component of the homemaker-chore services program.

The following recommendation is made for action by the Legislature:

—Discontinue the practice of separating the homemaker and chore services allocation from the social services allocation and apply the State's matching moneys to all social services instead of only to the homemaker-chore services program.

In comments summarized in the auditor general's report, representatives of the department of health stated, among other things, that it would cost approximately $2 million to implement statewide a management information system which has been piloted in two counties. They also stated that if the State were to distribute its matching funds to all social services programs, instead of only

to the homemaker-chore services program, some counties would have to use additional county moneys to continue the same program level.

Respectfully submitted,

BOB WILSON,
Chairman, Jt. Legislative Audit Committee.

[Attachment]

STATE OF CALIFORNIA,
OFFICE OF THE AUDITOR GENERAL,
Sacramento, Calif., May 1, 1975.

Hon. BOB WILSON,
Chairman, Member of the Joint Legislative Audit Committee, Sacramento, Calif.

DEAR MR. CHAIRMAN AND MEMBERS: Transmitted herewith is our report pertaining to a management review of the homemaker-chore services program administered by the county welfare departments and supervised by the State department of health.

Respectfully submitted,

HARVEY M. ROSE,
Auditor General.

[Enclosure]

INTRODUCTION

In response to legislative requests, we have conducted a management review of the homemaker-chore services program which is administered by the county welfare departments under the supervision of the department of health. This report addresses itself to an analysis of the department's role in:

—The administration of the program at the State and county levels,
—The State's allocation of Federal social service funds to counties to provide homemaker, chore, and other social services,
—The development of a range of homemaker and related services which are available to recipients of public assistance,
—The development of supplemental sources for funding homemaker and related services.

Prior to January 1974, in-home supportive services to aged, blind, and disabled adults were offered under the attendant care and homemaker program. Attendant care services were paid for out of the public assistance appropriation by providing the aged, blind, or disabled welfare recipient in need of such services a supplemental welfare payment. The recipient then was expected to use this supplemental payment to contract with a third party for a variety of in-home supportive services. Homemakers provided similar services but were generally county employees whose salary was also paid with public assistance funds. The public assistance program was financed with a 50 percent contribution from the Federal Government. The balance of the program was financed with a combination of State and county funds.

The passage of the Social Security Amendments of 1972 (H.R. 1) replaced the public assistance program, effective January 1, 1974, with the federally administered supplemental security income-State supplemental payment program (SSI–SSP). This program provided for cash grant living allowances to aged, blind, and disabled recipients but did not provide for supplemental payments to recipients to purchase attendant care services nor did it provide for the payment of the salaries of county-employed homemakers from SSI–SSP funds. However, Federal law does require that State provide homemaker services.

The California Legislature, through the passage of AB134 in 1973, authorized homemaker services and elected to offer chore services as part of the homemaker program. The department of health's current homemaker-chore services program was implemented in December 1973. The responsibility for providing these services was given to the counties by the legislature; the department of health was assigned the overall responsibility for the supervision of the program's administration.

The homemaker-chore services program was established to provide in-home supportive services to certain infirm aged, blind, and disabled adults to enable them to remain in their own homes. Persons eligible to receive in-home services are either former, current, or potential recipients of the SSI–SSP program.

Approximately 60,000 of the over 600,000 SSI–SSP recipients in California were receiving homemaker and chore services as of December 31, 1974. The disabilities of these clients prevent them from performing household tasks and caring for some of their bodily functions. Because the disabilities vary so widely from client to client, a county social worker evaluates each client in order to authorize the proper kind and level of supportive service. For example, many clients have permanent mental infirmities due to senility or alcoholism; other clients are mentally alert but have permanent physical infirmities due to disease or accident-related disabilities ranging from minor limb impairments to total paralysis; still other clients are temporarily disabled while recovering from a disease or accident.

Homemaker and chore services include, but are not limited to, the performance of household cleaning, essential shopping, cooking, laundry, and nonmedical personal care such as bowel and bladder care. These tasks are performed by homemaker and chore providers. Over 72 percent (see table 1 [p. 182]) of these providers are employed directly by the client for whom they are providing the service. Other providers work for county welfare departments and still others work for proprietary profitmaking or nonprofit corporations which contract with the counties and which provide some of the administrative services necessary to operate the program. Throughout this report we have used the term "provider" to refer to the individual workers regardless of their employment status, the term "contract agency" to refer to the proprietary and nonprofit corporations, and the term "county agency" to refer to the county welfare departments.

The homemaker-chore services program is funded jointly by the Federal and State Governments with 75 percent of the costs funded from a portion of the Federal title VI (Social Security Act) allocation for social services. Federal regulations require that 25 percent of the program cost be provided by local governments to match the 75 percent Federal moneys. The State has elected to provide the 25 percent matching moneys for the homemaker-chore services program and has required the counties to provide the 25 percent matching moneys for "other" social services authorized by title VI. "Other" social services include child and adult protection services, child support, family planning, money management, employment and rehabilitation services, and county social services administration.

For the 1974–75 fiscal year the State allocated to the counties a total of $65 million to pay for the delivery of homemaker and chore services. The counties used such funds to pay for the costs of their own staff providers, as well as disbursing such funds to client-employed providers and to contract agencies. At the end of the second quarter, 31 counties were expending at a rate which cause them to exceed their allocations before the end of the fiscal year. Based on a projection of the first and second quarter claims, the counties were expected to overexpend their allocation for the year by $12.2 million. In light of this, the Governor, on March 13, 1975, transferred an additional $12.4 million into the program. In addition, legislation has been enacted which appropriates another $2.7 million to the program. This amount raises the total available moneys to $80.1 million. The Homemaker-Chore Services Task Force (a joint committee of State and county staff) has concluded that $81 million will be needed by the counties to provide services at the necessary level through the 1974–75 fiscal year.

The Social Security Amendments of 1974 (title XX) may require changes in the homemaker-chore services program, but until Federal regulations to implement the amendments are published, it is not possible to assess the full effect of title XX. Initial reviews of the amendments indicate that eligibility for the program may be widened and that new payment procedures may be required. Both of these changes would increase program costs to the State. However, because of their tentative nature, we did not attempt to analyze these increased costs.

In the course of our review we:

—Interviewed appropriate department of health personnel,

—Analyzed pertinent program and fiscal documents in the department of health, the department of benefit payments, and the selected counties,

—Attended the meetings of the Homemaker-Chore Services Task Force,

—Reviewed the operations of the following county welfare departments, which provide service to 64 percent of the total homemaker-chore clients in the State:

Alameda	San Francisco
Contra Costa	Sonoma
Fresno	Sutter
Los Angeles	Tulare
San Diego	Yuba,

—Interviewed clients and independent providers in eight counties,
—Interviewer managers of contract agencies in four counties,
—Completed a telephone survey of all 58 counties to compile pertinent statistical data.
—Interviewed the homemaker services staff of the Nevada State Department of Human Resources, Welfare Division.
—Sent questionnaires to 15 States to assess the feasibility of alternative program and funding approaches.

We received excellent cooperation from the department of health and from the administrative staff of the counties that we visited. We also wish to thank the social services staff from the State of Nevada for their cooperation.

FINDINGS

THE DEPARTMENT OF HEALTH HAS NEITHER ADEQUATE REGULATIONS NOR APPROPRIATE MANAGEMENT TOOLS TO EFFECTIVELY SUPERVISE THE COUNTIES' ADMINISTRATION OF THE HOMEMAKER-CHORE SERVICES PROGRAM. AS A RESULT, THE ADMINISTRATION AND COST OF THE PROGRAM VARIES SIGNIFICANTLY FROM COUNTY TO COUNTY.

State and Federal laws require the department of health to supervise the counties' administration of the homemaker-chore services program. Our review has disclosed that the department has not met its responsibility in the following areas:

—Specifying those services available to homemaker versus chore recipients.
—Controling the costs of service delivery.
—Establishing a management information system and a staff capable of enforcing existing regulations and detecting potential problems.

The department of health has not specified which services are to be made available to homemaker recipients versus which services are to be made available to chore recipients

The department of health has the responsibility to develop regulations which provide for the effective administration of the homemaker-chore services program by the counties. Department regulations do not clearly define the difference between homemaker and chore services nor do they specify which services are to be made available to homemaker recipients versus chore recipients. The only operable distinction is furnished in the department's manual of policies and procedures, which basically defines a client in need of chore services as *not requiring the services of a "trained homemaker or other specialist"*, and defines a client needing homemaker services as *requiring a "trained and supervised homemaker"* (emphasis added). However, the duties of a "trained and supervised homemaker" and criteria that could be used to determine which clients are eligible to receive the services of a homemaker and which clients are eligible to receive the services of a chore provider are not further described. (Refer to appendix A [p. 192] for a possible set of definitions describing the various functions of persons providing in-home supportive services.)

The need for a clear distinction between these two types of service is important because it provides the framework necessary for the counties to effectively administer their programs, both from the standpoint of fiscal responsibility and from the standpoint of providing proper services. Without this distinction, the counties have no systematic way to properly classify the type of service their clients need and what they should pay for that service. Because of the training component, homemaker services are more expensive. In those counties included

in our review where a distinction was made, the hourly cost of providing homemaker services exceeded the hourly cost of providing chore services by approximately $1.50 per hour.

During our review, we found that because of the absence of a basic definition, the counties have established a variety of homemaker-chore services programs which operate at a wide range of monthly costs. However, our observations and subsequent verification in discussions with county administrative and staff personnel showed that there is virtually no difference between the tasks provided to the client regardless of whether the task is labeled "homemaker" or "chore." Some counties offer only "chore" services; others offer only "homemaker" services. In those counties offering both, the methods of evaluating the clients' needs often result in inappropriate services. The range of tasks being provided is illustrated by the following cases.

In 5 of the 10 counties we visited, a provider is authorized to perform "simple supervision," which is defined as simply having a provider available on the client's premises in case he falls, wanders off, or fails to take medication.

In three counties, interviews with county officials disclosed that some providers are performing tasks which they are not qualified to perform and which are inconsistent with the duties of either a homemaker or chore provider, such as blood pressure readings, colosstomy irrigations, and catheter changes, even though these activities are not officially sanctioned by the counties.

The department of health has not established adequate regulations to effectively control the costs of service delivery

The department of health has not established adequate regulations which would provide for a controlled range of rates for each delivery method. As a result, the costs of providing necessary services vary from county to county.

For example, in our visits to the counties we found two clients having nearly identical needs for meal preparation. In one county, the client was receiving "homemaking" services from a contract agency at an hourly cost of $6. In the other county, the client was receiving "chore" services from a client-employed provider at an hourly cost of $2.50. While no difference in the quality of service being provided could be discerned, the cost of service in the first county was 140 percent higher than the cost in the second county. Further, the rates vary even when counties use the same service delivery method. The following table identifies the variations in rates and provider salaries:

TABLE 1.—HOMEMAKER-CHORE SERVICES PROGRAM, HOURLY RATE RANGES, PROVIDER SALARY RANGES, NUMBER OF COUNTIES, AND NUMBER OF CLIENTS SERVED BY SERVICE DELIVERY METHOD AS OF DEC. 31, 1974

Delivery method	Agency rate per hour [1]	Provider's salary per hour	Number of counties [2]	Clients served [3]	
				Number	Percent
Client-employed provider		$1.65 to $2.51	45	43,300	72.4
Contract agency:					
Proprietary	$3.45 to $7.00	$2.00 to $3.10	12	4,800	8.0
Nonprofit	$3.39 to $7.75	$2.00 to $3.66	15	9,000	15.1
County staff	$4.24 to $4.32	$2.41 to $4.30	19	2,700	4.5
Total				59,800	100.0

[1] These rates should not be considered as comparable because none of the administrative overhead is included in the client-employed provider category. A part of the administrative overhead is included in the contract agency category, and all of the administrative overhead is included in the county staff category. County cost allocation systems did not permit comparable allocations of overhead.

[2] Exceeds 58 due to multiple delivery methods within some counties.

[3] See appendix B, [p. 194] for a county-by-county breakdown.

Since rates have not been established, the counties are allowed to bargain with prospective providers in the establishment of payment rates. This is a procedure which has both resulted in payment rates below the minimum wage and payment rates to contract providers as high as $7.75 per hour.

In counties using the services of a contract agency, the agency-employed provider receives a wage approximately 21 percent to 46 percent higher than the client-employed provider. In addition to paying higher wage rates, contract

agencies incur administrative costs and make profits. Therefore, the counties pay between 105 percent and 209 percent more to contract agencies than they pay to client-employed providers.

Section 12302 of the Welfare and Institutions Code allows counties to contract with agencies to provide homemaker and chore services to eligible clients. There are few guidelines or statutory restraints placed on the letting of these contracts. For example, neither the Welfare and Institutions Code nor the department of health require that the contracts be subject to competitive bidding. As shown in table 1, the hourly charge for providing this service ranges from $3.39 per hour to $7.75 per hour.

Section 12303(a) of the Welfare and Institutions Code says that a contract for the purchase of homemaker and chore services may not exceed by more than 10 percent the cost the department of health has said is allowable for those services. Department of health regulations define "allowable costs" for an individual county as the cost of providing homemaker or chore services through county-employed workers. But, if a county does not have homemaker or chore providers on its staff, the department regulations do not specify how the "allowable costs" will be determined. As a result, the basic requirement of any attempt to standardize contract costs, a definition of allowable costs, is missing in all counties that do not employ homemakers or chore providers. Only two counties both employ homemaker or chore providers directly and also contract for such services with agencies.

The department of health, however, is not standardizing contract costs even in the two counties which are subject to the limited regulations because it is not monitoring agency contracts. San Francisco County is one of the counties using both county-employed providers and contract agency providers and is the only county where there is adequate data to determine if the cost of services purchased from a contract agency is within the "allowable" range. We found that the State had not reviewed the counties' contracts to determine if the payment rates were within the "allowable" range. Our review disclosed that San Francisco County was overpaying on three contracts by an estimated total of $271,000 annually.

The department of health has not established a management information system or adequate staff capable of enforcing existing regulations and detecting potential problems in the program

Presently, the department's management information system for the homemaker-chore services program consists of the number of clients receiving services, the cost of providing these services (as reported on the county's quarterly claim) and the county plan, which contains a box to check if homemaker or chore services are provided by the county and the number of social workers assigned to the program. The county plans do not include essential information, such as the projected population to be served and the methods of service delivery to be used.

Department of health officials have stated that plans for a management information system have been developed to provide needed information for all social service programs but these plans have not been implemented nor have they indicated when or if such a system will be implemented; however, the program has been tested on a pilot basis in two counties.

The responsibility for supervising the county administration of the homemaker-chore services program is assigned to two separate offices within the department of health. In the services operation section, only 1.5 social service consultants have been assigned to develop regulations for this program and to provide consultation to all of the 58 counties to enable them to implement these regulations.

In the service management section, six management analysts were hired in January 1975 to review compliance for all social services programs provided by the counties including homemaker and chore services. However, in the absence of an adequate information system and comprehensive county plans for the delivery of social services, the analysts are handicapped in their efforts to evaluate the county programs.

Interviews with appropriate staff members have disclosed that there is minimal cooperation and exchange of information between these two offices. Therefore, despite the fact that both offices have responsibility for monitoring the program, there are no regulations which require monitoring on a periodic basis

and a systematic review of the county homemaker-chore services program had not been undertaken by the department as of January 1975. As of April 18, 1975, the department had reviewed homemaker and chore service operations in two counties.

The fact that San Francisco County was overpaying on three of its contracts with contract agencies (as discussed previously) could have been detected if a management information system had been implemented and sufficient staff had been assigned the responsibility to monitor the program.

Conclusion

The department of health has not issued adequate definitions of services relating to homemaker activities versus chore activities.

The department has not promoted fiscal responsibility in the homemaker-chore services program as evidenced by its failure to effectively control provider payment rates by the counties. Finally, the department has not instituted a management information system capable of generating sufficient program data and has not required periodic monitoring of the program.

Recommendations

We recommend that the department of health:

—Establish a listing of those services which would be available to clients eligible to receive "homemaker services" and to clients eligible to receive "chore services."

—Establish a range of provider payment rates, to be paid by counties to client-employed providers and to provider agencies under contract with the counties.

—Establish regulations requiring the periodic monitoring of contracts between counties and provider agencies.

—Implement a management information system that would enable it to meet its obligations to effectively supervise the county administration of the homemaker-chore services program.

—Require the counties to submit comprehensive social service delivery plans which would include the following:

Projected population served.

Methods of service delivery and number and description of recipients of each service.

Costs of providing service and method used to establish rates of payment.

Method of supervising the program (numbers and qualifications of supervising staff).

Training program used.

Availability of and use of community resources.

—Transfer sufficient department of health staff to the service operation section to permit the development of adequate regulations, county consultation, and compliance monitoring.

Benefits and Savings

Implementation of these recommendations will provide the department of health with the management tools necessary to effectively supervise the administration of the homemaker-chore services program and to insure that the services are being offered at the most economic cost. The enforcement of the regulations it has issued could result in a reduction of expenditures of $271,000 annually in San Francisco County with a possible greater reduction statewide.

DEFICIENCIES IN COUNTY ADMINISTRATION OF THE HOMEMAKER-CHORE SERVICES PROGRAM HAVE RESULTED IN INCONSISTENCIES RELATING TO EVALUATIONS OF CLIENT NEEDS, PAYMENTS TO RELATIVE-PROVIDERS, METHODS OF TREATING SOCIAL SECURITY CONTRIBUTIONS FOR INDIVIDUAL PROVIDERS, AND THE USE OF EXISTING COMMUNITY RESOURCES

In the absence of adequate and effective regulations from the department of health, as previously discussed, the counties' administration of the homemaker chore services program has produced inconsistencies.

Inconsistent Evaluation of Client Needs

Evaluation of client needs under the homemaker-chore services program is inconsistent in that some clients receive insufficient services and others receive too much. A primary cause of this inconsistency is the lack of communication between the social workers and the client, and between the provider and the contract agencies.

State regulations require all clients, except those judged to be severely impaired, to be evaluated every 6 months by the county welfare department to determine their current need for homemaker or chore services.

Our review of the program in 10 counties disclosed that the frequency of reevaluation of nonseverely impaired clients ranged from 1 month to over 1 year. Those counties which exceed a 6-month reevaluation period are out of compliance with State regulations.

In those counties that complied with the 6-month review requirement, we found that semiannual reevaluations were often not sufficient to adequately monitor the client's condition. Some clients required more attention than the social workers could afford because of their growing caseloads or inability to keep up with the clients' changing conditions.

An example of this involved a 74-year-old client in one county with a duodenal ulcer whose physician recommended the services of a provider solely for the purpose of meal preparation. The county authorized 9 hours of service a week and, in violation of State regulations, did not review the client's situation for a year. At the time of our review, it was determined that for the past year the client had been taking his meals two or three times a day at a local diner and having the homemaker clean his studio apartment rather than prepare meals. Since the client needed only 9 hours of service per week, the county had contracted with a proprietary agency at the rate of $6 per hour for the service. The annual cost was $2,808. While this was an extreme example of the 90 clients receiving homemaker or chore services, whom we interviewed in their homes, it is illustrative of the abuses and excessive levels of care that can occur in the absence of proper administration.

An example in the other direction involved a couple who were both receiving "chore" services and who had been visited twice annually by their social worker. On a regular reevaluation visit, the social worker found that the health of both the husband and wife had deteriorated. The social worker then authorized an increase in the amount of service. The social worker said that the couple could have qualified for the increased service much earlier if she had been aware of their need.

While the conditions of certain types of recipients of homemaker and chore services are not reviewed often enough, review requirements provided by statute for the severely impaired are excessive and costly. Section 12304(f) of the Welfare and Institutions Code requires county social workers to visit clients classified as "severely impaired" once every 3 months. A severely impaired client is defined by law as someone who requires at least 20 hours per week of personal care. These clients have acute physical disabilities, such as paralysis, and are usually confined to a wheelchair or bed.

In the course of our study, social workers and severely impaired clients agreed that this legal requirement forced unnecessary visits to the client and inefficient use of social worker time. Generally, severely impaired clients have been allowed to live independently only after lengthy hospitalization and only after expert medical testimony that their condition will not deteriorate. These clients have stable and well-defined disabilities.

Revising existing law to reduce the number of mandated visits to one per year would save an estimated $252,000 of social services money annually.

In counties where a contract agency provides program services, it is more difficult for the social worker to maintain contact with the clients. Social workers are still required to make the specified reevaluations and we found that this regulation is generally being followed. However, because the client deals almost exclusively with the agency-employed provider, effective communication between the client and the social worker is restricted. This results in the provision of inadequate or excessive services to the client.

An example of this involves an elderly client who was assigned a provider from a contract agency. Although the provider performed her duties to the satisfaction of her employer and the client, the client's condition steadily

declined to the point where hospitalization was considered by the contract agency and the client's family. At no time during this period was the social worker consulted concerning this client or the need for modified services.

More frequent review requirements would not be necessary if improved methods were devised for the client to contact the social worker as his need changed. We recognize that if the social workers are more accessible to the needs of the client it may result in increased costs. However, more frequent contact may result in reduced levels of services.

Inconsistent Payments to Relative-Providers

During our interviews with clients, providers and social workers, we found a marked inconsistency in the methods for determining the payments to be made to providers who are relatives of the client. (We have defined "relative" as a spouse, child, or parent of the client who occupies the same home as the client.)

We found that some counties allowed payment to the relative for normal household routines (cooking, cleaning, washing). For example, a county authorized payment for cooking, cleaning, and washing services which a wife had been doing as a normal part of her daily routine, and which were not increased as a result of her husband's needs. On the other hand, in other counties a relative is paid only for those tasks which are extraordinary to the normal household routine. In still other counties, a relative is paid for normal household activities only if he or she has quit a job to care for the client.

The department of health regulations are not specific about payment for services when a relative-provider lives in the home. As of December 31, 1974, there were approximately 8,000 relative-providers in the program. We were not able to estimate the household incomes of relative-providers. It appears that the majority are low-income households and it was also clear in some cases that the relative-provider terminated regular employment to provide homemaker or chore services. Administrators in seven of the counties we visited stated that relative-providers should not be compensated for this service unless the services provided are of an unusual nature. Another administrator stated that consideration should be given to establishing a "low income" definition for household income.

Inconsistent Methods of Treating Social Security Contributions for Individual Providers

Department of health guidelines state that individual providers are either employees of the county or the client and as such are entitled to social security contributions which must be equally shared by the employer and the provider. In cases where the county has elected to act as the employer, the county pays the employer's share of social security and deducts the employee's share from his earnings. Both shares are forwarded to the Internal Revenue Service (IRS) by the county. In cases where the county considers the client to be the employer, there are various methods of handling the payment:

—The county adds the employer's and employee's share of the social security payment to the provider's hourly salary rate and relies upon the client to collect the social security tax and forward both shares to the IRS. A typical example of this is where the hourly rate is $2.25; $2.01 represents the actual provider salary, 24 cents is both the employer's and the employee's share of social security. The client is supposed to collect both deductions and forward these payments to the IRS.

—Some counties pay nothing toward social security. From the $2 hourly salary, both the employer's and employee's shares are deducted. This means that the provider receives only $1.88 in wages, from which he must pay the employee's share of social security. The client again is expected to collect both deductions and forward these payments to the IRS.

In both of the above instances, the result is that the responsibility for handling the details of social security computations, deductions, and forwarding to the IRS falls on the client, who is the person least equipped to meet this responsibility. The counties have maintained that to assume the responsibility for social security contributions lends credence to the argument that the client-employed provider is actually a county employee and thus eligible for county salaries and benefits.

These discrepancies over the handling of social security contributions could be resolved if the counties were to act as the fiscal agent for their homemaker-chore services program clients. Serving as the fiscal agent would allow counties to treat client-employed providers as the employees of the clients and th assure that the provider receives full credit for his payroll taxes and preclude the responsibility that the provider would be considered a county employee.

Inconsistent Use of Existing Community Resources

The department of health's manual of policies and procedures requires the counties to establish a registry of available community service organizations. The purpose of such registries is to allow county welfare departments to use available community resources, many of which are publicly supported, to the greatest extent possible.

In the course of our review, we observed that counties authorize homemaker and chore services which are already available from existing community resources. While the cost of this duplication is not possible to determine, it does place an unnecessary burden on the restricted resources of the homemaker-chore services program, thereby preventing some clients from receiving needed services. Among the services most duplicated is meal preparation, which is available through congregate feeding sites for the elderly and needy or meals-on-wheels programs. Another duplicated service is transportation, which is available through local volunteer or public transit programs. Other services available in some communities include day care centers for the elderly which can eliminate reliance on the homemaker-chore services program for supervision, meal preparation, ambulation, exercise, and client training. Sacramento and San Francisco Counties are now offering such centers on a demonstration project basis.

An example of failing to use community resources involves a client who was dependent upon a chore worker to provide frequent transportation to and from medical appointments, despite the fact that some use could have been made of volunteer transportation services for the elderly and needy.

Conclusion

The inconsistencies in the county administration of the homemaker-chore services program, caused by the absence of adequate State regulations, have resulted in: inconsistent evaluation of client needs, varied payments to relative-providers, inconsistent methods of treating social security contributions for individual providers and inconsistent use of existing community resources.

Recommendations

We recommend that the department of health:

—Establish regulations to require improved channels of communication between the clients and county welfare workers so that changes in a client's condition will be met with appropriate changes in the level of service.

—Establish regulations allowing payments to relative-providers only when they are from low-income households or when they are providing extraordinary services which are in addition to normal household routine.

—Establish regulations requiring the counties to perform the bookkeeping functions now imposed on the client. To do this the counties would report both the employee's and the employer's share of the social security contributions to the proper authorities.

—Enforce regulations to use existing available community service organizations.

In those cases where clients have been diagnosed as having stable disabilities, we recommend that the legislature revise existing law to mandate an annual review of the service needs of the severely impaired client, instead of the presently mandated quarterly review.

Benefits and Savings

Implementation of our recommendations would make the administration of the individual county homemaker-chore services programs more uniform and consistent with client needs. In addition, excessive costs would be reduced to the extent of any payments currently being made for unnecessary services or to persons who should not receive payment.

Furthermore, the statutory requirement that severely impaired clients be visited by social workers quarterly promotes inefficient use of social worker time and the unnecessary expenditure of an estimated $252,000 annually.

FUNDS TO PROVIDE HOMEMAKER AND CHORE SERVICES HAVE NOT BEEN APPROPRIATED IN A WAY TO PROMOTE FISCAL RESPONSIBILITY IN THE ADMINISTRATION OF THE HOMEMAKER-CHORE SERVICES PROGRAM

In fiscal year 1974–75, the department of health allocated a total of $229.7 million to county welfare departments to provide adult and family social services in California. Of this amount, $172.3 million (75 percent) represented Federal social services moneys and $57.4 million (25 percent) represented the required State and county matching moneys.

The State legislature (Welfare and Institutions Code Section 12306) elected to fund $16.25 million of the local social services share and specifically allocated this money to the homemaker-chore services program. Combined with the matching Federal money, $48.75 million, a total of $65 million in social services moneys, was allocated to the counties for homemaker and chore services.

The counties were also allocated the remaining $123.5 million Federal social services moneys and were required to provide the local $41.15 million matching funds. These moneys were to be used for all other social services provided by the counties.

The net effect of this funding procedure was to separate homemaker and chore services from "other" social services and to provide for 100 percent Federal and State funding of this program which is administered by county welfare departments. In addition, "other" social services are funded 100 percent with Federal and county moneys. The absence of county participation in homemaker and chore funding does not encourage fiscal restraint.

This separation of funds in the State budget has led to the general belief that the homemaker-chore services program is a program for which the State has full fiscal responsibility. Therefore, there has been minimal effort by the counties to control program costs based on the assumption that any cost overruns had to be borne by the State. The separation of homemaker and chore services from "other" social services has resulted in the failure of the counties to establish appropriate fiscal and program priorities for the total package of social services that they provide. For example, county officials have stated that they did not have sufficient funds for the homemaker-chore services program for fiscal year 1974–75. Based on claims received from the counties for the quarters ending September and December 1974, the department determined that the counties did, in fact, have "other" social services moneys that will not be expended by the end of the current fiscal year. Consequently, in March 1975, the department reallocated in excess of $5.8 million to the homemaker-chore services program from the "other" social services appropriation (see appendix C [p. 195] of this report).

In some of the counties that we visited, officials stated that even before the March reallocation they had been forced to reduce their "other" social service programs in order to fund the social worker staff responsible for the homemaker-chore services program. Most of these counties had placed freezes on the hiring of social workers, which had an overall effect of increasing existing social worker caseloads thereby reducing the ability of the county to provide a total package of social services to current and prospective clients.

Conclusion

Fiscal responsibility has not been achieved in the administration of the homemaker-chore services program, in part because the method of budgeting social service moneys does not require the counties to share in a portion of the cost of the program.

Recommendation

We recommend that the legislature discontinue the practice of separating the homemaker and chore services allocation from the total social services allocation and apply the State's matching moneys to all social services instead of only to the homemaker-chore services program.

Benefits

Implementation of this recommendation will promote sound management of the homemaker-chore services program by requiring the counties to share in the cost of that program.

THE DEPARTMENT OF HEALTH DOES NOT PROVIDE THE FULL RANGE OF IN-HOME SUPPORTIVE SERVICES AUTHORIZED BY LAW; AS A RESULT, CERTAIN IN-HOME MEDICALLY-RELATED SERVICES ARE EITHER FURNISHED BY UNQUALIFIED PROVIDERS OR ARE NOT BEING PROVIDED AT ALL

Presently, homemaker and chore services are viewed primarily as social services despite the fact that clients, in order to be eligible for these services, have some medically-related infirmity. The result of this view is that clients are authorized those services which are designed to meet their social need to remain in their own homes. As a client's medical condition deteriorates, these services continue to be the only source of in-home aid until his condition requires institutionalization. Thus, a gap exists between the domestic kinds of services authorized under the homemaker-chore services program and the medically-related services provided by an institution.

Some counties have formally recognized the medical aspects of in-home supportive services by requiring an assessment by a physician of the client's medical needs prior to the authorization of homemaker and chore services. Some of these counties currently authorize home health agencies to provide medically-related personal services such as bed baths and passive exercises in addition to authorizing homemaker and chore services.

As previously noted, in 8 of the 10 counties included in our review we observed medically-related services being provided by unqualified persons. For example, we visited a client with acutely high blood pressure who was under medical advice to monitor her blood pressure on a regular basis. During our visit we observed the provider taking the blood pressure and noted that she did not know how to properly read the instrument.

In another instance, a relative-provider was performing renal dialysis for the client. Although this is clearly a medically related task, it was funded under the homemaker-chore services program. An analysis of the service needs of the client indicated that only 7 hours a month were needed for homemaker or chore services. Therefore, it was costing the homemaker-chore services program $400 per month when as much as $385 per month could have been funded through a medically-related program.

In our interviews with county officials, we found that these officials are aware that medically-related activities are being performed by unqualified providers. One welfare department administrator said, "I shudder at the idea that some providers go from waxing the floor to irrigating a catheter or giving an insulin shot." But he added, because the clients ask the providers to perform these tasks, the counties have virtually no control or means to prevent it even though it is recognized that these activities could result in a serious injury to the client and a potential liability for the county and provider.

Chore and homemaker services represent the first and second levels of a range of both social services and medical care that have been authorized for recipients of public assistance by both State and Federal law. The following table shows the position of homemaker and chore services in this range and their approximate monthly costs.

TABLE 2.—THE RELATIONSHIP AND COST OF HOMEMAKER AND CHORE SERVICES AND OTHER MEDICAL SUPPORTIVE SERVICES AND CARE AUTHORIZED FOR RECIPIENTS OF PUBLIC ASSISTANCE

Service or care	Range of costs	
	Daily	Monthly
Chore	$1.65 to 7.75/hour [1]—totaling $350/month.[2] (State average $119 per month.)	
Homemaker		
Personal care aide	Not currently authorized by California regulations.	
Home health aide [3]	$10.85	$350.
Boarding home		SSI grants less $15.[4]
Intermediate care facility	$14.13 to $15.09	$430 to $459.[4]
Nursing or convalescent hospital	$17.25 to $18.42	$525 to $560.[4]
Acute hospital	$115	[5]

[1] The actual upper limit was $24.32/h but applied to so few persons that $7.75 was assumed to be more representative.
[2] Clients classified as severely impaired may receive up to $450/mo.
[3] Home health aides are primarily used in California to provide services as a followup to hospitalization.
[4] Funded through public assistance, not Medi-Cal.
[5] Rate determined by bed space.

The absence of a personal care aide classification (described on page 193), the limited use of home health aides and the absence of a clear distinction between homemaker and chore services have widened the gap in the range of services available to the clients of public assistance.

The transfer of social services from the former State department of social welfare to the department of health in July 1973 was partially designed to provide the administrative machinery to facilitate this perspective. Despite this intention, homemaker and chore services have yet to be integrated into a total medical-social service package.

An integrated perspective would enable county welfare departments to respond more quickly in determining the optimum level of service for each recipient of benefits. For example, clients could more easily be moved from the homemaker-chore services program as their physical condition deteriorated. The need for flexibility in medical-social intervention becomes especially significant as a client begins to require increased medical care which is not the primary offering of the homemaker-chore services program. Provision of in-home medical service, while more expensive than homemaker and chore service, is less expensive than the alternative which is often institutionalization. Conversely, patients in institutions could be reviewed in light of all the medical and social services available in the community, a step which might enable a return to a less dependent and less expensive living arrangement.

As a client begins to require increased and more costly homemaker and chore services, his condition should be evaluated by a medical-social review team (as institutional patients currently are) to determine if medically related in-home services are indicated or if, in fact, he can still benefit from an independent living arrangement. In cases where the client is determined to be incapable of further benefiting from his independent living arrangement, he might be transferred to a program offering more intensive care and supervision, a move which would be more appropriate to his need and more appropriate to the homemaker-chore services program.

Medical-social review teams are currently used to review patients in intermediate care facilities (ICF) and nursing homes for appropriateness of care. Criteria could be developed to permit the use of this or a similar resource to review selected recipients of the homemaker-chore services program. The criteria could be based exclusively on medical indicators, on a combination of medical and fiscal indicators or be triggered semiannually by fiscal indicators only.

Whatever criteria are used, they could be developed so as to apply to only those recipients showing a heavy reliance on homemaker and chore services and/or deteriorating health. They would not need to apply to all users of these services.

Conclusion

In spite of statutory authorization to provide for a full range of in-home supportive services, the department of health has not done so. This has resulted in either the provision of medically-related services by unqualified providers or medically-related services which are not being provided at all.

Recommendations

We recommend that the department of health adopt regulations which would permit the use of the full range of in-home medical-social services so that homemaker and chore clients will not have to depend on unqualified providers for medically-related services.

We also recommend that the department require the use of medical-social review teams or their equivalent, where indicated, to assure provision of appropriate levels of services to clients.

Benefits

Implementation of these recommendations will permit the provision of the optimum levels of service at the minimum cost.

THE DEPARTMENT OF HEALTH RELIES EXCLUSIVELY ON A SINGLE SOURCE OF FUNDS TO FINANCE HOMEMAKER AND CHORE SERVICES. CONTINUATION OF THIS PRACTICE WILL RESULT IN AN ESTIMATED ANNUAL LOSS OF $11.3 MILLION IN FEDERAL MEDICAL MONEYS WHICH COULD BE USED TO FINANCE SOME PERSONAL CARE SERVICES CURRENTLY PROVIDED TO CLIENTS UNDER THE HOMEMAKER-CHORE SERVICES PROGRAM

The department of health has not exercised its full authority to obtain Federal moneys to fund homemaker type services. Section 12301.5 of the welfare

and institutions code authorizes the State department of health to fund in-home suportive services, where appropriate, under the Medi-Cal Act. Section 249 of the Code of Federal Regulations, title 45 shows personal care service as a Medi-Cal eligible service. Other States, including New York and Nevada (see appendix D [p. 196], have recognized the use of personal care services as a medically related expense.

Despite this authority, the department has not developed the necessary procedures for transferring the personal care components of homemaker and chore services to a personal care program under title XIX of the Social Security Act (Medi-Cal). Also, the department has not identified the amount and type of services which could qualify for Medi-Cal funding.

In the course of our review, we asked the counties to estimate the personal care component of their homemaker-chore services caseload. (We defined personal care to include passive exercise, bowel and bladder care, special dietary meal preparation, ambulation, and medicated bed baths.)

Our analysis of the information that we received from the county welfare departments discloses that approximately 35 percent of the clients in the homemaker-chore services program require an average of over 25 hours of personal care per month. Based upon this analysis we have estimated that qualifying personal care services under Medi-Cal would result in an additional $11.3 million annually in Federal title XIX money received by the State.

It has been argued that title XIX money requires a 50 percent State match, while title VI social services money requires only a 25 percent State match and therefore it would be monetarily advantageous for the State to continue to fund all aspects of the program under title VI. Although the basic concept of this argument is true, the Federal title VI is a fixed allocation which has not been increased for the last 3 years. When title VI is fully committed, as it now is, any additional program cost must be borne by State and local governments without additional Federal funds.

The following example illustrates the monetary and social effects of total reliance on a single funding mechanism. In March 1975, the State augmented the homemaker-chore services program by $12.4 million in order to avoid a cutback in the level of services (see appendix C [p. 195]. Of this amount, $8,448,000 was unspent State adoption funds from the 1973–74 fiscal year which were carried over as a fiscal year 1974–75 general fund surplus. Of the $8,448,000, $1,333,267 was used to replace county funds which had originally been budgeted by the counties for nonhomemaker social services. This money was used by the State to earn $4,000,002 in Federal social service funds to produce a total of $5,338,269. This action by the State, therefore, made available a total of $12,448,002 for the purchase of homemaker and chore services as follows:

State unmatched funds	$7, 114, 733
State matched funds	1, 333, 267
Total State	8, 448, 000
Federal funds	4, 000, 002
Total available	12, 448, 002

However, this increase in the amount of money for homemaker and chore services also resulted in a $5,333,269 decrease in the amount of funds available for social services to children and nonhomemaker social services to adults. Therefore, the net effect of the State's allocation of $8,448,000 in State funds for homemaker services was to increase by only $7,114,733 the total pool of funds available for all social services ($12,448,002 less $5,333,299 equals $7,114,733; see Appendix C).

While the precise impact of the March 1975 action on the provision of social services for fiscal year 1974–75 cannot be measured, it is clear that because of inflationary pressures, the impact in fiscal year 1975–76, in the absence of corrective action, will be either a cutback in the level of services or the funding of such services exclusively from State and county funds.

By March of 1975, however, the use of title XIX funds to supplement homemaker and chore type services was not an available option for fiscal year 1974–75. The reason for this is that the title XIX mechanism did not exist in State regulations when the deficit became apparent.

Section 249 of the Code of Federal Regulations, title 45 provides definitions for two classes of personal care providers. They are home health aide (section 249.10(b)(7)(iv)) and personal care aide (section 249.10(b)(17)(vi)).

The home health aide differs from the personal care aide primarily because the home health aide must be employed by a home health agency. The personal care aide, on the other hand, can work under an individual contract with the client or county.

Current regulations permit the counties to use home health aides; however, county administrators have informed us that they are reluctant to use home health aides partially because the non-Federal share of their cost (50 percent) comes entirely from county funds. There are no regulations which permit the use of personal care aides.

Conclusion

In light of the fact that the cost of the homemaker-chore services program will exceed its original allocation during fiscal year 1974–75 which has resulted in an augmentation, the department of health should take the necessary step to transfer the funding of the personal care elements from the homemaker-chore services program to Medi-Cal.

Recommendations

We recommend that the department of health exercise its existing authority to change the regulations which would permit the use of Medi-Cal funds for the purchase of personal care aide services.

In the absence of such action by the department of health, the legislature should amend section 12301.5 of the Welfare and Institutions Code to require the department of health to issue appropriate regulations.

Savings

By using Medi-Cal funds in conjunction with the homemaker-chore services program, the department of health will be able to obtain an estimated $11.8 million annually in Federal matching Medi-Cal funds.

SUMMARY OF COMMENTS BY DEPARTMENT OF HEALTH REPRESENTATIVES

Representatives of the department of health stated that because of the limited time available for their review of this report, they could not provide detailed comments at this time. Our summary of the comments made by the department's representatives at the exit conference are as follows:

—The estimated cost of total statewide implementation of the management information system, which has been piloted in two counties, would be approximately $2 million.

—If the State were to distribute its matching funds to all social services programs, and assuming the same program level, those counties that have a higher proportion of homemaker and chore services to total social services, when compared to the statewide proportion of homemaker and chore services, would have to use additional county moneys to partially fund that part of their program which exceeds the statewide proportion.

—There are two "myths" generally associated with the homemaker-chore services program. The first myth is that failure to provide homemaker or chore services will automatically result in institutionalization; it has been estimated that only 28 percent of those now receiving homemaker or chore services would have to be placed in an institution for care if these services were not provided. The second myth is that the use of the homemaker-chore services program to maintain a person in his own home always saves the State money when compared to the cost of institutional care; in actuality, in many cases the cost to the State for homemaker or chore services exceeds the cost to the State for institutional care, but the social value of in-home care must be considered even though a dollar value cannot be placed on it.

Appendix A

A MODEL FOR PROVIDING IN-HOME SUPPORTIVE SERVICES

The following descriptions of five provider classifications and their duties has been synthesized from suggestions and practice by State and county administrators and staff. They are presented here only for reference, and are not necessarily intended as a recommended course of action.

CHORE PROVIDER (TITLE VI FUNDS)

—Provider is employee of either client, county, or contract agency. (Current providers may qualify for this position.).
—County coordinates provider assignments.
—Function of the provider is to perform domestic services (i.e., cleaning, laundry, shopping, and cooking).
—Relatives of the client are paid only for the extraordinary services they provide.
—County deducts employee's share of social security contribution and adds the employer's share of social security.
—Taxes are paid to Internal Revenue Service by the county.

HOMEMAKER PROVIDER (TITLE VI FUNDS)

—Provider is a county employee, or an employee of a contract agency.
—Special training and certification required.
—Function of provider is to train clients to perform personal and household activities which are difficult to perform due to accident or illness.
—Service is expected to be of short duration.
—Client must have a high probability of being trained and becoming self-reliant.

PERSONAL CARE AIDE (TITLE XIX FUNDS)

—Aide is under contract to county, or is an employee of a contract agency.
—Special training and certification required.
—Supervised and coordinated by registered nurse.
—A doctor's plan is required to qualify for Medi-Cal funding.
—County is responsible for social security contribution as previously described.
—Service is not to exceed 20 hours per week.
—Services are of a personal care nature (i.e., bed baths, passive exercises, ambulation, and special diet preparation).
—Relatives of client do not qualify for this classification.
—Section 249.10(b)(17)(vi) of the Code of Federal Regulations, title 45, defines the conditions under which personal care services are Medi-Cal eligible:

"Personal care services in a recipient's home rendered by an individual, not a member of the family, who is qualified to provide such services, where the services are prescribed by a physician in accordance with a plan of treatment and are supervised by a registered nurse."

HOME HEALTH AIDE (TITLE XIX FUNDS)

—Aide is an employee of a home-health agency.
—Special training and certification required.
—Supervised and coordinated by a registered nurse.
—A doctor's authorization is required to qualify for Medi-Cal funding.
—County is responsible for social security contributions as previously described.
—Services are of a personal care nature.

ATTENDANT PROVIDER (TITLE VI AND TITLE XIX MIXED FUNDING) [1]

—Three-way contact between provider, client, and the county.
—Special training and certification for personal care (current attendants could qualify after training).
—Services are combined chore and personal care for clients requiring in excess of 20 hours of personal care per week (severely impaired).
—Doctor's plan required for personal care component of needed services.
—County registered nurse supervises personal care component.
—County is responsible for social security contributions as previously described.

[1] This class of provider embodies the chore providers who are now full-time providers for severely impaired clients and represents a mechanism whereby the personal care element of that service is Medi-Cal eligible.

APPENDIX B

Summary -- Survey of Counties as of 12/31/74

COUNTIES	Total County Population	Number of Clients by Delivery Method					Cost/client/mo (2nd quarter claim 1974-75)
		Co Empl	Indiv Provi	Contr Agency Non Profit	Contr Agency Profit	Total	
ALAMEDA	1,096,900	130	3800	---	---	3,930	$ 84.61
ALPINE	700	---	---	---	---	---	---
AMADOR	14,400	---	23	---	---	23	29.57
BUTTE	115,000	551	---	---	---	551	58.07
CALAVERAS	15,500	---	62	---	---	62	69.35
COLUSA	12,500	13	1	---	---	14	154.57
CONTRA COSTA	585,900	---	2761	---	---	2,761	109.48
DEL NORTE	15,500	68	---	---	---	68	106.70
EL DORADO	53,300	41	130	---	---	171	98.81
FRESNO	441,400	---	262	202	777	1,241	124.26
GLENN	18,500	38	1	---	---	39	132.61
HUMBOLDT	103,700	---	174	116	---	290	104.12
IMPERIAL	80,600	---	---	---	163	163	134.65
INYO	16,900	52	3	---	---	55	124.51
KERN	341,100	424	610	3	---	1,037	85.25
KINGS	69,500	112	41	---	---	153	89.33
LAKE	23,600	---	170	---	---	170	33.01
LASSEN	18,100	85	---	---	---	85	103.90
LOS ANGELES	6,961,200	---	18332	---	---	18,332	119.01
MADERA	45,200	---	25	---	231	256	62.36
MARIN	214,700	3	303	---	---	306	169.15
MARIPOSA	7,600	---	15	---	---	15	95.73
MENDOCINO	56,800	---	---	266	---	266	65.25
MERCED	118,100	---	64	381	---	445	73.38
MODOC	8,100	---	9	---	---	9	64.00
MONO	7,100	---	1	---	---	1	96.00
MONTEREY	261,200	---	356	---	---	356	127.68
NAPA	86,900	---	129	---	---	129	63.19
NEVADA	31,200	---	4	---	67	71	92.73
ORANGE	1,656,300	---	2230	---	---	2,230	71.28
PLACER	89,800	---	40	---	164	204	74.84
PLUMAS	13,400	---	---	---	53	53	134.87
RIVERSIDE	509,600	---	353	1700	---	2,053	91.09
SACRAMENTO	683,100	18	2397	---	---	2,415	154.27
SAN BENITO	19,400	---	26	---	---	26	124.30
SAN BERNARDINO	702,500	---	---	1626	---	1,626	103.31
SAN DIEGO	1,509,900	711	2731	---	---	3,442	168.53
SAN FRANCISCO	679,300	50	3962	490	898	4,400	204.61
SAN JOAQUIN	301,600	---	183	850	---	1,033	52.91
SAN LUIS OBISPO	123,300	---	---	---	285	285	102.30
SAN MATEO	573,700	---	1200	200	---	1,400	139.50
SANTA BARBARA	279,800	---	---	573	---	573	146.03
SANTA CLARA	1,178,500	---	1929	349	504	2,782	177.94
SANTA CRUZ	144,600	---	---	629	---	629	133.44
SHASTA	86,000	183	256	---	---	439	100.54
SIERRA	2,600	---	4	---	---	4	80.00
SISKIYOU	35,200	---	24	---	---	24	128.16
SOLANO	184,700	44	393	---	---	437	89.73
SONOMA	237,800	---	614	---	---	614	63.64
STANISLAUS	210,600	---	85	912	---	997	75.39
SUTTER	44,800	---	4	---	59	63	82.92
TEHAMA	31,900	---	---	---	106	106	70.60
TRINITY	9,200	9	6	---	---	15	145.06
TULARE	203,700	---	270		1533	1,812	59.18
TUOLUMNE	25,600	---	50	---	---	50	50.24
VENTURA	426,000	---	---	679	---	679	79.26
YOLO	104,400	131	81	---	---	212	164.58
YUBA	44,200	1	148	---	---	149	55.84
GRAND TOTAL	20,933,000	12,664	43271	0976	4840	59,751	$119.69

APPENDIX C.—CHANGE IN FUNDING FOR HOMEMAKER-CHORE SERVICES DUE TO THE ADDITION OF $8,448,000 STATE FUNDS TO THE PROGRAM

	Funding agency			
	State	County	Federal	Total
Approved budget:				
Homemaker-chore	$16,250,000		$48,750,000	$65,000,000
Other services		$41,192,972	123,579,128	164,772,100
Total social services	16,250,000	41,192,972	172,329,128	229,772,100
Changes to budget:				
Homemaker-chore	8,448,000		4,000,002	12,448,002
Other services		(1,333,267)	(4,000,002)	(5,333,269)
Total changes	8,448,000	(1,333,267)	0	7,114,733
Appropriation as changed:				
Homemaker-chore	24,698,000		52,750,002	77,448,002
Other services		39,859,705	119,579,126	159,438,831
Total social services	24,698,000	39,859,705	172,329,128	236,886,833

APPENDIX D

SUMMARY--SURVEY OF STATES

State	Method of Funding	Administering Agency	Approximate Number of Clients	Approximate Cost of Program	Cost/Client/Mo.	Primary Delivery Method	Comments
Alabama	Title VI	State	n/a*	n/a	n/a	State employees	Program not yet implemented statewide
California	Title VI	County	59,800	$7.2 million/mo.	$119	Individual contracts	
Hawaii	Title VI	State	425	n/a	n/a	State employees for H/M; agency contracts for chore	
Illinois	Title VI	State	4,084	$359,460/mo.	$88	State employees and agencies for H/M; individual contracts for chore	
Indiana		County	n/a	n/a	n/a	County employees	No chore services yet
Louisiana	Title VI	State	n/a	n/a	n/a	State employees	
Maryland	Title VI	County	1,500	$120,120/mo.	$80	County employees	
Michigan	Title VI	State	10,000	$1,478,922/mo.	$147	Individual contracts	
Nevada	Title XIX Phy. Aide Title VI H/M	State	25 250	$20,000/mo. (Title VI only)	$80	Agency contract for Title XIX physician's aide; state employees for H/M	Physician's aide used where personal care is primary need. No chore services offered.
New York (New York City only)	Title VI, XIX	County	11,000 (Title XIX only)	$1.7 million/mo. (Title XIX only)	$150 (Title XIX only)	County employees or agency for H/M; agency contracts or individual contracts for chore	Title XIX is for personal care and home health aid services
Oregon	Title VI	State	63 H/M 1,298 chore	$123,375/mo. (for chore only)	$95 (chore only)	Nonprofit agency contracts for H/M; individual contracts for chore	
Pennsylvania	Title VI	State	n/a	n/a		State employees and agency contracts	
Virginia	Title VI	County or city	1,896	$383,595/mo.	$202	County or city employees or agency employees for H/M; individual contractors and county or agency employees for chore	
Washington	Title VI	State	2,700	$306,300/mo.	$113	State employees for H/M; individual contracts for chore	
W. Virginia	Title VI	State	1,050 H/M 612 chore	$34,021/mo. (for chore only)	$55	State employees and agency contracts	
Wisconsin	Title VI	County	n/a	n/a	n/a	Individual contracts for chore	State has a home health aid program under Medicare

* Not available

Prepared from an Auditor General questionnaire answered by these states.

CALIFORNIA DEPARTMENT OF HEALTH,
Sacramento, Calif., August 12, 1975.

MR. KENNETH W. BRYAN,
General Manager,
Department of Social Services,
City and County of San Francisco,
San Francisco, Calif.

DEAR MR. BRYAN: The attached is an addendum to the original report on San Francisco's administration of the homemaker/chore program.

Sincerely,

GEORGE ELICH,
Chief, Field Review Unit.

[Attachment.]

ADDENDUM TO REVIEW OF HOMEMAKER/CHORE PROGRAM, SAN FRANCISCO COUNTY

This addendum is intended to allow officials of the San Francisco Home Health Service to express their views regarding the original report. Issuance of this addendum does not imply the State's agreement with the conclusions in or accuracy of the addendum or the documents mentioned therein.

INTRODUCTION

The methodology of the study conducted by the review team was faulty, undocumented, and inadequate in its coverage. Several conclusions about the San Francisco Home Health Service (SFHHS) were erroneous and the report is personalized. The State did not hold an exit conference, respond to the agency's "critique of the report," or suggest changes in minutes of the meeting held June 11, 1975. Copies of each document cited are available upon request from SFHHS.

ERRORS

1. Assessment and reassessment by professional staff at SFHHS are inherent in the supervisory process. Supervision is one of the two components that distinguish homemaker services from chore services. The costs quoted (10.2 percent) are appropriate for billing to DSS in the unit rate, and the level of professional staffing at SFHHS (in a minimum ratio of 15–1) is not "excessive."

2. The report fails to compare monthly costs of chore cases versus cases at SFHSS, or to compare chore cases with other homemaker service contractor's monthly costs.

The chief argument that $2,500,000 was being "over paid", is based on the assumption that the $100 limit on chore services is not being enforced, whether the case is with a contractor or a private chore person. This is an over-simplification. Some funds are unnecessarily expended because the county is unable to do the required assessment and reassessment (supervision) of private chore cases. This expenditure, as a separate entity, was not discussed in the report, nor was there an examination of how frequently SFHHS assesses and reassesses (supervises) its clients.

Other factors in the alleged overexpenditure of $2,500,000 result from a lack of adherence to and enforcement of recognized homemaker service standards which are still required by Federal regulations.

(a) Lack of adequate supervision by certain homemaker service providers results in overutilization of homemaker hours (the agency with the greatest amount of supervision—SFHHS—has the lowest monthly charge to DSS per client.)

(b) Lack of adequate training in certain homemaker service providers results in overutilization of homemaker hours (the agency with the greatest number of trained paraprofessional staff—SFHHS—has the lowest monthly charge to DSS per client.)

On page 8, the report states: "costs can be lowered if all contractors' cases were appropriately and more professionally assessed"—yet no solution to the present situation is offered except to insist that SFHHS and other contractors should discontinue this practice.

3. There was no evidence to verify the claim that SFHHS charges DSS for "unauthorized" nursing or medical services. Supervisory services of nurses are legitimate for inclusion in the DSS rate.

4. SFHHS determines neither the type of service needed (homemaker versus chore) nor the hours of service given to a client without approval by DSS.

The San Francisco Home Health Service is located at 2340 Sixteenth Street, San Francisco, 94103.

Appendix 3

REPORT ON AUDIT OF SAN FRANCISCO COUNTY (CALIF.) DEPARTMENT OF SOCIAL SERVICES' PURCHASE OF HOMEMAKER AND CHORE SERVICES FROM PROPRIETARY CONTRACTORS, FEBRUARY 1, 1971–FEBRUARY 29, 1976; SUBMITTED BY HERBERT WITT[1]

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
REGION IX
San Francisco, Calif., October 29, 1976.

JEROME A. LACKNER, M.D.,
Director, Department of Health
State of California
Sacramento, Calif.

DEAR DR. LACKNER: Enclosed for your information and use is a copy of an HEW Audit Agency report titled, "Audit of San Francisco County Department of Social Services, Purchase of Homemaker and Chore Services from Proprietary Contractors for the period February 1, 1971, through February 29, 1976." Your attention is invited to the audit findings and recommendations contained in the report. The below named officials will be communicating with you in the near future regarding implementation of these items.

In accordance with the principles of the Freedom of Information Act—(Public Law 90-23)—HEW Audit Agency reports issued to the Department's grantees and contractors are made available, if requested, to members of the press and general public to the extent information contained therein is not subject to exemptions in the act, which the Department chooses to exercise. (See section 5.71 of the Department's Public Information Regulation, dated August 1974, as revised.)

To facilitate identification, please refer to the above audit control number in all correspondence relating to this report.

Sincerely yours,

HERBERT WITT,
Regional Audit Director,
HEW Audit Agency.

[Enclosure.]

INTRODUCTION

BACKGROUND

Prior to January 1, 1974, titles I, X, and XIV of the Social Security Act, as amended, established grant programs providing Federal financial assistance in the costs incurred by States for the provision of social services on behalf of aged, blind, and disabled persons. Effective January 1, 1974, title VI established a consolidated grant program for social services previously provided pursuant to the three titles cited above. On October 1, 1975, title XX replaced title VI. One of the social service goals of title XX is "preventing or reducing inappropriate institutional care" through home-based or other forms of less intensive care.

The California State plan for social services authorizes local welfare departments to purchase social services from nonprofit and proprietary organizations. Under the plan these costs are reported to the California Department of Benefit Payments and claimed for Federal and State financial participation. The California State Department of Health has the responsibility for monitor-

[1] See statement, p. 1007.

ing program activities. Both of these State departments come under the purview of the California State Health and Welfare Agency (State agency).

The San Francisco County Department of Social Services (county agency) has elected to purchase through contracts about one-third of the services provided under its adult homemaker program. As of December 31, 1975 the county agency had awarded contracts to three proprietary and two nonprofit organizations. Each of these contracts began in either calendar year 1971 or 1972. The county agency program has been financed with 75 percent Federal and 25 percent State funds.

Homemaker services were defined in the Code of Federal Regulations (CFR), title 45, section 222.71, as home management and maintenance services, and personal care services, provided to maintain and strengthen the functioning of eligible persons in their own homes. Chore services were defined in 45 CFR, 222.65, as services in performing light work, or household tasks, such as simple household repairs, shopping, or running errands which do not require the services of a trained homemaker. On October 1, 1975, 45 CFR part 222 was replaced by 45 CFR part 228. This Federal regulation does not define homemaker and chore services. The California State plan has retained the section 222 definitions.

The contracts awarded by the county agency were written for the provision of homemaker services. However, one survey done by the county agency showed that over 40 percent of the cases assigned to the contractors required only chore services. Thus, the county agency has used the contracts to purchase both homemaker and chore services from the various agencies. County agency expenditures for services purchased under contracts covered in this report totaled $7,045,696. These expenditures represent contract payments to the three proprietary providers during the period February 1, 1971, through February 20, 1976.

SCOPE OF AUDIT

Our audit was made in accordance with standards for governmental auditing. The purpose of our review was to determine the reasonableness of the rates established for the purchase of homemaker and chore services by the county agency. We reviewed the county agency's procedures for establishing rates of payment as well as selected financial data and supporting documentation maintained by the contractors. The scope of this report was limited to the three private proprietary agencies under contract with San Francisco County. We plan to audit the two nonprofit organizations at a later date. We reviewed contractor records pertaining to unaudited financial statements for the following periods: (*i*) Calendar year 1973 for contractor A; (*ii*) calendar year 1974 for contractor B; (*iii*) fiscal years ending January 31, 1974 and January 31, 1975 for contractor C. We did not review contractor records for the entire contract period since cost statements for all periods were not available at the county agency.

HIGHLIGHT OF AUDIT RESULTS

PURCHASE OF SERVICE ARRANGEMENTS

The State agency has claimed Federal financial participation in the costs of homemaker and chore services purchased by the San Francisco County Department of Social Services at excessive hourly rates. We have determined that for the period July 1, 1972 to September 30, 1975 at least $981,596 was paid by the county agency to three proprietary providers in excess of the amounts "reasonable and necessary" to obtain the social services. The county agency purchased the services at unreasonable hourly rates because the San Francisco Social Services Commission directly negotiated the initial rates and subsequent increases of the rates using incomplete and inaccurate data. Also, the county agency did not require periodic audits of contractor records to assure that the rates were justified by reimbursable costs incurred by the providers. Because claimed and unaudited statewide social services costs after June 30, 1974 exceed available Federal appropriations, the ineligible costs incurred during fiscal years 1975 and 1976 could have been paid with only State funds. We are recommending that the State agency refund $415,190, the Federal share of the excessive costs of $553,586 pertaining to fiscal years 1973 and 1974. The remaining $428,010 of unreasonable costs for the period ended September 30, 1975 should be clearly identified on State agency records

CONTINUED

2 OF 4

as ineligible for Federal financial participation. Also, the State agency should require the county agency to implement certain procedures to assure that rates established for the purchase of homemaker and chore services are reasonable and necessary for obtaining the services.

DETERMINATION OF PROFIT

The San Francisco Social Services Commission did not consider essential profit factors when establishing and increasing the rates of payment for the proprietary contractors. As a result, each of the contractors made an excessive return on investment. We are recommending that the State agency (*i*) establish standards which define reasonable profit and (*ii*) require the county agency to consider various profit factors in evaluating the reasonableness of the rates of payment for the purchase of homemaker and chore services.

RECORDS SUPPORTING CONTRACT RATES

The county agency did not maintain records to support the reasonableness of the rates of payment for the purchase of homemaker and chore services from the proprietary contractors. Federal regulations effective October 1, 1975, for title XX provide for Federal financial participation in the costs of purchased social services only where records supporting the reasonableness of rates are available. We are recommending that the State agency discontinue claiming Federal financial participation in county agency expenditures for homemaker and chore services purchased from the proprietary agencies under title XX until such time as records supporting the rates are developed. In addition, the State agency should classify as ineligible for Federal financial participation county agency expenditures of $713,399 claimed under title XX for the period October 1, 1975, through February 29, 1976.

STATE RESPONSIBILITIES

The State agency did not control the rates negotiated by the San Francisco County agency for purchasing social services from the three proprietary contractors. It did not (*i*) publish cost and profit standards applicable to proprietary contractors; (*ii*) provide for fiscal audits of contractor cost records; (*iii*) promptly reduce rates of payment which were identified as excessive; and (*iv*) recover State and Federal funds claimed in excess of the amounts reasonable and necessary to obtain the services. The State agency relied primarily upon county agency administration for assuring that reasonable procurement practices were reflected in county contracts for homemaker and chore services. Also, when problems were identified, the State agency relied primarily upon voluntary corrective actions by the county agency. The expected voluntary corrective actions have not occurred and the State agency has since July 1972 continued to improperly claim Federal financial participation in the excessive purchased service costs incurred by the county agency. We are recommending that the State agency promptly reduce excessive rates of payment upon discovery and take appropriate action to recover overclaimed State and Federal funds.

STATE AGENCY RESPONSE

The State agency agreed that (*i*) the hourly rates established by the county agency were unreasonable; (*ii*) each of the contractor made excessive returns on investment; (*iii*) the county agency did not have records to support the reasonablenes of the rates of payment; and (*iv*) it had not provided the county agency with cost or profit standards applicable to proprietary providers of social services. However, the State agency indicated that it did control the county's purchase of service arrangements with the proprietary contractors and did not agree to refund the Federal share of the excessive payments. The State agency disagreed with our computation of the overclaim and commented that the excessive costs of the county agency's purchase of service arrangements were paid out of State funds. (The State agency's written comments to the audit report are included as appendixes A and B.)

AUDITOR'S COMMENTS

Our computation of the excessive costs was based on the best information available as to costs and prices in effect. The State agency has not provided us

with any alternative basis for computing the excessive costs which it acknowledged were incurred under the County Agency's purchase of service arrangements.

In addition, we have shown that Federal financial participation was claimed for excessive costs of $553,586 incurred during fiscal years 1973 and 1974. The Federal share of these costs was $415,190 and should be refunded by the State agency. The remaining $1,141,000 of excessive and unsupported costs claimed for periods beginning July 1, 1974 should be clearly identified on State records as ineligible for Federal financial participation.

Findings and Recommendations: Purchase of Service Arrangements

The California State Department of Benefit Payments has claimed Federal financial participation in the costs of homemaker and chore services that were purchased by the San Francisco County Department of Social Services (county agency) at fixed hourly rates which were excessive. Federal financial participation is not available for the costs of purchased social services which exceed the amounts reasonable and necessary to obtain the services. We determined that the State Department of Benefit Payments improperly included in its claim for Federal financial participation $981,596 of excessive county agency expenditures for purchased homemaker and chore services. One contractor made a profit of $178,092 on total county agency payments of $683,326 during calendar year 1973 under its established hourly rate. The county agency purchased homemaker and chore services at unreasonable hourly rates because the San Francisco Social Services Commission in response to contractor requests established and periodically increased the hourly rates of payment using incomplete and inaccurate data. Also, the county agency did not require periodic audits of contractor records to provide a basis for evaluating the approved rates of payment and assuring that the rates were justified by reimbursable costs incurred by the contractors.

We are recommending that the State agency (*i*) refund the Federal share in excessive payments of $981,596 made by the county agency and claimed for Federal financial assistance, and (*ii*) require the county agency to implement certain procedures to assure that rates established for the purchase of homemaker and chore services are reasonable and necessary for obtaining the services.

Background

The State agency has delegated the responsibility for purchasing services to the local county welfare agencies. As a result, county agency procurement procedures required by the city and county of San Francisco were used to purchase homemaker and chore services from various providers.

The administrative policies of the county agency are determined by the Social Services Commission (commission). The commission consists of five members who are appointed by the mayor of San Francisco. The commission authorized the county agency to purchase homemaker services through contracts with three proprietary and two nonprofit organizations. The commission also established the rates of payment for each contractor and approved various rate increases which were requested by the individual contractors.

The contracts awarded by the county agency had no fixed termination dates but could be canceled by either the county agency or the contractor upon 60 days written notice. The contracts specified that the county agency retained full responsibility for decisions regarding eligibility of payment and service plans for individual recipients. The purpose of the contracts is quoted from a sample as follows: "This contract * * * is intended to provide to the (county agency) continued and uninterrupted operation by the contractor of a homemaker program. This program shall include evaluation, periodic reevaluation and reporting, coordination of community resources, assignment of trained staff to provide appropriate homemaker services, and supervision of such personnel." The contracts stated that the county agency would refer selected recipients who were eligible for homemaker services to each contractor for one or more of the above mentioned services, and that payment would be made for each hour of service provided by a Homemaker and authorized by the county agency.

The contracts also specified that: "Rates of pay per hour of homemaker services under this Contract shall be adjustable after six (6) months of operation under this Contract, and periodically thereafter when and if it becomes

apparent that the cost to the Contractor of providing these services has increased or decreased."

Under 45 CFR part 226, dated January 25, 1969, Federal financial participation is available in expenditures for social services purchased under public assistance programs: "* * * to the extent that payment for purchased services is in accordance with rates of payment established by the State which do not exceed the amounts reasonable and necessary to assure quality of service. * * *"

On June 27, 1975, 45 CFR part 228 superseded part 226 and continued this requirement for services under title XX.

The California State plan, State Department of Social Welfare Manual, section 10–034, sets out certain general standards for purchase of service arrangements negotiated by local welfare agencies. Section 10–034.8 requires:

"Provision shall be made for the establishment of rates of payment for purchase of service which shall be a matter of public record.

"Such rates shall not exceed the amounts reasonable and necessary to assure quality of service."

CFR. title 45, part 74, sets out general requirements for the administration of HEW grants to State or local governments. Under subpart H, section 74.61, grantees shall establish: "Procedures for determining the allowability and allocability of costs in accordance with the applicable cost principles prescribed by subpart Q of this part."

Subpart Q. section 74.76, states that principles to be used in determining the allowable costs of work performed by commercial organizations under cost-type contracts under HEW grants are set forth in 41 CFR subpart 1–15.2. In addition, 45 CFR 74.61 requires audits to be made, usually annually, to assure the integrity of financial transactions and compliance with grant terms and conditions.

We recognize that 41 CFR subpart 1–15.2 establishes cost principles for use in cost-reimbursement type contracts rather than the labor-hour type of contract actually negotiated by the county agency. In a cost-reimbursement type of contract the contractor submits a claim representing the actual costs incurred and is reimbursed according to the principles of allowability. In a labor-hour type of contract payment is made to the contractor on the basis of direct labor hours at a specified hourly rate. Nevertheless, the applicability of subpart 1–15.2 is set out in section 1–15.102 to include the use of these cost principles not only in cost-reimbursement type contracts, but in the pricing of other types of negotiated contracts as well. Therefore, we used subpart 1–15.2 to determine federally reimbursable costs incurred by the proprietary agencies providing homemaker and chore services under contract in San Francisco County.

RATESETTING PROCEDURES

The San Francisco County Social Services Commission did not properly consider the factors of contractor cost and profit in establishing the hourly rates of payment under contracts negotiated with three proprietary agencies for the purchase of homemaker and chore services. The rates approved for these three vendors are summarized below:

EFFECTIVE DATES OF NEGOTIATED FIXED PRICE RATES PER HOUR OF SERVICE

Effective dates	Contractor A	Contractor B	Contractor C
Feb. 1, 1971	[1] $5.00	[1] $4.78	----------
July 1, 1971	[2] 6.00	4.98	----------
Oct. 1, 1971	[3] 6.00	([6])	----------
Jan. 1, 1972	([6])	6.00	----------
July 1, 1972	[4] 7.00	([6])	[1] $6.00
	[5] 7.00	[5] 6.00	[5] 6.00

[1] Initial rates.
[2] Rate for period July 1, 1971 to Sept. 30, 1971.
[3] Fixed rate Oct. 1, 1971 to June 30, 1972.
[4] Agency staff recommended $6.50.
[5] Effective rates through June 30, 1976.
[6] No change.

As shown above, contractor A was paid for the same type of service at a higher hourly rate than contractor B during each of the 11 months ended December 31, 1971. For the first 5 months, the difference was $.22 per hour and for the following 6 months the difference was $1.02 per hour. For the first 6 months of 1972, both contractors A and B were paid the same $6 per hour rate. Effective July 1, 1972 and continuing through June 30, 1976, contractor A was paid $7 per service hour, or $1 per hour more than the $6 rate paid to contractors B and C.

The Social Service Commission minutes do not contain a reasonable explanation for paying a higher rate to contractor A and for the periods described above. Our review of the minutes disclosed that contractor A's rate of $5 was provisionally increased by $1 effective July 1, 1971 to $6 per hour of service in order to allow a recovery of earlier losses which were reflected in the contractor's unaudited cost records. The commission apparently also approved a $6 hourly rate for contractors B and C in order to provide for equivalent rates. None of the three contractors had submitted audited cost data.

Effective July 1, 1972 the commission, without documentation for its action, approved for contractor A an hourly rate which was $.50 per hour greater than the $6.50 rate recommended by the county agency general manager. At the July 13, 1972, meeting the commission rejected proposals by two other organizations to provide the services which had been provided since February 1, 1971 by contractor's A and B and initiated July 1, 1972 by contractor C. At that time the approved hourly rates were $7 for contractor A and $6 for contractors B and C. The minutes show that the offers were rejected on the basis that "* * * with (contractor C) just starting it would not be fair to enter into new contracts at the present. * * *" These rejected offers were at lower rates ranging from $4.75 to $5.75 per hour of service. As a result, excessive hourly rates were continued for the three contractors.

This may have occurred in part because San Francisco County funds were not affected by any of the ratemaking decisions. The homemaker and chore services program was funded by 75 percent Federal funds and 25 percent State funds. The chronology of negotiations for each of the three contractors is outlined in the following sections of this report.

CONTRACTOR A

Effective February 1, 1971 the commission authorized an initial rate of payment for contractor A of $5 per hour of service. This rate was not supported by cost data. Commission minutes dated September 17, 1970 indicate that contractor A's experience in providing similar services to welfare recipients under a limited pilot program which began in August 1970 justified the $5 hourly rate requested by the contractor.

Contractor A subsequently requested that its hourly rate be increased by $1 effective July 1, 1971. According to the commission minutes dated July 15, 1971, the general manager of the county agency provided the following information about contractor A's costs: "* * * hourly costs appear to be $5.45 from January through May 1971, and are estimated for June at $5.38; 3,311 of their total 3,790 hours of service were provided to Department clients; and while it appeared that possibly as their volume increases, their costs will be reduced, at the present time they seem to have lost some $7,000 under contract with the Department. * * *"

Based on this information the commission approved a $6 per hour rate effective July 1, 1971 for contractor A. According to the minutes, this rate was approved with the provision that: "* * * financial statements certified to by their Certified Public Accountant, be submitted in early October, setting forth their actual cost per hour of service for the first six months of 1971 and for the third quarter, i.e., July through September, 1971, together with the combined figure for the first nine months of 1971; and that the rate be subject for review at the October (1971) meeting of the Commission. * * *"

Contractor A did not supply audited financial statements at the October 1971 meeting of the commission. Nevertheless, the commission approved the contractor's request for continuing the $6 hourly rate through June 1972. The commission's extension of the $6 rate overruled the recommendation of county agency staff. According to the commission minutes dated October 21, 1971, the general manager of the county agency had recommended continuing the $6

rate only through December 1971. The general manager's position is quoted from the minutes as follows: "* * * at a meeting with (contractor A's) director and his certified public accountant they went over all cost figures except for the month of September which were not yet available. Their cost for the first 6 months ran at $5.45 per hour with a $12,000 loss. During July and August their actual cost based on their figures was $4.96 per hour; however, there was some indication that some costs had increased or were not included. Based on $4.96, a net profit of $6,600 was estimated for the 2 months, with a net loss for the first 8 months of over $5,200. He recommended that the rate of $6 per hour be continued for the months of October, November and December in order to offset the loss (contractor A) had incurred earlier, with the rate to be reviewed again at the December meeting or early in January for establishment of a continuing rate effective January 1."

The general manager's recommendation permitted an estimated net profit of $3,300 for each of the 4 months ending December 31, 1971, or a total of $13,200. Since there was an estimated loss of $5,200 through August 31, 1971, the general manager's recommendation would have provided an estimated net profit of $8,000 for the year ended December 31, 1971. Also, a new and presumably lower rate would have been negotiated effective January 1, 1972. However, the commission's action allowed an estimated monthly profit of $3,300 to continue for the period January through June 1972, or $19,800 for that 6-month period.

In July 1972 contractor A requested another rate increase to $7.30 per hour effective July 1, 1972. This proposal was discussed in commission minutes dated July 13, 1972. The general manager stated that county agency staff had recently met at various times with contractor A's representatives regarding its costs. His summary of the meetings is quoted from the minutes: "Their figures for the first 5 months of this year show their actual average cost at $5.08 per hour of service * * * They have increased costs as a result of their signing a union contract, and increased office rental, and they anticipate a cost of $3,000 per month for their training program which has just started; this amount also covers the cost of the time of the homemakers while they are in training. They intend to hire four additional administrative staff for a total $3,450 monthly and plan to give salary increases, approaching 25% on the average, to present administrative staff which includes in some cases the devoting of increased time. He estimated that these cost increases would bring their hourly cost for the provision of homemaker services up to $6.02 per hour."

Based on the anticipated cost increases referred to above, the general manager presented several rate increase figures ranging from $6.50 to $6.70 per hour.

Following further discussion concerning contractor A's costs, a representative for the contractor is quoted in the commission minutes as follows: "He recalled that (contractor A) has proposed a rate increase to $7.30 per hour; however, if they would maintain their present level of cases, he proposed that the commission approved an hourly rate of $7. * * * "

The commission voted to accept Contractor A's request and established a $7 hourly rate effective July 1, 1972 for contractor A. This rate was still in effect as of June 30, 1976.

Commission minutes show that the commission: (*i*) approved rates in excess of those recommended by the general manager; (*ii*) did not obtain adequate cost data to support its decision prior to making rate changes; and (*iii*) did not obtain audited cost data on an after-the-fact basis to confirm the propriety of its decisions.

In a letter to the commission dated July 10, 1972, the general manager recommended that the rate for contractor A be increased to $6.50 per hour of service. The general manager pointed out in his letter that the contractor's actual hourly cost for the first 5 months of 1972 was $5.08. He further stated that the contractor anticipated various cost increases which would result in an hourly cost of $6.01, based on an estimated 10,000 hours of service per month. Thus, the general manager's recommendation would have allowed the contractor a monthly profit of $4,900, or $58,000 a year. The commission, without documentation for its action, did not approve the general manager's recommendation of an increase to $6.50 per hour of service. Instead it approved the contractor's request for an increase to $7 per hour. Based on cost data which the general manager submitted to the commission in his July 10, 1972 letter, the commission's action implicitly alowed the contractor a monthly profit of $9,900 ($18,000 a year), or approximately twice that proposed by the general manager.

The rate setting negotiations with contractor A were not based on audited cost data. Although the rates of payment were approved by the commission based on either unaudited cost data or cost increases which were anticipated by the contractor, the county agency never obtained audited financial statements to assure that the established rates were reasonable and necessary. Also, our discussion with contractor A's outside accountant disclosed that certified financial statements have never been prepared for contractor A for any period after February 1, 1971.

CONTRACTOR B

The commission established an initial hourly rate of $4.78 effective February 1, 1971, for contractor B. This rate was not established based on an analysis of any cost data. Minutes of the commission meeting dated November 19, 1970, indicate that this was the rate recommended by county agency staff based on contractor B's cost experience involving a small pilot program in 1970. Subsequently, contractor B requested a rate increase which was discussed at the June 17, 1971, meeting of the commission and reported in the minutes as follows: "(A representative from the county agency) referred to a request from (contractor B) for establishment of a rate of $5.23 per hour while training homemakers with their funds as public funds are not presently available, and a rate of $4.98 per hour if and when public funds or training becomes available, and that they are planning a rather thorough training program in conjunction with other agencies. He requested approval for further investigation and discussion with the agency on the $5.23 rate before making a recommendation and recommended that the present rate of $4.78 per hour be increased to $4.98 effective July 1, 1971."

The proposed increase was not accompanied by any cost data. The commission approved the county agency representative's recommendation that the rate of payment for contractor B be increased to $4.98 per hour effective July 1, 1971. It also gave approval for the county agency to further study the request for an increase to $5.23 per hour.

At the July 15, 1971 meeting of the commission, the general manager of the county agency informed the commission that it appeared that public funds would soon become available for the training of homemakers. As a result, contractor B had agreed to postpone its request for a rate increase to $5.23 per hour.

In September 1971 contractor B requested a rate increase to $5.95 per hour. The commission did not act on the request during the September meeting. In November 1971 the contractor requested that its rate be increased to $6 per hour. These requests were not accompanied by any cost data. According to the minutes of the November 18, 1971, commission meeting, the general manager explained that the contractor's request for an increase to $6 per hour would enable the contractor to put its homemakers on a weekly salary, to provide in-service training and to meet other costs. In December 1971 the commission approved the contractor's request for a rate increase to $6 per hour of service, although no cost studies had been made to support this rate. This rate became effective for contractor B on January 1, 1972, and was still in effect as of June 30, 1976.

Contractor B never submitted any cost data, audited or unaudited, to the commission as a basis for negotiating the hourly rates of payment. The $6 rate approved for contractor B apparently represented an attempt by the commission to reimburse the contractor at the same rate paid to contractor A. However, it should be noted that the $6 rate was established as a provisional rate for contractor A in order that earlier losses could be recovered.

Contractor B never reported a loss incurred under the county agency contract. The commission minutes contain no reasonable explanation for the establishment of a continuous $6 hourly rate for contractor B since there is no discussion of the contractor's cost/profit experience. Also, the county agency never subsequently obtained any audited cost data to assure the propriety of the commission's actions.

CONTRACTOR C

In March 1972 a representative for the county agency made a brief report before the commission regarding contractor C. According to the minutes of the meeting dated March 16, 1972, the representative explained that contractor C was: " * * * a new agency being started by (two persons named) homemaker services to the blacks in the community. (One of the persons named above) is

presently a department (county agency) homemaker coordinator who has a great deal of knowledge on the subject, and she will resign if the department enters into a contract with this agency. * * *"

The commission authorized the county agency to continue negotiations toward a contract with contractor C.

In April 1972 a county agency representative informed the commission that since negotiations with contractor C had been completed, the commission should authorize the county agency to enter into a contract with this new proprietary agency. Minutes of the April 13, 1972, commission meeting showed that the commission authorized the county agency to award a contract to contractor C "* * * for the provision of adult homemaker services to department clients at the prevailing rate of $6 per hour for the proprietary agencies under contract with the department * * *." No cost data were submitted by the contractor. The county agency employee associated with contractor C resigned on June 14, 1972, and the contract became effective on July 1, 1972. The hourly rate of $6 continued in effect through June 30, 1976.

Contractor C did not submit any cost data to the commission to be used in negotiating its $6 hourly rate. The commission's approval of this rate was apparently an attempt to reimburse contractor C at the same rate paid to the other two proprietary contractors. The commission minutes do not indicate any discussion regarding the cost/profit experience anticipated for contractor C. Also, the county agency never subsequently obtained audited cost data from contractor C to assure the reasonableness of the $6 hourly rate.

OTHER PROPOSALS

In July 1972 the general manager informed the commission that two other organizations had submitted proposals for contracts with the county agency for the provision of adult homemaker services. He presented the hourly rates requested by these two organizations which ranged from $4.75 to $5.75 depending on the volume and number of continuous hours of service to be provided. The minutes dated July 13, 1972 are quoted as follows: "Members of the commission agreed that with (contractor C) just starting it would not be fair to enter into new contracts at the present."

The decision to reject contract proposals of these two organizations was made although the offered rates were lower than the contracted rate of $6 per hour paid to each of the three proprietary agencies. In addition, at the same July 1972 commission meeting contractor A's rate was increased to $7 per hour of service.

CONTRACTOR COSTS

Our review disclosed that unaudited financial statements prepared on behalf of the proprietary contractors did not fairly present federally reimbursable contract costs and substantially understated actual profits made by the individual contractors. The financial statements did not represent a fair presentation of contract costs because: (*i*) the county agency never specified the cost standards applicable to the contracts; (*ii*) the financial statements were "unaudited" and included costs of activities not related to the San Francisco contract; and (*iii*) salaries, fees and other forms or remuneration to the owners and their immediate family members were not adequately disclosed by the three closely held proprietary contractors.

Federal cost standards applicable to proprietary organizations are cited in 45 CFR Part 74, dated September 19, 1973.

Section 74.175(b) states: "The principles to be used in determining the allowable costs of work to be performed by commercial organizations under cost-type contracts awarded to them under HEW grants are set forth in 41 CFR Subpart 1–15.2."

One of the principles presented in 41 CFR 1–15 that was consistently overlooked by the county agency related to the necessity of advance understandings on particular cost items. Section 1–15.107 states: "The extent of allowability of the selected items of cost covered in subparts 1–15.2, (etc.) * * * has been stated to apply broadly to many accounting systems in varying contract situations. Thus, as to any given contract, the reasonableness and allocability of certain items of cost may be difficult to determine, particularly in connection with firms or separate divisions thereof which may not be subject to effective competitive restraints."

Section 1-15.107 concludes that in order to avoid subsequent disallowance or dispute based on unreasonableness or nonallocability, advance agreements on selected cost elements become important. Examples of costs on which advance agreements may be particularly important include compensation for personal services of executive officers and employees.

Section 1-15.205-6 states that in relation to compensation for personnel services, certain conditions give rise to the need for special consideration and possible limitation as to allowability for contract cost purposes where amounts appear excessive. Among such conditions is the following: "Compensation to owners of closely held corporations, partners, sole proprietors, or members of the immediate family thereof, or to persons who are contractually committed to acquire a substantial financial interest in the contractor's enterprise. Determination should be made that such compensation is reasonable for the actual personal services rendered rather than a distribution of profits."

The county agency did not reach advance agreements with the proprietary contractors regarding compensation to the owners of closely held corporations and their immediate family members. Our review disclosed that the salaries of the sole owner of contractor A and two of his immediate family members in calendar year 1973 was $77,750. Wages and fees paid to the four owners of contractor C, two of whom were part-time, totaled $83,750 in fiscal year 1974 and $94,950 in fiscal year 1975. We believe that these payments to the owners of contractor A and contractor C should have been clearly disclosed and specifically negotiated by the commission. If this had been done, the amounts paid in excess of reasonable compensation would have been properly identified as profit rather than a reported expense justifying the contract rates.

Also, contractor B paid $22,549 in service fees based on gross revenue under its October 8, 1973, agreement with the original contractor. These service fees appear to represent a commission or franchise fee. The agreement did not indicate that the consideration exchanged for those fees was necessary for purposes of performing the San Francisco contract. On this basis the service fees of $22,549 should have been reported as a division of profits earned on the San Francisco contract and the financial statements supplied by the contractor should have been appropriately annotated.

The results of our review of contractor costs included the unaudited financial statements for each proprietary contractor are presented in the following captions of this report. We have determined the allowability of contractor costs in accordance with the cost standards set forth in 43 CFR 1-15.2. The contractors have advised us that these Federal cost principles were not brought to their attention by either the county or the State.

CONTRACTOR A

The costs of services provided in calendar year 1973 by contractor A under its contract with the county agency were not fairly disclosed in the contractor's unaudited financial statements which were supplied to the county agency on March 14, 1974. The March 14, 1974, transmittal letter signed by the President and sole owner of contractor A is quoted:

"* * * The statement should be selfexplanatory (sic) and according to the figures we delivered 98,704 hours of professional Homemaker Services for the year (average 8,225 hours per month).

"Our total cost for the year after taxes was $679,396. This proves that our cost per hour was $6.88 which constitutes a 12 cent profit per hour at our rate of $7 per hour * * *"

The financial statements consisted of an exhibit titled "Balance Sheet, December 31, 1973," and an exhibit titled "Statement of Income and Expense, Year Ended December 31, 1973." Both exhibits were identified as "unaudited." These statements included financial transactions involving corporate activities which were not related to the San Francisco contract. The contractor did not point out that its accounting records were not designed to clearly identify and report costs related to the San Francisco contract separately from other corporate activities.

The financial statements showed total revenue of $690,931 and total expenses of $679,396 resulting in net profit after taxes of $11,535.

Our audit showed that payments from the county agency for services billed for calendar year 1973 totaled $638,326. Reimbursable costs under the contract

totaled $505,234 resulting in a net profit before taxes of $178,092, or 25 percent of total costs. On this basis the net profit before taxes was $1.82 per hour ($178,092 ÷ 97,658 hours).

The $7,605 difference between reported and actual revenue and the 1,046 difference between reported and actual hours occurred because the reported amounts were based on estimates. The difference between reported costs of $697,396 and reimbursable costs of $505,234 is $174,162. The difference is explained in detail under the following sections:

SUBSIDIARY CORPORATION COSTS

The financial statements, while presented as a basis for justifying the $7 per hour contract rate, are misleading primarily because they reflect corporate account balances that include the costs of an affiliated corporation. The costs of this affiliated corporation were not incurred for purposes of the San Francisco contract. These costs were commingled in the expense accounts of the contractor and were included in the $679,396 of reported costs to which the contractor referred in its March 14, 1974 letter. The costs identified in our audit penetrating to this subsidiary corporation totaled $91,276 and are further explained as follows. Administrative and clerical salary expense accounts totaling $147,545 included $79,804 for salaries which were directly chargeable or allocable to the subsidiary corporation. However, the entire $79,804 was included in the line item salary and wages shown on the subject financial statements at a total cost of $497,274. Also, the line item payroll taxes reported at a cost of $38,105 included $6,478, which was applicable to the $79,804 of subsidiary salaries. In addition, contractor records indicated that $4,094 was chargeable to the subsidiary for jointly used office space and telephone lines. The contractor's letter and the attached reports were not appropriately qualified to reflect the fact that approximately 13.4 percent of the total reported costs were unrelated to the San Francisco County contract. The $91,276 represents a material overstatement of actual contract costs and substantially understates actual profit under the contract by $0.93 per hour ($91,276 ÷ 97,658 hours).

A representative of the contractor advised us that some expenses incurred on behalf of the affiliated corporation were inadvertently included on the financial statements submitted to the county on March 14, 1974. He did not dispute the $4,094 chargeable to the subsidiary for jointly used office space and telephone lines. However, he advised us that we had substantially overstated the salary and related payroll tax expenses which were allocable to the affiliate. He was unable to provide time and effort reports or other support for his statement. Our determination was based on internal memorandums which the contractor prepared in the latter part of calendar year 1973. We believe the costs applicable to the affiliate would have been disclosed if the county agency had obtained audited data from the contractor.

UNSUPPORTED COSTS

The statement of income and expenses included $57,566 of expenses which were not related to the San Francisco contract for calendar year 1973. These costs are explained below.

Training expenses of $3,000 were unsupported. This amount represents a 1973 year-end adjustment for which we could find no documentation of training expenses actually incurred. Since the adjustment was not supported, we have classified the $3,000 of training as unrelated to the San Francisco contract. A representative of the contractor agreed that this year-end adjustment was not supportable.

In addition, most of the $7,791 of reported travel and promotion expense appeared to be unrelated to the San Francisco contract. Our review indicated $449 charged to this account was paid for recruiting contractor staff through public advertisements. The remaining $7,342 of costs were not documented or shown to be necessary for the performance of the San Francisco contract.

Also, $19,689 reported for automobile, parking and insurance expenses appears to have been incurred for purposes which were unrelated to the San Francisco contract and therefore allocable to the subsidiary corporation or to other non-contract purposes.

A representative of the contractor advised us that a major portion of the automobile and travel expenditures were related to the San Francisco con-

tract. However, in the absence of documentation showing the relationship between these expenses and the provision of social services in San Francisco County, there is no basis for accepting these costs.

We have classified $27,535 of salaries and wages as unsupported cost. Our review of the $497,274 of salaries and wages included in the statement of income and expense for 1973 showed that $468,187 of this amount was supported by payroll records leaving a difference of $29,087. Of this amount $19,087 represented unidentified expenses which we have reclassified as unrelated to the San Francisco contract. The remaining $10,000 represented an estimate by the contractor for accrued salaries at December 31, 1973. Our review disclosed that salaries payable at December 31, 1973, were actually $14,390. However, we also found that salaries and wages reported and paid in 1973 included $12,838 of costs for the 2-week period ended December 31, 1972. This resulted in an overclaim of salaries and wages as compared below:

Estimated unpaid salaries at Dec. 31, 1973	$10,000
Salaries expense for 1972	12,838
Less: Actual unpaid salaries at Dec. 31, 1973	(14,390)
Total	8,448

Therefore, we classified an additional $8,448 of reported salaries and wages expense as an unsupported cost. This $8,448 plus the $19,087 earlier explained, total $27,535 of unsupported salary costs.

3. INELIGIBLE COSTS

Certain costs reported by the contractor were not subject to Federal reimbursement under 41 CFR, subpart 1–15.2. Under this criteria we have classified $13,691 of expenses as nonreimbursable. This amount included $4,092 for Federal income taxes, $3,015 for payment of a tax penalty, $5,504 of interest expenses and $180 of organizational expense. A representative of the contractor advised us that these Federal cost principles were not brought to his attention by either the county or the State and were not specified in the contract.

NONCONTRACT HOURS

The contractor's records indicated that 99,906 hours of service were provided during 1973. However, the county agency only authorized payment to be made for 97,658 hours of service. The costs associated with 2,248 hours which were not reimbursable under contract provisions amounted to $11,629.

The contractor did not receive payment from the county for these noncontract hours. However, the costs of the services were included in the financial statements which were used to justify the contractor's hourly rate of payment, without indicating the total hours of service.

CONTRACTOR B

This contractor's unaudited financial statements for calendar year 1974, the most current year for which data were available, showed payments from the county agency totaling $538,458, less operating expenses of $535,228, resulting in a net profit of $53,230. Our review disclosed that actual payments from the county agency were $585,799, the contractor's reimbursable costs were $493,281, and the contractor's profit for calendar year 1974 was $92,518, for 19 percent of reimbursable contract costs.

The $2,659 difference between reported and actual payments made by the county agency occurred because the reported revenue was based on an estimate. There is a $41,947 difference between the $535,228 of expenses shown on the contractor's unaudited financial statements and our determination that contract costs totaled $493,281. This difference is explained below.

Contractor B's unaudited financial statements included a line item expense category labeled "service fees" which totaled $22,549. This amount represented payments made to another corporation under whose name the county agency contract had been initially awarded effective February 1971. Pursuant to an agreement dated October 8, 1973, the original corporation assigned the county agency contract to an organization formed by staff members of contractor B. The assignment of the contract was approved by the commission in September

1973. The county agency general manager's summary of the arrangements is quoted from the commission minutes dated September 20, 1973: "The general manager reported that he had received a letter from (the original corporation) * * * relating their plan which they wish to follow. This is to license their bay area contractors as an organization called (contractor B), instead of operating them as wholly owned. The licensee could use (the original corporation's trade name) and (the original corporation) would provide some accounting service and stand behind the credit of its licensee to the extent of 80 percent of their accounts receivable * * * The (county agency) staff is of the opinion that if the assignment is made the operation would continue to operate in much the same manner and with the same staff."

The assignment agreement dated October 8, 1973, provided that the licensee created by the agreement would make certain payments to the first contracting corporation. The payment schedule was based on a percentage of gross revenues received by the licensee from the county agency and does not appear to represent the cost of services which were necessary to the county agency for the purpose of obtaining homemaker and chore services.

The $6 hourly rate paid to contractor B was negotiated effective January 1, 1972, at which time there was no expectation of incurring the service fees which the licensee paid under its October 8, 1973, agreement with the original contractor. We have classified the $22,549 of service fees as a nonreimbursable cost.

Other costs included on the contractor's unaudited 1974 financial statements were expenditures incurred for purposes not related to the county agency contract. The statements showed $2,402 of expenses which were directly chargeable to a related organization not providing services in San Francisco County. These expenses included professional fees of $1,220 incurred on behalf of this related organization, charges of $697 relating to a houseboat not located in San Francisco County and other miscellaneous expenditures of $485. Also included on the statements were $3,739 of expenses associated with an automobile used by the President of contractor B. There was no documentation indicating the need and use of this car for contract purposes. Available records indicated that this automobile was used primarily for commuting to and from work, weekend and out-of-town travel. In addition, travel expenses totaling $5,523, consisting primarily of cash payments to the owner, were included in the statements. There was no documentation available to show a relationship between the expenditures and the provision of homemaker and chore services under the contract. These unrelated costs totaled $11,564.

Representatives of contractor B advised us that the costs associated with the houseboat were inadvertently included in the financial statements. Also, they believed that a major portion of the travel and automobile expenses were contract related. However, in the absence of specific documentation showing the relationship between these expenses and the provision of social services under the contract, we do not have a basis for accepting these costs.

The contractor's financial statements also reflected expenses of $4,201 which were nonreimbursable under 41 CFR 1–15.2. Of this amount, $3,233 represented interest charges, $918 was classified as "entertainment" and $50 was classified as a "contribution" made by the contractor. Representatives for the contractor advised us that the Federal cost principles set forth in 41 CFR 1–15.2 were not brought to their attention by either the county or the State and were not specified in the contract.

Other costs related to service hours which were not authorized for payment by the county agency. While the contractor's records showed that 98,332 hours of service were provided during 1974, the county agency authorized payments to be made for the delivery of only 97,633 hours. We determined that the costs associated with the 699 hours, which were not chargeable to the contract, were $3,533. The contractor did not receive payment from the county for these noncontract hours. However, the costs of providing the services were not identified in the contractor's records as a noncontract expense.

CONTRACTOR C

This contractor's unaudited financial statements combined for the fiscal years ended January 31, 1974, and January 31, 1975, showed contract income of $745,043, and contract costs of $735,110, resulting in a net profit of $9,933. Our review of contractor C's records for the same period disclosed that payments

from the county agency were $744,744, reimbursable costs were $611,956 and the contractor's profit for the 2 years was $132,788, or 22 percent of total costs.

The $299 difference between reported revenue and actual payments made by the county agency occurred because the reported revenue was based on estimates. The difference of $123,154 between reported expenses and reimbursable costs is explained below.

Contractor C's financial records show substantial payments made to the owners in their fiscal years 1974 and 1975. Contractor C was a California corporation which was totally owned by two families. The wives were employed full-time while the husbands were employed part-time by the contractor. Each of the husbands was otherwise employed full-time; one as a practicing attorney and the other as a San Francisco County employee. Contractor C's financial income statements showed that $178,700 of salaries and fees were paid to the owners for the 2 years ended 1974 and 1975. This amount represented $169,100 classified as "officer wages" and $9,600 as "director fees." Our review of corporate records indicated that the four owners and administrators received biweekly salary payments totaling $92,450 during the 2 years as shown in the following table:

OFFICER SALARIES

Employee	Fiscal years		
	1974	1975	1974-75
1	$18,300	$21,600	$39,900
2	18,300	21,600	39,900
3	250	6,000	6,250
4	400	6,000	6,400
Total	37,250	55,200	92,450

Note.—Employees 1 and 2 were full-time and employees 3 and 4 were part-time.

The difference between reported wages of $169,100 and the $92,450 of salaries shown above is $76,650. The $76,650 was distributed to the owners and administrators during the 2-year period in lump-sum amounts which varied from $3,000 to $18,000.

As noted earlier, Federal regulations require advance agreements on certain elements of cost to avoid subsequent disallowance based on unreasonableness. One such element of cost is compensation to owners of closely held corporations or members of their immediate family. The biweekly salaries paid to employees 1 and 2 appear to be within the range of salaries paid to administrators of other similar agencies. In our opinion, however, the lump-sum payments totaling $76,650 and the $9,600 in directors fees appear to be a distribution of profits generated under the contract.

For the 12 months ended January 31, 1974 the biweekly salaries paid to officer employees Nos. 1 and 2 totaled $36,600, excluding fringe benefits. The average monthly caseload for this period was about 130 persons. On this basis, the salaries paid to the two officials and administrators represented about $23.46 per month for the cost of care provided to each welfare recipient.

In commenting on our draft report, representatives of contractor C advised us that the wages and fees totaling $178,700 for the 2-year period represented reasonable compensation for the four owners and administrators of the subject homemaker agency. Their position underscores the necessity for the county to reach advance agreements with prospective contractors regarding the reasonableness of compensation to owners of closely held corporations in accordance with 41 CFR 1-15.2.

Other expenses totaling $22,803 on the contractor's unaudited financial statements have been classified as unrelated to the contract. Reported expenses included $10,395 involving two automobiles used by the owners of contractor C. Documentation was not available to support the need and use of these cars for contract purposes. Available records indicated that the cars were used primarily for commuting, weekend and out-of-town travel. An additional $12,408 of reported expenses included automobile parking fees, credit card charges, and cash payments for which there was no documentation of relevant service costs incurred.

Representatives for the contractor commented that they believed the major portion of the travel and automobile expenses were contract related. However, in the absence of documentation showing the relationship between these expenditures and the provision of social services, we do not have a basis for accepting these costs.

Other costs of $8,444 were ineligible for Federal financial participation under 41 CFR 1-15.2. These costs included $6,550 of legal fees paid for services provided by an employee who was also a corporate officer. Under Federal procurement regulations, since these fees were in addition to the employee's regular salary, the fees are not reimbursable. Other reported costs which are nonreimbursable under Federal criteria included $937 for entertainment and promotions, $880 for donations an $77 of amortized organizational expenses.

Representatives for the contractor advised us that these Federal cost principles were not brought to their attention by either the county or the State and were not specified in the contract.

Other expenses appearing on the contractor's financial statements reflected a bookkeeping error which resulted in a duplicate charge of San Francisco County business taxes. Fiscal year 1974 taxes of $2,486 were included on that year's statements as an example. However, the taxes were actually paid in fiscal year 1975 and charged as a contract cost for that year also. This duplicate charge resulted in an overstatement of actual contract costs of $2,486.

The contractor's financial statements also included expenses for service hours for which the county agency did not authorize payment. While 124,767 service hours were provided by the contractor during the 2-year period, the county agency authorized payment for only 124,124 hours. The difference of 643 hours between actual and authorized service hours resulted in costs of $3,171 which were not chargeable to the county agency contract.

The contractor did not receive payment from the county for these noncontract hours. However, the costs associated with providing these services were not identified in the contractor's records as a noncontract expense.

COMPUTATION OF FEDERAL FINANCIAL PARTICIPATION

The costs of homemaker services claimed for Federal financial participation were not reasonable and necessary because excessive hourly rates were paid to contractors. According to 45 CFR Part 226, Federal financial participation is not available for purchase of service costs which exceed the amounts reasonable and necessary to obtain the services. The rates were negotiated by the county which did not use generally accepted procedures for assuring that the rates were fairly established. Since the excessive rates could have been lower by the application of reasonable administrative procedures, Federal participation is not available in the excessive costs which were incurred through county agency error.

The county agency did not establish the rates by verifying the reasonableness of proposed costs, including salaries paid to owners and family members, and evaluating the projected contract profit. Cost experience was generally not obtained from the contractors and incomplete cost data submitted by contractors were accepted and not verified by county audit. Also, allowable cost principles were not clearly defined. One rate was approved in excess of county staff recommendations. Offers by other vendors in July 1972 at substantially lower hourly rates than those of the existing contractors were rejected by the Commission without documented justification. The offers were at an average of $5.25 per hour as compared with the minimum rate of $6 per hour in effect at that time. In addition, contractor A's rate was increased to $7 per hour in July 1972 without documentation in support of the change. Our audit showed that reimbursable contract costs incurred by the three contractors for later periods, based on the earliest cost reports available at the county agency, averaged about $5.05 per hour, and that excessive profits were received by all of the contractors. The county agency also received bids for providing services in February 1976 at hourly rates below $5 per hour, based on a weighted average of homemaker and chore services.

The State and county agencies should evaluate the reasonableness of the rates based on the above information. We believe that an adjustment should be made for at least the amounts paid in excess of $5.25 per hour of service. Therefore, we recommend that the State refund the Federal share of at least

$981,596 of overpayments for the homemaker and chore program. The recommended reduction was determined by allowing each contractor a rate of $5.25 per approved hour of service for the period July 1, 1972, through September 30, 1975, as shown below:

	Contractors			
	A	B	C	Total
County agency payments—July 1, 1972 through Sept. 30, 1975 (see note)	$2,436,588	$1,912,069	$1,067,536	$5,416,193
Reasonable payments per audit at $5.25 per hour	1,827,441	1,673,060	934,096	4,434,597
Amount not eligible for FFP	609,147	239,009	133,440	981,596

Note.—Contractor A payments were at $7 per hour and payments to contractors B and C were at $6 per hour.

RECOMMENDATIONS

We recommend that the State agency:

1. Refund at least the Federal share of the $981,596 overclaimed social service expenditures.
2. Require the county agency to establish procedures to assure that hourly rates are approved only after receipt and analysis of complete and accurate contractor cost data.
3. Provide the county agency with specific standards pertaining to the reasonableness and allowability of contract costs as set forth in 41 CFR 1–15.2.
4. Require the county agency to reach advance agreements with purchase of service providers regarding the reasonableness of selected cost elements, including compensation to the owners of closely held organizations.
5. Provide for periodic independent audits of purchase of service provider records in accordance with the "Standards for Audit of Governmental Organizations, Programs, Activities and Functions" issued by the Controller General of the United States.

STATE AGENCY COMMENTS

The State agency agreed that the fixed hourly rates paid by the county agency to the three proprietary contractors were excessive. Also, it agreed to (i) revise its regulations pertaining to reimbursable costs by including no later than October 1, 1976 cost standards for proprietary providers as set forth in 41 CFR 1–15.2; and (ii) provide for periodic independent audits of purchase of service provider records.

However, the State agency did not agree with our computation and recommendation for refund of the excessive payments which are not subject to Federal financial participation:

"We cannot accept the amount of $981,596 because of the way in which it was computed.

"The report described certain cost principles to follow in determining federally reimbursable costs and in determining reasonable profits. However, the report arrived at the $981,596 on the basis of bids submitted by other organizations in July 1972.

"Computation of excessive costs on such a basis is not supportable. The report did not establish the appropriateness and validity of those bids in relation to the organizations' ability to perform, the level of services offered, and the amount of anticipated profit.

"It would seem more equitable for excessive costs to be computed on the basis of the principles described in the report. However, the validity and feasibility of such after the fact computations are questionable because of the inherent meaning in the term 'negotiated contract'.

"The report shows that the audit of contractors, records was limited to one fiscal period for contractors A and B and to two fiscal periods for contractor C. DHEW should limit its attempts to determine excess profits to the fiscal periods actually audited."

Also, the State agency commented that for periods after July 1, 1974, all excessive costs resulting from the county agency's purchase of service arrangements were paid from only State funds because of Federal appropriation limitations. The State indicated that excessive costs incurred after July 1, 1974, were not subject to Federal concern:

"This program became heavily supported with State general fund moneys. There were more than enough expenditures from State funds to provide the minimum match required. The following schedule shows that the excessive amounts were paid from State funds.

	State (in percent)	Federal (in percent)	Total funding (in millions)	Federal (in millions)
Jan. 1974 to June 1974	25	75	$43	
Fiscal year 1975	40	60	80.99	48.75
Fiscal year 1976	48	52	93.7	48.75

"In the 1975 fiscal year, California provided $16 million in State funds over the minimum (25 percent) match required; in the 1976 fiscal year it was $28.7 million. Total State funds expended over and above the minimum required match—$44.7 million."

The State agency also disagreed with our recommendations to (i) assure that hourly rates are approved only after receipt and analysis of complete and accurate contractor cost data; and (ii) require the county agency to reach advance agreements with purchase of service providers regarding the reasonableness of selected cost elements, including compensation to the owners of closely held organizations. The State agency indicated that the recommendations are not necessary under currently required State purchasing procedures. These procedures, set forth in social services letter No. 75–10 dated June 16, 1975, and expiring June 28, 1976, requires the solicitation of bids prior to the purchase of services by county welfare departments.

However, the State agency also commented:

"* * * Department of health recognizes the importance of assuring that contractors know, before submitting bids, the standards for deciding the reasonableness of selected cost elements, including compensation to the owners of closely held organizations.

"Therefore, department of health will require county agencies to include a stipulation in the invitation for bids (IFB) that contractors will submit bids based on the principles set forth in CFR 41 part 1–15 and that allowability of the contractors' costs will be determined in accordance with those principles."

AUDITOR'S COMMENTS

The State agency did not agree with our computation of the excessive costs. However, neither the State nor the county provided us with any alternative basis for computing the amount of unreasonable costs. We believe that $5.25 per hour of service is the maximum rate which was "reasonable and necessary" to purchase the services provided by the proprietary contractors. This conclusion was based on the following: (i) Unsolicited offers received from other home care agencies and rejected without documented justification by the Commission in July 1972 averaged $5.25 per hour; (ii) contractor cost experience for the periods covered by our audit averaged about $5.05 per hour; and (iii) some publicly solicited bids received by the county agency in February 1976 were at rates lower than $5 per hour.

The State commented that the audit report did not establish the appropriateness and validity of the July 1972 bids. The essential point is that the county did not document its evaluation of these bids and the Commission rejected them on the basis that with contractor C just starting it would not be fair to enter into new contracts.

The State has not commented on the action which it plans to take with regard to refunding the 75 percent Federal share of $553,586 of unreasonable costs which were claimed for Federal financial participation in fiscal years 1973 and 1974, and which were fully matched. The Federal share of these costs is $415,190 and should be refunded by the State Agency. The remaining $428,010

of unreasonable costs ($981,596 less $553,586) paid in fiscal year 1975 and the quarter ended September 30, 1975, were improperly included in the total amount of social service cost which the State claims was subject to Federal participation. Federal grant maximums limit the amount of social services which can be reimbursed under titles IV and VI for the 15-month period ended September 30, 1975. However, the total statewide social service cost pool identified by the State for each grant year has not been verified by Federal audit. Based on prior experience the social service cost pool will be reduced by subsequent State and Federal audit findings. Thus, if the total $16 million allegedly spent in excess of the amount subject to reimbursement for fiscal year 1975 were found to be nonmatchable, Federal participation would be directly affected by the subject nonmatchable costs. Therefore the entire $428,010 should be clearly identified on State records as only payable from State funds and the excess expenditures claimed for 1975 and for 1976 reduced accordingly.

Although the State agency did not agree with our recommendation that hourly rates be approved only after the receipt and analysis of complete and accurate cost data, we have noted that State purchasing procedures, social services letter No. 75–10, provide: "An estimate or budget of expenses and income is required. It is instructive in considering whether or not rates of payment exceed amounts reasonable and necessary to assure quality of service * * *"

We believe that the intent of this provision would be strengthened by requiring actual prior cost data from those bidders who are seeking contract renewal. Actual cost data would support the reasonableness of estimated expenses submitted by the bidders. Also, this recommendation is consistent with 45 CFR 74.156 which requires that proposed procurements include a consideration of contractor's record of past performance.

In addition, we do not agree with the State that public bidding procedures alone will prevent the award of contracts which reflect questionable costs. These procedures do not relieve the county agency from its responsibilities under 41 CFR 1–15 for reaching agreements with prospective providers regarding the reasonableness of selected cost elements, including compensation to the owners of closely held organizations. Such agreements should be reached after bids are obtained, but before the award of contracts, in order to clearly identify at the outset the anticipated cost and profit amounts.

Determination of Profit

The Commission did not consider essential profit factors in establishing the original hourly rates or approving subsequent rate increases with the contractors. As a result, each of the contractors made excessive returns on investment. For example, one contractor made a 7,232 percent return on its stockholders' equity. No consideration was given to profit factors because there were no published State guidelines defining reasonable profit. Also, the county agency had not established its own procedures to analyze profit factors and determine reasonable profits. Federal regulations state that certain factors, such as the degree of risk and the extent of a contractor's investment, should be considered in determining profit or fee in all contracts. We recommend that the State establish standards which define reasonable profit and require the county agency to adequately consider various profit factors in negotiating future homemaker and chore program contract rates.

BACKGROUND

Factors to be considered in determining profit or fee in all contracts, whether for supplies, or services, and whether of the fixed-price type or cost reimbursement type of contract are set forth in 41 CFR section 1–3.808.

Among the factors to be considered are the degree of risk assumed by a contractor and the extent of a contractor's investment. The degree of risk assumed by a contractor should influence the amount of profit anticipated. Where a portion of the risk has been shifted to the Government through price redetermination provisions, unusual contingency provisions, or other risk-reducing measures, the amount of profit should be less than where the contractor assumes all risk. Also, the extent of a contractor's total investment in the performance of the contract should be considered in determining a reasonable profit. In the absence of financial risk, allowable contract profit should seldom exceed a reasonable return on investment.

CONTRACTOR PROFITS

Our review disclosed that the profits made in the San Francisco contract by each of the three proprietary contractors were unreasonable. Profits received by each of the three organizations for 1 year's operation were:

	Contractor		
	[1] A	[2] B	[3] C
County agency payments	$683,326	$585,799	$314,949
Reimbursable contract costs	$505,234	$493,281	$252,825
Profits per audit	$178,092	$92,518	$62,124
Profit as percent of costs	35.25	18.76	24.57
Average monthly caseload	305	289	130
Annual profit per welfare recipient	$594	$320	$478

[1] Calendar year 1973.
[2] Calendar year 1974.
[3] Fiscal year ended Jan. 31, 1974.

The above profits were excessive considering the risk and investment required under the county agency homemaker services contract. If the Commission had properly considered the factors of risk and investment when establishing and increasing each contractor's rate of payment, the profits made under the contracts would have been smaller.

Our review disclosed that the various profit factors were not considered by the Commission because (i) the State agency did not provide the county agency with guidelines for the determination of reasonable profit amounts; and (ii) the county agency had not established its own procedures for determining reasonable profit. The factors of risk and investment are discussed in the following subcaptions.

EXTENT OF RISK

The contractors experienced little risk under the county agency contracts. The county assigned cases to assure that a relatively level volume of services was purchased through each contractor. Also, provisions in the homemaker contracts minimized the extent of the contractors' risks through a price escalation clause. The clause provided that hourly rates of pay would be adjustable after 6 months of operation under the contract and periodically thereafter if the cost of providing services increased or decreased.

In addition, we noted that the county eliminated contractor risks by rate increases to recover earlier losses. For example, as discussed in the finding "Purchase of Service Arrangement," the county agency gave a rate to contractor A exceeding its current cost requirements in July 1971 to make up for a loss incurred in the previous 5 months. The county agency, by this action, appeared to be assuming the essential elements of risk and protecting the contractors from any ordinary operating loss.

CONTRACTOR INVESTMENT

The county agency and the commission did not adequately consider the amount of each contractor's capital investment when the hourly rates were established. Our review disclosed that the return on each contractor's investment was excessive. The return on stockholder's equity for each of the three contractors in a 1-year period was:

	Contractor		
	A [1]	B [2]	C [3]
Stockholders' equity beginning of year [4]	$18,140	$27,282	$859
Profit per audit	$178,092	$92,518	$62,124
Return on invested capital	982	339	7,232

[1] Calendar year 1973.
[2] Calendar year 1974.
[3] Fiscal year ended Jan. 31, 1974.
[4] Per unaudited financial statements supplied by contractors.

The nature of the work performed by the contractors required only a minimum investment in office equipment used for contract administration. For example, contractor C was established in 1972 with an initial capital investment of $3,000. Major capital investment in property and equipment was not required since the majority of work was performed in the homes of the recipients. Also, cash flow requirements of each contractor were partially met by the county agency in that funds were advanced based on anticipated service hours. For the above reasons, only minimum capital investments were required by the contractors.

Under another program, medicare, proprietary providers are reimbursed for eligible costs and in addition receive an annual allowance based on the amount of equity capital invested and used in the provision of patient care. This allowance is computed by applying to the dollar value of providers' equity capital a percentage which does not exceed 1½ times the average of the rates of interest on public debt obligations issued to the Federal Hospital Trust Fund. The percentage is computed by the Social Security Administration and communicated as public information through the Medicare intermediaries. The allowance is set forth in 20 CFR 405.429 and is discussed in "Return on Equity Capital of Proprietary Providers," Chapter 12 of the Health Insurance for the Aged Provider Reimbursement Manual (HIM 15). Under the medicare program the investment allowance rate for proprietary providers for the fiscal year beginning August 1973 was 10.656 percent. The rates since August 1973 have fluctuated with the highest rate being slightly over 12 percent.

RECOMMENDATIONS

We recommend that the State agency:

1. Provide the county agency with guidelines on profit factors, such as contractor risk and return on investment, to assure that only reasonable profits are included in future homemaker contracts.
2. Require the county agency to analyze all of the profit factors before negotiating new hourly rates for homemaker services.
3. Consider implementing a method similar to the one prescribed for medicare providers in determining reasonable profits for homemaker contractors.

STATE AGENCY COMMENTS

The State agency agreed that each of the contractors made excessive returns on investment because the commission did not consider important profit factors in establishing the original hourly rates or approving subsequent rate increases with the contractors. The State agency commented on our recommendations as follows:

"The recommendations pertain to negotiated contracts and are not applicable in the case of contracts let under the competitive bidding process.

"However, department of health will establish guidelines for determining reasonable profits in accordance with 41 CFR 1-3.808 so that counties can evaluate cost and profit data of current contractors and use this analysis in evaluating future bids. These guidelines will be included in the revised regulations."

AUDITOR'S COMMENTS

The solicitation of bids alone does not relieve the county agency from its responsibilities for awarding contracts which do not generate excessive profits. The proposed establishment of profit guidelines and dissemination to the counties for their use in evaluating future bids would meet the intent of our recommendations.

RECORDS SUPPORTING CONTRACT RATES

The county agency did not maintain information to support the reasonableness of the rates of payment established for the purchase of homemaker and chore services from the three proprietary contractors. Federal regulations in 45 CFR part 226, dated January 25, 1969, require that this information be available. This requirement was strengthened by 45 CFR part 228, effective October 1, 1975, for title XX. This later regulation provides that Federal financial participation is available for expenditures for social services purchased only when records are available which support the rates of payment. The county agency did not have records supporting the reasonableness of the rates

because adequate data was never used to establish or increase the rates. As a result, the State agency has improperly included $713,390 in its claim for Federal funds under title XX in county agency expenditures for homemaker and chore services purchased from the proprietary contractors. We are recommending that the State Agency: (*i*) Require the county agency to develop and maintain records to support the contract rates; (*ii*) discontinue claiming Federal financial participation in county agency expenditures for homemaker and chore services purchased under title XX from the three proprietary contractors; and (*iii*) refund the Federal share of the $713,390 in title XX funds already claimed for services purchased from these contractors for the period October 1, 1975 through February 29, 1976.

BACKGROUND

Certain requirements regarding the purchase of services under public assistance programs are listed in 45 CFR part 226. Specifically, section 226.1(a)(7) provides that a State plan must, with respect to services which are purchased:

"Provide for the establishment of rates of payment for such services which do not exceed the amounts reasonable and necessary to assure quality of services. * * *

"Indicate that information to support such rates of payment will be maintained in accessible form."

The California State plan states that this requirement will be met by each local welfare agency when services are purchased.

Effective October 1, 1975, 45 CFR part 228 superseded 45 CFR part 226. Section 228.71(a) provides: "FFP is available for expenditures for services provided under purchase of service contracts only where the rates of payment for services do not exceed the amounts reasonable and necessary to assure quality of service * * * and records are available which describe and support the rates of payment and the methods used to establish and maintain such rates."

INFORMATION MAINTAINED BY THE COUNTY AGENCY

The county agency maintained incomplete and unaudited financial information pertaining to the three proprietary contractors. This data did not adequately support the reasonableness of the established rates of payment. Our review disclosed that the only financial data available for these three contractors at the county agency were unaudited financial statements covering partial contract periods as follows: (*i*) Calendar year 1973 for contractor A; (*ii*) Calendar year 1973 for contractor B; and (*iii*) Fiscal year ended January 31, 1974 for contractor C. Thus, these statements did not show complete cost data for the entire contract period. Also, as explained in our finding titled "Purchase of Service Arrangements," unaudited financial statements prepared on behalf of the contractors did not fairly present federally reimbursable contract costs, and substantially understated actual profits made by the individual contractors. The county agency did not have any financial information, either audited or unaudited, for other contract periods. Since records were not available to support the rates of payment to the contractors, the county has included $713,390 in its claim to the State which is not eligible for Federal financial participation.

REQUESTS FOR AUDITED STATEMENTS

Although the county agency requested the proprietary contractors to submit audited financial statements for calendar year 1973, the contractors supplied only unaudited statements. The county agency did not subsequently request or obtain audited cost data from the three proprietary contractors. Also, the county agency neither analyzed the data presented nor performed an independent review of the contractor's records pertaining to the statements.

According to commission minutes dated July 13, 1972, the commission established a policy that its members be furnished with the latest certified financial statements for all homemaker organizations with which the county agency had a contract. In a letter dated February 15, 1974, the county agency general manager requested the contractors to submit financial statements as of December 1, 1973 "as audited and certified by a Certified Public Accountant." However, audited statements for the three proprietary contractors were never obtained.

Our review indicated that the three contractors were reluctant to comply with the county agency's request for audited financial statements. This was evidenced by a letter dated February 28, 1974 from contractor C to the county agency general manager regarding the request for audited cost data. Copies of this letter were sent to contractor A and contractor B. The letter is quoted as follows:

"We believe that you have possibly over stated the nature of the financial statements in use of the words 'as audited and certified.'

"A certified audit would, according to our certified public accountant cost in the neighborhood of $5,000.00 and would not in any way increase the amount of information which would be furnished to you should we report to you the identical figures that we intend to report to the Internal Revenue Service."

The county agency accepted the unaudited financial statements submitted by the proprietary contractors, and never obtained audited cost data for any period from any of the three contractors. As stated in our finding on "Purchase of Service Arrangements," audits of program expenditures are required in 45 CFR part 74.

RECOMMENDATIONS

We recommend that the State agency:

1. Require the county agency to develop and retain records which support a reasonable rate of payment for each proprietary contractor.
2. Discontinue claiming Federal financial participation in county agency expenditures for services purchased under title XX from the proprietary contractors until such time as records supporting reasonable rates of payment are developed.
3. Refund the Federal share of $713,390 of title XX funds already claimed for homemaker and chore services purchased from these contractors.

STATE AGENCY COMMENTS

The State agency agreed that the county did not have data to justify the reasonableness of the hourly rates paid to the three proprietary contractors. Also, the State agency pointed out that their June 16, 1975 social services letter No. 75-10 requires that records to support the rates be developed: "In the regulations for competitive bidding, department of health requires counties to develop and submit records which support the rate of payment, justification for selection of contractor, and all bids submitted. All contracts are subject to advance department of health approval before execution."

However, the State agency did not agree to discontinue claiming Federal financial participation in county agency expenditures for services purchased from the three providers under title XX until such time as these records are developed:

"The counties are required to conduct a competitive bidding process to allow them to purchase services according to specified criteria and at a reasonable cost.

"The current funding for homemaker/chore services is at a ratio of 52 percent Federal title XX funds and 48 percent State funds. The State funds exceed the necessary match by 23 percent. The department of health is thus funding the excessive rates until the competitive bidding procedures can reduce those rates."

The State agency also did not agree to refund the Federal share of $713,390 of title XX funds claimed for the period October 1, 1975 through the audit cut-off date for services purchased from the contractors: "* * * The homemaker and chore service program is heavily supported with State general fund moneys. Federal funds are not being used to pay for excessive costs."

AUDITOR'S COMMENTS

The State agency agreed that there were no records to justify the rates of payment. As stated in our finding, Federal regulations for title XX, 45 CFR part 228, effective October 1, 1975, preclude Federal financial participation in purchased social service costs when adequate records are not developed and maintained. Therefore, the State agency should clearly identify unsupported costs as nonreimbursable under title XX.

In addition, the State agency's own guidelines preclude State reimbursement of costs incurred at the county level under contracts which have not been

approved by the State department of health. A letter dated August 22, 1975 from the State agency to all county welfare directors is quoted: "This letter is to serve as a reminder that social services letter 75–10 dated June 16, 1975 requires that all social services contracts funded under title IV–A, IV–B and/or VI (or XX) must receive prior approval by the department of health before the costs of those contracts may be claimed. The department of benefit payments will not reimburse any contract costs claimed on the administrative expense unless the contract has been approved by the department of health and has been assigned a control number."

Although the San Francisco County agency contracts were not approved by the department of health, the State agency continued to reimburse contract costs claimed by the county as of June 30, 1976.

The costs reported by San Francisco County since October 1, 1975 and reimbursed by the State agency are included in a statewide social service cost pool for which Federal financial participation is claimed. At this time, the total amount of recorded social service costs exceeds the amount for which Federal funds are available. Most of the costs recorded in this pool have not been audited and are subject to adjustment. Therefore, the State agency has prematurely concluded that all of the unsupported and excessive costs were paid by State general fund moneys. Because of inadequate records, there is no basis for claiming Federal financial participation under title XX, and the costs reported since October 1, 1975 should be clearly identified on State records as nonmatchable.

STATE RESPONSIBILITIES

The State of California Health and Welfare Agency (State agency) did not control the San Francisco County agency's purchase of service arrangements with the three proprietary contractors. The State agency did not: (*i*) Publish guidelines which defined reasonable and necessary cost in terms of allowable cost and profit for contracts negotiated at the county level; (*ii*) provide for fiscal audits of contractor cost records; and (*iii*) take appropriate action to correct identified problems including prompt reduction of excessive rates and recovery of State and Federal funds claimed in excess of the amounts which were "reasonable and necessary" to obtain the social services. As a result, the State agency has since July 1972 continued to improperly claim Federal financial participation in excessive costs incurred under contracts which San Francisco County negotiated with proprietary providers of homemaker and chore services. Excess costs were paid because the State agency relied primarily on county agency administration for assuring that reasonable business practice was reflected in county contracts for the purchase of social services. As stated in our finding on "Purchase of Service Arrangements" this has not been the case. In addition, existing Federal/State/county relationships have relied primarily upon voluntary corrective actions by the county agency. The expected voluntary corrective actions have not occurred. We are recommending that the State take appropriate corrective actions to promptly reduce purchase of service rates which are identified as excessive and recover overclaimed State and Federal funds.

BACKGROUND

The county agency awarded the original contracts for the purchase of homemaker and chore services effective February 1, 1971. From that time through June 30, 1973, the department of benefit payments (DBP) had the responsibility for administering and claiming the costs of purchase of service arrangements entered into at the county level. Under a reorganization plan effective July 1, 1973, the department of health (DOH) was assigned responsibility for the administration of social services programs including homemaker and chore services. Responsibility for processing county fiscal reports and claiming the cost of social services was retained by DBP.

The State agency relies upon the division of field audits, State controller's office for identifying and recommending the recovery of overclaimed county expenditures for assistance, administration and social service expenditures. DBP determines the extent of audit coverage by the State controller.

The rates approved by San Francisco county in July 1972 continue to be paid as of June 30, 1976. The county agency intends to discontinue the use of negotiated rates by terminating all contracts for the purchase of homemaker and chore services.

On January 27, 1976, the county agency advertised for public bids to supply services for its adult homemakers program.

COST AND PROFIT STANDARDS

The State agency has not provided the county agency with standards for determining the reasonableness of costs and profits for purchase of service arrangements with proprietary contractors. As stated in our finding on "Purchase of Service Arrangements," the Federal cost principles are set forth in 41 CFR 1–15.2. Also, our finding on "Determination of Profit" discusses the lack of State agency guidelines specifying what constitutes reasonable profit amounts. Our recommendations in these two areas are included in the findings cited above.

CORRECTIVE ACTIONS

The State agency did not require prompt corrective action when significant problems concerning the county agency purchase of service arrangements were identified. Also, the State agency made no attempt to recover overclaimed funds.

DEPARTMENT OF HEALTH REVIEW

In a report dated April 4, 1975 the DOH presented to the county agency the results of its review of the county agency's adult homemaker program. Among other matters the report stated that offers by qualified providers of homemaker and chore services had been rejected for contracts despite lower rate offers. The report is quoted as follows: "Manual section 10-034.81 states: 'Such rates shall not exceed the amounts reasonable and necessary to assure quality of service.' This would not necessarily be the case during midterm of existing contracts, but we hasten to add, existing contracts had an open term. Further, (one prospective contractor's) bid was submitted 3 years in succession without formal response or county justification. It is doubtful that the county is meeting that test, for the principle implies accepting the lowest qualified bid."

Although the report concluded that the rates of payment established for the purchase of homemaker and chore services did not appear to be reasonable and necessary, DOH did not recommend recovery of Federal and State funds for the reasons explained in its transmittal letter:

"The attached report represents our findings in the review of homemaker/chore services which the county of San Francisco administers.

"Please note, however, that this is not a traditional, compliance audit report and does not represent an intent to retrieve expended funds. It may be viewed as a management report intended to pinpoint areas of needed improvement, and as such, may be viewed as a report to county management.

"The review was conducted in accordance with generally accepted standards and included such tests as were considered necessary. Because of a limited time budget, the size and complexities of delivery systems, establishment of priorities relating to problems encountered, and because administrative expense claims fall within the purview of the State controller, our review was limited to cost effectiveness and management related aspects of the program. Further, records of one of the two contractors selected for review were unavailable because of a death in the accountant's family. Our subsequent findings of this contractor's records will be discussed in a future report. * * *"

In a report dated August 11, 1975, DOH reported the results of additional effort which involved a review of the financial records for contractor A. The summary of this review is quoted from the "Highlights" section of the report: "Our findings indicate that some costs are questionable in terms of reasonableness and necessity and records do not adequately provide audit trails."

In view of these findings concerning contractor A, the report states the following: "The county is advised that there are a number of deficiencies which may lead to audit exceptions if corrective action is not taken promptly."

However, DOH made no attempt to recover from the county agency overclaimed State and Federal funds. Also, the identified question of unreasonable rates was not referred to the State controller for audit.

AUDITOR GENERAL REVIEW

In June 1975 the California State auditor general (auditor general) issued a report titled "A Management Review of the Homemaker-Chore Services Program." This report presented the results of a statewide review of the homemaker-chore services program. One of the problems identified in the report

is quoted: "The department of health has not established adequate regulations which would provide for a controlled range of rates for each service delivery method. As a result, the costs of providing necessary services vary from county to county."

In a table showing the range of hourly rates paid to various providers of services, the lowest rate charged by proprietary agencies within the State was $3.45 and the highest was $7.00.

The report specifically identified the rates established by San Francisco county for the purchase of homemaker and chore services as outside the "allowable" range. The report states that San Francisco County was overpaying on three contracts by an estimated total of $271,000 annually.

The report makes the following conclusion with respect to the wide range of rates established for providers: "The (department of health) has not promoted fiscal responsibility in the homemaker-chore services program as evidenced by its failure to effectively control provider payment rates by the counties."

Another problem identified in the auditor general's report is quoted: "Funds to provide homemaker and chore services have not been appropriated in a way to promote fiscal responsibility in the administration of the homemaker-chore services program."

The report discussed the fact that the homemaker and chore services program was funded with 100 percent Federal and State moneys. The report is further quoted as follows:

"The absence of county participation in homemaker and chore funding does not encourage fiscal restraint.

"* * * there has been minimal effort by the counties to control program costs based on the assumption that any cost overruns had to be borne by the State."

Although the auditor general's report identified these significant problems in the homemaker and chore program statewide, and with San Francisco county in particular, the State agency made no effort to recover overclaimed county agency costs.

STATE CONTROLLER AUDITS

The division of field audits, State controller's office has not reviewed the rates negotiated by San Francisco county with the three proprietary providers. The controller's most recent audit report of the San Francisco Department of Social Services was issued September 29, 1975 and covered the period October 1, 1971 through June 30, 1974. The report did not comment on the rates paid under homemaker and chore contracts which the social services commission negotiated effective February 1, 1971 and continued through their audit period.

The report states "county records were examined to the extent considered necessary to appraise the efficiency and effectiveness of operations and adherence to State regulations and fiscal procedures. * * *"

With regard to social services costs including homemaker and chore services which are reported on the administrative expenditure claim for State and Federal participation, the report scope was qualified to exclude costs incurred by other county agencies. "The examination of administrative expenditures was restricted to the review of direct charges for the Welfare Department's budgetary expenditures. * * *"

DBP has not specifically requested the State controller to audit the records of the San Francisco homemaker contractors. A specific audit request was required because the normal controller audit scope is limited to records of the county agency. As a result, the State Controller field audit division covered other aspects of the homemaker program, but has not audited the contract rates. A State audit division representative advised us on April 14, 1976 that the planned scope of its in-process State audit of the county agency did not include records of any of the contractors and this coverage had not been requested by DBP.

As of June 30, 1975 both DOH and the auditor general had identified particular problems in the rates paid under the San Francisco contracts for the purchase of homemaker and chore services. However, the State agency made no effort to recover from the county agency or from the contractors overclaimed Federal funds which represented 75 percent of total costs and overclaimed State funds of 25 percent. In addition, the county agency did not reduce the excessive rates. As of June 30, 1976 the rates established in July 1972 remained

in effect. The county agency intends to discontinue the use of negotiated rates by terminating all contracts for the purchase of homemaker and chore services. On January 27, 1976, the county agency advertised for public bids to supply services for its adult homemaker program.

RECOMMENDATIONS

We recommend that the State agency:

1. Take prompt action to reduce excessive rates of payment for purchased social services at the time of discovery.
2. Recover overclaimed funds either by the direct action of its staff or by requesting the division of field audits, state controller's office to specifically audit known problem areas.

STATE AGENCY COMMENTS

The State agency has indicated that the issuing of new regulations which require competitive bidding represents a positive improvement in controlling purchase of service arrangements and assuring that costs are reasonable. This improvement would eliminate the need for our recommendation that prompt action be taken to reduce excessive rates of payment for purchased social services at the time of discovery. The State agency concurred that procedures could be improved for assuring that audits, to recover overclaimed State and Federal funds, are made of known problem areas. The State commented that it has arranged to request specific audits from the State controller when needed. The State agency concluded that no credit was given in our report to the prompt, aggressive, and positive steps taken to correct the problems identified by the department of health fully 12 months before our draft audit report was issued. Also, although there were excessive costs, Federal participation in those costs was nonexistent or minimal at most and no Federal moneys should be refunded.

AUDITOR'S COMMENTS

The State agency did take steps to improve its control over county-level purchase of services by issuing social services letter No. 75–10 dated June 16, 1975, with an expiration date of June 28, 1976. However, the San Francisco county agency, as of June 30, 1976, had not implemented the requirements of this letter.

The State agency's response did not address the specific deficiencies cited in the finding; namely, that the State agency did not: (i) Publish cost and profit standards applicable to proprietary providers of services; (ii) provide for fiscal audits of contractor cost records; (iii) promptly reduce excessive rates of payment upon discovery; and (iv) recover overclaimed State and Federal funds.

As the State pointed out, reasonable procurement policies, when properly carried out, should eliminate the award of contracts which result in unreasonable costs. However, reasonable procurement procedures were not reflected in San Francisco County's purchase of service arrangements which continued as of June 30, 1976, without revision. The State agency identified the rates paid by San Francisco county as excessive on April 4, 1975, but did not require the county to promptly reduce these rates upon discovery. As a result, the rates remained in effect as of June 30, 1976, over 13 months later.

In addition, even though the State agency agreed with our recommendation to improve its procedures for recovering overclaimed State and Federal funds, it apparently did not agree to recover overpayments to San Francisco county. While agreeing that the county's purchase of service arrangements have resulted in excessive costs, the State agency has continued to reimburse the county agency for current contracting costs.

As pointed out in our comments to other findings, excessive county agency contract costs of at least $553,586 were incurred during fiscal years 1973 and 1974. These costs were reimbursed by 25 percent State and 75 percent Federal funds. Other unreasonable costs of at least $428,010, reimbursed by the State agency for fiscal year 1975, and the quarter ended September 30, 1975, were improperly included in the statewide social service cost pool which the State agency claimed was subject to Federal financial participation under title VI. In addition, unsupported costs of $713,390 were reimbursed by the State agency

for San Francisco county payments to the proprietary contractors during the period October 1, 1975, through February 29, 1976. These expenditures were also improperly included in the statewide cost pool which was claimed for Federal participation under title XX.

The Federal share of the excessive costs of $553,586 claimed through June 30, 1974, should be refunded by the State agency. The Federal share of these costs is $415,190. The $1,141,400 ($428,010 plus $713,390) claimed for periods beginning July 1, 1974, should be clearly identified on State records as nonmatchable costs.

The State should also take steps to recover from the county the entire $1,694,986 ($553,586 plus $428,010 plus $713,390) of improper county agency purchase of service expenditures, which were reimbursed from State and Federal funds for the period from July 1, 1972, through February 29, 1976. In addition, the State agency, in accordance with its own instructions, should discontinue any further reimbursement of contract costs incurred by San Francisco county until Federal and State requirements for title XX are met.

EXIT CONFERENCE COMMENTS

An exit conference attended by officials of the county agency, the State department of health, and HEW was held in San Francisco on August 24, 1976, to discuss the draft audit report. As a result of this meeting, the State agency provided us with additional comments in a letter dated August 27, 1976. (The letter is attached to this report as appendix B.)

STATE AGENCY COMMENTS

The State agency reiterated its position that is was not appropriate to arrive at a reasonable rate of payment on the basis of bids submitted in July 1972. The State, to support its position, quoted in part an internal memorandum which was prepared currently by the county agency on August 4, 1976: "Unsolicited offers received from other homemaker agencies and rejected without justification by the county agency in July 1972, averaged $5.25 per hour. The unsolicited offers were from (two organizations named). Neither of these agencies provided homemaker services in San Francisco county. Neither was under union contract in San Francisco. The offers made for homemaker services were based on minimum wage of $1.60 per hour rather than the entrance union wage of $2.35, or a difference of $0.75 per hour."

The State agency indicated the above quote favors a conclusion that the actions taken by the county reflect reasonable administration: "We believe it would be difficult to reconstruct events, at that earlier period in time, to support an alternative conclusion of unreasonableness of county administrative actions."

The department of health also commented that the positive steps it had taken to improve procedures for the purchase of services were not adequately covered in our report: "As a result of the review by department of health staff in April 1975, the department of health issued regulations, initiated legislation, and strengthened bidding contract procedures and negotiation in order to effect improvement in the program. Moreover, we have initiated a plan for additional homemaker/chore reviews of county practice and State procedures. HEW cannot support its contention that the department of health was remiss in carrying out its responsibilities."

The department of health has suggested that HEW should not hold the State financially accountable for Federal funds which were overpaid as a result of weak administrative practices. The State has also indicated that our audit represented an unnecessary follow-in review of problems which the State first uncovered and was in the process of correcting.

The State agency concluded that our recommendation that it reduce prior year claims by $1,694,986 and refund $415,190 is not warranted.

AUDIT AGENCY COMMENTS

The $5.25 hourly rate which we have recommended as a reasonable rate of payment was based primarily on the experienced costs of the contractors. Reimbursable contract costs incurred by the contractors during periods we reviewed averaged about $5.05 per hour. In addition, some publicly solicited

bids received by the county agency in February 1976, in a current period, were at rates lower than $5 per hour. It should be noted that the State has not indicated what a reasonable rate should have been.

The county agency did not document its evaluation of the two proposals which the commission rejected in July 1972. In commenting on the audit report county representatives said that the two proposals were unacceptable to the county because the organizations paid below union wage scale. Available records do not show whether the organizations were encouraged to resubmit proposals that reflected a pay scale which was acceptable to the county.

The county agency memorandum dated August 4, 1976 and cited in part by the State further clarifies the commission's rejection of the two contract proposals: "* * * the reaction of the original contractors—contractor A and contractor B—to the fact that we had entered into a contract with—contractor C—and the resulting difficulty was so unpleasant, that the Commission, without—county agency—recommendation, decided it did not wish to consider additional contracts."

The State agency's opinion that San Francisco county's purchase of service arrangements reflected reasonable administration is inconsistent with the State agency's agreement that excessive rates were negotiated and paid. The San Francisco Social Services Commission negotiated the rates of payment based on incomplete and inaccurate data. The commission rejected, without reasonable explanation, lower rates proposed by other vendors and approved one rate which was substantially higher than the rate recommended by county agency staff. The county agency generally did not obtain cost data from the contractors and never specified to the contractors the principles for determining allowable contract costs.

The State agency has agreed that the rates negotiated by the commission were excessive. We believe that the application of reasonable administrative procedures would have prevented the establishment of excessive rates. Under 45 CFR 226 Federal financial participation is available for purchased services only to the extent that the rates are reasonable and necessary to assure quality of service. Therefore, we are recommending a recovery of overclaimed Federal funds.

The State Department of Health has indicated that Federal funds are earned by disbursement. Applicable public law and published regulations stipulate the conditions under which Federal financial participation is available in State administered formula grant programs. Under Federal regulations, overpayments that have resulted from errors which the State could have prevented by the application of reasonable administrative procedures cannot be validated by correcting State procedures to avoid continuance of the errors.

Our audit was initiated in November 1975 to review problems associated with San Francisco county's purchase of service arrangements. These problems were partially disclosed by the State in an internal report issued in April 1975 and some corrective actions were initiated by the State. However, the State did not (i) require the County to promptly reduce the rates which the State identified as excessive and (ii) take steps to recover State and Federal funds which were improperly claimed for the excessive costs incurred by San Francisco county. The excessive rates continued to be paid by the county and reimbursed by the State as of July 31, 1976, over 1 year after the State's report. The State has not attempted to determine the amount of overclaimed Federal or State funds and has rejected our recommended financial adjustment.

The State has indicated that the issuance in June 1975 of guidelines for the purchase of services represents a positive improvement which will assure that future rates will be reasonable. However, the State did not take steps to assure that the procedures were implemented and that corrective action was taken. In addition, San Francisco county did not follow generally accepted procurement procedures which were applicable under the circumstances. Therefore, we believe the Federal share of overclaimed costs should be refunded.

[Appendixes to the report follow:]

[Appendix A]

STATE OF CALIFORNIA,
HEALTH AND WELFARE AGENCY,
DEPARTMENT OF HEALTH,
Sacramento, Calif. June 1, 1976.

Mr. RICHARD E. BALLARD,
Branch Manager, HEW Audit Agency, San Francisco Branch Office, San Francisco, Calif.

DEAR MR. BALLARD: Mr. Mario Obledo has asked us to reply to your April 15 and 16, 1976, letters enclosing the draft findings on a proposed report on your review of the San Francisco County homemaker and chore program. Our response is attached.

You will also find copies of pertinent regulations and guidelines in support of our response to the recommendations.

We object to the tone of the report. The report draws heavily on previous work done by State Department of Health staff but fails to recognize the strong, positive steps the Department of Health began taking over 12 months ago to correct the problems. We are very disturbed that HEW allowed an inaccurate and inadequate draft report to be released to the press in direct violation of HEW's own instructions: "This draft is not to be considered final as it is subject to further review and revision. Please safeguard this draft report against unauthorized use."

Sincerely,

GARY D. MACOMBER,
Deputy Director for Social Services.

Attachments.

HEW FINDING

PURCHASE OF SERVICE ARRANGEMENTS

"The California State Department of Benefit Payments has claimed Federal financial participation in the costs of homemaker and chore services that were purchased by the San Francisco County Department of Social Services at fixed hourly rates which were excessive." Excessive County Agency expenditures claimed—$981,596.

Department of Health concurs in part only. We agree that the fixed hourly rates were excessive. We cannot accept the amount of $981,596 because of the way in which it was computed.

The report described certain cost principles to follow in determining federally reimbursable costs and in determining reasonable profits. However, the report arrived at the $981,596 on the basis of bids submitted by other organizations in July 1972.

Computation of excessive costs on such a basis is not supportable. The report did not establish the appropriateness and validity of those bids in relation to the organizations' ability to perform, the level of services offered, and the amount of anticipated profit.

It would seem more equitable for excessive costs to be computed on the basis of the principles described in the report. However, the validity and feasibility of such after-the-fact computations are questionable because of the inherent meaning in the term "negotiated contract."

The report shows that the audit of contractors' records was limited to one fiscal period for contractors A and B and to two fiscal periods for contractor C. HEW should limit its attempts to determine excess profits to the fiscal periods actually audited.

HEW RECOMMENDATIONS

The State agency should:

1. Refund at least the Federal share of the $981,596.

DEPARTMENT OF HEALTH COMMENTS

Department of Health does not concur.

As stated above, we dispute the amount of excessive costs and the method of computing the costs.

This program became heavily supported with State General Fund moneys. There were more than enough expenditures from State funds to provide the minimum match required. The following schedule shows that the excessive amounts were paid from State funds.

	State (In percent)	Federal (In percent)	Total funding (In millions)	Federal (In millions)
Jan. 1974 to June 1974	25	75	$43	
Fiscal year 1975	40	60	80.99	$48.75
Fiscal year 1976	48	52	93.7	48.75

In the 1975 fiscal year, California provided $16 million in State funds over the minimum (25 percent) match required; in the 1976 fiscal year it was $28.7 million. Total State funds expended over and above the minimum required match—$44.7 million.

2. Require the county Agency to establish procedures to assure that hourly rates are approved only after receipt and analysis of complete and accurate contractor cost data.

DEPARTMENT OF HEALTH COMMENTS

Department of Health does not concur.

Department of Health has established regulations which require counties to follow the competitive bid process in purchase of homemaker and chore services (also required by State statutes). (See exhibits B and C.)

The competitive bid process eliminates the need for advance review of cost data.

3. Provide the county agency with specific standards pertaining to the reasonableness and allowability of contract costs as set forth in 41 CFR 1–15.2.

DEPARTMENT OF HEALTH COMMENTS

Department of Health concurs.

Department of Health is presently in the process of revising the regulations pertaining to reimbursable costs. The principles set forth in 41 CFR 1–15.2 will be incorporated. Effective date of the revised and expanded regulations will be no later than October 1, 1976.

4. Require the county agency to reach advance agreements with purchase of service providers regarding the reasonableness of selected cost elements, including compensation to the owners of closely held organizations.

DEPARTMENT OF HEALTH COMMENTS

Department of Health does not concur.

The recommendation pertains to purchase of service arrangements arrived at by negotiation with contractors. Since county agencies must go to competitive bidding, this recommendation cannot be implemented because such negotiations are not necessary, and in direct violation of competitive bidding requirements. (See exhibit B.)

However, Department of Health recognizes the importance of assuring that contractors know, before submitting bids, the standards for deciding the reasonableness of selected cost elements, including compensation to the owners of closely held organizations.

Therefore, Department of Health will require county agencies to include a stipulation in the invitation for bids (IFB) that contractors will submit bids based on the principles set forth in CFR 41 part 1–15 and that allowability of the contractors' costs will be determined in accordance with those principles.

5. Provide for periodic independent audits of purchase of service provider records in accordance with the Standards of Audit of Governmental Organizations, Program Activities, and Functions issued by the Comptroller General of the United States.

DEPARTMENT OF HEALTH COMMENTS

Department of Health concurs.

Department of Health established this requirement by means of Social Services Letter 75–10, dated June 16, 1975. [See exhibit B.]

HEW FINDING

DETERMINATION OF PROFIT

The Commission did not consider important profit factors in establishing the original hourly rates or approving subsequent rate increases with the contractors. As a result, each of the contractors made excessive returns on investment.

DEPARTMENT OF HEALTH COMMENTS

Department of Health concurs.

HEW RECOMMENDATIONS

The State agency should:

1. Provide the county agency with guidelines on profit factors, such as contractor risk and return on investment, to assure that only reasonable profits are included in future homemaker contracts.
2. Require the county agency to analyze all of the profit factors before negotiating new hourly rates for homemaker services.
3. Consider implementing a method similar to the one prescribed for Medicare providers in determining reasonable profits for homemaker contractors.

DEPARTMENT OF HEALTH COMMENTS

Department of Health does not concur with the above recommendations.

The recommendations pertain to negotiated contracts and are not applicable in the case of contracts let under the competitive bidding process.

However, Department of Health will establish guidelines for determining reasonable profits in accordance with 41 CFR 1-3.808 so that counties can evaluate cost and profit data of current contractors and use this analysis in evaluating future bids. These guidelines will be included in the revised regulations.

HEW FINDING

RECORDS SUPPORTING CONTRACT RATES

The county agency did not maintain information to support the reasonableness of the rates established for the sole source purchase of homemaker and chore services from the three proprietary contractors.

DEPARTMENT OF HEALTH COMMENTS

Department of Health concurs.

HEW RECOMMENDATIONS

The State agency should:

1. Require the county agency to develop and retain records which support a reasonable rate of payment for each proprietary contractor.

DEPARTMENT OF HEALTH COMMENTS

Department of Health concurs.

In the regulations for competitive bidding, Department of Health requires counties to develop and submit records which support the rate of payment, justification for selection of contractor, and all bids submitted. All contracts are subject to advance Department of Health approval before execution.

2. Discontinue claiming Federal financial participation in county agency expenditures for services purchased under title XX from the proprietary contractors until such time as records supporting reasonable rates of payment are developed.

DEPARTMENT OF HEALTH COMMENTS

Department of Health does not concur.

The counties are required to conduct a competitive bidding process to allow them to purchase services according to specified criteria and at a reasonable cost.

The current funding for homemaker/chore services is at a ratio of 52 percent Federal title XX funds and 48 percent State funds. The State funds exceed the necessary match by 23 percent. The Department of Health is thus funding the excessive rates until the competitive bidding procedures can reduce those rates.

3. Refund the Federal share of $713,790 of title XX funds already claimed for homemaker and chore services purchased from these contractors.

DEPARTMENT OF HEALTH COMMENTS

Department of Health does not concur.

As pointed out in response to recommendation 2 above, the homemaker and chore service program is heavily supported with State general fund moneys. Federal funds are not being used to pay for excessive costs.

Additionally, the recommendation overlooks the fact that the major portion of the payments to contractors would be reimbursable. This is not consistent with the HEW recommendation for Purchase of Service arrangements.

HEW Finding

STATE RESPONSIBILITIES

The State of California Health and Welfare Agency (State agency) did not control the San Francisco County agency's purchase of service arrangements with the three proprietary contractors.

DEPARTMENT OF HEALTH COMMENTS

Department of Health does not concur.

Department of Health has issued regulations which require that all homemaker/chore services be purchased through competitive bidding.

HEW Recommendations

The State agency should:

1. Take prompt action to reduce excessive rates of payment for purchased social services at the time of discovery.

DEPARTMENT OF HEALTH COMMENTS

This recommendation is inapplicable to the current situation.

The competitive bidding process properly carried out eliminates excessive rates beforehand.

In addition, the Department of Health is revising and expanding regulations and guidelines for contracting to ensure that county agencies' purchase of service arrangements do not result in excessive or nonreimbursable charges.

2. Recover overclaimed costs either by the direct action of its staff or by requesting the Division of Field Audits, State Controller's Office, to specifically audit known problem areas.

DEPARTMENT OF HEALTH COMMENTS

Department of Health concurs.

Department of Health has established a specific function within the Social Services Division to review all audit and evaluation reports on social services programs. This function analyzes the reports to determine the necessity of a fiscal audit. Where needed, Department of Health will request that the State Controller conduct an in-depth fiscal audit of county agencies' contractors.

Department of Health Conclusion

The HEW preliminary draft audit report addresses deficiencies which were previously discovered by the Department of Health's own staff. The Department of Health's Field Review Unit reported on these deficiencies fully 12 months before HEW issued the draft audit report. As a result of the report issued by the Field Review Unit, the Department of Health took prompt, aggressive and positive steps to correct the problems.

We have shown that, although there were excessive costs, Federal financial participation in those costs was nonexistent or minimal at most. A refund of Federal funds is not warranted.

Exhibit:	*Subject or title*
A	Letter to county welfare directors re requirement for prior approval by department of health for all social services contracts.
B	Social services letter No. 75–10 and attachment, Outline for Writing Purchase of Service Agreements.
C	Assembly bill 1792—addition of section 12302.1 to the Welfare and Institutions Code to require competitive bidding for providers of in-home supportive services.

STATE OF CALIFORNIA,
DEPARTMENT OF HEALTH,
Sacramento, Calif., August 22, 1975.

To: All county welfare directors.

This letter is to serve as a reminder that Social Services Letter 75–10 dated June 16, 1975, requires that all social services contracts funded under titles IV–A, IV–B, and/or VI (or XX) must receive prior approval by the Department of Health before the costs of those contracts may be claimed. The Department of Benefit Payments will not reimburse any contract costs claimed on the administrative expense unless the contract has been approved by the Department of Health and has been assigned a control number.

If you have not already done so, please submit all of these contracts to: Martin Warren, Chief, Services Resources Control Unit, 714 P Street—Room 350, Sacramento, Calif. 95814.

If you have any questions, please call Randy Jamison, telephone: 916—445–2174.

Sincerely,

CHARLES ————————,
for ALBERT SELTZER,
Manager, Social Services Branch.

STATE OF CALIFORNIA,
DEPARTMENT OF HEALTH,
Sacramento, Calif., June 25, 1975.

ERRATA NOTICE

SOCIAL SERVICES LETTER NO. 75–10—OUTLINE FOR WRITING PURCHASE OF SERVICE AGREEMENTS, DATED JUNE 16, 1975

Page 2, paragraph 3 reading "on or after Oct. 1, 1975" should read "on or after July 1, 1975."

This refers to the county's responsibility to obtain departmental approval on any social service contract funded in part or entirely by title IV–A or IV funds with an effective date on or after July 1, 1975. The competitive bidding requirement referred to on page one, paragraph 5 is required only on contracts with an effective date after September 30, 1975.

Due to the late issuance of this requirement, it is possible that the Department will review contracts after their execution. Ordinarily, any required changes will not result in canceling the contract.

OFFICE SERVICES SECTION.

STATE OF CALIFORNIA,
DEPARTMENT OF HEALTH,
Sacramento, Calif., June 16, 1975.

SOCIAL SERVICES LETTER NO. 75–10—OUTLINE FOR WRITING PURCHASE OF SERVICE AGREEMENTS

To: All county welfare directors.

The county welfare department may purchase services from other public

and private agencies and from individuals as provided in the county plan. The county is required to negotiate a written purchase of service agreement with each contracting public or private agency or organization. A written agreement for purchase of service from an individual shall be required when the individual acts as agent for other providers.

All contracts to be funded with Federal Social Service funds (titles IV–A, IV–B, VI, and XX) must be approved by the State prior to execution (contracts with individual providers excepted). Immediately upon receipt of a contract, the Department of Health will notify the county of a date by which the county may expect a decision. Departmental review will usually take about 3 weeks; at the end of which time, the Department will advise the county whether the contract is approved or if it must be revised. If revisions are required, the county must resubmit the revised contract for review and approval. If a county is planning to contract with more than one agency for a given service, the county must submit reasons and obtain State approval. Generally, only one contractor per service will be allowed. The term of the agreement may not exceed 1 year.

A budget of expenses and income must be submitted as part of the contract. The budget must include, but need not be limited to costs for: (a) employee salaries, (b) fringe benefits, (c) training, (d) travel, (e) administrative supervisory staff, (f) operating expenses, and (g) other.

To assure that costs are reasonable and necessary, bidding is required if any of the following apply: (a) when the maximum amount of the contract being renewed is increased, (b) when the rate charged increases by more than the cost of living, (c) when changing to the contracting method or changing contractors, (d) when 2 years have elapsed since the contract has been subject to bid. A minimum of three bids is required for each contract to be negotiated.

When a county requests bids, (using RFP guidelines in All County Letter 74 as guide), a summary of bids received must also be submitted with the contract. The summary must include the names of all bidders, the proposed rate of each bidder, the criteria used in selecting the contractor and the means used for requesting bids from the public. When fewer than three bids are received, an explanation must be included. This requirement for submission of a summary of bids applies to all contracts with a beginning date after September 30, 1975. A performance report is required on all service contractors. When a county is renewing any service contract (public or private agency), the performance report on the contractor must be submitted with the contract renewal. If the contract is not being renewed, the performance report must be submitted within a reasonable period of time from the date of termination. Please refer to Monitoring Guidelines (Social Service Letter No. 74–12) dated April 17, 1974, for assistance in preparing the report. In addition to each performance report, the county must also submit an audit report on all service contractors. This report must verify that costs were reasonable and necessary and, where necessary, that payments were adjusted to actual cost as required by regulations. Please refer to Standards for Audit of Governmental Organizations, Programs, Activities, and Functions. If the contract has been terminated, both the performance and audit report must be submitted together. If the contract is being renewed, the audit report must be submitted within 4 to 6 weeks from the date of renewal.

All of the above requirements must be met before contracts can be approved and costs claimed. A fiscal sanction may be imposed on all county administrative expense claims for contracts which have not been approved by the Department of Health. All or a portion of the claimed amount may be disallowed.

In claiming contract costs, county must itemize each contract on the DFA 325.3 under group III, No. 3, Purchase of Services. Each itemization must include the name of the contractor, the services purchased, and the contract number assigned by this department. Contracts with individual providers will continue to be claimed under group III, No. 2, Operating Costs. It is mandatory that each agreement be identified separately on the administrative expense claim by the Department of Health control number. Failure to do so could result in a delay in reimbursement for that contract. This applies to all contracts, new or renewed, with beginning dates on or after July 1, 1975.

There are many components of a purchase of service agreement. Each serves a purpose and should not be omitted or revised casually. The following outline identified areas that should be covered in an agreement. Of course, all items will not be needed in every contract; however, be certain that any exclusion does not omit necessary safeguards. For further clarification and detail of these components, see the attached guidelines. Please note the asterisks (*) which indicate that the item is optional depending upon each individual contract.

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ALBERT SELTZER,
Program Manager, Social Services Program.

Attachment.

Contact Reference: Randy Jamison, Services Resources Control Unit, 916—445–2174.

This letter is effective until June 28, 1976, unless sooner rescinded or superseded.

[Attachment]

GUIDELINES FOR WRITING PURCHASE OF SERVICE AGREEMENTS

The following guidelines should serve to clarify items in the outline which may not be completely self-explanatory. Those items marked by an asterisk (*) may be applicable only for certain agreements. They may be omitted if they do not apply to the specific agreement you are writing.

I. DECLARATION

The declaration of the agreement should contain a list of all parties to the agreement, a date, the legal authority, and the purpose of the agreement.

Example: "This agreement is entered into this —— day of ———— 1973 in the State of California by and between County of ————

hereinafter referred to as County and ——————————, hereinafter referred to as provider, in accordance with (cite legal authority) for the purpose of (state objectives of the contract)."

*II. DEFINITIONS

Use this section to define words having significant meaning to the particular contract which otherwise would not be clear.

III. DUTIES AND RESPONSIBILITIES

The responsibilities of each party must be delineated so that both parties are made aware of the obligations imposed by the terms of the contract. The following points include items that should be included in the contract as well as items that the county need not incorporate into the contract but should consider in developing the contract. Many of these latter points are responsibilities that the county has in regard to the State which have no real place in a contract between the county and a provider. It is also possible to have a section enumerating responsibilities shared by both parties.

A. County responsibilities

1. Assure that the services purchased under the terms of this contract comply with State regulations, including divisions 10, 30, and 31.

2. Retain ultimate responsibility for the determination of the eligibility of persons for services provided through purchase agreements, authorize types of service for an individual, and specify the duration of service. It is the responsibility of the county to assess the continuing need for service at least annually and to evaluate the effectiveness and quality of services provided.

*3. Monitor the performance of the provider in meeting the terms of the agreement.

*4. The county shall establish a system through which recipients may have opportunity to present their views about the services program. The presentation of views may be either oral or written and a procedure to be followed shall be incorporated as part of the county plan and subject to approval by the Department of Health as part of the plan.

B. Provider responsibilities

The provider's responsibilities must clearly delineate deliverables in terms of resources to be provided and benefits to be derived.

1. Description of Services Provided.—This should be an expansion of the reasons and objectives stated under the purpose in the declaration. This paragraph should contain a clear description of what services will be provided to whom, when, where, and how. To help assure quality of service, the duties can include a description of the provider's resources that will be devoted to accomplish the objectives of the contract. Any service which is purchased must be identified by one or more of the social services regulations in the State Department of Social Welfare Social Services Standards.

2. Provide number, professional titles, and job descriptions of staff and percentages of each person's time spent on serving the terms of the agreement.

3. Provide information regarding number of persons to be served. Describe how persons to be served will be brought into the program (public information, referral door-to-door, et cetera).

4. The provider must agree to keep proper program records to make them available for inspection, to collect program narrative and statistical data, and must agree to include these requirements in all approved subcontracts and assignments.

Records must be kept which will include the county assessment of need, a service plan, goals to be achieved, case opening and closing dates, and a description of actual services provided and results obtained.

Under special circumstances and when mutually agreed upon, this responsibility may be performed in whole or part to the county.

5. Advise applicants or recipients of public social services under this contract who are dissatisfied with action taken by the contracting agency—with regard to the function or denial of services—of the right to present grievances.

Example: "The provider must develop a fair hearing system whereby recipients may present their grievances about the operation of the service program."

6. All notices, informational pamphlets, press releases, research reports, and similar public notices prepared and released by the contractor shall include the statement, "This project is funded—in part—under an agreement with the (applicable State or Federal agency)."

7. The contractors must submit periodic progress reports at intervals agreed upon by both parties.

*8. If the provider has some responsibility in the collection of data to be used in the eligibility determination process, the extent of responsibility and the way it will meet this responsibility must be carefully spelled out.

9. The provider must guarantee to abide by the applicable sections of the Civil Rights Act of 1964 which prohibits discrimination to employees and recipients of the programs.

10. An entry should be made that the provider indemnifies the county, or anyone directly or indirectly involved with the county, in the performance of this contract.

11. The provider must agree to give preference to the training and employment of recipients of public assistance when appropriate.

12. Other duties and responsibilities to be determined by the contracting parties.

IV. FISCAL PROVISIONS

A. Maximum amount and source of funds

The maximum dollar amount of the contract must be stated. It must also state the source of funding and the amounts reimbursable by Federal, State, and county allocations.

Example: "The maximum amount of this contract shall not exceed $———— and shall be funded as follows:"

The county and provider must specify that the contract is subject to the availability of State and/or Federal funds.

B. Method, time, and conditions of payment

1. Specify time of billing (lump sum billing not acceptable).

2. Billing must be itemized as to services provided if the contractor is providing more than one type of social service.

3. Specify the time(s) when the payment is to be made.

4. Conditions of payment (i.e., contract must be performed in accordance with its terms before payment is due).

Example: "Within —— days following each calendar month, contractor shall submit an invoice to the county for all services provided in the preceding month. The county shall pay the contractor within —— days following receipt of invoice the amount claimed unless the county determines that the amount claimed is not in accordance with the provisions of this agreement."

5. The county should develop a schedule for reimbursement based on the number of recipients served by the contract. No flat amount should be paid without specific relationship to the number of cases served. The county should establish a number of cases as necessary to receive full payment or establish rates of payments for meeting less than minimum performance requirements. Any time the number of cases served falls below a minimum, the payment will be adjusted accordingly.

C. Rate of payment

The county welfare department must provide for the establishment of rates of payment for such services which do not exceed the amounts reasonable and necessary to assure quality of service and in the case of services purchased from other public agencies, are in accordance with the costs reasonably assignable to such services. The rates of payment must be an identifiable price per unit of service, such as X number of units of service at X dollars per unit or services for X number of recipients at X dollars per recipient, or total amount for X number of units of service.

1. If county/private profit contractor contract, the costs must be reasonable and necessary to assure quality service.

2. If county/private nonprofit contractor contract, the costs must be determined in accordance with OASC–5.

3. If county/public agency contract, the costs must be determined in accordance with OASC–8.

The rate of payment may be stated in one of the following manners:

Hourly rate.—Two individuals for 2 hours per day at $2 per hour.
Unit rate.—Four individuals at $5 per person.
Budgetary rate.—$20 will provide 10 hours of service.
Relative to nonprofit contractors, if hourly or unit rate is used, payments must be adjusted to actual cost up to the maximum amount of the contract before final payment is made. The methods used in establishing and maintaining such rates must be described. The rate of payment will be based on consideration of the full cost of the services. (Indicate that information to support such rates of payment will be maintained in accessible form.)

D. Budget of expenses and income (estimate when unavailable)

An estimate or budget of expenses and income is required. It is instructive in considering whether or not rates of payment exceed amounts reasonable and necessary to assure quality of service and the cost reasonably assignable to such services and is a valuable tool in monitoring and evaluating the amount and worth of services being rendered.

1. The budget attachment documents the county's compliance with requirements that costs are reasonable and necessary and further defines the deliverable responsibilities. A significant failure to provide resources promised may be construed as a failure to perform in terms of delivering the quality promised.

2. The agreement should spell out the manner of handling any applicable credits. The term applicable credits refers to fees that the provider is allowed to collect and any other direct or indirect receipts or reductions of expenditures which offset or reduce expense items properly allocable to the subject matter of the agreement.

Examples of such transactions are purchase discounts, rebates, or allowances; recoveries or indemnities on losses; sale of publications, equipment, and scrap; income from personal or incidental services; and adjustments of overpayments or erroneous charges. Applicable credits may also arise when Federal funds are received or are available from sources other than the program involved to finance operations or capital items. This includes costs arising from the use or depreciation of items donated or financed by the Federal Government to fulfill matching requirements under another program. These types of credits should likewise be used to reduce related expenditures in determining the rates or amounts applicable to the purchase agreement. The agreement must specify the means of segregating out the costs of operation allocable to such applicable credits or the method of adjusting the per diem charges to reflect such credits.

E. Right to monitor and audit

An ongoing program must be implemented to monitor all purchase of service agreements from fiscal and program viewpoints, and a maximum of 5 percent of the total cost of an agreed upon purchase of services agreement must be expended for this purpose and for technical assistance.

Example: County, State, and Federal government shall have the right to monitor and audit all work performed under this contract. The examination will place particular emphasis on (*a*) the social services component, and (*b*) the underlying internal controls and financial records.

County will notify contractor in writing within 30 days of any potential Federal exception(s) discovered during such examination. Where such findings indicate that program requirements are not being met and Federal participation in this program may be imperiled, such written notification will constitute county's intent to terminate this contract in the event that corrections are not accomplished by contractor within 60 days.

Audits performed by an independent CPA must comply with Standards for Audit of Government Organizations, Programs, Activities and Functions. These standards are also recommended for use by county auditing staff.

F. Conformity with Federal cost regulations

One: The following clauses must be inserted in all intercounty or intracounty contracts where indirect costs are involved.

Costs allowable for reimbursement will be in accord with the provisions of the following U.S. Department of Health, Education, and Welfare document:

OASC-8.—A Guide for Local Government Agencies—Establishing Cost Allocation Plans and Indirect Cost Proposals for Grants and Contracts with the Federal Government.

This document will be used by both parties to implement U.S. Bureau of the Budget Circular No. A–87, which provides principles and standards for determining costs applicable to grants and contracts with State and local government agencies.

Where indirect costs are involved and a cost allocation plan and/or an indirect cost rate proposal is required, the plan and/or proposal should be submitted to the appropriate agency for approval.

Two: The following clauses must be inserted in all contracts between a county agency and a private nonprofit organization where indirect costs are involved.

Costs allowable for reimbursement will be in accordance with the provisions of the following U.S. Department of Health, Education, and Welfare document:

OASO–5.—A Guide for Nonprofit Institutions—Cost Principles and Procedures for Establishing Indirect Cost Rates for Grants and Contracts with the Department of Health, Education, and Welfare.

This document will be used by both parties to implement U.S. Bureau of the Budget Circular No. A–87, which provides principles and standards for determining costs applicable to grants and contracts with State and local government agencies.

Three: The provider must agree to indemnify the county for Federal and/or State audit exceptions resulting from noncompliance herein on the part of the provider.

**G. Title to equipment and supplies*

The contract should state which party will have title to equipment and supplies purchased under the contract.

**H.* Provide that where payment for services is made to the recipient for payment to the vendor, the State or local agency will specify to the recipient the type, cost, quantity, and the vendor of the service and the agency will establish procedures to insure proper delivery of the service to, and payment by, the recipient.

I. The county must guarantee that Federal funds will not be used to obtain other Federal funds unless specifically authorized by Congress.

J. In no case can Federal social services funds be used to supplant State or local funding for already existing services. In every case the addition of Federal social service funds to funds of another public agency must result in a commensurate, significant program expansion as demonstrated by the increase in the number of eligible persons served, by the addition of new services to eligible persons, or a combination of both.

**K. Donated private funds*

If donated private funds are involved, to be considered for Federal financial participation, the following conditions must be met:

One: The contribution must be in cash and deposited with the agency.

Two: The donation must be unrestricted. The funds must not be designated to be used to purchase services from a specific organization or individual. Specifying an activity or a community for the expending of funds is permissible provided that the donor does not sponsor or provide the service or activity being funded.

Three: A donation cannot revert to the donor, either directly or indirectly, through a purchase of service from the donor. Indirectly refers to the donation being made by a third party which controls or is controlled by the organization providing the service.

In conjunction with the last requirement, any purchase of services from the donor is considered a reversion of the donated funds and is not eligible for Federal financial participation, even if it can be argued that the donated funds were not used for the specific services purchased or that the agency exercised free choice in purchasing donor services. The unmatchable amount would equal the amount of purchased services or the donation, whichever is less. Thus, a portion of the donation may still be matchable.

V. GENERAL PROVISIONS

A. Effective period and right of termination

One: The effective period of the contract must be stated. The contract must not be automatically renewable.

Example: This agreement is effective for the period from _____ through _____.

If the termination date is dependent upon the exhaustion of funds rather than a given date, it must be so reflected.

Example: This agreement is effective from _____ until $_____ have been expended.

The agreement may include provisions for renewal. No agreement should be automatically renewable. Renewal may be conditioned on the availability of public moneys, satisfactory performance of the provider, and competitive bidding requirements. A comprehensive progress report must be submitted at least 90 days before the renewal request. A contract renewal will not be approved by the State until the progress report is submitted.

Two: *State methods of termination.* (*a*) Written notice.

Example: Upon _____ days _____ written notice to the other party, either party may terminate this agreement.

(*b*) There can be several reasons for terminating the agreement:

Termination at will with notice—it may be desirable to allow either party to terminate the agreement upon notice.

Termination because of lack of funds—the parties may want to recognize the possibility of future unavailability of public funds.

Termination for default—the agreement should include provisions for termination in case of default.

Termination agreement—the agreement should include a provision for orderly winding up the agreement and the relationship between the parties.

Waiver of default—the agreement should include a provision for dealing with the effect of waiver of default.

It is the responsibility of the county to insure the continuing provision of service in the event of termination of an agreement.

(*c*) Any excuse for nonperformance may be inserted into the agreement.

(*d*) The means of handling disputes may be set forth.

B. *Confidentiality*

All parties shall agree to keep confidential all information concerning a recipient or a potential recipient in accordance with Federal and State requirements.

Example: Provider agrees to require his employees to comply with the provisions of Section 10850 of the Welfare and Institutions Code to assure that:

One: All applications and records concerning any individual made or kept by any public officer or agency in connection with the administration of any provision of the Welfare and Institutions Code relating to any form of public social services for which grants in aid are received by this State from the Federal Government will be confidential and will not be open to examination for any purpose not directly connected with the administration of such public social service.

Two: No person will publish or disclose or use or permit or cause to be published, disclosed, or used any confidential information pertaining to an applicant or recipient.

Contractor agrees to inform all employees, agents, and partners on the above provisions and that any person knowingly and intentionally violating the provisions of this paragraph is guilty of a misdemeanor.

C. *Retention of records*

The agreement must provide for the retention of records and their availability for inspection for a certain period after the agreement expires.

Examples: "The contractor and county agree to retain all documents relevant to this agreement for 3 years from the termination of the contract or until all Federal/State audits are complete for this fiscal year, whichever is later. Upon request, contractor shall make available these records to county, State, or Federal Government's personnel."

D. *Place*

Include a description or location of physical facilities to be utilized.

E. *Nondiscriminatory services*

Example: "Within the limits set forth in this agreement, contractor assures that all goods and services (pursuant to this agreement) shall be available

to all persons regardless of sex, race, religion, or ethnic background. No program shall be used, in whole or in part, for religious worship or instruction."

F. *Fair employment*

Example:

[Deleted.]

G. *Totality of contract*

A section should provide that all terms and conditions are included in the agreement; that all items incorporated by reference are physically attached to the agreement.

Example: "This agreement contains all the terms and conditions agreed upon by the parties. No other understandings, oral, or otherwise, regarding the subject matter of this agreement, shall be deemed to exist or to bind any of the parties hereto."

*H. *Appendix* (for use if appropriate)

Example: "All items incorporated by reference are attached to this contract."

I. *Alterations and modifications*

An agreement may be renegotiated or modified by consent of the parties, but any modification must be in writing and must be attached to the original agreement. Such modifications are subject to prior approval by the State.

Example: "Any alterations, variations, modifications, or waivers of provisions of this agreement shall only be valid when they have been reduced to writing, duly signed, and attached to the original of this agreement."

J. *Assignment*

Example: "Any assignment made by the county or contractor will be void without the written consent of the nonassigning-contracting party."

K. *Subcontracting*

The contractor shall not enter into subcontracts without the prior written approval of the county.

Example: "The contractor shall not enter into subcontracts for any of the work contemplated under this agreement without first obtaining written approval from the county. Such approval shall be attached and made a part of this contract."

L. *Law governing contract*

Example: "This contract shall be governed and construed in accordance with all of the laws of the State of California, in addition to any cited herein."

*M. *Licensing or accreditation*

An appropriate provision must be inserted when services are being performed by a party who must be licensed or accredited in accordance with State law.

Example: "The contractor agrees to comply with all State licensing standards, all applicable accrediting standards, and any other standards or criteria established by the State to assure quality of services."

N. *Bonding*

"Prior to entering upon performance of this contract, the contractor shall submit to the county for its approval a blanket fidelity bond in the amount of $_____ covering all officials, employees, and agents handling or having access to funds (other than petty cash which is an amount no greater than $_____) received or disbursed by the contractor under this contract, or who are authorized to sign or countersign checks."

O. *Insurance*

Example: "Contractor shall throughout the period of this contract provide comprehensive insurance in the amount of $_____ covering all bodily injury and property damage arising out of its operations of this contract. Said policy shall constitute primary insurance as to the county, the State, and Federal Governments, and their officers, agents, and employees, and shall name such governments and persons as additional insured.

"The contractor shall provide automobile insurance covering all bodily injury and property liability incurred during the performance under this contract with minimum coverage of $_____ for property liability per accident; $_____ for each person per accident; but no more than $_____ per accident blanket coverage.

"Said policies shall constitute primary insurance as to the county, the State, and the Federal Governments, its officers, agents, and employees, so that any other policies held by them shall not contribute to any loss under said insurance. Said policies shall provide thirty (30) days' written notice to county of cancellation or material change.

"Contractor shall throughout the period of this agreement maintain in full force and effect a policy of Workmen's Compensation Insurance covering all of its employees."

P. *Indemnification*

Example: The contractor agrees to indemnify, defend, and save harmless the county, its officers, agents, and employees from any and all claims and losses accruing or resulting to any and all contractors, subcontractors, materialmen, laborers, and any other person, firm, or corporation furnishing or supplying work, services, materials, or supplies in connection with the performance of this contract, and from any and all claims and losses accruing or resulting to any person, firm, or corporation who may be injured or damaged by the contractor in the performance of this contract.

If desired, other clauses may be inserted in the contract if not contrary to the mandatory provisions listed herein.

*Q. *Right to data*

It may be advisable to include a section dealing with the right to use data. The need is quite likely in special cases such as section 1115 demonstration projects where the results may be published.

R. *Signatures*

The agreement must be signed by an authorized representative of each party to the agreement.

Assembly Bill No. 1702

CHAPTER 1226

An act to add Section 12302.1 to the Welfare and Institutions Code, relating to public social services.

(Approved by Governor September 30, 1975. Filed with Secretary of State September 30, 1975.)

LEGISLATIVE COUNSEL'S DIGEST

AB 1702, Egeland. Public social services.

Under current law, the county may contract with certain entities to perform in-home supportive services for recipients under the State supplementary program.

This bill requires that such contracts be for periods not exceeding 1 year and that the county publicize its intention to solicit bids to enter into such contracts; requires the county board of supervisors, at a regularly scheduled meeting, to hold a public hearing on the proposed contracts, and requires a 30-day waiting period before such contracts becomes effective.

This bill also provides that in awarding the service contracts, the board of supervisors may consider the fiscal responsibility and experience of the service provider, and any other consideration in the public interest. To insure fiscal and program compliance, the county shall review the contract during the contract term. Such review may include, but shall not be limited to, a fiscal audit.

The bill also provides that neither appropriation is made nor obligation created for reimbursement of any local agencies for any costs incurred by it pursuant to the act.

The people of the State of California do enact as follows:

SECTION 1. Section 12302.1 is added to the Welfare and Institutions Code, to read:

12302.1. Contracts entered into by a county under section 12302 shall be for periods not exceeding 1 year and shall, in addition to including provisions required by section 12303, be subject to the following:

(a) Prior to initiating a contract or contracts pursuant to section 12302, the county shall publicize its intention to solicit bids to enter into such contracts.

(b) When the county has selected one or more contract proposals for tentative acceptance, the county board of supervisors shall conduct a hearing on the proposed contract or contracts, which shall be at a regularly scheduled meeting of the board of supervisors, and open to the public.

(c) Public findings based on the hearing shall be made available to interested parties.

(d) No contract for services provided under this article shall take effect until 30 calendar days have elapsed from the time of the public hearing required under this section.

(e) The county board of supervisors may award one or more service * * *[1] responsibility of the service provider, experience of the service provider in providing services pursuant to this article, and any other consideration in the public interest; provided that nothing in this subdivision shall preclude a requirement that contracts under this section be awarded on a competitive bid basis.

(f) The county, to insure fiscal and program compliance, shall review the contract during the contract term. Such review may include, but shall not be limited to, a fiscal audit.

SEC. 2. No appropriation is made by this act, nor is any obligation created thereby under section 2231 of the Revenue and Taxation Code, for the reimbursement of any local agency for any costs that may be incurred by it in carrying on any program or performing any service required to be carried on or performed by it by this act.

[Appendix B]

STATE OF CALIFORNIA,
DEPARTMENT OF HEALTH,
Sacramento, Calif., August 27, 1976.

MR. RICHARD E. BALLARD,
Branch Manager, Health, Education, and Welfare Audit Agency, San Francisco Branch Office, San Francisco, Calif.

DEAR MR. BALLARD: The following comments regarding the exit conference draft report outline the position taken by my staff as a result of the meeting held in San Francisco, August 24, 1976.

COMPUTATION OF EXCESSIVE COSTS

We have pointed out before that attempts to arrive at a "reasonable rate" on the basis of bids submitted by other orgainzations in July 1972 are not appropriate. This position is further supported by information presented by Marion Brislane, San Francisco Department of Social Services, as follows:

"Unsolicited offers received from other homemaker agencies and rejected without justification by the county agency in July 1972, averaged $5.25 per hour. The unsolicited offers were from Unicare Incorporated and Professional Nurses Bureau. Neither of these agencies provided homemaker services in San Francisco County. Neither was under union contract in San Francisco. The offers made for homemaker services were based on minimum wage of $1.60 per hour rather than the entrance union wage of $2.35, or a difference of $.75 per hour."

The above stated position of San Francisco further clarifies, in our view, that the actions taken reflect reasonable administration. We believe it would be difficult to reconstruct events, at that earlier period in time, to support an alternative conclusion of unreasonabelness of county administrative actions.

STATE RESPONSIBILITIES

Your exit conference draft report does not give adequate weight to the positive steps taken by the state to improve the purchase-of-service procedures. As a result of the review by Department of Health staff in April 1975, the De-

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[1] This part of the bill, as submitted to the committee, is illegible.

partment of Health issued regulations, initiated legislation, and strengthened bidding contract procedures and negotiation in order to effect improvement in the program. Moreover, we have initiated a plan for additional homemaker/chore reviews of county practice and state procedures. DHEW cannot support its contention that the Department of Health was remiss in carrying out its responsibilities.

FOLLOWUP OF DOH REVIEWS BY DHEW AUDITS

We would like to raise a basic management question which has application to the respective Federal, State, and local evaluation systems. Consider the principle that when a State or local entity conducts a review and takes appropriate action in respect to negative findings, that a Federal agency should not immediately review the same components and take audit exceptions. The State conducted the subject homemaker/chore review in San Francisco in April 1975. Your offices conducted a follow-on review and is now taking audit exception to findings which the State uncovered in the first instance even though the State was vigorously and on a timely basis developing control measures to correct deficiencies in administration. Such Federal practice may become counterproductive because State and local agencies may become reluctant to identify findings which would create Federal audit exceptions thereby rendering State and local evaluation efforts less effective. Moreover, the practice may not reflect efficient utilization of scarce Federal, State, and county evaluation staff. The State does not question Federal review of other administrative elements not evaluated recently by State or local agencies. The State would further suggest that DHEW would find it more productive to follow up State and local reviews with a view towards assuring that corrective action is timely and appropriate.

CONCLUSION

DHEW's recommendation that the Department of Health should reduce prior year claims by $1,694,986 and refund $415,190 is not warranted.

Sincerely,

GARY D. MACOMBER,
Deputy Director for Social Services.

Appendix 4

CALIFORNIA HEALTH AUDITS BUREAU REPORTS ON SOCIAL AND REHABILITATIVE SERVICES; SUBMITTED BY GARY MACOMBER[1]

ITEM 1. AUDIT REPORT OF VISITING HOME SERVICES, INC., AND HEALTH HELP, INC., SAN FRANCISCO, CALIF., JULY 1, 1975 TO JUNE 30, 1976

CALIFORNIA HEALTH AND WELFARE AGENCY MEMORANDUM, OCTOBER 29, 1976.

To: Gary Macomber, Chief, Social Services Division.
From: Department of Benefit Payments.
Subject: Visiting Home Services, Inc., and Health Help, Inc.

Pursuant to your request, we have examined the available records of Visiting Home Services, Inc., and Health Help, Inc., located in San Francisco at 450 Sutter Street, contract providers for the Homemaker and Chore Program for ten (10) California counties and four (4) other States during the period from July 1, 1975, through June 30, 1976. The examination was limited in scope to a review of financial position, claims statistics, and contract costs.

We are unable to express an opinion regarding the fairness of the financial data contained herein because of the absence of records. Also, because the organizations were nonfunctioning this report must be viewed as a historical documentation of a defunct organization. Any conclusions, accordingly, about the operation of these organizations are susceptible to modification with the availability of new and additional supporting information.

Therefore, this is a special review made at your request and should not be construed to be a full scope audit. Certain recommendations, however, of a general nature are being made and will be found at the conclusion of this report.

JACK R. REAGAN,
Chief, Health Audits Bureau.
STUART M. MANLEY,
Manager, Field Region I,
Sacramento Health Audits Bureau.

[Enclosures.]

INTRODUCTION

BACKGROUND

Prior to January 1, 1974, titles I, X, and XIV of the Social Security Act, as amended, established grant programs providing Federal financial assistance in the costs incurred by States for the provision of social services on behalf of aged, blind, and disabled persons. Effective January 1, 1974, title VI established a consolidated grant program for social services prevously provided pursuant to the three titles cited above. On October 1, 1975, title XX replaced title VI.

Pursuant to the titles cited above, more specifically title XX, the California State Plan (Plan) for social services was developed. The Plan authorizes local welfare departments to purchase social services from nonprofit and proprietary organizations. Pursuant to the Plan, the following counties in the State of California had contracts with Visiting Home Services, Inc. (VHS) for services within the period from July 1, 1975 through June 30, 1976.

[1] See statement, p. 1016.

Fresno County
Imperial County
Madera County
Merced County
Nevada County
Plumas County
San Luis Obispo County
Santa Barbara County
Tehama County

During the period from July 1, 1975, through June 30, 1976, San Francisco County had a contract for services with Health Help, Inc. (HH), a wholly owned subsidiary of VHS.

In addition to the contracts with the above nine California Counties, VHS had contracts with the following governmental agencies within the period from July 1, 1975, through June 30, 1976. Utah, Department of Social Welfare; Minnesota, Office of Purchase Services, Hennepin County; Missouri, Department of Social Services; and Washington, D.C., Assistant Director of Administration.

SCOPE OF REVIEW

During August 1976 the Department of Health was informed that employee payroll checks for VHS and HH were not being honored by the bank because of insufficient funds. The program representatives of the Department of Health became concerned regarding the financial stability of VHS and HH. This concern resulted in a request to the Health Audits Bureau to perform an audit of the books and records of the above contract providers of Homemaker and Chore Services to determine their financial solvency.

The original plan of audit was to perform the following general procedures:

1. Determine the financial position as of August 31, 1976.
2. Verify claims statistics for the period of services from July 1, 1975 through June 30, 1976.
3. Audit for contract compliance and cost for the fiscal year from July 1, 1975 through June 30, 1976.

FINANCIAL POSITIONS

We did not determine the financial position as of August 31, 1976 due to the following circumstances which indicated VHS was insolvent at August 31, 1976 and the insolvent position would not improve in subsequent months.

We reviewed the unaudited consolidated financial statements of VHS and its subsidiary, HH, as of June 30, 1976, prepared by David Prince, Certified Public Accountant. To prepare the financial statements, Mr. Prince reconstructed a workpaper general ledger from the accounting records made available to him. The resulting financial statements at June 30, 1976, reflected a negative equity. Furthermore, in analyzing the statement of operating costs and receipts for the 6 months of January 1, 1976, to June 30, 1976, the conclusion was evident that the organization showed a negative equity even at the close of 1975; that is, they were operating at a deficit.

During the month of August 1976, the bank stopped honoring the employee payroll checks due to insufficient funds. As a result, the employees stopped performing services and the counties began cancelling their contracts with the two organizations due to this breach. Without revenue from these contracts the financial position deteriorated even further than indicated at June 30, 1976, and on or about September 1, 1976, VHS and HH filed a petition for bankruptcy.

Based on the above circumstances the financial position of VHS and HH was self evident, and further attempts to ascertain a more precise financial position would have been futile. These circumstances were discussed with program representatives of the Department of Health, and it was agreed that a determination of the financial position was no longer necessary.

CLAIMS STATISTICS

Confirmation letters were sent to each California County and to each State which appeared to have, or which appeared possible to have, contracted with VHS or HH for services.

The confirmation letter requested schedules of amounts billed by and paid to VHS or HH, hours of services billed by VHS or HH and if the respective agency intended to audit the billings submitted by VHS or HH.

Telephonic or written communications have been received from each county/State indicating general satisfaction with claims statistics. Two counties, Fresno and Santa Barbara, intend to audit the local service offices with county staff.

REVIEW FOR CONTRACT COSTS

Shortly after we began our field work, we determined that we would not be able to perform an audit as originally planned due to inadequate records, therefore, we made a review of available records for contract costs. The scope of this review was limited due to inadequate accounting books and records made available to us. Our review included the following procedures for the period from July 1, 1975, through June 30, 1976.

1. Using the check copies for VHS, we prepared a workpaper schedule of checks showing a distribution to each county contract, contracts in other states, Home Office costs, questionable items of cost and payments made to principal officers and owners.
2. Using check stubs for HH, we prepared a workpaper schedule similar to the schedule for VHS above.
3. Using computerized payroll data by Bank of America and Dental Data, Inc., for VHS and HH, we prepared a workpaper summary of payroll by contract and home office.
4. On a test basis, an attempt was made to trace disbursements to original source documents, such as vendors' invoices and expense claims, however, we were unable to locate many of the supporting documents.

When requests were made for missing documents, we were told that the missing documents were with the other supporting documents.

The distribution of costs represented by the check copies and stubs was based on information included on the applicable check copy or check stub.

A request was made of VHS officials for the general ledger, cash receipts journal, cash disbursements journal, accounts receivable ledger, accounts payable ledger and general journal. Of the items requested, only a partial general ledger was available.

In preparing this report, we are accepting the contract compliance determinations made by the respective contracting governmental agency. The statistics supplied by each contracting governmental agency is accepted as correct and, if applicable, is incorporated in this report.

ORGANIZATIONAL STRUCTURE

CORPORATE ORGANIZATION

Visiting Home Services, Inc., a corporation organized under the laws of the State of California, originally issued 500 shares of stock to Ron Gottheiner (250 shares) and Vivian Gottheiner (250 shares). In December 1972, the stockholders transferred 100 shares each to Salvatore Marconi. As of August 31, 1976, the issued and outstanding shares were owned as follows:

Stockholder:	*Number of shares*
Ron Gottheiner	150
Vivian Gottheiner	150
Salvatore Marconi	200

Health Help, Inc., originally issued 1,000 shares of stock to Peter Gottheiner and on January 23,1976, Peter Gottheiner transferred the 1,000 shares to VHS.

Peter Gottheiner held no stock interest in VHS. However as president of both organizations, and ostensibly only an employee of VHS, he operated both HH and VHS as sole proprietorships.

HH held the only lucrative contract, and funds from this revenue source were generally used indiscriminately to finance both personal and business expenses of both organizations. Statements indicating amounts as owed by VHS to HH were found. However, the condition of the records was such that it was impossible to segregate accountability between orgainzations. Funds were shifted back and forth and payments were made from available resources. Accordingly, our review treats the two organizations as a single entity.

Peter Gottheiner was president of VHS until June 12, 1976. As a result of an internal power struggle between Peter Gottheiner and Ralph Gomez, Mr. Gottheiner was forced to resign on June 12, 1976. As consideration for Mr. Gottheiner's resignation, Mr. Gottheiner and VHS entered into a written severance agreement dated June 11, 1976. Under the terms of the agreement, VHS is required to make the following payments to Peter Gottheiner:

1. Severance pay totaling $25,730 to be paid in five varying amounts beginning on or before June 12, 1976 and ending on or before August 12, 1976.
2. Repayments on or before June 12, 1976, of a $2,500 personal loan owed to Peter Gottheiner by VHS.
3. Payment of the remaining $6,000 balance of a personal loan, plus unpaid interest of $816 as of the date of the agreement, owed to Peter Gottheiner and his nominee by VHS. The payments are to be made in monthly installments of $1,000 per month beginning on August 12, 1976. VHS acknowledged that the note provides for interest at 6 percent per year on the remaining balance due until fully paid.

The Intelligence Unit of the Investigation Section, Department of Health, has additional information regarding the capital structure of Visiting Home Services, Inc., and Health Help, Inc.

MANAGEMENT AND RELATED INDIVIDUALS

Peter Gottheiner was president of the organization until June 12, 1976. His son, Ron Gottheiner, and daughter, Vivian, are corporate stockholders. Peter Gottheiner was paid a salary from both VHS and HH and also received payments represented as expense reimbursements, consultant fees, and loan repayments.

Ron Gottheiner, one of the stockholders, became president of the orgainzation on or about June 13, 1976. Ron Gottheiner was paid a salary from VHS and also received payments represented as expense reimbursements and loan repayments.

Peter Gottheiner's daughter, Vivian, was one of the stockholders and received payments from VHS represented as consultant fees.

Peter Gottheiner's ex-wife, Eva, and Ron Gottheiner's wife, Jeanie, were paid salaries by VHS.

The amounts paid to the above individuals during the period from July 1, 1975, through June 30, 1976, are included in schedule 5 and are discussed under "Review Findings" in this report.

FINANCIAL BACKERS OF VHS

Despite calculations made by the president, projecting a 16 percent net profit on revenues, the organization's finances appear to have been chronically depleted due to the extraordinary amounts disbursed to Peter Gottheiner for:

1. Salaries (drew wages from both VHS and HH).
2. "Take out moneys" (consultant fees and loan repayments).
3. Travel and promotion expenses (excessive).
4. Personal expenses (nonprogram related expense).
5. Ex-wife on the payroll (no evidence of employment).

In addition, the expansion of the business through new contracts created a demand for additional capital needs to support the organization until initial contract revenues were received. Accordingly, it became necessary to obtain a financial backer to underwrite the cash balance necessary to continue expanding operations.

Salvatore Marconi, a San Francisco restaurateur, became involved as a financial lender to VHS in November 1972 and continued supporting VHS until November 1973.

Ralph Gomez became involved as a financial lender to VHS in August 1975, supplanting Mr. Marconi, and continued supporting VHS until August 1976.

Mr. Marconi and Mr. Gomez were financing current operating cash requirements on an "as needed" basis.

Mr. Gomez received payments from VHS represented as consultant fees. The amounts of these consultant fees are included in schedule 5 and are discussed under "Review Findings" in this report.

REVIEW FINDINGS

GENERAL COMMENTS

The only substantially complete accounting books and records available to us were the check copies for VHS, the check stubs for HH and the computerized payroll data. The accompanying schedules were based upon these records and we were not able to substantiate that actual payments were made and/or that the payments indicated were for the purposes stated in these records.

We began our field examination on August 31, 1976, however, all of the accounting employees had terminated before August 30, 1976. Therefore, the only individuals available for questions were Ron Gottheiner and, occasionally, Ralph Gomez and Peter Gottheiner.

The following review findings for the period from July 1, 1975, through June 30, 1976, are based upon the accounting books and records enumerated above, auditors' observations, and inquiry. These findings are detailed in the order corresponding to the accompanying schedules and are identified herein by the applicable schedule heading.

COST BY CONTRACT (SCHEDULE 1)

The Schedule of Costs by Contract shows the amounts of direct costs and two line items for home office costs allocated to the contracts.

The basis used to distribute direct cost to the contracts was the information contained on the check copies of VHS, check stubs of HH and the computerized payroll data.

HOME OFFICE COST ALLOCATION (SCHEDULE 2)

We sent confirmation letters to all of the contracting governmental agencies requesting the number of hours of services applicable to the period under review. We did not receive a response from some of the agencies, therefore, the total hours of services, provided by VHS and HH, could not be used as a basis for allocating the home office costs. We used, instead, direct salary costs as a basis for allocating the home office costs since the direct salaries were related to the hours of service provided.

The Schedule of Home Office Cost Allocation shows the allocation of the home office costs (schedule 3) considered to be necessary, reasonable and program related, and the allocation of questionable home office costs (schedule 4).

HOME OFFICE COSTS (SCHEDULE 3)

The costs included in the Schedule of Home Office Costs are costs which appeared to be reasonable, necessary and program related and which are not identified as direct contract costs. These costs do not include the cost items shown in the Schedule of Questionable Home Office Costs (schedule 4). However, due to the lack of adequate substantiating documentation we were unable to adequately perform the audit procedure of vouching costs, therefore, some costs included herein may not actually be necessary or program related. Alternately, there are some costs included in the Schedule of Questionable Costs which are program related, such as salaries for Peter Gottheiner and Ron Gottheiner. However, we are not in a position to determine the portion of the salary amounts which are reasonable, necessary and/or program related.

QUESTIONABLE HOME OFFICE COSTS (SCHEDULE 4)

The costs included in the Schedule of Questionable Home Office Costs are costs which we were not able to verify as necessary, reasonable and/or program related or costs which may have been the result of multiple payments.

Comments regarding the salaries, consultant fees, travel advances and reimbursements, national credit cards, direct charge accounts and ex-wife on the payroll are included in the section for "Distributions to Principals" and the costs are also included in schedule 5.

Included in Peter Gottheiner's expense claims are allowances for the use of his home and resident telephone for business. Due to the lack of supporting documentation and the limitation on audit time, we were not able to substantiate the amounts claimed for his home and private telephone.

These questionable costs have been allocated to the various contracts as a separate item, are specifically identified in the Schedule of Home Office Cost Allocation (schedule 2) and are shown as a separate line item in the Schedule of Costs by Contract (schedule 1).

DISTRIBUTIONS TO PRINCIPALS (SCHEDULE 5)

Peter Gottheiner was paid salaries of $24,000 by VHS and $29,000 by HH for a total of $53,000 during the period. In our opinion, the salary for the period is excessive and, for this reason, 100 percent of the salaries paid to Peter Gottheiner is also included in the Schedule of Questionable Home Office Costs (schedule 4).

In addition, Peter Gottheiner was paid $58,815 as expense advances and reimbursements during the period. Some of the expenses claimed for reimbursement were identified as purchases from tobacco shops, flower shops, liquor stores, et cetera. Other major expenses were identified as personal expenses at local San Francisco hotels and restaurants. Many of the expense items are susceptible to duplicate payments by VHS or HH through reimbursement of expense claims and through direct payment on national credit card and direct charge accounts. Expense advances paid to Peter Gottheiner could also have been paid through expense claims reimbursements, thus resulting in possible duplicate or triplicate payments. Since we did not have access to a general ledger and/or all of the expense claims, we were not able to verify if reimbursements were proper. For this reason, part of the expense advances and reimbursements are also included in the Schedule of Questionable Home Office Costs (Schedule 4).

Furthermore, Peter Gottheiner was paid $43,100 as consultant fees during the period. In our opinion, if an individual is receiving a salary for services, the individual is not entitled to consultant fees from the same entity.

Also Peter Gottheiner received $81,168 stated to be loan repayments during the period, however, we did not find any evidence that Peter Gottheiner loaned any funds to VHS or HH.

Ron Gottheiner was paid a salary of $25,875 by VHS and $2,500 by HH for a total of $28,375 during the period.

Furthermore, Ron Gottheiner received $8,300 stated to be loan repayments during the period. However, we did not find any evidence that Ron Gottheiner loaned any funds to VHS.

Vivian Gottheiner received $1,875 for consultant fees during the period. However, we did not find any evidence that Vivian Gottheiner performed any services as a consultant.

Eva Gottheiner, Peter Gottheiner's ex-wife, received $11,000 represented as salaries during the period. We did not find any evidence that Eva Gottheiner was actually an employee. Based on a letter to the firm's attorney, dated November 23, 1975, Peter Gottheiner considers Eva's salary as a personal benefit to him. For this reason, the total paid to Eva Gottheiner is also included in the Schedule of Questionable Home Office Costs (Schedule 4).

Jeanie Gottheiner, Ron Gottheiner's wife, received a salary of $10,400 during the period. While it appears that she was active in the organization, the extent of her duties was not substantiated. Therefore, this salary is also included in the Schedule of Questionable Home Office Costs (Schedule 4).

Ralph Gomez was paid salaries of $5,000 by VHS and $3,750 by HH for a total of $8,750 during the period. Furthermore, Ralph Gomez received $50,432 for consultant fees during the period. Based on inquiry, Ralph Gomez came into the office for approximately 1 hour each day to review the cash receipts. We were not able to verify the services, if any, performed by Ralph Gomez. Therefore, only the salaries paid were included in the Schedule of Questionable Home Office Costs (Schedule 4).

It should be noted that those items included in the Schedule of Questionable Costs include costs that may be legitimate to the program, but are either unsubstantiated or excessive in our opinion. In no case are payments for consultant fees or loan payments, as reflected in schedule 5, considered to be legitimate costs. Therefore, amounts reflected in schedule 5 for consultant fees and loan repayments are not included as costs in any schedule of this report.

Conclusions and Recommendations

CONCLUSION

Based on data examined, we determined that further auditing of Visiting Home Services and Health Help would be of no value to these organizations nor would it be of value in developing any additional program improvements.

RECOMMENDATIONS

One: A more timely audit is needed when weakness are observed regarding contract providers. In April 1975, Mr. George Elich, chief of the field review unit, Department of Health, issued a report stating problem areas regarding the San Francisco County contracts. In addition, the Department of Health, Education, and Welfare—HEW—issued a report on San Francisco County homemaker contracts dated July 2, 1976, to the Department of Health. The HEW report stated problem areas in the San Francisco County homemaker and chore programs regarding three specific contractors identified only as contractors A, B, and C.

Upon close review of the HEW report and with very little background knowledge of the specific contracts in San Francisco County, contractor A can be identified as Health Help, Inc.

This is the second time within 5 years that an organization headed by Peter Gottheiner, and heavily involved in providing medical or social benefits under governmental programs, has sought refuge in bankruptcy action. Some $39,000 in audited overpayments is still due the State of California from California Coordinated Healthcare Services, Inc. for services provided under title XIX. Other amounts are due the medicare—Federal—program from the same organization.

Two: The counties should be required to monitor their respective contracts and contractors. The counties appear to be placing too much reliance on lowest bids without sufficient investigation of the financial stability of the contractors. Continuing contracts such as those in San Francisco County should not be allowed.

Three: The State should perform audits of the counties and contractors within the social services program, to protect Federal and State funds.

SCHEDULE 1.—VISITING HOME SERVICES, INC., AND SUBSIDIARY SCHEDULE OF COSTS BY CONTRACT FOR PERIOD FROM JULY 1, 1975, THROUGH JUNE 30, 1976

	California counties										Other States			
	Fresno	Imperial	Madera	Merced	Nevada	Plumas	San Luis Obispo	San Fransicco	Santa Barbara	Tehamá	Minnesota	Missouri	Utah	Washington D.C.
Direct costs:														
Salaries	$393,225	$185,520	$125,574	$178,738	$3,023	$47,498	$72,491	$436,184	$256,618	$74,382	$100,208	$93,631	$823,266	$5,114
Rent	1,759	2,002	900	700	400	45	2,370	7,364	1,503	1,500	1,607	1,060	11,898	
Telephone	4,469	1,928	3,107	1,097	717	1,289	2,567	6,947	3,066	1,252	1,951	3,538	19,721	50
Auto and travel							1,237	9,660	324	171			2,413	
Supplies	12,231	2,263	1,673	6,677		602	3,540	3,504	8,016	815	1,959	3,355	21,782	1,993
Legal								1,779						
Insurance	25		125	10			134	29,246	358		52		6,732	
Miscellaneous	2,139	2,661	1,454	336	344	277	829	37,796		430	382	275	6,758	
Accounting:														
V. Harvey								6,134						
W. Lander														
Travel and promotion								1,239						
Total direct costs	413,848	194,374	132,833	187,558	4,484	49,711	83,168	539,853	269,885	78,550	106,159	101,859	892,570	7,157
Allocation of home office costs deemed program related (schedule 2)	62,627	29,547	19,999	28,467	481	7,565	11,545	69,469	40,870	11,846	15,960	14,912	131,117	814
Total costs before questionable home office costs	476,475	223,921	152,832	216,025	4,965	57,276	94,713	609,322	310,755	90,396	122,119	116,771	1,023,687	7,971
Allocation of questionable home office costs (schedule 2)	20,860	9,841	6,661	9,482	160	2,520	3,845	23,139	13,613	3,946	5,316	4,967	43,672	271
Total costs	497,335	233,762	159,493	225,507	5,125	59,796	98,558	632,461	324,368	94,342	127,435	121,738	1,067,359	8,242

SCHEDULE 2.—VISITING HOME SERVICES, INC. AND SUBSIDIARY SCHEDULE OF HOME OFFICE COST ALLOCATION FOR THE PERIOD FROM JULY 1, 1975, THROUGH JUNE 30, 1976

Contractor	Allocation basis-salaries (from schedule 1)	Home office costs	
		Program related (from schedule 3)	Questionable (from schedule 4)
Merced	$178,738	$28,467	$9,482
San Luis Obispo	72,491	11,545	3,845
Plumas	47,498	7,565	2,520
Fresno	393,225	62,627	20,860
Nevada	3,023	481	160
Tehama	74,382	11,846	3,946
Madera	125,574	19,999	6,661
Imperial	185,520	29,547	9,841
Santa Barbara	256,618	40,870	13,613
San Francisco	436,184	69,469	23,139
Utah	823,266	131,117	43,672
Minnesota	100,208	15,960	5,316
Missouri	93,631	14,912	4,967
Washington, D.C.	5,114	814	271
Total	2,795,472	445,219	148,293
		To schedule 1	To schedule 1
Allocation factors:			
Total home office costs deemed to be program related (schedule 3) divided by total salaries		.15926434	
Total questionable home office costs (schedule 4) divided by total salaries			.05304757

SCHEDULE 3.—*Visiting Home Services and subsidiary schedule of home office costs for the period July 1, 1975, through June 30, 1976*

	Amount
Salaries (excluding executives)	$88,470
Rent	7,332
Telephone	29,122
Auto expense	9,501
Supplies	19,638
Legal fees	83,557
Insurance	92,910
Miscellaneous	76,927
Accounting:	
V. Harvey	20,192
W. Lander	11,018
Travel and promotion	6,543
Total home office costs (to schedule 2)	445,210

SCHEDULE 4.—*Visiting Home Services and subsidiary schedule of questionable home office costs for the period July 1, 1975, through June 30, 1976*

	Amount
Executive salaries	$111,525
Travel and promotion	36,768
Total questionable home office costs (to schedule 2)	148,293

SCHEDULE 5.—VISITING HOME SERVICES, INC. AND SUBSIDIARY SCHEDULE OF PAYMENTS TO PRINCIPALS FOR THE PERIOD JULY 1, 1975, TO JUNE 30, 1976

	Peter Gottheiner		Ralph Gomez		Vivian Gottheiner, Health Help Inc.	Ron Gottheiner		Eva Gottheiner, Health Help Inc.	Jeanie Gottheiner, Health Help Inc.
	Health Help Inc.	Visiting Home Services	Health Help Inc.	Visiting Home Services		Health Help Inc.	Visiting Home Services		
Salaries	$29,000	$24,000	$3,750	$5,000	----------	$2,500	$25,875	$11,000	$10,400
Consultant [1]	7,200	35,900	18,182	32,250	$1,875	----------	----------	----------	----------
Loan repayments [1]	60,225	20,943	----------	----------	----------	----------	8,300	----------	----------
Travel and promotion	40,230	18,585	----------	----------	----------	----------	----------	----------	----------
Total	136,655	99,428	21,932	37,250	1,875	2,500	34,175	11,000	10,400

[1] These categories of payment are not considered reimbursable nor program related and are therefore not included as costs.

[Attachment A]

STATE OF CALIFORNIA HEALTH AND WELFARE AGENCY,
DEPARTMENT OF HEALTH,
Sacramento, Calif., March 26, 1976.

Nine counties were warned today by the State Department of Health that Visiting Home Services, Inc., of San Francisco may be in financial difficulties so severe that the aged, blind, and disabled persons who depend upon the company for in-home services may be in trouble.

Welfare directors in Tulare, Tehama, Fresno, Santa Barbara, San Francisco, Imperial, San Luis Obispo, Plumas, and Madera counties were advised by telegram that VHS employees in two counties recently have been paid with checks that failed to clear even though some were submitted for payment a second time.

State Health Deputy Director Gary Macomber said attempts to telephone company officials in San Francisco to discuss VHS' financial condition have met with no success. Clerical employees who responded to calls advised Department of Health staff that no officials were available but did offer to relay messages to them.

The program, financed by a combination of State and Federal funds, provides services to those persons who can retain a high degree of personal independence only when some outside assistance is available to them. Domestic services are often the key to keeping such persons from becoming nursing home residents. Routine housekeeping, food preparation, and shopping for necessities are typical of the assistance provided to them. Also important is personal care. Assisting the person to get out of bed, to bathe, to exercise, and perform other routine items connected with daily living are typical of their needs.

More seriously disabled persons can also receive health-related service. A person recovering from an operation and living at home or a permanently disabled person are typical of individuals who receive such care.

The program is an outgrowth of California's attendant care program which began in 1968 and was transformed into the in-home supportive services program in January 1974 by State and Federal legislation. It is administered by each county with 24 counties choosing to contract with outside agencies to provide direct services to clients.

At present, there are almost 70,000 California residents enrolled in the program and the current State budget allocates approximately $100 million to it.

This year's financial allocations to the nine counties and the average number of individuals receiving service on a monthly basis are as follows:

County	Financial allocations	Number of individuals
Tulare	$1,244,568	1,273
Tehama	123,088	126
Fresno	1,012,400	700
Santa Barbara	535,000	594
San Francisco	561,024	314
Imperial	282,372	179
San Luis Obispo	332,849	351
Plumas	120,000	45
Madera	54,539	246
Totals	4,265,840	3,828

The text of Macomber's telegram is: "Information which has come to my attention which indicates that Visiting Home Services, Inc., has failed to meet some payroll obligations. Because this threatens an interruption of Homemaker/Chore services to aged and disabled recipients in your county, you should immediately verify the situation with regard to this firm's performance and compliance with the terms of your contract.

"If nonperformance is discovered you should immediately seek advice from county counsel to determine the county's position in enforcing performance or terminating the contract.

"You also should take those steps necessary to insure that service to recipients is not interrupted. The Department of Health will assist you, if necessary, to assure continu service to your recipients.

"Please keep th. Department advised of developments on a current basis."

[Appendix B]

AUGUST 6, 1976.

Re National Home Care, Inc., financial statements.
Hon. BOARD OF SUPERVISORS,
County of San Diego,
County Administration Center,
San Diego, Calif.

DEAR MR. CHAIRMAN AND MEMBERS OF THE HONORABLE BOARD, Subsequent to the financial statements of the above-captioned corporation dated June 20, 1976, please be advised that I have been assured by the general counsel of the corporation, who is also a director and secretary of National Home Care, Inc., that the company will receive increased capitalization by indivduals who have pledged their continuous and additional investments as needed for new contracts such as the one in the county of San Diego.

I hope that this information will satisfy you and remove any possible doubts in the stability, solvency, and fiscal responsibility of National Home Care, Inc.

Thank you very much for your anticipated consideration.

Very truly yours,

VICTOR L. HARVEY, C.P.A.

[Attachment C]

MAY 7, 1976.

To Whom It May Concern:

The attached financial statements for Visiting Home Services, Inc., and subsidiary were prepared by the company and, accordingly, I do not express any opinion thereon.

It should be noted that, due to several recent contract awards to the company, one shareholder has agreed to invest an additional sum of $250,000 in the shares of the company, as per prior agreement. Such additional sum has been reflected on the January 31, 1976, statement of financial condition.

Further capitalization in addition to that noted above has been assured, based on new contract awards, and will be reflected in future financial statements of the company.

Very truly yours,

VICTOR L. HARVEY.
Certified Public Accountant.

[Attachment D]

PROMISSORY NOTE

I, Ralph P. Gomez, promise to pay to the order of Visiting Home Services, Inc., upon demand, the sum of $250,000 as additional paid-in capital.

Dated: January 15, 1976.

RALPH P. GOMEZ.

STATE OF CALIFORNIA,
County of San Francisco, ss:

Subscribed to and sworn before me this 21st day of June 1976 by Ralph P. Gomez, who is known to me to be the person whose signature appears here.

ROBERT G. TEMBY,
Notary Public.

[Attachment E]

STATE OF CALIFORNIA, HEALTH AND WELFARE AGENCY,
DEPARTMENT OF HEALTH,
Sacramento, Calif., January 19, 1977.

SERVICES MEMORANDUM NO. 4–77

To: All County Welfare Directors—Division 10, MPP, regulations concerning purchases of social services and monitoring requirements.

Attached is a copy of the regulations governing purchases of social services and requirements for county monitoring plans which were filed on December 30, 1976.

Please note that all purchasese over $2,500—except in special circumstances—are subject to the competitive bidding requirements.

The cost principles established in 45 CFR Part 74, Subpart Q were previously published in brochure format by HEW and by the Federal General Services Administration—GSA. The GSA publications were simply a renumbering of brochures originally published by the Federal Office of Management and Budgets—OMB. The following table shows the corresponding designations by each Federal agency.

Code of Federal Regulations designation: 45 CFR 74 Subpart Q	Department of Health, Education, and Welfare designation: OASC No.	General Services Administration designation: FMC No.	Office of Management and Budget designation: circular No.
Appendix C	8	74-4	A-87
Appendix D	1	73-8	A-21
Appendix E	3	None	None
Appendix F	5	None	None

The cost principles for commercial organizations can be found only in the Code of Federal Regulations.

These regulations are effective immediately. Please disseminate them to all staff who are responsible for initiating purchase of service arrangements.

Sincerely,

GARY D. MACOMBER,
Deputy Director for Social Services.

(This letter is effective until January 15, 1978, unless sooner rescinded or superseded.)

Enclosure.

[Endorsed, filed, in the Office of the Secretary of State of the State of California, January 3, 1977, at 4:10 p.m., March Fong Eu, Secretary of State]

FACE SHEET FOR FILING ADMINISTRATIVE REGULATIONS WITH THE SECRETARY OF STATE

ORDER ADOPTING, AMENDING, OR REPEALING REGULATIONS OF THE STATE DEPARTMENT OF HEALTH

Pursuant to the authority vested by section 10554 of the Welfare and Institutions Code and to implement, interpret, or make specific section 10554 of the Welfare and Institutions Code, the State Department of Health repeals, adopts, and amends regulations referred to in title 22, California Administrative Code, as follows:

(1) Section 10-202 is added to read:

10-206 Purchase of Service From a Public or Private Agency

.1 Any service program or service-funded resource defined in division 30 or authorized in CASP may be purchased by the CWD from a public or private agency other than the department directly responsible for the delivery of social services.

.2 Any purchase of service agreement entered into between the CWD and a contract provider which exceeds $2,500 annual shall be subject to the requirements for competitive bidding, except in special circumstances with prior approval by SSD such as an inadequate number of responsive bidders or contracts using state rates for payment.

.21 Public notice shall be given to announce the intention to enter into a contract for the purchase of services.

.22 An Invitation For Bid (IFB) shall be prepared according to SSD guidelines and distributed to the potential bidders. The IFB shall be submitted to SSD for review and approval prior to distribution to potential bidders. The IFB shall include, but not be limited to, the following:

.221 A complete description of the services to be purchased, including citation of applicable regulations and instructional material.

.222 Complete description of the methods to be used in providing the services, including any restrictions on staffing, supervision, salaries and benefits, training, agency certification and prior experience, and employee qualifications.

.223 Contract specifications and standards.

.224 Statement that successful bidders shall comply with the principles established in 45 CFR Part 74, Subpart Q—Cost Principles. Nonprofit agencies or governmental agencies shall use Appendices C–F of the subpart as appropriate. Proprietary organizations shall apply the cost principles established in 41 CFR Subpart 1–15.2.

.225 Statement of bidder and contractor obligations.

.226 The timetable for the accepting and public opening of bids, and the awarding of the contract.

.227 Statement of the closing date and time and of the place for the acceptance of bids.

.3 Contracts shall be submitted to Department of Health for review and approval. Submission may be either before or after implementation, at county option. Contracts submitted after implementation may be subject to change as a condition of Department of Health approval.

.4 The county shall evaluate bidders for contracts in accordance with the following provisions.

.41 The prospective contractor shall possess required business license or licenses such as: General business license as a corporation to do business in California; local business license; joint venture license if two or more contractors are bidding in joint venture.

.42 The prospective contractor shall submit a Statement of Experience. This will, as a minimum, include the following information:

.421 Business name of the prospective contractor and the legal entity in which a bid will be submitted such as:

.4211 Corporation.

.4212 Co-partnership.

.4213 Individual.

.4214 Combination.

.422 License to do business in California.
.423 Number of years the prospective contractor has been in business under the present business name.
.424 Number of years of experience the prospective contractor has had in providing required, equivalent or related services.
.425 Contracts completed during last 5 years showing:
.4251 Year.
.4252 Type of services.
.4253 Dollar amount of services provided.
.4254 Location.
.4255 Contracting agency.
.426 Any failure or refusals to complete a contract, including details.
.427 Controlling interest in any other firms providing equivalent or similar services.
.428 Financial interests in other lines of business.
.429 Names of persons with whom the prospective contractor has been associated in business as partners or business associates in each of the last 5 years.
.4210 Pending litigation, involving prospective contractor or any principal officers thereof, in connection with contracts for similar services.
.4211 Service experience, equivalent, or similar experience of principal individuals of the prospective contractor's present organization giving:
.42111 Names of principal individuals of present organization.
.42112 Present position or office in present organization.
.42113 Years of service experience, including capacity, magnitude, and type of work.
.4212 Equipment owned by present organization, including the following for each item:
.42121 Name.
.42122 Description.
.42123 Quantity.
.42124 Capacity of item.
.42125 Purchase price.
.42126 Depreciation charged off.
.42127 Current book value.

.43 The prospective contractor shall:
.431 Have a minimum of 1 year's experience in providing required, equivalent, or similar services.
.432 Have demonstrated capacity to perform required services on the contracts for which he bids.
.433 Have an organization that is adequately staffed and trained to perform required services or demonstrate capability for recruiting such staff.
.434 Agree to comply with the requirements of Civil Rights Act of 1964 as an equal rights opportunity employer.
.435 Agree to provide county with any other information necessary for an accurate determination of the prospective contractor's qualifications to perform services.
.436 Submit a complete financial statement, based on an audit, not more than 12 months old at time of submission and certified by an independent certified public accountant. This financial statement shall be used in Department of Health to determine the prospective contractor's financial condition including the working capital position that would permit him to perform a contract of the size indicated by the Invitation for Bids. The financial statement shall be prepared in conformity with generally accepted accounting principles and Department of Health guidelines.
.437 Agree to right of Department of Health to conduct an audit of the prospective contractor's financial records for the purpose of determining the contractor's financial condition.

.44 The Department of Health shall, after examination of the material provided by the prospective contractor and by an audit where necessary, make available to the CWD such material and information provided by the audit. This material, information, and any investigative findings made by DOH or the CWD shall be used by the counties in determining the award of contract.

(2) Section 10-215 is added to read:

10-215 Purchase of Service From Private Agencies

.1 Counties shall monitor performance of private contract agencies from which social services are purchased. Monitoring shall be as extensive, thorough and frequent as reasonably necessary to assure early awareness of lack of compliance with contract terms. Each county shall prepare, as part of its CASP, a plan describing the monitoring activities to be undertaken, including a description of methods to be used and of staff to be assigned.

.2 The Department of Health shall approve, reject, or modify the proposed contract monitoring plan. Following approval or modification, the county shall carry out the plan. At the midpoint and the termination of the contract, the county shall transmit to the DOH a contract monitoring report detailing findings for the preceding 6 calendar months. The county shall retain copies available for public inspection with all client identification deleted.

.3 A plan shall not be approved which provides for monitoring by the contractor provider or his agents.

FINDING OF EMERGENCY

The State Department of Health finds that an emergency exists and that the foregoing regulations are necessary for the immediate preservation of the public peace, health and safety, or general welfare. A statement of the facts constituting such emergency is:

STATEMENT OF FACTS

1. Regulations setting standards for the purchase of services to increase control over integrity of provider agency, quality of service, and costs must be issued without delay to prevent or minimize disruption or discontinuance of services necessary to protect the health and welfare of recipients.

2. Recent bankruptcy of a social service provider agency left many homemaker/chore employees in 7 counties without remuneration, thus threatening disruption or termination in those counties of services without which recipients would be unable to maintain themselves adequately outside of costly institutions, including nursing homes, long-term care facilities, and hospitals.

3. Numerous and disruptive changes in Federal laws and regulations during the past 3 years have delayed the promulgation of corrective State regulations prior to this date.

4. New bids and new contracts are being prepared currently in some counties. These regulations are needed immediately for adequate supervisory control by the State.

The said regulations are therefore adopted as emergency regulations to take effect immediately upon filing with the Secretary of State as provided in section 11422(c) of the Government Code.

The State Department of Health has determined that pursuant to section 2231 of the Revenue and Taxation Code, no increased costs or new costs to local governments will result from the regulation changes in this order.

Dated: December 30, 1976.

STATE DEPARTMENT OF HEALTH,
JEROME A. LACKNER, M.D.,
Director of Health.

ITEM 2. AUDIT REPORT OF UNICARE, INC., CAMPBELL, CALIF., JULY 1, 1975, TO SEPTEMBER 30, 1976

STATE OF CALIFORNIA, HEALTH AND WELFARE AGENCY,
DEPARTMENT OF BENEFIT PAYMENTS,
Sacramento, Calif., March 3, 1977.

MRS. FLORA SOUZA,
President, Unicare, Inc.,
Campbell, Calif.

DEAR MRS. SOUZA: Homemaker and chore program fifteen-month period ended September 20, 1976.

Enclosed is the program report of our examination of the home office costs of Unicare, Inc. Our examination covered the 15-month period from July 1, 1975, through September 30, 1976.

If you have any questions regarding the report, please contact Lester Campbell at 916-322-2823.

Sincerely,

JACK R. REAGAN,
Chief, Health Audits Bureau.
STUART M. MANLEY,
Manager, Field Region I,
Sacramento Health Audits Bureau.

[Enclosure.]

INTRODUCTION

BACKGROUND

Prior to January 1, 1974, titles I, X, and XIV, of the Social Security Act, as amended, established grant programs providing Federal financial assistance for the costs incurred by the States for providing social services on behalf of the aged, blind, and disabled persons. Effective January 1, 1974, title VI established a consolidated grant program for social services previously provided pursuant to the three titles cited above. On October 1, 1975, title XX replaced title VI.

Pursuant to title XX, the California State Plan (plan) for social services was developed. The plan authorizes local welfare departments to purchase social services from nonprofit and proprietary organizations. In accordance with the plan, the following counties in the State of California had contracts with Unicare, Inc., for providing services within the period from July 1, 1975, through September 30, 1976.

Humboldt County
Madera County
San Luis Obispo County
San Mateo County
Santa Clara County
Tulare County
Ventura County

In addition to the contracts with the above seven California counties, Unicare, Inc., was providing homemaker and chore services and home health agency services to private clients in the following California counties and communities during the period from July 1, 1975, through September 30, 1976.

Downey (community)
Humboldt County
Sacramento County
San Diego County
San Francisco County
San Jose (community)
San Luis Obispo County
San Mateo County
Santa Clara County
Santa Cruz (community)
Ventura County

Approximately one-third of Unicare's revenues during the audit period was derived from private business.

HIGHLIGHTS OF THE REVIEW

The following are some of the more significant items discovered during our examination of Unicare, Inc., and are amplified in our report at the pages indicated.

Unicare's surety and fidelity bond coverage is below contractual requirements (see page 1214).

Unicare has not provided nor is able to provide management reports required in certain county contracts (see page 1214).

An adequate system of controls for live-in homemakers is lacking (see page 1215).

Internal controls for cash handling and accounts receivable are weak (see page 1215).

The strength of Unicare's financial position has deteriorated from March 31, 1976, to September 30, 1976, due to the rapid expansion from 3 to 7 contracts (see page 1220).

Prompt processing and payment of service billings by counties will be critical in maintaining financial stability (see page 1221).

ORGANIZATION STRUCTURE

CORPORATE ORGANIZATION

Unicare, Inc. (Unicare), is a closely held Subchapter S Corporation organized under the laws of the State of California. During the period from July 1, 1975 through September 30, 1976, Unicare had issued an outstanding 1,000 shares of common stock with a stated value of $1,000. Originally, 800 shares were issued to Flora Souza, 100 shares to Sharon Jack (daughter of Flora Souza), and 100 shares to Greg Jack (son of Sharon Jack). In January, 1976, Flora Souza transferred 40 shares each to Sharon and Greg Jack. As of March 31, 1976 and September 30, 1976, the issued and outstanding shares were owned as follows:

Stockholder:	*Number of shares*
Flora Souza	720
Sharon Jack	140
Greg Jack	140

OTHER RELATED ENTITIES

The following six (6) corporations, 100 percent owned by Flora Souza, are related to Unicare by common ownership and control: Homekare, Inc., a Home Health Agency, providing services to Medicare and Medi-Cal beneficiaries; Ambikare, Inc., an outpatient rehabilitation clinic; Allied Paramedical, Inc., a training school for home health aides; Physical Therapy, Inc., an in-home physical therapy service; Flora's Inc., dba the Showcase, a beauty salon and dress shop; and Home Health Services Association, an inactive association of for-profit home health agencies.

Flora Souza also owns one seventh interest in a building partnership, Good Samaritan Drive Associates, with equal interests owned by Sharon Jack, Dr. Louis Lackner, Dr. Ed Lackner, Dr. Ed Cohn, Dr. Leslie Weeks, and Mr Yosh Yoshita. The building, nearing completion at the time of this examination, will be leased to Unicare, the five other active related corporations, and others in January, 1977.

MANAGEMENT AND RELATED INDIVIDUALS

Unicare is licensed by the State of California to provide home health agency services to private patients. Homemaker and chore services are also provided to public assistance recipients under contract with various California counties and to private patients.

Flora Souza is president of the organization and has been since its inception. Flora Souza received payments from Unicare for salary, travel, and promotional expenses, deferred compensation, rent, and dividends.

Flora Souza's daughter, Sharon Jack, secretary of the corporation, received payments from Unicare for salary, travel, and promotional expenses, and a leased company car, while serving as administrator of the private business component of Unicare.

Flora Souza's daughter, Sharon Jack, secretary of the corporation, received payments from Unicare for salary, travel, and promotional expenses, and a leased company car, while serving as administrator of the private business component of Unicare.

Flora Souza's son-in-law, Robert Jack, received payments from Unicare for travel and promotional expenses applicable to program development and contract implementation while being neither an officer nor an employee of Unicare. He is however an employee of Homekare, Inc., one of the related organizations.

Flora Souza's sister, Vivian Ascunsion, received payments from Unicare for travel and promotional expenses, a leased company car, and deferred compensation. Her responsibilities were limited to the private business component of Unicare.

The amounts paid to Flora Souza and Robert Jack, together with other key employees (Jack Stewart, treasurer of Unicare, and Mike Powell, controller of Unicare) during the period July 1, 1975, through September 30, 1976, are included in schedule 5 and are discussed under payments to key officers, principals, and relatives of Flora Souza in this report.

SCOPE OF REVIEW

Unicare's fiscal year end is March 31. Because of the contractor's fiscal year end and his practice of producing quarterly adjusted financial statements, March 31, 1976, and September 30, 1976, were selected as the periods ending for our review. The scope of the audit was to perform the following general procedures:

1. Audit for contract compliance for the fiscal period from July 1, 1975, through September 30, 1976.
2. Conduct a management review through verification of the system of internal control during the period from July 1, 1975, through September 30, 1976.
3. Verify revenues and claims statistics for the period of services from April 1, 1975, through September 30, 1976.
4. Audit for contract costs for the fiscal period from April 1, 1975, through September 30, 1976.
5. Determine the financial position as of March 31, 1976, and as of September 30, 1976.

CONTRACT COMPLIANCE

All of the contracts were reviewed through tests of the books and records, auditors' observations and inquiry. Our review was limited to the information available at the home office.

The review disclosed that the provider is not in compliance with certain contract requirements.

1. SURETY AND FIDELITY BOND COVERAGE

Certain agreements require Unicare to maintain surety and fidelity bond coverages in specified minimum amounts. (*a*) The contract with Ventura County from July 1, 1976, to June 30, 1977, requires a surety bond of $176,437 which is 25 percent of the total contract; (*b*) the contract with San Mateo County from April 1, 1976, to May 31, 1977, requires a fidelity bond of $100,000.

At no time between July 1, 1976, and September 30, 1976, was surety bond coverage carried. From April 1, 1976, to May 1, 1976, fidelity bond coverage was limited to $25,000. From May 1, 1976 to September 30, 1976, fidelity bond coverage was in effect for $63,000.

2. HIRING PUBLIC ASSISTANCE RECIPIENTS

The State Department of Social Welfare Manual, section 30-550.64 requires that preference in hiring of homemakers be given to current, former, or potential recipients of public assistance. A test sample of Santa Clara County contract homemakers' personnel files was reviewed, 45 percent of the files tested did not indicate that the homemakers were selected from the public assistance category. By inquiry, we established that public assistance recipients represent only one of many recruiting resources being utilized by Unicare.

We were not able to determine if Unicare had made a concerted effort to recruit workers from the public assistance rolls during the period under examination. The employee who had knowledge regarding recruitment of workers during the period terminated prior to our arrival at Unicare.

3. REPORTING REQUIREMENTS

Certain agreements require Unicare to submit specific reports to the county and/or to maintain others in-house.

(*a*) The Santa Clara County contract requirements for maintaining in-house monthly cost reports and for the submission of quarterly cost reports were not being met.

(*b*) The requirement in the San Luis Obispo County contract for submission of budgetary, fiscal, and program reports, current lists of personnel including post training and experience, and a list showing current personnel and their assignments to individual recipients was not fulfilled.

(*c*) The provision in the Madera County agreement requiring information providing the number, professional titles and job description of staff, together with the percentage of each person's time spent on serving the terms of the agreement was not met.

4. MONITORING BY COUNTY

The State Department of Social Welfare Manual, section 10-034.72 and the State Comprehensive Annual Services Program Plan require the counties to monitor their contracts. The contracts with San Luis Obispo, Santa Clara, Humboldt, and Ventura Counties make specific provision for county monitoring. The agreements with the remaining counties make no provision for monitoring.

We established that there is no county monitoring aside from the verification of claims statistics. The counties are not insisting on compliance as exemplified by the violations in insurance coverage, homemaker hiring practices, and reporting requirements cited above.

5. LIVE-IN HOMEMAKERS

Unicare's controls over live-in homemakers in counties for which Unicare is acting as fiscal intermediary revealed the following.

(*a*) Live-ins are not supervised, thus they may be providing paramedical services which they are neither authorized nor trained to deliver.

(*b*) Unicare is acting as the fiscal intermediary for live-in services for the counties of San Luis Obispo, Madera, Humboldt, Tulare, and Ventura. Based on inquiry of Unicare's executive personnel, these counties are not exercising controls over the live-in services.

(*c*) The live-ins being paid by Unicare are not afforded malpractice coverage under Unicare's current policies.

(*d*) The counties are responsible for control of live-in services. Based on our inquiry at Santa Clara County, the County does not contract for live-in services with Unicare. We did not inquire at the offices of the other counties. Therefore, we cannot report on operations regarding live-in services at the county level.

6. MANAGEMENT REVIEW

We reviewed the system of internal controls and noted the following deficiencies:

1. All cash receipts are received, summarized, and deposited by a single individual.

This condition creates the opportunity to misappropriate funds.

To eliminate this possibility, the duties involving cash receipts should be segregated. One person should be responsible for listing and summarizing the receipts. The bank deposits should be made by a second person. Bank reconciliations should be made by a third person.

2. The accounts receivable records are readily accessible to all individuals in the Home Office at any time and are not protected against a loss by fire.

This presents the opportunity for collusion, misappropriation and loss by fire.

To prevent this, accounts receivable records should be kept in a fireproof, secure and restricted place. When needed for posting or information, these records should be available only to properly authorized personnel.

3. Vouchers and invoices are not consistently voided at the time of payment. Because of this, duplicate payment is possible.

To prevent a possible duplication of payment, all vouchers and invoices should be voided at the time the checks are signed.

4. Unicare does not prepare an accounts payable ledger. The general ledger is maintained on the cash basis. When financial statements are produced, unrecorded liabilities generally exist.

The accounting system for an organization with a volume of transactions similar to Unicare is usually maintained on the accrual basis. An accrual system of accounting is recommended to avoid omission of unrecorded liabilities when financial statements are prepared.

5. Monthly financial statements for internal purposes are not prepared.

Sound business practice requires interim financial statements to assess the efficiency of operations.

Furthermore, some of the contracts require interim financial reports and Unicare is unable to properly prepare the necessary reports on a timely basis. We recommend that Unicare prepare monthly financial statements for adequate monitoring of the contract requirements by both the county and Unicare.

Revenue Verification

Revenues from the private sector were accumulated by summarizing all charges to clients. A test sample of these charges was traced to the individual client ledgers and reconciled to payments received from or on behalf of the client.

All billings to the counties contracting with Unicare were summarized by dollar and hourly statistics. These summaries were verified on a test basis to the detail of the billings. We verified the billings by comparing the billings to the computerized payroll data and, on a test basis, to the client files.

Revenues from the county contracts were scheduled from copies of the warrants applicable to the services provided during the period. All payments were traced to the related billings. No verification was made with the individual counties as copies of the warrants were considered sufficient proof of payment.

Cost Verification

GENERAL COMMENTS

The general ledger is maintained on a cash basis. The books of original entry consist of a cash disbursements journal, a computerized payroll run, and a cash receipts journal. At fiscal year end, or intermittently as needed, the general ledger is adjusted to the accrual basis for financial statement purposes.

Our review included the following procedures for the period from April 1, 1975 through September 30, 1976.

1. On a test basis, the postings to the general ledger were traced back to the cash disbursements journal and to supporting invoices.
2. The general ledger cost centers were analyzed for reasonableness, propriety and adequate documentation.
3. Unicare's computerized payroll data was prepared by Automatic Data Processing. Test summaries were made of the payroll data. These summaries were anaylzed for propriety and traced to the general ledger.
4. At the end of the accounting period, adjusting entries are made to convert the general ledger from the cash basis to the accrual basis. These adjusting entries were tested for propriety and reasonableness.

ALLOCATION OF SHARED COSTS

The costs of Unicare appear to include part of such items as executives' salaries and travel expenses. The total cost of these items appear to have been allocated between Unicare and one or more of the related organizations. The cost of each of these individual items cannot be fully determined without an examination of the books and records of the other related organizations.

We requested access to the books and records of the other organizations but the requests were denied. The books and records of the other organizations do not appear to be crucial for the current examination of the homemaker chore contracts with Unicare since:

1. These costs have been included in other home office costs (schedule 5).
2. No cost recoveries are anticipated.
3. The effect on homemaker chore contract costs will probably be minimal for this period of review.

CONTRACT PERIODS UNDER REVIEW

Our review of the home office costs included the 15-month period from July 1, 1975, through September 30, 1976. The home office costs for the 15-month period were allocated to the following county contracts and for the indicated number of months applicable to the specific contract:

County	Contract period ended	Contract span (months)	Number of months subject to allocation
Santa Clara	July 31, 1976	13	13
Santa Clara	July 31, 1977	12	2
San Luis Obispo	June 30, 1976	8	8
San Mateo	Mar. 31, 1977	12	6
Ventura	June 30, 1977	12	3
Humboldt	do	12	3
Tulare	do	10	1
Madera	Dec. 31, 1976	4	1

COST FINDINGS

The following financial review findings for the period from July 1, 1975, through September 30, 1976, are described in the order corresponding to the accompanying schedules.

COMPARATIVE ANALYSIS OF HOURLY COST AND REIMBURSEMENT RATE (SCHEDULE 1)

The audited hours of services used in this schedule were examined as described in this report under "Revenue Verification."

The costs included in other home office costs are described in this report under "Other Home Office Costs."

SAN LUIS OBISPO COUNTY CONTRACT

For the San Luis Obispo County contract, period ended June 30, 1976, the total cost before other home office costs was $114,701 and the total cost after other home office costs was $123,286. These amounts were divided by audited hours billed under the contract to obtain the cost per hour of $3.57 and $3.83 respectively.

Unicare's accounting system does not provide for a segregation of costs for homemaker services and chore services. Therefore, a weighted average, or composite, reimbursement rate is used in this schedule for the comparison with the hourly cost for this contract.

The contract specifies reimbursement rates of $3.86 per hour for homemaker services and $3.78 per hour for chore services. Unicare billed 8,624.75 homemaker hours and 23,543.25 chore hours from November 1, 1975, through June 30, 1976. Based on the hours billed, the weighted average of the two reimbursement rates is $3.80 per hour.

The results of the computations applicable to this contract are as follows:

The hourly cost of $3.57 excluding other home office costs results in a $0.23 per hour profit when compared to the composite reimbursement rate of $3.80 per hour. The hourly cost of $3.83 per hour which includes other home office costs results in a $0.03 per hour loss when compared to the composite reimbursement rate.

SANTA CLARA COUNTY CONTRACT

The Santa Clara County contract costs, for the period ended July 31, 1976, were $285,730 before including the other home office costs and $310,157 after the other home office costs. These amounts were divided by the audited hours billed under the contract to obtain the cost per hour of $4.22 and $4.58 respectively.

The contract reimbursement rate of $5.68 per hour is a flat rate applicable to both homemaker and chore services.

The results of the computations applicable to this contract are as follows:

The hourly cost of $4.22 excluding other home office costs results in a profit of $1.46 per hour when compared to the reimbursement rate of $5.68 per hour. When other home office costs are added, the hourly cost was increased to $4.58. When compared to the reimbursement rate of $5.68 per hour, Unicare's net profit is $1.10 per hour.

Similar computations are included in schedule 1 for six current and incomplete contracts with the countries of Santa Clara, Madera, San Mateo, Humboldt, Tulare, and Ventura. The data as it relates to these six contracts does not reflect amortization of certain items of fixed costs over the entire life of the agreements. Therefore, no conclusions should be drawn with respect to costs, profit, or losses on these contracts since they are not completed.

COSTS BY CONTRACT (SCHEDULE 2)

The direct contract costs for the counties of San Luis Obispo, Madera, Humboldt, Tulare, and Ventura include amounts attributable to live-in workers. Unicare acts as a fiscal intermediary for these counties for paying the live-in workers. These counties reimburse Unicare for the specified amounts paid to the workers plus a specified percentage for Unicare's fiscal intermediary costs. Therefore, since these amounts are not true costs to Unicare and they have no relationship to the contract reimbursement rates, these costs have been eliminated from the total direct cost applicable to the respective counties.

The adjusted direct costs included in this schedule consist of costs directly applicable to the contract. These costs were found to be program related, necessary and reasonable for providing the contracted services.

This schedule also provides for two line items of home office costs allocated to the contracts. The first line item includes home office costs which we found to be program related and necessary. These costs are discussed in detail under "Home Office Costs Deemed to be Program Related and Necessary" in schedule 4. The second line item includes costs which we were not able to determine as being necessary, reasonable and program related. These costs are discussed in detail under "Other Home Office Costs" and are included in schedule 5.

Unicare used separate cost centers in the general ledger to record the direct costs for the contracts with Santa Clara County, period ended July 31, 1977, Madera County and Tulare County. The direct costs for the contracts with the other counties were comingled with the costs applicable to the private recipients and the home office.

For the Santa Clara County contract, period ended July 31, 1976, and the San Luis Obispo County contract, we determined the direct homemaker salaries by applying the hourly wage rate per the bid proposals to the total hours of service billed under the contract.

The other costs, which could not be specifically identified as direct costs, were considered to be home office costs.

Unicare's accounting system did not provide for a segregation of direct costs between the private recipients and the contract recipients. These direct costs were allocated to the contract recipients based on revenues from the private recipients and the contracts.

We have excluded, from the cost finding process, portions of the direct contract costs applicable to nurses, directors of nurses and program directors. In our opinion, the regulations do not require this level of skill for the delivery of homemaker and chore services. However, this level of personnel is required for the home health agency part of Unicare which is for private recipients only.

In accordance with the terms of the contract, Santa Clara County charged Unicare $12,209 for county administrative costs during the contract period ended July 31, 1976. The $12,209 has been included as direct costs to this Santa Clara County contract.

This situation could result in duplicate reimbursements through allocation of the administrative costs to other programs funded by the State and/or the Federal Government.

HOME OFFICE COST ALLOCATION (SCHEDULE 3)

This schedule shows the allocation of the "Home Office Costs Deemed to be Program Related and Necessary" (schedule 4), and the allocation of the "Other Home Office Costs" (schedule 5).

Revenues are used as a basis for allocating home office costs to both private and contract services.

HOME OFFICE COSTS DEEMED TO BE PROGRAM RELATED AND NECESSARY

(SCHEDULE 4)

These home office costs include items such as nonexecutive salaries, rent, advertising and promotion, supplies, communications, insurance, legal and accounting expenses. This schedule does not include any of the costs shown in the Schedule of Other Home Office Costs—schedule 5.

Estimated costs associated with the preparation and delivery of contract bid proposals have been excluded from this schedule. These costs are not related to the services to be delivered under the terms of the contract.

OTHER HOME OFFICE COSTS (SCHEDULE 5)

The costs included in this schedule are payments made to key officers, principals and relatives which we could not verify as necessary, reasonable, and/or program related.

Comments regarding the salaries, consultant fees, travel and promotional expenses, deferred compensation and rent are included in the section for Distributions to Key Officers, Principals, and Relatives of Flora Souza—schedule 6.

DISTRIBUTIONS TO KEY OFFICERS, PRINCIPALS, AND RELATIVES OF FLORA SOUZA
(SCHEDULE 6)

This schedule shows, by cost classification, the total amounts paid to these individuals during the 18 months from April 1, 1975 through September 30, 1976. The amounts applicable to the 15 month period from July 1, 1975 through September 30, 1976 are included on schedule 5.

From April 1, 1975 through September 30, 1976, Unicare paid to Flora Souza total salaries of $64,700, travel and promotion expenses of $3,544, deferred compensation of $7,650, and rental income of $3,400. Since we were denied access to the books and records of the other entities, we were not able to determine the reasonableness of these costs charged to Unicare. Therefore, the portion of these costs allocated to the period from July 1, 1975 through September 30, 1976 are being included in the Schedule of Other Home Office Costs—schedule 5.

Robert Jack, an employee of Homekare, Inc. was paid $853 for travel expenses. These expenses are included in the schedule of Other Home Office Costs.

We were unable to determine the amounts Mr. Mike Powell and Mr. Jack Stewart were being paid by the other related entities for whom they were also providing services. Therefore, we were unable to determine the reasonableness of certain amounts paid to Mr. Powell, corporate controller, and Mr. Stewart, corporate treasurer, from April 1, 1975 to September 30, 1976. Mr. Powell received $22,223 in salaries and $2,064 in auto lease costs. Mr. Stewart received $900 in salaries, $530 in consultant fees and $1,145 in travel expenses. The portion of these costs allocated to the period from July 1, 1975 through September 30, 1976 are included in the Schedule of Other Home Office Costs—schedule 5.

The following distributions to relatives of Flora Souza are not included in the Schedule of Distributions to Key Officers, Principals and Relatives of Flora Souza—schedule 6.

In addition, from April 1, 1975 to September 30, 1976, Sharon Jack was paid salaries of $32,800, travel and promotion expenses of $2,265, and was provided with a leased car at a cost of $4,778. At the exit interview we were informed that all of Ms. Jack's costs were being charged directly to the private business sector of Unicare. Accordingly, they are not included in any hourly cost computation for county contracts.

Moreover, Vivian Ascunsion, sister to Flora Souza, received compensation of $694 in travel expenses, $5,052 benefit for a leased car, and $5,199 in the form of deferred compensation. At the exit interview we were informed that all of Ms. Ascunsion's costs were being charged directly to the private business sector of Unicare. Accordingly, they are not included in any hourly cost computation for county contracts.

FINANCIAL STABILITY

We examined the unaudited financial statements of Unicare as of March 31, 1976 prepared by Temkin, Ziskin, Kahn, & Matzner, Certified Public Accountants, and the adjusted trial balance as of September 30, 1976 prepared by Unicare.

Our examination of the above financial statements was directed toward a determination of Unicare's financial stability. The data used in the analysis was obtained from the financial statements and represents the results of changes during the 6-month period.

When analyzing the financial stability of a specific entity and comparative data is to be used, it should be for a period of 5 years or more in order to provide a valid financial trend analysis.

The data used for the analysis of Unicare's financial position was based on a 6-month period. The analytical data, shown in schedule 7 and described below, is not sufficient to make a conclusive statement regarding Unicare's financial stability. Caution should therefore be exercised in using the following information for a comprehensive evaluation of the financial stability of Unicare.

Certain technical terms are used in explaining the analysis of Unicare's financial stability. The technical terms, and their respective meanings, are as follows:

The term "current assets" is used to designate cash and other assets or resources commonly identified as those which are reasonably expected to be realized in cash or sold or consumed during the normal operating cycle of the business.

The term "normal operating cycle" is used to designate the time period from the date service is performed to the date payment is received.

The term "current liabilities" is used principally to designate obligations whose liquidation is reasonably expected to require the use of existing resources properly classified as current assets, or the creation of other current liabilities.

For the analysis of the financial positions of Unicare, the following analytical tools were used.

A comparative analysis of the balance sheet accounts and their respective changes will provide clues to problems that require further analysis by the use of ratios and by the study of comparative rates of change of accounts on the financial statements.

The ratio of debt to net worth shows the dollars the creditors have extended in relation to the dollars the owners have invested. This ratio is chiefly a measure of creditors' protection in the event of liquidation. If the ratio is 1 to 1, the assets could decline 50 percent in value before threatening the actual solvency of the business. With a ratio of 2 to 1, creditors are financing two-thirds of the assets, and thus, assets could lose only one-third of their value before bringing on insolvency.

The current ratio is a rough measure of a companys' ability to meet its current debt. An unusually low current ratio indicates that a company may face some difficulty in meeting its bills; whereas an unusually high current ratio suggests that funds are not being used economically within the firm.

The acid test ratio serves as a check on the adequacy of the current ratio and is a measure of the extent to which cash and near cash cover the current liabilities. The near cash consists of accounts receivables and marketable securities.

The receivables turnover is used to measure the liquidity of the receivables. If the annual rate of turnover is six times, this means that, on the average, receivables are collected in 2 months, whereas if the turnover is four times, receivables are collected in 3 months.

COMPARATIVE BALANCE SHEET ANALYSIS—SCHEDULE 7

This schedule shows comparative financial statement data as of March 31, 1976, and September 30, 1976, which was used in our analysis of the financial stability of Unicare. From this data, we computed the change in Unicare's financial position, certain ratios, and the accounts receivable turnover.

The comparative analysis shown on schedule 7 does not include the noncurrent assets which increased by $7,022 during the 6-month period ending September 30, 1976. The increase in the noncurrent assets was financed by the increase in total current liabilities and/or the increase in total stockholder's equity.

The comparison of the totals for current assets, current liabilities, and stockholders' equity as of March 31, 1976, and September 30, 1976, shows the changes which occurred during the 6-month period. The increase in total current assets was $209,481. The increase in total current liabilities was $134,980 and the increase in total stockholders' equity was $81,523. A comparison of the increase in total current assets to the increase in the totals for current liabilities and stockholders' equity indicates the increase in total current assets was financed 62 percent by current liabilities and 38 percent by increase in stockholders' equity. These percentages indicate that for every $1 of operating costs financed by the increase in equity, the creditors—including employees wages—are financing the operations by $1.65.

The ratio of debt to net worth is obtained by dividing the total liabilities by the stockholders' equity. This ratio was 0.43 to 1 at March 31, 1976, and 0.86 to 1 at September 30, 1976. The increase in this ratio during the 6-month period further supports the above conclusion that Unicare is utilizing $1.65 of credit for each $1 of equity to finance current operations.

The current ratio is the result of dividing the total current assets by the total current liabilities. The current ratio at March 30, 1976, was 3.24 to 1—$3.24 in current assets for each $1 of current liabilities. The current ratio at September 30, 1976, was 2.10 to 1. The decline in the relationship of the cur-

rrent assets to the current liabilities also indicates the use of credit for financing current operations.

The acid test ratio is the result of dividing the total of cash and accounts receivable by the total current liabilities. This ratio was 3.15 to 1 at March 31, 1976, and was 2.09 to 1 at September 30, 1976. A comparison of these two ratios indicates a decline in the relationship of total cash and accounts receivable to the current liabilities during the 6-month period. This comparison further supports the conclusion that credit is being used to finance the current operations.

The accounts receivable turnover for Unicare averaged 72 days for the fiscal year ended March 31, 1976, and averaged 62 days for the 6-month period ended September 30, 1976. The turnover ratio of 72 to 62 indicates the accounts receivable are being collected more rapidly. This turnover ratio indicates that Unicare's normal operating cycle is approximately 62 days. Based on the turnover rates, the accounts receivable amounts, shown in schedules 7 and 8, consist of approximately 2 months billings.

Since the receivable turnover has decreased by only 10 days, we cannot place too much reliance in its magnitude since we have available only a yearend balance and a 6-month-end balance rather than an average monthly figure for accounts receivable. We conclude that the decline of the current position cannot be attributed to the collections on accounts receivable.

The net accounts receivable at September 30, 1976, were $333,328, which is an increase of 101 percent when compared to the balance of $165,880 at March 31, 1976. Since the increase in accounts receivable has been of a relatively permanent nature, the funds to finance their growth should have been provided by the owner. Instead, Unicare has sought to build a higher debt structure without reinforcing the equity foundation.

As a result of Unicare's use of credit to finance the increase in accounts receivable, prompt processing of service billings by Unicare and prompt payment of service billings by the counties is critical in maintaining the financial stability of Unicare.

Unicare obtained five new county contracts during the period from March 31, 1976, to September 30, 1976. The addition of these new contracts created a need for additional funds for operations. As indicate in the previous analysis. Unicare is utilizing credit resources to finance operating assets rather than increasing stockholders' equity.

All of the above ratios and comparisons indicate that Unicare should evaluate the use of their resources on a periodic basis to avoid overuse of credit versus stockholders' contributions to equity.

If Unicare continues to expand its operations to other counties, additional capital should be contributed to the business to avoid financial difficulties in the near future. Furthermore, we recommend that Unicare make a concerted effort to maintain a current ratio of 2 to 1 or better. In our opinion, a 2 to 1 or better ratio is necessary to finance the operating costs during Unicare's normal operating cycle and to finance the initial costs of business expansion.

COMPARATIVE BALANCE SHEETS—MARCH 31, 1976 AND SEPTEMBER 30, 1976—SCHEDULE 8

For comparison of balance sheets, we used the unaudited financial statements at March 31, 1976, prepared by Temkin, Ziskin, Kahn & Matzner, Certified Public Accountants, and the adjusted trial balance at September 30, 1976, prepared by Unicare. As shown in Schedule 8, we made the following adjustments:

One: Elimination of inter-related accounts.

Two: Reclassified credit balances in prepaid insurance and debit balances in other liabilities.

Three: Correction of Unicare's adjustments to convert the general ledger from the cash basis of accounting to the accrual basis.

CONCLUSIONS AND RECOMMENDATION

Our review of Unicare's operations disclosed the following activities for which improvements or changes should be made.

CONTRACT COMPLIANCE

Our review for contract compliance disclosed that Unicare is not in compliance with certain contract requirements and may not be in compliance with other contract requirements.

The contracts with Ventura and San Mateo Counties require specified surety and fidelity bond coverage. The coverage amounts maintained by Unicare is less than the required amounts.

RECOMMENDATION

In general, the counties should be required to monitor their respective contracts and contractors as required both in the State Department of Social Welfare Manual, section 10-034.72, and in the State comprehensive annual services program plan. Monitoring should not be limited to verification of claims statistics, but cost and other compliance requirements should also be monitored at frequent intervals. County monitoring would have disclosed inadequate surety and fidelity bond coverage.

LIVE-IN HOMEMAKERS

Controls over the live-in homemakers are virtually nonexistent.

RECOMMENDATIONS

An adequate system of controls over the live-in homemakers should be implemented by both the contractor and the county. In the absence of such controls, effective program and fiscal management is impossible.

MANAGEMENT REVIEW

Our review of the contractor's operating procedures disclosed the following areas of management control which need improvements.

1. SEGREGATION OF DUTIES

Unicare's procedures regarding cash receipts utilizes one individual to receive, summarize and deposit cash. This procedure permits the opportunity to misappropriate funds.

RECOMMENDATIONS

The contractor's system of internal control should be modified to make provision for adequate segregation of duties as they relate to control of cash.

2. ACCOUNTS RECEIVABLE RECORDS

The accounts receivable records are readily accessible to all individuals at the home office at any time and are not protected against a loss by fire.

RECOMMENDATION

The accounts receivable records should be kept in a fireproof, secure, and restricted place until they are needed for posting or information.

3. VOIDING DOCUMENTS SUPPORTING DISBURSEMENTS

Vouchers and invoices are not consistently voided at the time of payment which may result in duplicate payments.

RECOMMENDATION

All vouchers and invoices should be voided at the time the checks are signed to prevent possible duplicate payments.

FINANCIAL STABILITY

Unicare, as a separate entity, independent of the other related entities, was financially stable at March 31, 1976, and at September 30, 1976.

Unicare's financial position declined during the 6-month period ended September 30, 1976. This decline resulted from two basic factors:

One: Unicare expanded operations by obtaining five new county contracts during this 6-month period.

Two: Unicare utilized its credit resources to a greater extent rather than relying upon additional contribution to capital for financing the increase in operating costs.

Due to the greater utilization of its credit resources, Unicare's current ratio decreased from a ratio of 3.24 to 1 at March 31, 1976, to a ratio of 2.10 to 1 at September 30, 1976.

RECOMMENDATION

If Unicare continues to expand its operations to other counties at the present rate, we recommend additional capital be contributed to finance the increase in operating costs. Furthermore, we recommend that Unicare make a concerted effort to maintain their current ratio at 2 to 1 or better, or they will begin to have difficulty in meeting their payroll costs on a regular and consistent basis.

PROGRAM RECOMMENDATIONS

During our review of Unicare's costs, we determined that certain cost control improvements could be made. Therefore, we are recommending the following improvements.

1. FINANCIAL REPORTING

Financial data that is timely and accurate is needed by management to make informed decisions as well as to provide monitoring tools to counties. In order to produce reports for internal purposes and to generate the periodic reports as required under the separate contracts, an accrual basis accounting system should be instituted.

RECOMMENDATION

Specific provision should be made for general ledger cost centers into which only direct county contract costs are entered. This system would facilitate the reports mentioned above and would insure adequate and accurate cost data as required in the contracts.

2. REGULATIONS NEEDED

The State has no clearly defined regulations that pertain to the determination of allowable cost and/or cost containment.

RECOMMENDATION

The Department of Health should exercise its authority to either formulate regulations at the State level or adopt the existing Federal regulations as they relate to the administration of the grant-in-aid programs.

3. UNIFORM CONTRACTS

Of Unicare's eight contracts, no two are alike and each have different special provisions. Uniform contracts would simplify State and county monitoring and enhance the review of the various contracts. Furthermore, we have reviewed approximately 47 homemaker contracts to date. The content of the contracts have varied widely.

RECOMMENDATIONS

The State should require uniform contract drafts from all counties. These drafts should incorporate all applicable Federal and State regulations which

pertain to the program. For instance, our examination disclosed that the contractor's intent was to include expenses which do not appear to be reasonable or necessary, that is, nursing and/or program director costs, which inflate administrative costs.

4. RESPONSIBILITY OF ADMINISTRATION

The Federal regulations, Title 45, Subtitle A, Part 74, Subpart P, stipulates that the State, as grantee, is the authority responsible for all contractual and administrative issues as they relate to the procurement contracts it approves. Abrogation of this responsibility may result in Federal fiscal exceptions.

RECOMMENDATION

In the interest of protecting and preserving the Federal share of program funding, the Department of Health should monitor these contracts on an ongoing basis. In order to assure adequate controls over program and fiscal matters, the State should enforce county monitoring as required in the State Department of Social Welfare Manual, section 10-034.72 and the State comprehensive annual service program plan.

5. FUTURE AUDIT OF UNICARE, INC.

Based on the data examined, we determined that further auditing at the Home Office of Unicare, Inc., at this time would be of no value to the organization, nor would it be of value in developing any additional program improvements.

RECOMMENDATION

We recommend that another audit of Unicare, Inc., be made in July 1977. At this time the remaining six contracts will be completed and a complete determination of cost can be made.

SCHEDULE 1.—UNICARE, INC. COMPARATIVE ANALYSIS OF HOURLY COST AND REIMBURSEMENT RATE FOR THE PERIOD FROM JULY 1, 1975, THROUGH SEPT. 30, 1976

	County and contract periods ended							
	Completed contracts		Current contracts					
	San Luis Obispo, 8 mo ended June 30, 1976	Santa Clara, 13 mo ended July 31, 1976	Santa Clara, 12 mo ended July 31, 1977 [1]	Madera, 4 mo ended Dec. 31, 1976 [2]	San Mateo, 12 mo ended Mar. 31, 1977 [3]	Humboldt, 12 mo ended June 30, 1977 [4]	Tulare, 10 mo ended June 30, 1977 [5]	Ventura, 12 mo ended June 30, 1977 [6]
Total costs before other home office costs (from schedule 2)	$114,761	$285,730	$97,161	$10,169	$135,025	$47,224	$55,676	$155,474
Divided by total hours billed	32,168	67,721	19,468	2,976	27,306	12,686	16,878	45,123
Audited per hour cost	3.57	4.22	4.99	3.42	4.94	3.72	3.30	3.45
Less contract rate per hour	[7] 3.80	5.68	5.28	4.10	[7] 4.30	[7] 3.50	3.80	[7] 3.45
Cost over (under) contract rate	(.23)	(1.46)	(.29)	(.68)	.64	.22	(.50)	0
Total costs including other home office costs (from schedule 2)	123,286	310,157	103,702	11,037	143,258	52,144	61,683	164,296
Divided by total hours billed	32,168	67,721	19,468	2,976	27,306	12,686	16,878	45,123
Audited per hour cost	3.83	4.58	5.33	3.71	5.25	4.11	3.65	3.64
Less contract rate per hour	[7] 3.80	5.68	5.28	4.10	[7] 4.30	[7] 3.50	3.80	[7] 3.45
Cost over (under) contract rate	.03	(1.10)	.05	(.39)	.95	.61	(.15)	.19

[1] The contract period is for 12 mo ended July 31, 1977, however, costs for only 2 mo are included in this schedule.
[2] The contract period is for 4 mo ended Dec. 31, 1976, however, costs for only 1 mo are included in this schedule.
[3] The contract period is for 12 mo ended Mar. 31, 1977, however, costs for only 6 mo are included in this schedule.
[4] The contract period is for 12 mo ended June 30, 1977, however, costs for only 3 mo are included in this schedule
[5] The contract period is for 10 mo ended June 30, 1977, however, costs for only 1 mo are included in this schedule.
[6] The contract period is for 12 mo ended June 30, 1977, however, costs for only 3 mo are included in this schedule.
[7] These rates are averages of homemaker and chore rates as specified in the agreement.

SCHEDULE 2.—UNICARE, INC., SCHEDULE OF COSTS BY CONTRACT FOR THE PERIOD FROM JULY 1, 1975, THROUGH SEPT. 30, 1976

	County and contract periods ended							
	Completed contracts		Current contracts					
	San Luis Obispo, 8 mo ended June 30, 1976	Santa Clara, 13 mo ended July 31, 1976	Santa Clara, 12 mo ended July 31, 1977 [1]	Madera, 4 mo ended Dec. 31, 1976 [2]	San Mateo, 12 mo ended Mar. 31, 1977 [3]	Humboldt, 12 mo ended June 30, 1977 [4]	Tulare, 10 mo ended June 30, 1977 [5]	Ventura, 12 mo ended June 30, 1977 [6]
Direct costs:								
Salaries and employee benefits	$11,714	$238,641	$85,220	$9,895	$119,805	$73,825	$86,402	$150,376
Rent	470	1,000	534	100	815	444	764	1,193
Advertising and promotion	274	----------	732	----------	268	21	130	226
Supplies	1,486	----------	760	194	320	901	1,779	1,899
Communications	2,727	----------	843	293	2,194	982	851	2,974
Taxes and licenses	166	----------	----------	----------	----------	95	----------	50
Maintenance and utilities	319	----------	----------	----------	203	----------	----------	----------
County administration fee	----------	12,209	----------	----------	----------	----------	----------	----------
Miscellaneous	----------	----------	----------	----------	----------	20	----------	415
Total direct costs	117,156	251,850	88,089	10,482	123,605	76,288	89,926	157,133
Less—cost of live-in workers	14,219	----------	----------	1,517	----------	35,888	42,581	13,895
Total direct contract costs	102,937	251,850	88,089	8,965	123,605	40,400	47,345	143,238
Allocation of home office costs deemed program related and necessary (schedule 3)	11,824	33,880	9,072	1,204	11,420	6,824	8,331	12,236
Total cost before other home office costs (to schedule 1)	114,761	285,730	97,161	10,169	135,025	47,224	55,676	155,474
Allocation of other home office costs (schedule 3)	8,525	24,427	6,541	868	8,233	4,920	6,007	8,822
Total cost (to schedule 1)	123,286	310,157	103,702	11,037	143,258	52,144	61,683	164,296

[1] The contract period is for 12 mo ended July 31, 1977, however, costs for only 2 mo are included in this schedule.
[2] The contract period is for 4 mo ended Dec. 31, 1976, however, costs for only 1 mo are included in this schedule.
[3] The contract period is for 12 mo ended Mar. 31, 1977, however, costs for only 6 mo are included in this schedule.
[4] The contract period is for 12 mo ended June 30, 1977, however, costs for only 3 mo are included in this schedule.
[5] The contract period is for 10 mo ended June 30, 1977, however, costs for only 1 mo are included in this schedule.
[6] The contract period is for 12 mo ended June 30, 1977, however, costs for only 3 mo are included in this schedule.

SCHEDULE 3.—UNICARE, INC. SCHEDULE OF HOME OFFICE COST ALLOCATION FOR THE PERIOD FROM JULY 1, 1975, THROUGH SEPT. 30, 1976

Contractor		Allocation basis revenue	Home office costs: Program related and necessary (from schedule 4)	Home office costs: Other (from schedule 5)
County:				
San Luis Obispo	June 30, 1976	$133,301	$11,824	$8,525
Santa Clara	July 31, 1976	381,951	33,880	24,427
Madera	Dec. 31, 1976	13,572	1,204	868
San Mateo	Mar. 31, 1977	128,739	11,420	8,233
Humboldt	June 30, 1977	76,929	6,824	4,920
Tulare	do	93,924	8,331	6,007
Ventura	do	137,945	12,236	8,822
Santa Clara	July 31, 1977	102,272	9,072	6,541
Private: All facilities		478,277	42,425	30,588
Total		1,546,910	137,216	98,931
			To schedule 2	To schedule 2
Allocation factors:				
Total home office costs deemed to be program related and necessary (schedule 4) divided by total revenue			.08870329	
Total other home office cost (schedule 5) divided by total revenue				.06395395

SCHEDULE 4.—*Unicare, Inc. schedule of home office costs deemed to be program related and necessary for the period from July 1, 1975, through Sept. 30, 1976*

	Amount
Salaries (excluding executive salaries)	$73,472
Rent	8,154
Advertising and promotion	6,319
Supplies	12,438
Communications	6,373
Taxes and license	290
Insurance	20,468
Legal and accounting	5,330
Maintenance and utilities	3,548
Miscellaneous	10,327
Subtotal	146,719
Less: Cost of bid proposals	(9,503)
Total home office costs deemed to be program related and necessary (to schedule 3)	137,216

SCHEDULE 5.—*Unicare, Inc. schedule of other home office costs for the period from July 1, 1975, through Sept. 30, 1976*

	Amount
Salaries (including executive salaries)	$88,549
Consultant fees	434
Travel and promotion	1,905
Deferred compensation	6,731
Rent paid to owner	1,312
Total other home office costs (to schedule 3)	98,931

SCHEDULE 6.—UNICARE, INC., DISBURSEMENTS TO KEY OFFICER, PRINCIPALS, AND RELATIVES OF FLORA SOUZA FOR THE PERIOD FROM APRIL 1, 1975, THROUGH SEPTEMBER 30, 1976

	Flora Souza, president/ owner	Jack Stewart, treasurer	Michael Powell, controller	Robert Jack, relative	Totals
Disbursements Apr. 1, 1975 through Mar. 31, 1976:					
Salary	$38,000	$300	$15,600	0	$53,900
Consultant fees	0	530	0	0	530
Travel and promotion	2,950	516	805	0	4,271
Deferred compensation	5,100	0	0	0	5,100
Rental income	2,200	0	0	0	2,200
Period total	48,250	1,346	16,405	0	66,001
Disbursements Apr. 1, 1976 through Sept. 30, 1976:					
Salary	26,700	600	6,623	0	33,923
Travel and promotion	594	629	1,259	853	3,335
Deferred compensation	2,550	0	0	0	2,550
Rental income	1,200	0	0	0	1,200
Period total	31,044	1,229	7,882	853	41,008
Grand total	79,294	2,575	24,287	853	107,009

SCHEDULE 7.—UNICARE, INC. COMPARATIVE BALANCE SHEET ANALYSIS

	As adjusted balances		Change increase (decrease)
	Mar. 31, 1976	Sept. 30, 1976	
Cash (schedule 8, line 2)	$41,070	$85,661	$44,591
Accounts receivable (schedule 8, line 3)	165,880	333,328	167,448
Total Cash and Accounts Receivable	206,950	418,989	212,039
Total current assets (schedule 8, line 6)	212,786	422,267	209,481
Total current liabilities (schedule 8, line 19)	65,645	200,625	134,980
Total stockholders' equity (schedule 8, line 26)	152,293	233,816	81,523
Current ratio (total current assets divided by total current liabilities)	3.24 to 1	2.10 to 1	(1.14)
Acid test ratio (total cash and accounts receivable divided by total current liabilities)	3.15 to 1	2.09 to 1	(1.06)
Ratio of debt to net worth (total liabilities divided by stockholders' equity)	.43 to 1	.86 to 1	.43
Total revene from operations	$832,386	$970,259	
Accounts urecelvable turnover:			
Number of months of operations	12	6	
Ratio of total revenue from operations to accounts receivable	÷5.02	÷2.91	
Number of months divided by the ratio	2.39	2.06	
Number of days per month	×30	×30	
Turnover in days	72	62	(10)

SCHEDULE 8.—UNICARE, INC., COMPARATIVE BALANCE SHEETS

	Mar. 31, 1976			Sept. 30, 1976		
ASSETS	Per unaudited financial statement	Adjustments increase (decrease)	As adjusted	Adjusted trial balance	Adjustments increase (decrease)	As adjusted
1. Current assets:						
2. Cash	$41,070		$41,070	$85,661		$85,661
3. Accounts receivable (net)	185,375	[1] ($19,495)	165,880	333,328		333,328
4. Loans to related organizations and officers				7,144	[1] ($7,144)	
5. Prepared expenses	5,836		5,836	(7,100)	[2] 7,100 [3] 3,278	3,278
6. Total current assets	232,281	(19,495)	212,786	419,033	3,234	422,267
7. Noncurrent assets:						
8. Rent deposit				923		923
9. Equipment (net)	5,052		5,052	11,151		11,151
10. Organization cost	100		100	100		100
11. Intercompany loans receivable				12,351	[1] (12,351)	
12. Total assets	237,433	(19,495)	217,938	443,558	(9,117)	434,441
LIABILITIES AND STOCKHOLDERS EQUITY						
13. Current liabilities:						
14. Accounts payable	11,678		11,678	5,627	[2] 7,100 [4] 11,510	24,237
15. Accured wages and benefits	29,530		29,530	131,388		131,388
16. Accured profit sharing plan	10,000		10,000	10,000		10,000
17. Loans payable				35,000		35,000
18. Income taxes payable	14,437		14,437			
19. Total current liabilities	65,645		65,645	182,015	18,610	200,625
20. Other liabilities:						
21. California franchise tax				(3,278)	[3] 3,278	
22. Total liabilities	65,645		65,645	178,737	21,888	200,625
23. Stockholders' equity:						
24. Capital stock, 1,000 shares issued and outstanding, stated value $1,000	1,000		1,000	1,000		1,000
25. Retained earnings	170,788	[1] (19,495)	151,293	263,821	[1] (19,495) [4] (11,510)	232,816
26. Total stockholders' equity	171,788	(19,495)	152,293	264,821	(31,005)	233,816
27. Total liabilities and stockholders equity	237,433	(19,495)	217,938	443,558	(9,117)	434,441

[1] To eliminate interrelated accounts.
[2] To reclassify credit balance for prepaid insurance to accounts payable.
[3] To reclassify prepaid California Franchise Tax from other liabilities to prepaid expenses.
[4] To correct Unicare's adjustment in converting from cash basis to accrual basis.

Appendix 5

REPORT ON REVIEW OF HOMEMAKER/CHORE SERVICES ADMINISTERED BY SAN FRANCISCO COUNTY; SUBMITTED BY GARY MACOMBER [1]

CALIFORNIA DEPARTMENT OF HEALTH,
Sacramento, Calif., April 4, 1975.

MR. KENNETH W. BRYAN,
Acting Director, City and County of San Francisco,
Department of Social Services, San Francisco, Calif.

DEAR MR. BRYAN: The attached report represents our findings in the review of homemaker/chore services which the County of San Francisco administers.

Please note, however, that this is not a traditional, compliance audit report and does not represent an intent to retrieve expended funds. It may be viewed as a management report intended to pinpoint areas of needed improvement, and as such, may be viewed as a report to county management.

The review was conducted in accordance with generally accepted standards and included such tests as were considered necessary. Because of a limited time budget, the size and complexities of delivery systems, establishment of priorities relating to problems encountered, and because administrative expense claims fall within the purview of the State Controller, our review was limited to cost effectiveness and management related aspects of the program. Further, records of one of the two contractors selected for review were unavailable because of a death in the accountant's family. Our subsequent findings of this contractor's records will be discussed in a future report.

Should you have questions on this report, you may reach me at (916) 322–6333. Program consultation may be obtained from the Services Operation Section and consultation on matters relating to fiscal, contracts, and monitoring may be obtained from the Services Management Section.

Sincerely,

GEORGE ELICH,
Chief, Field Review Unit.

[Enclosure.]

INTRODUCTION

We have reviewed the Homemaker/Chore Services Program under which the County of San Francisco delivered homemaker/chore services.

Unlike boards in most counties, the county's board of supervisors acts only as a legislative body. The Social Service Commission, whose members are appointed by the mayor, determines administrative policy and appoints the manager (welfare director) of the Department of Social Services (DSS).

Approximately one-third of homemaker/chore services are provided by direct purchase from five contracting agencies. Three of these are proprietary agencies and two are nonprofit agencies. Approximately two-thirds of the caseload is serviced through purchase by the direct payment process. Nine county-employed homemakers provide a minor portion of the services.

Homemaker/chore services are funded 75 percent Federal and 25 percent State participation. The county's original allocation of State funds totaled $1,720,589 which would generate $5,161,767 in Federal participation within the Federal funds allocated to the county. The county reported an estimated need for $2,604,844 in addition to the total of $6,882,354 originally allocated for fiscal year 1974–75.

The purpose of this review was to determine the effectiveness with which the county managed its program and allocated funds, and to determine the extent of county compliance with State and Federal regulations.

[1] See statement, p. 1016.

HIGHLIGHTS OF REVIEW RESULTS

In our opinion, the county does not maintain efficient cost-effective practices and funds sufficient to cover the county estimated deficit may have been saved if regulatory compliance and prudent business practices were in effect.

BIDDING PRACTICES

We found bidding practices and contractual competition virtually nonexistent. The contracts have been open term and open-ended. Most were entered into on February 1, 1971 and were never submitted for State approval.

At least one qualified contractor who already operates a home health/aid service in San Francisco was recently advised that there was no interest in new contractors despite a proposal and bid of $4 per hour for chore service and $6 per hour for homemaker services. This bid was substantially lower than the rates which prevailed in San Francisco County; rates which ranged as high as $7.75 per hour regardless whether the service was homemaker or chore. This contractor's proposal was rejected in each of the past 3 years.

The county also practices caseload equalization between contractors regardless of rates or quality. This practice entails contractor participation with the Social Service Commission and the DSS manager in effecting agreement on equitable caseload distribution. In our opinion, this practice removes incentives for competition and effective cost management.

COST LIMITATIONS

We found that the county makes no provision to control chore cases within the $100 limitation; nor was any awareness of this regulatory requirement discernible. Although the contracts stipulate that "usual" cases would be limited to $150 (retained from the old attendant care regulations), there is also no effort to control within this inappropriate limitation.

Although a recent study conducted by the county shows that over 40 percent of the cases assigned to contractors are chore cases, contractors were allowed to continue reporting and billing all cases as homemaker cases. We urge separate rates for homemaker and chore services. While there is some validity to the county's contention that the rate established represents an average of homemaker and chore cases, this argument does not recognize that costs would be lower if chore cases were properly identified and subjected to the less costly supervisional and training requirements. The county's argument also fails to recognize that the rates are preestablished and the contract specifies no desired mix of homemaker/chore cases. More importantly, this argument does not recognize that this arrangement does nothing to control chore services within the $100 limitation.

We note that the county study of chore services was based only upon the need for personal services. Because of this inappropriate definition, and because of our sample results, we believe that their estimate of 40 percent chore services may be grossly understated.

Recognizing the deficiency in identifying all cases as homemaker cases, the county issued new directives to be effective on January 1, 1975, which stipulated that chore cases would no longer be assigned to contractors, but would be treated as direct pay cases. Again the inappropriate definition was used and only new cases were subject to identification. As stated earlier, contractors were allowed to continue the status quo. The new directive made no mention of the $100 limitation.

Our review of 66 cases, randomly selected from the entire county caseload without regard to provider, confirms our opinion of the lack of control of $100 limited cases in both agency and direct payment cases. While we acknowledge that the sample was not sufficiently large to establish a statistically valid projection, a judgmental projection provides a basis for estimating the magnitude of error. This estimate suggests that approximately $2,500,000 is annually being overpaid because of this problem. The estimate is based upon payments exceeding $100 without documented justification.

The county contended that they felt there was no use in controlling to the $100 limitation because appeal referees consistently rule that the $100 maximum should not hold. Because this issue arose during the exit interview, the field

review unit was unable to evaluate the contention. However, appeals do not arise until after program implementation, and we found no evidence that a control was instituted at any time during implementation.

RESPONSIBILITY ABROGATION

A major finding shows that the county has substantially abrogated its responsibilities to the contractor and does not exercise the care that would be expected of a prudent buyer with the result that:

1. Costs of up to 10 percent of contractor costs are inappropriately charged to the homemaker/chore services program.
2. The vendors largely determine how much service the county will buy.
3. The county is failing to comply with regulations.
4. The county is allowing the contractor to determine when a case is to be discontinued.
5. The county allows the vendor to unnecessarily duplicate some costs of the Department.

Various interviews and a review of one contractor's records revealed that 10.2 percent of this contractor's costs were attributable to assessments and reassessments. These are responsibilities of the county, and if appropriately performed, would be charged against adult services rather than State-funded homemaker/chore services.

While the county usually makes the initial assessment, so does the contractor. In most cases, the reassessment is left to the contractor. Because the volume of change is great, contractors can increase the need determination with little more than unverified approval of the contractor's justification. Frequently, changes were approved via telephone.

The contractor subjected to review has issued considerable plaintive documentation to the legislature, HEW, the county, and the State demanding that other contractors adhere to the high standards of assessment employed by his agency and has documented arguments to show that while his hourly rate was the highest, the cost per case was lowest because of timely discontinuances.

We agree wholeheartedly that costs can be lowered if all contractor's cases were appropriately and more professionally assessed, but disagree with his proposed solution. The answer is not to force other contractors to adopt higher standards but in recognizing that assessment and reassessment is a county responsibility, which if exercised, would affect all contractors in the county.

Even if 3 percent of the contractor's costs for assessment were continued as an ongoing check, realinement of these functions within the county welfare department would reduce this contractor's estimated 1974 cost of $8.44 by 7.2 percent or $0.60 per hour. His rate is $7.75 and he has requested an increase.

During the exit interview, county officials concerned with our criticism regarding assignment of these responsibilities to the contractors, but contended they could not do otherwise because of [illegible]ck of staffing. They further added that even if staffed, the county may not [illegible] able to do the job as effectively as this particular contractor.

In our opinion, the funds that could be saved justify staffing, and the argument does not recognize that this contractor is only one of five vendors. If the contractor's reported allegations regarding other contractors are correct, it would seem reasonable to assume that county staff could improve on the average assessment quality provided by all five contractors.

Further, in our opinion, management of public funds should always be subject to the precautions of a prudent buyer, regardless of the vendor and there is no justification for shifting county participatory costs to State participatory costs.

UNAUTHORIZED NURSING SERVICES

Our review revealed that little distinction was made between health/aid services and homemaker/chore services. Review of cost records and interviews with contractors and county officials led us to believe, and later confirmed, that homemaker/chore services by one contractor, who also provided nursing or home health/aid services, were not only often provided in lieu of nursing home care, but that such services often included nursing costs.

County officials contended that this was because allowable medical care rates were too low and nursing homes could not be found within the borders of the county. While we make no judgments regarding the validity of this argument,

and agree that patients cannot be compelled to enter nursing homes, we hasten to point out that the homemaker/chore services program was never intended to substitute for medical care programs. In short, nursing cost components are not authorized as a cost of this service.

Too, we found no evidence that patients leaving acute care are offered an option. According to his own discussion, one contractor no longer able to claim medical care for patients leaving acute care, routinely reverts to homemaker/chore funding. The other contractor providing health care services was not reviewed. In our opinion, a prudent buyer would not assume that the vendor is exercising options which are in the best interests of the State or patient.

Because of the complexities involved in trying to isolate these nursing costs, limited staff, and our inability to make medical determinations, no estimate of financial impact was made of this deficiency. However, record analysis and discussions with contractors and county officials lead us to believe the impact is of major proportions.

MONITORING

We found very little evidence of an organized monitoring effort. Except for a few minor studies, the county relies very heavily upon financial statements provided by the vendors.

Although the contracts call for certified statements from a certified public accountant, only one of the five statements examined were so certified.

Even where statements were certified, we believe the customary certification employed by certified public accountants does nothing to assure compliance with State and Federal regulations.

CONTRACTS

As previously indicated, contracts are basically those implemented in 1971 for the attendant care program. Little has been amended except to note new case payment maximums and rate increases. The county was advised in July of 1974 to submit contracts for State approval and that guidelines indicate that open-term contracts are unacceptable.

Subsequent minutes of the Social Service Commission show that the Manager of DSS recommended and the Social Service Commission approved a resolution to submit contracts for approval prior to the fiscal year 1975–76.

Such delay postpones correction of serious deficiencies in the contract and recognition of the $100 limitation on chore services within the contractor's caseloads.

REASSESSMENTS

As previously stated, contractors were performing reassassments.

A problem was also found in the greater mass of direct pay cases. Of 66 cases randomly selected from both contractor and direct pay caseloads, only 35 had been reevaluated within the last 6 months. Seventeen cases were not reevaluated in more than 1 year.

ELIGIBILITY

The county does not redetermine eligibility as required.

COMPLIANCE

Our discussions during the exit interview met with several indications that some deficiencies were previously known to the county. As indicated above, no action is planned to correct contracts until July 1975. A discussion of one major problem met with the comment "I thought of this as something we should start to think about 6 months from now."

In our opinion, regulatory compliance is not something one postpones for future consideration.

RECOMMENDATIONS

BIDDING PRACTICES

We recommend that contracts be limited to terms of 1 year and submitted to the State for prior approval. We further recommend that:

1. Requests for proposals be utilized to encourage open competition. Requests should specify the deliverables. All bids should do likewise and we

recommend that they include line item budgets which detail the resources committed.

2. To facilitate competition, and more reasonably diminish fixed costs per unit of service, we recommend that as few contractors as practical be employed—perhaps one for homemaker and one for chore. For each contract, a minimum of three qualified bids should be sought. For example, if two contracts are to be let, six different qualified bidders should be contacted for a bid. Rates should not be revised during the term of the contract. Even better, the bid request should be advertised to obtain the greatest degree of competitive bidding.

3. No composite rates should be requested. A separate rate for homemaker and chore should be required.

COST LIMITATIONS

We recommend that guidelines to employees be immediately issued to reflect the $100 limitations on chore services and specify justification necessary to establish exceptional social circumstances. More importantly, control systems should immediately be established to effectively control payments within regulatory limitations.

We further recommend that services staff reassess all cases and appropriately identify all chore cases in accordance with regulations.

RESPONSIBILITY ABROGATION

We recommend that the county assume its rsponsibility for assessments and reassessments, and that contractor rates be reduced accordingly.

AUTHORIZED NURSING SERVICE

We recommend that the county seek other means of providing nursing care or absorb such costs themselves. There is no authority to charge such costs to the homemaker/chore program.

MONITORING

We recommend that the county implement an organized monitoring effort in accordance with Social Service Letter No. 74–12 to assure that services are delivered and quality is consistent with contractual specifications and regulatory requirements.

Where contractors provide cost statements, these should be certified as specified by the contract. More importantly, they should not employ the standard certification form but should be certified in accordance with Standards for Audit of Governmental Organizations, Programs, Activities, and Functions as issued by the Controller General of the United States.

CONTRACTS

By virtue of the short time between issuance of this report and the beginning of the fiscal year, we recommend that the county concentrate on designing effective requests for proposals and cancel all current contracts effective June 30, 1975.

REASSESSMENTS

We recommend that the county reassess all cases including direct pay cases in accordance with regulations to assure that old cases are eligible, discontinued on a timely basis, and receiving appropriate levels of care.

ELIGIBILITY

We recommend the redetermination be made in accordance with regulations and that systems be established to more effectively retrieve SSI eligibility information.

FINDINGS

BIDDING PRACTICES

Between February 1, 1971, and May 15, 1972, contracts were signed with five vendors for the provision of homemaker services. These contracts were open-

term contracts and continue in effect. Thus, opportunities for new competitive proposals are nonexistent.

Because rumors suggested that qualified bidders were being denied an opportunity to bid, despite a lower rate offer, the field review team sought and managed to identify one such bidder.

This bidder, Unicare, Inc., submitted a proposal to provide chore service for $4 per hour and homemaker service for $6 per hour. This rate was up to $1.75 per hour less for homemaker service and $2 per hour to $3.75 per hour less for chore service than the rates for which the county contracted. Unicare, Inc., appears to meet standards for homemaker/home-health aide services, and their proposal gave every indication of providing quality of service comparable to that of the present contractors. Unicare, Inc., was already operating a home-health aide agency in San Francisco and was acquainted with the labor market; wages paid by Unicare were the same as those paid by some vendors with which the county contracted. Unicare already provides homemaker/chore services in Santa Clara County.

When contacted by the field review team, the officers of Unicare provided a copy of the proposal submitted to the county and a written statement which indicates that no response to the bid was received in writing. They further report that follow up elicited the response, "We have all the contracts we need."

Unicare also reported this problem to two members of the Board of Supervisors and received no responses.

Manual section 10-034.81 states: "Such rates shall not exceed the amounts reasonable and necessary to assure quality of service." This would not necessarily be the case during mid-term of existing contracts, but we hasten to add, existing contracts had an open term. Further, Unicare's bid was submitted 3 years in succession without formal response or county justification. It is doubtful that the county is meeting that test, for the principle implies accepting the lowest qualified bid.

A review of the minutes of the Social Service Commission for the 13 months beginning January 17, 1974, and ending January 16, 1975, shows that contractors participate along with the Social Service Commission and the Department of Social Services manager in equalizing caseloads without apparent consideration of differences in cost or quality. Aside from the problem of negating incentives for competition, this practice is also questionable as meeting the test of section 10-034.81 and precautions expected from a prudent buyer.

COST LIMITATIONS

Several maximums are applicable within the homemaker/chore services program. One of these applies to chore cases. We found a two-fold problem relating to chore maximums and identifications subject to that maximum:

San Francisco County has not properly identified chore cases. Manual section 30-500.2 states: "Chore services include the performance of household tasks, essential shopping, simple household repairs, or other light work necessary to enable an individual to remain in his own home when he is unable to perform such tasks himself and the services of a trained homemaker or other specialist are not required."

San Francisco County purchases services identified as homemaker from the contracting agencies. In 17 of 22 agency cases reviewed, the services being provided fall into the category of chore services to self-directing recipients. The county itself acknowledges (by its own estimate) that 40 percent of the cases serviced by agency homemakers need and receive domestic chore services only. However, this lower county estimate was based upon personal care and did not include self-direction as a criteria. Our findings in 17 of the 22 sampled agency cases support the belief that the 40 percent county estimate is understated.

Current procedures call for San Francisco County to stop referring incoming cases requiring pure chore services to agencies, but allow the agencies to continue providing services to cases already in their caseload without distinguishing them as chore cases. The total amount paid to the five contracting agencies in December 1974 was $283,491. Using the ratio of 17 chore cases out of a total of 22 agency cases surveyed, this means that 77 percent of the total amount billed was paid for chore cases. We recognize that this sample size is not large enough to be statistically valid and use it only as a means of approximation.

Payments in excess of the $100 maximum. Manual section 30-500.51 states: "The maximum allowance for chore services, except as provided in sections 30-500.511 and 30-500.52 shall not exceed $100 per month."

Sixty-six cases were selected at random and included 44 cases from direct pay and 22 cases from agency caseloads. Forty-eight of the 66 cases reviewed had payment of over the $100 maximum and 18 cases were under the $100 maximum. Of the 48 cases paid over $100, 17 contained documentation that the recipient did have needs falling within the definition of exceptional social circumstances. Thus, 31 cases lacked documentation supporting payments in excess of the $100 maximum.

When asked how the $100 chore service maximum was observed in making assessments, one division supervisor stated that "every case is an exceptional circumstance in San Francisco." In reviewing assessment procedures with four social workers in the ATD division, it became apparent that no attempt is made to limit the payment to the $100 maximum. The assessment practice is to determine the number of hours of service needed per week and then translate this into a monthly flat rate without regard to the $100 limitation on usual cases.

In the 31 cases (41 percent) without adequate documentation, the average overpayment was $128. Taking 41 percent of the total monthly caseload of 4,000 cases, an approximation of 1,640 cases are being overpaid a total of $210,000 per month, or $2,500,000 per annum.

RESPONSIBILITY ABROGATION

A review of the San Francisco Home Health Service reveals that 10.2 percent of the contractor's costs are attributable to assessments and reassessments. This is a responsibility of the county welfare department, which if properly applied by Department of Social Services would be chargeable to adult services rather than State funded homemaker/chore services.

Manual section 10-034 states:

.7 County Responsibility for Purchase of Services
.71 The county welfare department shall retain continuing, basic responsibility for:
.712 The authorization, selection, quality, effectiveness, and execution of a plan or program of services suited to the needs of an individual or group of individuals."

Manual sections 30-500.4 and 30-550.4 state:

".4 Determination of Need for Services
.41 The need for services shall be evaluated at least every 6 months to assure their effectiveness in helping the individual remain in his own home."

In a letter to the Manager of Department of Social Services dated November 28, 1973, concerning approval of the county plan for fiscal year 1973-74, Lucille C. Hood advised:

".6 Contracting agencies should not make the assessment of the need for service. The welfare department is required to review the need for such service every 6 months."

As indicated, one contractor expends 10.2 percent of his costs for this function. In most cases, the county has abrogated the responsibility for reassessments to the contractor. Detailed discussions indicate that the contractor always performs initial assessments and reassessments whether the county performed an initial assessment or not.

Most of this contractor's cases originate from the community rather than by referral from the county. In many instances, these are cases that were once in acute care. Statements by staff of two contractors indicate that often the county makes no initial assessment and some clients never see a county social worker.

The contractor reviewed issued considerable correspondence regarding the quality of assessments by other contractors. Both his correspondence and our contact with other contractors indicates that the situation of responsibility abrogation exists in all contractor assignments.

The contractor reviewed (San Francisco Home Health Service) offered protestations similar to his legislative correspondence regarding the quality of assessments by other contractors. His allegations seem to suggest that the State and county are remiss in not enforcing the standards of the National Council for Homemaker-Health Aide Services, Inc.

In a letter dated December 17, 1974, to the Social Service Commission, Mr. Born correctly stated that, "contract agencies must attest that they meet standards such as those of the National Council for Homemaker/Home Health Aide Services."

Correspondence from the San Francisco Home Health Service which urged that all contractors provide high quality assessments and reassessments appears to suggest that regulations use the words "Exactly as." We suggest that they do not. There is no justification for assuming that the basic national standards negate the specific regulations which clearly indicate these as county responsibilities. (See quotations from manual sections 10–034, 30–500.4, and 30–550.4 above.) It should be apparent from a review of the standards that standards relate to both homemaker and health aides and that some judgment is necessary regarding the applicability of the various terms. It should be further apparent that these standards do not apply to chore cases. According to the county survey, 33.46 percent of this contractor's caseload consists of chore cases.

In our opinion, the responsibility for assessments and reassessments is that of the county and should not be duplicated by the contractors. We recognize, of course, that some minimal degree of assessment may need to take place between 6-month assessments. Our contention that this responsibility has been abrogated is further supported by the contracts (clause 3, items a through d).

Further, we note that the San Francisco Home Health Service reports a cost of $8.44 per hour. Yet in September 1973, they offered chore services at $4.00 per hour based upon the assumption that the county would determine and redetermine the need. This is an additional indication of costs affected by inappropriate assignment of functions. In effect, the bid confirms our views relating to standards.

AUTHORIZED NURSING SERVICES

As authorized under regulation 3–500/550, homemaker/chore services do not include medical or skilled nursing services. An examination of the records of San Francisco Home Health Services (SFHHS) clearly shows that such costs are included, as is the overhead attributable to these services.

This contractor draws heavily on nursing and home-health aides in its staffing pattern. The San Francisco Home Health Service employs 9 nurses and 150 home-health aides. The nurses are used for initial and followup assessments of recipient needs and progress. This assessment is more related to medical care than to homemaker services; yet, homemaker/chore shares in these costs. The home-health aides do double duty in providing both homemaker and home-health aide services. That is, the same practitioner can provide either a homemaker service or a home-health aide service, depending on whether the DPSS or Medi-Cal (or Kaiser) is to be billed.

While the review team did not review costs of the Visiting Nurses Association, comments from the Social Service Commission minutes suggest that their operation also has medical care functions and should be examined more closely. SFHHS costs for 1973 show that only $6,788 of the $33,939 expended for professional nurses was charged to the title XIX cost pool. The remaining $27,151 was charged to a cost pool primarily funded by homemaker/chore services as was proportionate shares of operating and overhead expenses.

Although SFHHS provides services to others including insurance companies, and although nursing staff described each service as unique, no distinction is made between them except for two categories which may be described as medical care and all others comprised of homemaker/chore and miscellaneous contracts. There is the potential that homemaker/chore may be unduly burdened by medical cost attributable to miscellaneous contracts.

The agency's accountant stated that the differences would probably not justify a more elaborate costing system and that if a study was made, it would probably show that homemaker/chore should be charged more and the others less. This presumes that only the "other" category should be considered. It is probably likely that the result would leave less in the "other" pool if medical care was also considered. Since it is our understanding that Medi-Cal operates on a rate of $10.85 per hour, there is no advantage to the State to understate Medi-Cal costs. On the contrary, if medical care costs are understated, there may be duplication of cost reimbursement because of reported Medi-Cal costs of $10.10 as opposed to the Medi-Cal rate of $10.85.

Further, in our opinion, the percentages used for some costs seemed to be highly judgmental and no data was offered to support their use. In many cases,

costs were allocated between medical care and others based upon caseloads. This presumes that the services are alike. They are not supposed to be.

We note that the same situation exists for health aide costs. Homemaker/chore does not require the use of higher salaried home/health aides. Yet, only 3.04 percent of this cost was charged to Medi-Cal costs. We note that the hourly pay scales of home health aides is 50 cents per hour greater than for homemaker/chore. We acknowledge that this account may include some homemaker salaries.

MONITORING

Manual section 10-034.7 states:

".71 The county welfare department shall retain continuing, basic responsibility for:

.714 The preparation at least annually of a written record of the performance of service contractors, both qualitative and quantitative, which shall be readily available for SDSW review."

Manual section 10-211 states: "The county welfare director shall provide for an effective and objective means of regularly evaluating the results of the county's public social service programs in terms of the objectives in Section 10-005 and adherance to the established plan."

Social Service letter No. 74-12 delineated the county's responsibilities for monitoring.

In our opinion, the county's monitoring effort needs considerable strengthening to avoid the type of problems enumerated in this report. Monitoring can search out answers to questions raising doubts that costs are reasonable and necessary. Some areas need further exploration and justification. A few examples are:

1. Officers of Homemaking Sojourners consist of two husband and wife teams whose salaries of $78,950 equal 61 percent of homemaker salaries and almost 50 percent of homemaker and office salaries combined.

2. Homemaker/chore's share of the Director and Administrative Assistant's salary increased by 39 percent in 1 year and accountant fees increased by 32 percent in reported SFHHS costs.

3. Exceptional staffing found in San Francisco Home Health Services where 8 of the nonnursing staff out of 14 have MSWs should be explored. There are nine nurses on the payroll.

The above are questions not raised elsewhere in this report. While all of the above may be seen as necessary, discussion with county officials indicates that they have not been justified. We add that such exploration would be less necessary if contracts were subject to competitive bidding. Conversely, with such a gross absence of competitive incentives, such justification becomes imperative.

CONTRACTS

SFDSS has contracts with five agencies: San Francisco Home Health Services; Health Help, Inc., Homemakers, Inc., of San Francisco Bay Area; Visiting Nurse Association of San Francisco; and Homemaking Sojourners.

Except for minor variations, all five contracts are alike.

The contracts, first entered into in February 1971, essentially reflect 1971 regulations and designate $150 as a limit on usual cases. We found no evidence of compliance with these terms, and discussions with various individuals, such as the EDP manager of one contractor, gave no indication of awareness of limitations lower than $350 and $450.

Although the county study (which we believe underestimates the chore caseload) shows that more than 40 percent of the contractor's cases are chore cases, the contract terms make no mention of chore or the $100 limitation on usual cases.

Manual section 30-500.51 states: "The maximum allowance for chore services, except as provided in sections 30-500.511 and 30-500.52 shall not exceed $100 per month."

During a meeting in July 1974 on other matters, Mr. George Elich of the Department of Health inquired why San Francisco's homemaker/chore contracts were never submitted for prior State approval. Mr. Born stated that because contracts were initiated in February 1971, they preceded and therefore were not subject to the guidelines. The contract with Homemaking Sojourners was signed on May 15, 1972, almost 2 months after issuance of contract guidelines specifying limited-term contracts. Mr. Born was advised that old regulations cannot be

perpetuated by contract and that the new guidelines provide for definite term contracts rather than unlimited contracts.

He further advised Mr. Born to submit the contracts for approval. In our opinion, contractual terms do not negate regulation, and where they so contradict, the terms become invalid.

Subsequent minutes of the Social Service Commission show that Mr. Born recommended and the Commission resolved to submit contracts for approval prior to fiscal year 1975–76. We wish to point out, this further delays regulatory compliance regarding such matters as the $100 limitation.

The contract, in effect, puts administrative control into the hands of the contractors and to a great extent, represents an abandonment of responsibility by the county. While it would appear on the surface that the county exercises some control by virtue of their authority to assign cases, control is lost because the contractor has freedom to determine the hours to be provided to each client. (See discussion on assessments and reassessments.)

For purposes of discussion, the contract with San Francisco Home Health Services is quoted here. The contract delegates the following authorities to the contractor which, for the most part, should not be delegated to anyone outside the Welfare Department (see discussion of responsibility abrogation).

1. Evaluation, reevaluation, and coordination of community resources.
2. Assessment of functional ability.
3. Assessment of recipient's attitude and willingness to accept homemaker services.
4. Evaluation of the physical environment in the recipient's home.
5. Evaluation of special needs.

We also note that the contract has no ending date and thus, competition is further discouraged.

REASSESSMENTS

In addition to the problem discussed under abrogation of responsibility, our findings show deficiencies in the area of reassessment and documentation of need in direct pay cases.

Manual section 30–500/550.41 states: "The need for services shall be evaluated at least every 6 months to assure their effectiveness in helping the individual remain in his own home."

Of the 66 agency and direct pay cases reviewed, only 35 had been reevaluated within the last 6 months. The county stated that because of lack of staff, they do not schedule reassessments as required by regulation, but instead set reevaluations on an annual basis. In 17 cases, even these annual reevaluation, were overdue.

Manual section 30–500/550.43 states: "Such assessment shall document the basis of the need for services, level and quality of services required and the plan of delivery of the services."

Assessment of need was to be documented on the form 880. While this form is adequate to serve the purpose, 6 cases out of 66 reviewed did not contain an 880. Since the form 880 also serves as the document to control payment, there was no way to determine whether the payment was in accordance with the authorization in these six cases. The county explained the absence of the 880 by saying that some eligibility staff had been unsure where to file the forms and may have thrown them out.

REDETERMINATION OF ELIGIBILITY

Manual section 30–500/550.322 states: "The Service System of the County Welfare Department shall redetermine eligibility for services at least once every 6 months."

There was no evidence that the county redetermines eligibility according to any schedule once a case is approved. The recipient's SSI/SSP status is verified initially, but therafter the county makes no effort to redetermine eligibility. Thus, the county is relying on an initial certification of SSI/SSP eligibility which may or may not remain current.

Another problem occurs if the welfare department opens a homemaker/chore service case when a person is still an applicant for SSI/SSP. Applicants for SSI/SSP can appropriately receive homemaker/chore service under the regulation (30–550/550.311), but no procedure exists for the county to determine the

outcome of a person's application. If this person's application for SSI/SSP is eventually denied, the homemaker/chore service case established by the count remains open.

STATE OF CALIFORNIA,
DEPARTMENT OF HEALTH,
Sacramento, Calif., June 26, 1975.

MR. KENNETH BRYAN,
Acting General Manager,
City and County of San Francisco,
San Francisco, Calif.

DEAR MR. BRYAN: As you may recall, an addendum to our report was proposed to accommodate our review of an additional contractor. Since our previous exit interview did not include discussion of this contractor, you may wish to have one, or if you prefer, you may comment in writing.

Since this segment pertains only to one contract, the entire addendum will be discussed with the contractor as well. We prefer to discuss the draft with the county first.

Please let me know if a meeting is desired. Because I will be in the field during much of the time, I suggest contacting the Services Management Section so that I may arrange a flight from the field to San Francisco.

Sincerely,

GEORGE ELICH,
Chief, Field Review Unit.

SCOPE

As an addendum to our original report of April 4, 1975, we have examined the financial records of a proprietary contractor providing homemaker/chore services on behalf of San Francisco County. Our review was made in accordance with generally accepted monitoring standards except that our review was limited to the following tests:

One: A review of financial statements for 1973 and 1974.
Two: A review of loans and promissory notes.
Three: A reconciliation of ledgers and cost summaries.
Four: A reconciliation of cost summaries and tax returns.
Five: An analysis of transactions between the corporation and its sister corporation.
Six: Detailed analysis of cost documentation for October 1973.
Seven: A detailed analysis of political contributions for 1973 and 1974.
Eight: A detailed analysis of the corporate president's expense reimbursement.

It is important to note that this is a review of the county's performance and adherence to regulations rather than the contractor's. Therefore, no assumptions should be made of the contractor's compliance or noncompliance failings without a careful review of the contract. All findings are stated in the context of county obligations and no attempt is made to limit discussions to the terms of the contract which were not submitted for state approval.

HIGHLIGHTS

Our findings indicate a serious deficiency in audit trails and questionable costs in terms of reasonableness and necessity.

GENERAL DISCUSSION

Because of a death in the family of this contractor's certified public accountant, the records could not be examined during our previous visit. Our findings support recommendations previously made.

The county is advised that there are a number of deficiencies which may lead to audit exceptions if corrective action is not taken promptly.

GENERAL RECOMMENDATION

No one act such as contract approval can effect necessary safeguards. Each act is dependent upon the other for effectiveness. Therefore, the county is advised to adhere to all of the following recommendations:

One: Competition should be sought through open-bidding procedures. At least three bids for each contract should be sought. If, for example, two contracts are to be awarded, six different contract bids should be sought. No more than one contract should be considered without strong justification. Justification can be found in instances such as inability to find three bidders, each capable of handling all cases alone. In no case should so many contracts be allowed that competition is eliminated.

Two: Bids should be sought with a request for proposal. To put it simply, a request for proposal defines precisely what the buyer wishes to purchase in terms of type, quality, and quantity. It also precisely defines what the contractor is expected to deliver. Quality definition is essential to eliminate unqualified bidders.

In terms of quality, regulations and law call for what is necessary. There is no valid reason to make the standards so high that only one or two contractors can qualify. By the same token, they should not be lower than required by law and regulation. The word "necessary" is significant in both fiscal and program language.

Only by defining precisely what is to be delivered can a contractor's performance be measured.

Three: The request for proposal should be made a part of the contract. As previously advised, the contract should be submitted for state approval prior to execution. It should also include a budget to indicate what resources are committed and identify what is acceptable as expense.

Four: The county should monitor the contractor to see that the terms of the contract are being met. If statements from contractors are to be accepted as a part of the monitoring effort they should be certified. We trust that our findings are sufficiently conclusive to discourage admonitions that certified statements are too expensive. Certifications should attest that the costs are reasonable and necessary and the certification should be stated in accordance with standards for audit of governmental organizations, programs, activities, and functions, issued by the Comptroller General of the United States.

PROBLEM

Although the accounting procedures seem to be vastly improved in 1974, our test month of October 1973 and other months in 1973 indicate that some costs shown may be unrelated to provision of homemaker/chore services for San Francisco County.

DISCUSSION

A considerable number of charges were made for entertainment, business expenses, and travel. Some of these were incurred out of state. During 1973 those that were attributable to a sister corporation were not always carefully identified. As a result, a one-time adjusting entry for $8,000 was made to reduce contractor costs and bill the sister corporation.

When questioned, the certified public accountant referred us to the corporate president. He, in turn, could not support the adequacy of the adjustment with documentation or detail. We have no recourse except to assume that the adjustment was an educated guess. This leaves all remaining expenses questionable in terms of reasonableness and necessity. Indeed, some may not be relevant to provision of services in San Francisco County.

As discussed elsewhere, the original expenditure documentation itself is so lacking that one cannot determine what is definably relevent.

Further, when promotional and entertainment expenses are so out of the ordinary, they are questionable as being reasonable and necessary even though they may be related to provision of service in San Francisco County. We recognize the possibility that some business lunches may occasionally be necessary, but when a firm engages in a contract with governmental agencies, and the contract is competitively awarded on the basis of quality and costs, such costs should be minimal and promotion, political contributions, and entertainment should be relatively unnecessary.

RECOMMENDATION

We urge the county to follow the procedures outlined under general recommendations. Adherence should substantially eliminate this problem.

PROBLEM

Expense reimbursements claimed by the corporate president and included as expenditures are not adequately supported. Further, they are questionable in terms of the test of reasonable and necessary.

DISCUSSION

Our review of October 1973 costs led us to review all costs described as "reimbursements" to the president. These totaled $45,430.97 for 1974 exclusive of March and $31,954.72 for 1973 exclusive of May. The reasons these 2 months were excluded is that the statement submitted for reimbursement in these 2 months could not be found. Since our workpapers were intended to group items by vendor or type, these 2 months could not be detailed.

This reimbursement is supported by a monthly statement prepared by the president for expenses at restaurants, etcetra. A test of two statements indicates that credit card billings can be found in the files to support the items, but receipts showing any detail are often missing. As for out-of-pocket expenses, these were totally unsupported by bills or receipts. While we recognize that a corporation is a separate legal entity and the president of that corporation is an employee, we must take issue with the expenditures.

Any Government letting a contract based upon cost has a right and a responsibility to assure that such costs are at least relevant to the cost of providing such service. This would be the case even if the employee did not own a controlling interest in the corporation.

In a situation where the employee does own a controlling interest and obviously incurs many of the expenses out of State while pursuing contracts for a sister corporation, such reimbursements are particularly open to question and should be supported by receipts, details as to when travel occurred, who was entertained, and what business was discussed. None of these conditions were found. Even if they were, the magnitude gives rise to doubt of their reasonableness or necessity.

Although almost every part of expenditures should be questioned by county monitoring, we cite only those that seemed to most require explanation and justification.

	1973	1974
Prorated home office	$1,498.00	$1,900.00
Benadarets (pipe and tobacco store)	1,690.97	2,389.53
John Walker (liquor store)	2,580.91	2,083.67
Out-of-pocket expenses	2,600.00	4,998.58
Washington, D.C. (inaugural)	925.00	
Alfred Dunhill (men's botique)		254.00
Honolulu expenses		405.00

While some of these costs may or may not have been reimbursed by the sister corporation during 1973, there is no way of knowing if any were—see discussion of first problem. Those in 1974 represent that which was not reimbursed.

RECOMMENDATION

The county should monitor contractors as required. Further, this finding substantiates our belief that contracts based upon unaudited costs and not subject to competition should not be pursued.

PROBLEM

Reported expenses included political contributions to both political systems. Since reported costs included these contributions and were used to support contractual rates, title IV funds, in effect, were used for political contributions.

DISCUSSION

Our review of October 1973 expenditures led us to analyze political contributions to both parties for the entire years of 1973 and 1974. Because such contributions were not consistently recorded in the same place, we may not have

identified all. Those that were identified for the 2 years totaled $2,200. There were also contributions to police officer associations totaling $57.50. These are exclusive of contributions made on behalf of the sister corporation and separately identifiable in 1974.

One of the requirements of reimbursable costs are that they be reasonable and necessary. In our opinion these are not necessary for the provision of service under this contract and title VI funds were never intended for such purposes.

RECOMMENDATION

County monitoring should be utilized to prevent such charges and the contractor should be advised that they cannot be reimbursed by this contract and should not be reported as valid costs.

PROBLEM

The records do not offer an adequate audit trail. This was touched upon in the discussion of the president's reimbursements and, although somewhat repetitive in more detail, this discusses the problem of audit trails.

After reconciling statements to accounting summaries and income tax returns, the month of October 1973 was selected for detailed examination. Our findings indicate considerable deficiencies in audit trail. It must be stated, however, that the situation appears to have improved in 1974.

Certain entries were not supported with receipts. It would appear that receipts did exist at one time, but due to misfiling and other problems, they could not be readily traced. A few examples include:

One: An American Express invoice, mailed November 17, 1973, for $1,059.34. Most of this payment was for a prior balance with no detail as to what the balance was for. Office staff could not explain the lack of support.

Two: A Carte Blanche invoice for $363.68, mailed October 25, 1973, had receipts enclosed totaling only $169.68.

Three: A Diner's Club bill, mailed on October 18, 1973, for $626.03, was supported by receipts totaling only $88.85.

While it should be noted that in one case missing bills were tracked down after considerable searching and found to be misfiled, this does not represent an adequate audit trail. In effect, we were reconstructing records. Presumably, we could have done so with other questioned items, but records requiring reconstruction by audit do not represent an audit trail.

RECOMMENDATION

The firm's accountant should be consulted to establish more acceptable detail record procedures. In fairness to the CPA, we note that the firm's agreement with the CPA is based upon an unaudited statement and some of the improvements noted were due to his guidance.

PROBLEM

The contractor appears to believe that income taxes and tax penalties for late payment of payroll taxes are a reimbursement cost. There is no way of knowing if the county allowed income tax to be weighed as a cost. The tax penalty was.

DISCUSSION

On March 14, 1974, the contractor submitted cost data and stated: "Our total cost for the year after taxes was $679,396. This proves that our cost per hour was $6.88 which constitutes a 12 percent profit per hour at our rate of $7 per hour."

The statement attached shows that the cost reported above includes provision for income taxes of $6619. We do not know if the county accepted this as a part of the cost. At any rate, this statement seems to presume that the contractor is entitled to tax-free income by requesting that taxes be reimbursed by the county.

Further, the reconciliation of cost summaries to tax returns revealed that tax penalties for late payment of payroll taxes were included in costs and

were not clearly identifiable on the statement. The penalty was incurred because of an honest misunderstanding of payroll tax requirements. This does not alter the fact that the county is not responsible for the contractor's negligance and such costs cannot be considered necessary for the performance of this contract.

RECOMMENDATION

The county should monitor contract costs and should disalow any reported costs which include income taxes and tax-penalty provisions.

STATE OF CALIFORNIA,
DEPARTMENT OF HEALTH,
Sacramento, Calif., August 11, 1975

MR. KENNETH BRYAN,
Acting General Manager,
City and County of San Francisco,
Department of Social Services,
San Francisco, Calif.

DEAR MR. BRYAN: The attached addendum represents our report on the return visit to San Francisco.

If you have any question, please call me at 917-322-6333.

Sincerely,

GEORGE ELICH,
Chief, Field Review Unit.

[Enclosure.]

FOREWORD

As an addendum to our original report of April 4, 1975, we have examined the financial records of a second contractor providing homemaker/chore services on behalf of San Francisco County.

Because our findings relating to both contractors reviewed indicates a deficiency in the direction and control exercised by the county, we believe it is reasonable to assume that the direction and control exercised over the three contractors not reviewed was equally lacking.

We also believe that with appropriate direction and control each of the contractors reviewed can serve the county well. Just as these two providers should not be disadvantaged in future bidding procedures, providers not reviewed should not be advantaged and presumed to be without need of improved direction and control by virtue of their exclusion from our sample of contractor operations.

SCOPE

We have examined the financial records of a proprietary contractor providing homemaker/chore services on behalf of San Francisco County. Our review was made in accordance with generally accepted monitoring standards except that our review was limited to the following tests:

One: A review of financial statements for 1973 and 1974.
Two: A review of loans and promissory notes.
Three: A reconciliation of ledgers and cost summaries.
Four: A reconciliation of cost summaries and tax returns.
Five: An analysis of transactions between the corporation and its sister corporation.
Six: Detailed analysis of cost documentation for October 1973.
Seven: A detailed analysis of political contributions for 1973 and 1974.
Eight: A detailed analysis of the corporate president's expense reimbursement for 1973 and 1974.

It is important to note that this is a review of the county's performance and adherence to regulations rather than the contractor's. Therefore, no assumptions should be made of the contractor's compliance or noncompliance without a careful review of the contract. All findings are stated in the context of county obligations and no attempt is made to limit discussions to the terms of the contract which were not submitted for State approval.

HIGHLIGHTS

Our findings indicate that some costs are questionable in terms of reasonableness and necessity and records do not adequately provide audit trails.

GENERAL DISCUSSION

Because of a death in the family of this contractor's CPA, the records could not be examined during our previous visit. Our findings support recommendations previously made.

The county is advised that there are a number of deficiencies which may lead to audit exceptions if corrective action is not taken promptly. Following is a summary of the problems to be discussed in this report: business travel and entertainment expense, political contributions, inadequate audit trails.

GENERAL RECOMMENDATION

No one act such as contract approval can effect necessary safeguards. Each act is dependent upon the other for effectiveness. Therefore, the county is advised to adhere to all of the following recommendations:

One: Competition should be sought through open-bidding procedures. At least three bids for each contract should be sought. If, for example, two contracts are to be awarded, six different contract bids should be sought. Competitors must know in advance that high bidders will receive none of the awards if competition is to be a reality. No more than one contract should be considered without strong justification. Justification can be found in instances such as inability to find three bidders, each capable of handling all cases alone. In no case should so many contracts be allowed that competition is eliminated.

Two: Bids should be sought with a request for proposal. To put it simply, a request for proposal defines precisely what the buyer wishes to purchase in terms of type, quality, and quantity. It also precisely defines what the contractor is expected to deliver. Quality definition is essential to eliminate unqualified bidders.

In terms of quality, regulations and law call for what is necessary. There is no valid reason to make the standards so high that only one or two contractors can qualify. By the same token, they should not be lower than required by law and regulation. The word "necessary" is significant in both fiscal and program language.

Only by defining precisely what is to be delivered can a contractor's performance be measured.

Three: The request for proposal should be made a part of the contract. As previously advised, the contract should be submitted for State approval prior to execution. It should also include a budget to indicate what resources are committed and identify what is acceptable as expense.

Four: The county should monitor the contractor to see that the terms of the contract are being met. If statements from contractors are to be accepted as a part of the monitoring effort, they should be certified. We trust that our findings are sufficiently conclusive to discourage admonitions that certified statements are "too expensive". Certifications should attest that costs are reasonable and necessary and the certification should be stated in accordance with Standards for Audit of Governmental Organizations, Programs, Activities, and Functions, issued by the Comptroller General of the United States, 1972.

PROBLEM

Although the accounting procedures seem to be vastly improved in 1974, our test month of October 1973 and other months in 1973 indicate that some costs shown may be unrelated to provision of homemaker/chore services for San Francisco County.

DISCUSSION

A considerable number of charges were made for entertainment, business expenses, and travel. Some of these were incurred out of State. During 1973 those that were attributable to a sister corporation were not always carefully identified. As a result, a one-time adjusting entry for $8,000 was made to reduce contractor costs and bill the sister corporation.

When questioned, the CPA referred us to the corporate president. He, in turn, could not support the adequacy of the adjustment with documentation or detail. We have no recourse except to assume that the adjustment was and educated guess necessitated by deficiencies in record keeping procedures. This leaves all remaining expenses questionable in terms of reasonableness and necessity. Indeed, some may not be relevant to provision of services in San Francisco County.

As discussed elsewhere, the original expenditure documentation itself is so lacking that one cannot determine what is definably relevant.

Further, when promotional and entertainment expenses are so out of the ordinary, they are questionable as being reasonable and necessary even though they may be related to provision of service in San Francisco County. We recognize the possibility that some business lunches may occasionally be necessary, but when a firm engages in a contract with governmental agencies, and the contract is competitively awarded on the basis of quality and costs, such costs should be minimal and promotion, political contributions, and entertainment should be relatively unnecessary.

RECOMMENDATION

We urge the county to follow the procedures outlined under general recommendations. Adherence should substantially eliminate this problem.

PROBLEM

Expense reimbursements claimed by the corporate president and included as expenditures are not adequately supported. Further, they are questionable in terms of the test of reasonable and necessary.

DISCUSSION

Our review of October 1973 costs led us to review all costs described as reimbursements to the president. These totaled $45,430.97 for 1974, exclusive of March, and $31,954.72 for 1973, exclusive of May. The reasons these 2 months were excluded is that the statement submitted for reimbursement in these 2 months could not be found. Since our workpapers were intended to group items by vendor or type, these 2 months could not be detailed.

This reimbursement is supported by a monthly statement prepared by the president for expenses at restaurants, et cetera. A test of two statements indicates that credit card billings can be found in the files to support the items, but receipts showing any detail are often missing. As for out-of-pocket expenses of $2,600 and $4,098 in 1974, these were totally unsupported by bills or receipts. While we recognize that a corporation is a separate legal entity and the president of that corporation is an employee, we must take issue with the expenditures.

Any government letting a contract based upon cost has a right and a responsibility to assure that such costs are at least relevant to the cost of providing such service. This would be the case even if the employee did not own a controlling interest in the corporation.

In a situation where the employee does own a controlling interest and obviously incurs many of the expenses out of State while pursuing contracts for a sister corporation, such reimbursements are particularly open to question and should be supported by receipts, details as to when travel occurred, who was entertained, and what business was discussed. None of these conditions were found. Even if they were, the magnitude gives rise to doubt of their reasonableness or necessity.

Our review clearly indicates that county monitoring went no further than statements provided. It is not until one looks at the detail behind statements that expenses which do not meet the tests of reasonableness and necessity become apparent. Related to this discussion, these include such items as out-of-State travel, unusually high entertainment, and other related expenses. In the case of entertainment expenses, there is no assurance or basis for determining that these are related to provision of service in San Francisco County. As for a smaller portion of these items, there is no assurance that these are not personal expenses.

RECOMMENDATION

The county should monitor contractors as required. Further, this finding substantiates our belief that contracts based upon unaudited costs and not subject to competition should not be pursued.

PROBLEM

Reported expenses included political contributions to both political systems. Since reported costs included these contributions and were used to support contractual rates, title VI funds, in effect, were used for political contributions.

DISCUSSION

Our review of October 1973 expenditures led us to analyze political contributions to both parties for the entire years of 1973 and 1974. Because such contributions were not consistently recorded in the same place, we may not have identified all. Those that were identified for the 2 years totaled $2,200. There were also contributions to police officer associations totaling $57.50. These are exclusive of contributions made on behalf of the sister corporation and separately identifiable in 1974.

One of the requirements of reimbursable costs are that they be reasonable and necessary. In our opinion these are not necessary for the provision of service under this contract and title VI funds were never intended for such purposes.

RECOMMENDATION

County monitoring should be utilized to prevent such charges and the contractor should be advised that they cannot be reimbursed by this contract and should not be reported as valid costs.

PROBLEM

The records do not offer an adequate audit trail. This was touched upon in the discussion of the president's reimbursements and although somewhat repetitive in more detail, this discusses the problem of audit trails.

After reconciling statements to auditing summaries and income tax returns, the month of October 1973 was selected for detailed examination. Our findings indicate considerable deficiencies in audit trail. It must be stated, however, that the situation appears to have improved in 1974.

Certain entries were not supported with receipts. It would appear that receipts did exist at one time, but due to misfiling and other problems, they could not be readily traced. A few examples include:

One: An American Express invoice, mailed November 17, 1973, for $1,059.34. Most of this payment was for a prior balance with no detail as to what the balance was for. Office staff could not explain the lack of support.

Two: A Carte Blanche invoice for $363.68, mailed October 25, 1973, had receipts enclosed totaling only $169.68.

Three: A Diner's Club bill, mailed on October 18, 1973, for $626.03, was supported by receipts totaling only $88.85.

While it should be noted that in one case missing bills were tracked down after considerable searching and found to be misfiled, this does not represent an adequate audit trail. In effect, we were reconstructing records. Presumably, we could have done so with other questioned items, but records requiring reconstruction by audit do not represent an audit trail.

RECOMMENDATION

The firm's accountant should be consulted to establish more acceptable detail record procedures. In fairness to the CPA, we note that the firm's agreement with the CPA is based upon an unaudited statement and some of the improvements noted were due to his guidance.

PROBLEM

The contractor included income taxes and tax penalties for late payment of payroll taxes as a reimbursable cost. In this case, the item was clearly reflected

on the statement. There is no way of knowing if the county allowed income tax to be weighed as a cost. The tax penalty was.

DISCUSSION

On March 14, 1974, the contractor submitted cost data and stated: "Our total cost for the year after taxes was $679,396. This proves that our cost per hour was $6.88 which constitutes a 12 cent profit per hour at our rate of $7 per hour."

The statement attached shows that the cost reported above includes provision for income taxes of $6,610. This statement seems to presume that the contractor is entitled to tax-free income by requesting that taxes be reimbursed by the county.

Further, the reconciliation of cost summaries to tax returns revealed that tax penalties for late payment of payroll taxes were included in costs and were not clearly identifiable on the statement. The penalty was incurred because of an honest misunderstanding of payroll tax requirements. This does not alter the fact that the county is not responsible for the contractor's negligence and such costs cannot be considered necessary for the performance of this contract.

RECOMMENDATION

The county should monitor contract costs and should disallow any reported costs which include income taxes and tax-penalty provisions.

STATE OF CALIFORNIA,
DEPARTMENT OF HEALTH,
Sacramento, Calif., August 12, 1975.

Mr. KENNETH W. BRYAN,
General Manager,
Department of Social Services,
City and County of San Francisco,
San Francisco, Calif.

DEAR MR. BRYAN: Attached is an addendum to the original report on San Francisco's administration of the homemaker/chore program.

Sincerely,

GEORGE ELICH,
Chief, Field Review Unit.

[Enclosure.]

ADDENDUM TO REIEW OF HOMEMAKER/CHORE PROGRAM, SAN FRANCISCO COUNTY

This addendum is intended to allow officials of the San Francisco Home Health Service to express their views regarding the original report. Issuance of this addendum does not imply the State's agreement with the conclusions in or accuracy of the addendum or the documents mentioned herein.

INTRODUCTION

The methodology of the study conducted by the review team was faulty, undocumented and inadequate in its coverage. Several conclusions about the San Francisco Home Health Service—SFHHS—were erroneous and the report is personalized. The State did not hold an exit conference, respond to the agency's critique of the report or suggest changes in minutes of the meeting held June 11, 1975. Copies of each document cited are available upon request from SFHHS.

ERRORS

One: Assessment and reassessment by professional staff at SFHHS are inherent in the supervisory process. Supervision is one of the two components that distinguish homemaker services from chore services. The costs quoted—10.2 percent—are appropriate for billing to DSS in the unit rate, and the level of professional staffing at SFHHS—in a minimum ratio of 15–1—is not excessive.

Two: The report fails to compare monthly costs of chore cases versus cases at SFHHS, or to compare chore cases with other Homemaker Service contractor's monthly costs.

CONTINUED

3 OF 4

The chief argument that $2,500,000 was being over paid, is based on the assumption that the $100 limit on chore services is not being enforced, whether the case is with a contactor or a private chore person. This is an over-simplification. Some funds are unnecessarily expended because the county is unable to do the required assessment and reassessment—supervision—of private chore cases. This expenditure, as a separate entity, was not discussed in the report, nor was there an examination of how frequently SFHHS assesses and reassesses—supervises—its clients.

Other factors in the alleged overexpenditure of $2,500,000 result from a lack of adherence to and enforcement of recognized Homemaker Service standards which are still required by Federal regulations.

(*a*) Lack of adequate supervision by certain Homemaker Service providers results in overutilization of homemaker hours—the agency with the greatest amount of supervision—SFHHS—has the lowest monthly charge to DSS per client.

(*b*) Lack of adequate training in certain Homemaker Service providers results in overutilization of homemaker hours—the agency with the greatest number of trained paraprofessional staff—SFHHS—has the lowest monthly charge to DSS per client.

On page 3, the report states: "Costs can be lowered if all contractors' cases were appropriately and more professionally assessed"—yet no solution to the present situation is offered except to insist that SFHHS and other contractors should discontinue this practice.

Three: There was no evidence to verify the claim that SFHHS charges DSS for unauthorized nursing or medical services. Supervisory of nurses are legitimate for inclusion in the DSS rate.

Four: SFHHS determines neither the type of service needed—homemaker versus chore—nor the hours of service given to a client without approval by DSS.

The San Francisco Home Health Service is located at 2940 Sixteenth Street, San Francisco 94103.

Appendix 6

STATEMENT OF HADLEY D. HALL, EXECUTIVE DIRECTOR, SAN FRANCISCO HOME HEALTH SERVICES, SAN FRANCISCO, CALIF.

I am Hadley Dale Hall, executive director of San Francisco Home Health Service, a United Way agency established 20 years ago. I have been its executive for over a decade. I am an elected member of:

One: The Board of Directors of the National Council for Homemaker-Home Health Aide Services, Inc., and an active member of its Executive, Legislative and Standards Approval Committees;

Two: The Board of Directors of the National Association of Home Health Agencies; an active member of its Executive Committee and several others;

Three: The Board of Directors of the California Association for Health Services at Home, and serve as Chairman of one of its active committees and as a member of two others.

In addition, I am the project director for the San Francisco Expanded Medicare Benefits project, financed by section 222 of Public Law 92-603. The San Francisco project is more comprehensive and larger than the other five projects in the Nation, combined.

Recently, I was appointed to California's State Benefits and Services Advisory Board's Task Force on Homemaker/Chore Services to examine issues related to these human services at the request of Governor Edmund G. Brown, Jr.

I do not speak for these groups, or the San Francisco Home Health Service. I come to testify as an individual, at your invitation. I speak from 15 years of vigorous involvement and commitment to caring for children and adults in their homes, when such care is appropriate and safe.

THE ISSUES

There are some very basic issues of public policy which must be resolved in our Nation. Some of these issues were discussed in testimony before the joint hearings of the Senate Subcommittee on Long Term Care and the House Subcommittee on Health and Long-Term Care on October 28, 1975.

At that time, five public policy issues were discussed:

First: The important question of quality assurance and the conflict between quality assurance and the profit incentive.

Second: The question of the source of the margin of profit in profit-taking services.

Third: The effect of a policy which allows for the siphoning off of profit dollars upon a relatively fixed budget for In-Home Health Services, particular in medicaid and, more particularly, for para-professional services financed by title XX of the Social Security Act.

Fourth: The question of real economy—does profittaking in competition with nonprofit services result in a product which is equal in quality, but less costly? It has been contended that profittaking businesses provide services at a less costly unit price. If quality guarantees are not observed, they may be able to do this. But, the incentive to sell more units of service is an element in all business, and this has been demonstrated in my community.

Finally: Abuses have occurred in the In-Home Health Services delivery business which do not occur in services which observe ethical standards.

A copy of that complete testimony is included as a part of this presentation.

There are other important public policy issues to consider, too. In-Home Health Services have many names: Homemaker Services, Home Health Agency Services, "Homemaker/chore" services, attendant care, Visiting Nurse Services, Long Term Care at home, Hospice Care, among others. They all have the same purpose—to prevent, postpone or reduce the unnecessary institutionalization of

our citizens. These worthwhile, but fragmented, programs are spending an estimated $2½ billion annually of tax funds.

Definitions of services for people in need of them are available, but have not been adopted by government. Definitions of the provider are available from many sources, but they have never been accepted by government. Alternatives have not been offered by representatives of government responsible for these services. If a population at risk is defined and the services to be provided are defined, then it would not seem so difficult to agree on who was going to provide the services. Small neighborhood groups, without financial resources, need to be included where their quality can be measured. Giant corporations, regardless of financial reserves, should be excluded, where their standards and quality cannot be or are not measured.

The public policy issue of who is the employer and who is the employee cannot continue to remain unresolved. The massively handicapped individuals, able to supervise their care, may need to have control of their caretakers.

However, the public policy issue of who is the employer of the workers who serve 90 percent of the recipients cannot continue unresolved—as it is now.

Federal and State labor codes, and court decisions confirming those codes, essentially establish that if an individual or group controls any one of the following, that person or group is an employer:

1. Effective hiring and firing Federal, State, and local regulations clearly establish that government has accepted this role in a large number of situations;

2. Control of hours and working conditions—Federal, State, and local documents establish that government has established hours and working conditions;

3. Control of wages and benefits—again, government has accepted this responsibility;

4. Assignment of tasks and duties—documents from governmental units establish that government controls this area for these services.

Therefore, the government is the employer. If government is not, who is the employer? No one would advocate that the many recipients (who are ill and frequently poor) should each keep track of income tax withholding, workers' compensation, unemployment benefits, and social security. Yet, staff of the Department of Health, Education, and Welfare (DHEW), the States and local governments have involved themselves in a "constructive conspiracy" to avoid the employer issue, in the mistaken belief that total costs would increase—they will not increase, in total, even though the unit price will increase dramatically.

The Supreme Court has ruled that public employers are not bound by applicable Federal and State minimum wage laws and statutory benefits; however, no government official has ever taken the position that the workers in this field, who are public employees, should be paid less than the minimum wage, without statutory benefits.

WHAT NEEDS TO BE LEGISLATED

Standards for providers and services must be developed which are objective, verifiable and verified, now and in the future. A system of monitoring and validating providers and services can and must be instituted. Full and complete disclosure of owners, partners (including silent partners) and other principals must be required, and they must be public. Cost effectiveness and quality assurance must be guaranteed. Criminal sanctions must be established and imposed for those who abuse recipients, workers or taxpayers.

The Congress, the administration, and the States have copies of: many internal reports and studies; three reports by the Special Committee on Aging of the United States Senate; fraud and abuse hearings by former Senator Frank Moss and Senator Lawton Chiles; the study and report of the General Accounting Office; Congressman Claude Pepper's extensive hearings; "Home Health Care, Report on the Regional Public Hearings," by DHEW, among other thoughtful statements, testimonies, and reports. This "library of information" also identifies issues, problems, and solutions.

A careful analysis of these documents leads many knowledgeable people to conclude that our governments have responsibility for the services. These documents also suggest that the officials of our governments have largely abdicated their legal and moral responsibilities for them. They have shown almost no leadership and when they have, the leadership has been focused on a crisis, finally perceived because it was called to its attention by the public, the legisla-

ture, or the news media. However, the causes of the crisis had been known and documented for an extended period of time. Governments' actions have been based, too often, on personal whim, fantasy, false or untested assumptions, misleading data or no data at all—without available consultation, coordination with other units of Federal, State, or local governments, or participation by the public. Our governments neither perceive the possibilities of the abuses nor know the extent of them. The result has been an invitation for a series of shocking abuses to take place, which were predictable, predicted, and unnecessary: Abuses of vulnerable recipients; abuses of and by providers, 80 percent of whom are individuals without any protections, while the other providers are profittaking corporations, public entities and tax-exempt community groups; abuses of the taxpayers' money and trust; and abuses by a few public servants who have the protections of civil service—but whose continued protections must be questioned, seriously.

A "CONSTRUCTIVE CONSPIRACY"

The need to resolve these issues of public policy may be exemplified by a dramatic and seemingly sinister example—but by no means the only case study. It was called "The Gottheiner File" by one newspaper. The use of names and titles is not to suggest wrongdoing but to underscore some of the ways some respected people have been used by profittaking interests. It is a complicated story. The complexity may have occurred by careful design.

Peter Gottheiner's reputation is very well known—it has been known, and documented—for over a decade.

In 1971, a company called Health Help, Inc., secured a contract for Homemaker Services with the Department of Social Services in San Francisco. This company's sole owner and president was Gottheiner, a physical therapist. Just prior to receiving this contract, Gottheiner "dissolved" one of his other companies, California Coordinated Home Care, which, in 1971, was having audit disputes with Medicare, involving $846,271. These audit disputes have never been resolved. The Government did not prosecute, even though action was recommended by Medicare. Medicare and the section of the law under which Gottheiner received his Homemaker Services contract are both part of the Social Security Act.

In addition to the problems Gottheiner had with Medicare in 1971, he also had "problems" with the San Francisco Retirement System. According to one newspaper account, when Gottheiner got his last contract with the San Francisco Retirement System, the Grand Jury " * * * demanded it be rescinded because of irregularities in the procedures granting the contract. The jury report claimed the contract was being rushed through before a staff evaluation of physical therapy programs containing unfavorable comments about Gottheiner could be released. The upshot of the dispute was a new vote by the board. Gottheiner, who was then represented by former Assemblyman William T. Bagley, kept his contract."

The head of the San Francisco Retirement Board was and is Daniel Mattrocce—who later appears as a director for one of Gottheiner's companies.

Gottheiner had other difficulties, too. In Santa Clara County his contract was canceled in the 1960's after extensive investigations and the repayment of certain funds for services billed and paid for, but not delivered. Gottheiner was working with Flora Souza, another physical therapist, at that time. No prescutions were undertaken.

A Gottheiner company was suspended from participation in the California Medical Assistance program on September 28, 1967. The "Certified Mail—Return Receipt Requested" letter, issued by Carel E. H. Mulder, director of the Department of Health Care Services stated:

"The legal basis for this suspension is your repeated violation of section 51455(b) of title 22 of the California Administrative Code. This section provides in material part: 'Causes for suspension shall consist of the following or substantially equivalent actions under this program or the previous Public Assistance Medical Care program or the Medical Assistance for the Aged program.'

"(1) Billing for visits not made or services not rendered.

"The factual basis for this suspension consists of the following violations:

"Subdivision (1) was violated by continuous billings to the State of California for 1 full hour of physical therapy when in fact half hour or less of physical therapy was given."

The same Carel E. H. Mulder later appears on Gottheiner's letterhead as a consultant and director. Mulder has participated in meetings with Gottheiner, acting as a consultant and advisor and acting as though he were a principal in the Gottheiner business enterprise.

With all of this background, proof and knowledge, Gottheiner was able to obtain a contract worth over one-half million dollars in tax funds from another section of the same law administered by DHEW for 1 year. That contract increased several times—under interesting circumstances.

In mid-1970, Gottheiner was authorized to provide "chore services" under "an arrangement" that was to become title XX of the Social Security Act to welfare recipients for $3.25 per hour. In September of 1970, Gottheiner reported to the Department of Social Services and the Social Services Commission that the level of care required by San Francisco welfare recipients required $5 an hour. In February 1971, Gottheiner was able to change his "arrangement." He secured a contract for these services at $5 an hour. The San Francisco Department of Social Services received a staff recommendation 1 month before the contract was signed, stating: "Do not sign a contract with this man."

In July, 1971, Gottheiner's rate was increased to $6 an hour ,with the requirement that financial statements, certified by a Certified Public Accountant, be submitted by October, 1971.

Although no audited or certified financial statements were ever submitted, the Social Services Commission of the city and county of San Francisco voted to keep Gottheiner's rate at $6 an hour through June 1972.

In July 1972, with the help of arguments and lobbying from his attorney (a former member of the Board of Supervisors, Harold Dobbs) Gottheiner managed to get his contract increased from $6 to $7 an hour, despite a negative recommendation from the general manager of the Department of Social Services.

According to the DHEW draft audit report, reported in the press last year, this rate increase more than doubled the amount of profit available to Gottheiner. To date, no certified audits of any of the Gottheiner operations are known to exist, to my knowledge.

Gottheiner had excellent legal counsel, Dobbs, a sometimes candidate for mayor of San Francisco, and former Assemblyman William T. Bagley. Bagley was chairman of California's Assembly Welfare Committee, which had jurisdiction over legislation in this particular area in the California Legislature. Bagley wrote letters on official stationery to Carel E. H. Mulder in support of the "errors" made by Gottheiner's company while Bagley was an elected Assembly representative and Mulder was director of the Department of Health Care Services. Bagley ran for the office of State Controller in 1974, but was defeated. Bagley later received a Presidential appointment to the Commodities Futures Trading Commission.

In the 1971 dispute with Medicare, Dobbs met with Janet Aitken, assistant U.S. Attorney and a former local judge. Dobbs convinced her in a brief discussion that there was little chance of convicting Gottheiner. A review of the DHEW documents might lead reasonable people to believe that the U.S. Attorney should have done more than have a brief discussion with Dobbs.

More recently, Gottheiner formed a sister corporation to Health Help, Inc., called Visiting Home Services—sometimes referred to as VHS. Gottheiner was president of Health Help, Inc., and Visiting Home Services. Visiting Home Services was organized to sell Homemaker Services throughout the United States and the rest of California. Visiting Home Services secured contracts in Utah, Missouri, Minnesota, and Washington, D.C., and obtained contracts in nine counties in California. Health Help, Inc., continued the San Francisco contract. Previous testimonies suggest some questionable events, especially in the Utah situation, regarding Gottheiner and Jay Wimmer, a former employee of Utah's State government and, later, a vice president of one of Gottheiner's companies.

In May 1976, a Federal DHEW audit report charged several companies with major abuses. This report expanded upon serious questions of multiple abuse raised by a California Department of Health report, issued the previous year. Neither report mentions Gottheiner by name and neither report identifies any of Gottheiner's companies, although Gottheiner's company was one of the providers criticized in the State and DHEW reports. Is the exposure of serious abuse without names public disclosure? Is this public accountability?

Gottheiner ran for a seat on the Board of Supervisors in Marin County in June 1976, stating that he earned over $100,000 per year from his companies,

which he admitted were supported by Government funds. (Gottheiner received 686 votes out of 17,999 cast in the election.) The voters seemed to reject Gottheiner's "bid" for public office and public trust rather decisively; did DHEW and California's Department of Health know something the citizens of Gottheiner's district did not know when his "bids" for human services and public trust were accepted?

According to a newspaper account, when Gottheiner's bid in Kansas was turned down, former California Senator George Murphy and Dobbs were engaged to write letters of support and to blunt criticism of Gottheiner. Former Senator Murphy asked Senator Robert Dole to look into the matter. The Kansas public servants handled the inquiry as a routine matter, but saw the "Murphy-Dole inquiry" as a political threat.

A BANKRUPTCY

In June 1976, things became more complex and confused. Gottheiner quickly resigned from his recent corporate creations, after securing a large loan ($126,000), allegedly for expansion into additional States. The loan was arranged by one of Gottheiner's attorneys, Dobbs, through a Dobbs friend, Ralph P. Gomez. In August 1976, just 2 months later, Health Help, Inc., and Visiting Home Services filed bankruptcy, leaving several hundred helpless elderly people without care and hundreds of homemakers unpaid, in several States. Meanwhile, after the VHS bankruptcy, still another company of the same promoters, secured a "temporary" arrangement to collect the title XX Government funds in place of Visiting Home Services in Washington, D.C. The new company in our Nation's capital included, as a principal, Jay Wimmer from Utah and Visiting Home Services.

Meanwhile, Gottheiner was forming a new company, called National Home Care, Inc., now in business and collecting tax funds in Illinois. National Home Care, Inc., was the successful bidder is San Diego, Calif., though the contract has not been awarded, partly because of recent publicity.

Most homemakers are middle aged women from minority groups, most of whom had been on welfare and, for many, this was their first job. Recent facts disclose that Gottheiner was not meeting his union contract obligations. He was paying an average of 30 cents an hour below what the Hospital and Institutional Workers' Union, Local 250, contract required. Gottheiner's employees were not being paid for travel time or holiday pay. Taxes and health insurance were unpaid. The union was mysteriously silent for several years on some of these matters and failed to pursue enforcement for reasons which cannot be explained to the satisfaction of their members. Only the supposition that a "sweetheart" arrangement existed between certain union officials and Gottheiner makes sense, in light of the union's general reputation for aggressively policing and enforcing its agreements with employers.

While the elderly were being neglected and the homemakers were unpaid, Gottheiner said that Gomez was taking a "consultant" fee of $8,250 per month, plus "payment for a Cadillac." Dobbs received $40,000 after the loan was arranged, for "past legal work," according to Gottheiner. The unanswered questions are: why would a loan be arranged for "expansion" only to be followed almost immediately by bankruptcy? Aside from the fees given to Dobbs, what happened to the rest of the loan and tax moneys received by these companies while homemakers went upaid and patients went unserved?

Health Help, Inc., had a payroll of $34,399.44 for July 1976, but billed San Francisco $59,668, leaving $25,268.56 for overhead, profit, and taxes, although, I am told, employee and corporate taxes have not been paid for several months. There does not seem to be any real insolvency in the San Francisco operation.

For the 10 months ended October 31, 1975, VHS reported $1,684,326 income, and homemaker, clerical and other salary expenses of $1,403,056. According to sources outside the companies, there were sufficient funds then to operate and make a generous profit in both companies. In fact, the income and expense for 1976 appear to be more than sufficient to finance expansion, leave a healthy profit and pay excessive salaries and fees to the principal owners and their "consultants," or the financial statements are not a true account of the facts.

Nevertheless, no known charges have been filed—even for bad checks issued to the staff. Indeed no other law may have been breached or broken. Even with this set of circumstances, the "constructive conspiracy" continued.

Bankruptcy trustee, John England, stated that Sanwa Dank "* * * has first claim to any money received (from government) because it holds a security

agreement which, in effect, gives the bank ownership of all * * * outstanding accounts receivable."

A newspaper account goes on to record:

"Nobody is very precise about the figures involved in the case since * * * (General ledgers, other records and documents) as well as Peter Gottheiner's expense statements and other financial records seem to have disappeared from the firm files.

"The sorry state of the books was the rationale England offered for employing Ron Gottheiner, Peter's son and final owner of the business, to work on the bankruptcy * * *.

"Ronald Gottheiner, the son, meanwhile, is in the bullpen over at England's office pulling down a substantial salary considering that he is not yet 30"—a reported $1,200 per month.

Those responsible for these programs—Federal, State, and local officials; bankruptcy trustees; prosecutors; attorneys; et cetera—have not appeared to be very energetic or thorough about their responsibilities. For example, Gomez testified that the tax arrears figure came: "as a very great surprise"; yet, repeated statements by others suggest that it was Gomez who ordered the withholding of these tax payments. Other statements suggest that Gomez' resignation was backdated. Former employees, such as the principal office manager, Joan Katkoff, have not been questioned by responsible government employees. Bookkeepers, secretaries and other staff, to my knowledge, have not been questioned. Why?

The bankruptcy trustee, England: "* * * has an agreement with Sanwa Bank that he will receive 1 per cent of any money collected on its account * * *" leading to the reported charge: "The Trustee has taken to represent Sanwa Bank at the expense of other creditors"—including the Internal Revenue Service.

Homemakers do not have their yearend income tax forms for Federal or State withholding taxes—allegedly, because there are no funds to process the automated payroll. The bankruptcy trustee has not requested the court's permission for this extremely small expenditure for this important matter.

Furthermore, the bankruptcy trustee, John England, has systematically refused to return phone calls, answer questions or—in the minds of government officials—be responsible. For example, auditors were in the bankrupt companies' offices in early September 1976. Certain records and documents, previously seen and used were no longer around when the auditors returned—after England and the younger Gottheiner were in charge. An auditor freely states: "We didn't do an audit, there was very little to even review." A homemaker asked: "Is England working for Gottheiner?"

THE COMPLEX WEB OF RELATIONSHIPS AND THE RELATIONSHIP BETWEEN PUBLIC SERVANTS AND PROFIT-TAKING INTERESTS

These abuses, and others, didn't just happen. Public servants were irresponsible or negligent and in some cases may have been, wittingly or unwittingly, a part of the action.

When Gottheiner got his contract in 1971 with San Francisco, Robert Buckley was president of the Social Services Commission which approved the contract. Buckley was also an officer of a nonprofit corporation formed by the profit-making companies and the union to get government training funds. Funds for training homemakers were already included in the welfare contracts, however. When Buckley, a friend of former Mayor Joseph Alioto, was moved from the Social Services Commission to the Police Commission, another friend became head of the Social Services—Welfare—Commission, John F. Henning, Jr., son of the State and national labor leader. Henning was friendly with Franklyn K. Brann, part owner of another company in San Francisco who, together with Gottheiner, tried to take over all of the San Francisco business at one point. In May of last year, Brann committed suicide after Mayor George Moscone nominated him to be head of the Public Utilities Commission in San Francisco, and after public disclosure that he made 7,036 percent profit on an investment of $850 plus a salary; and other business and legal problems. When Brann was nominated, the new head of the Public Utilities Commission was the former welfare commissioner, John F. Henning, Jr.

The Federal audit that had been leaked in May of last year disclosed that Brann and his wife received compensation of over $43,000 in 1974, on the

total investment of $859. With the same investment, a full-time San Francisco police officer and his wife, Patricia Tull, reimbursed themselves a similar amount. In 1975, the wages and fees to the four owners—two of whom were part time and a third was in college—totaled $96,600.

At the time the contract was let, Mrs. Tull was the head of the local welfare department's homemaker unit—an acknowledged conflict of interest now, but ignored by the commission of which Henning was president when the original contract was awarded. No conflict of interest issue was raised for officer Tull by the Police Commission on which Buckley sat until January 1976. The Police Commission has rules against police officers having a direct or indirect interest in any city contract.

The Gottheiner companies had an interesting board of directors. Buckley, the former welfare commissioner and a then-current police commissioner, was a member of the board of directors of Visiting Home Services, who received payments for attending board of directors' meetings. So was Daniel Mattroce, head of the San Francisco retirement system—with which Gottheiner had experienced considerable difficulty before 1971. Dobbs acted as general counsel for Gottheiner and his companies. Another law firm was needed to keep up with Gottheiner's lawsuits. Several major legal actions were taken against counties, California and Gottheiner's competitors—many more legal actions were threatened.

The local governments blame the California Department of Health for a lack of standards or guidelines, since it is not county money. The State blames the Federal bureaucrats. The changing cast of public servants in Washington, D.C., and the States makes it nearly impossible to pin responsibility on anyone. A few public servants went through some bureaucratic motions, but there was no cessation of the activities of this person's companies outlined above and elsewhere.

Under the current laws and regulations—and notwithstanding documented audit exceptions in medicare and gross abuses in title XX—it would be no surprise if Gottheiner received sizable funds from another unit of DHEW so the same game could be repeated.

This possibility is almost assured. It is assured by the most callous policy that could be established: sending out the delivery of human services to the lowest bidder, without standards, without monitoring, without penalty for default or abuse, without a fair pay to paraprofessionals, or without their being professionally trained and supervised.

It may be a little short of allowing the manager of a slaughterhouse or animal shelter to bid on open heart surgery to be financed by tax dollars.

There has been enough publicity—up and down California and across this country—testimony and other documentation about the activities of Gottheiner and his companies. However, numerous public servants have implied and stated: "Although Gottheiner had certain deficiencies, there were no complaints to suggest that the services his companies provided were inadequate." Such statements are callous and shocking for protected public servants to make without facts. How many complaints from nursing home patients are received if they are in institutions where the pattern is to drug them and to tie them into a bed? How many complaints are received from employees of such institutions?

THE AFTERMATH OF BANKRUPTCY

On August 27, 1976, following the bankruptcy of Health Help, Inc., 106 clients and 26 homemakers were randomly assigned from Health Help, Inc., to San Francisco Home Health Service by the local Department of Social Services.

Although these employees had not been paid for July 1976 and had not been paid for traveltime, holiday pay, or their correct union wages, as required under a collective bargaining agreement, there were no demonstrations by these employees at any government office or anywhere else. The patients didn't complain, either—they could not. The employees had been badly treated for a very long time and did not complain—even to their union. The patients didn't complain to their welfare workers, only in part because the welfare workers have as many as 350 other service cases.

The 26 women who came to San Francisco Home Health Service were frightened, angry, demoralized, and depressed. They had been cheated, again. It was necessary to provide immediate cash loans for bus fare, food, and rent;

and it was necessary to call creditors so that lights and phones would not be discontinued, or furniture repossessed.

These 26 employees are and were hard-working, dedicated, compassionate people, who were hungry for help with their patients. These middle-aged, mostly minority women wanted a job with dignity. They wanted to be employees, treated with respect, and paid the agreed-upon wage. Their expressions about their former employer described slavery—not employment. How can people with the attitudes of hate and fear of their employer help the old and sick for whom government has accepted responsibility?

After providing for immediate cash needs, San Francisco Home Health Service embarked upon a crash program of orientation. The first item of this orientation was providing each new employee with a copy of the union contract, explaining its content and answering questions with union representatives present. The second activity of orientation was relating employee pay stubs to the agreed-upon rates of pay. When this was completed, the employer's rules and regulations were explained—not for the purpose of providing a list of "do's and don'ts," but for the purpose of helping employees understand why the rule was important for the patient and them. Matters discussed included: not accepting gifts—of any kind or value—from a patient; why toenails should not be cut or tub baths given, without professional permission and guidance; how giving a patient a simple massage could lead to instant death for certain patients; and, among other rules, why they should not change their schedules—for the patients' protection, as well as their own.

Without major difficulty, these 26 women received a paycheck in the correct amount, on the agreed-upon date. They began, almost immediately, to seek help for their patients who needed more services, as well as advising the supervisor when they thought patients could do more for themselves, thereby reducing services. (See table 1.)

With a relatively simple, inexpensive, and widely used computer analysis—Statistical Package for the Social Sciences—and by applying some standard tests for variables and comparisons, it is possible to determine a great deal of factual data about this situation. Such an analysis discloses some interesting information about these patients and this provider. (See attached chart.)

Of the 106 patients transferred from Health Help, Inc., to San Francisco Home Health Service on August 27, 1976, 83 had been active with Health Help, Inc., in July 1976. Their services had been billed to the San Francisco Department of Social Services for that period. The same 83 patients were active with San Francisco Home Health Service in September and October 1976 (See table 2.)

Of the 23 patients missing, some were transferred to other providers for reasons of logistics and other administrative reasons. However, some cases were closed immediately. For example, one recipient had been authorized and had been receiving 10½ hours per week service because of depression. The service had been continuous since August 1975. Assessment by the San Francisco Home Health Service nurse and social worker determined that the client was no longer depressed and had two healthy sons—15 and 17 years old—living with the recipient and able to do the tasks assigned to the homemaker. Another example was a client receiving 10 hours per week service for cleaning only. Yet, the client did not have health conditions or an environmental situation that indicated the need for cleaning 5 days per week.

In July 1976, Health Help, Inc., delivered an average of 27.57 hours to their 314 total patients and 29.25 hours to the 83 patients, active and transferred to San Francisco Home Health Service. During October 1976, San Francisco Home Health Service provided an average of 23.05 hours per patient, a decrease of 21 percent.

Repeatedly, homemakers have told the new employer's staff that they were rerequired to stay with the client for the assigned number of hours, regardless of need. More than one-half have reported that they were afraid to report that a patient did not need the alloted time for fear the homemaker would lose income or be disciplined in other ways. About one-half of the hours San Francisco Home Health Service has reduced occurred following professional reassessment, in conjunction with the recommendation of the physician and the homemaker, who knew the real situation.

Of the 83 patients active with Health Help, Inc., who were transferred and are still active, every single person was under active medical care. The number

of diagnoses given by the 61 different physicians ranged froma minimum of two—three patients—to a maximum of eight—two patients. The diagnoses were listed in the following order of frequency: Cardiovascular disease, fractures, neurosensory (including sight, hearing defects), cancer, arthritis, castro-intestinal disease, respiratory disease, mental illness, orthopedic condition—except fracture, genito-urinary disease, cerebro-vascular accident and residuals, and diabetes.

In terms of professional help, there were also some significant differences. Excluding initial evaluation visits which were made in late August, and through the Labor Day weekend, the 83 clients transferred to San Francisco Home Health Service received an average of two professional visits to arrange and provide the necessary supervision, referral and professional help the recipient needed to improve functioning and quality of life.

During July, 98 supervisory visits were made for Health Help, Inc.'s 314 clients. Of the Health Help, Inc., supervisors, three of them (Austin, Cruel and Hector) also served as homemakers. The one professional supervisor for the 314 clients of Health Help, Inc., made only 39 visits in the whole month of July. (See table 3.)

This analysis seems to confirm:

1. This group of patients need part-time intermittent services of differing durations and intensities;
2. Unsupervised staff overutilize services;
3. Unsupervised patients remain on service when the need for help is no longer present. Such an outcome may contribute to the creation of dependence—an opposite goal of the programs;
4. The absence of monitoring and management systems allows abuses to continue;
5. The homemaker is an employee and therefore has an employer which is responsible for certain statutory benefits;
6. The reason for the service is predominantly caused by health problems; and
7. A $2½ billion program of tax funds has moved from "* * * compassion * * * to outrage."—without much activity on the part of responsible government officials.

In summary:

1. Gottheiner billed for services not rendered in Santa Clara County in the 1960's;
2. Gottheiner billed for services not rendered in what is now Medi-Cal, being suspended in 1967;
3. Gottheiner had "problems" with the San Francisco Retirement System contract;
4. Gottheiner has audit disputes with Medicaid of over $39,000;
5. Gottheiner "dissolved" his medicare company, with outstanding audit disputes of $846,217; and
6. Now, title XX companies, formerly owned by Gottheiner, have gone bankrupt.

SUMMARY

What does all of this mean? There is an army of consumers, providers and dedicated public servants—many of whom have no civil service protections—who want to help. This army is waiting, willing, and has offered its knowledge and energy. This army must be led and utilized.

The efforts of this army of citizens are best summarized by the following conversation:

First public servant: "You have read all of these position statements, criticism and proposals. In summary, what do they say?"

Second public servant: "When you boil it all down, they all say that you have to have honest and good providers.

The second public servant was more correct than he realized. Responsible Government officials have not regulated these services with precise requirements, provided for effective monitoring, or established a means for penalizing irregular activities in government funded programs of health care.

Finally, there must be acceptance of the fact that agency standards, in themselves, are the best safeguards for good care. Agency standards may in fact be the only safeguards available to us. No army of investigators can guarantee

adequate standards as well as the knowledgeable people in the field of In-Home Health Services. We must support national standard-setting organizations.

If we hope the abuses of nursing homes are the most damning about which we will see or hear, let us be candid in recognizing that the potential for abuse is far greater when caring for people at home. Our many programs are caring for people whose average age is 74, who usually live alone, who are already dependent and ill, and who are at the mercy of ot' 's. We are all concerned about crime in the streets; we must prevent crime i' ie homes of our citizens and beneficiaries. The mandating of standards may be no panacea, but you can make no better beginning.

TABLE 1.—HOMEMAKERS

[Based on 26 transferred employees]

	Health Help, Inc., July 1976—21 working days	San Francisco Home Health Service, October 1976—21 working days
Average hourly rate of pay	$2.75	$3.18.
Average travel time	(1)	10.25 h or $32.55.
	(7.32)	
Average travel cost	(1)	$6.60.
Average training time	0	1.75 h or $5.65.[3]
Average time in patients' homes (hours)	111	104.5 h or $332.47.
Average total earnings	[2] $345.62	$377.27.

[1] Because of obvious errors in the payroll and billing systems, it is not possible to be precise about allocations. However, the totals are correct. For example: travel time and travel cost are not segregated in the Health Help, Inc. payroll system; employee No. 12 shows payroll hours of 120 for July, but bill to the Department of Social Services state that employee No. 12 served for 222 h—or 122 h were billed, for which employee No. 12 was not paid.

[2] Includes overtime paid.

[3] In August, every transferred patient was assessed by a professional staff member. In September, these employees received average paid training time of 2.92 h—in addition to two orientation sessions held in August, 1976.

TABLE 2.—PATIENTS

[Based on 83 active patient transfers]

	Health Help, Inc., $7 per hour, July 1976—21 service days	San Francisco Home Health Service, $7.75 per hour, October 1976—21 service days
Average hours authorized	[4] 32.79	[5] 32.79
Average hours utilized	[1] 29.247	[3] 23.05
Average monthly cost per patient	$204.73	$178.64
Average number of "supervisory visits"	[2] .18	[4] .45

[1] Of the 314 active Health Help, Inc. patients in July 1976, the average hourly utilization was 27.573 hr. Therefore, statistically—even with random assignment—San Francisco Home Health Service received cases "requiring" more hours of service.

[2] See table 3.

[3] San Francisco Home Health Service, October 1976, Department of Social Service saverage utilitzation per patient was 21.27 hr, which tends to confirm that San Francisco Home Health Service may have received a "sicker" or more "needy" caseload from Health Help, Inc.

[4] In September 1976, 70 pct of the 83 patients were visited by a professional staff member, following the original assessment visit made in late August 1976.

[5] 32.5 pct of Home Health, Inc. patients utilized 100 pct of authorized hours in July. 7.3 pct of the patients active and transferred to San Francisco Home Health Service utilized 100 pct of authorized hours in October 1976. See chart 1.

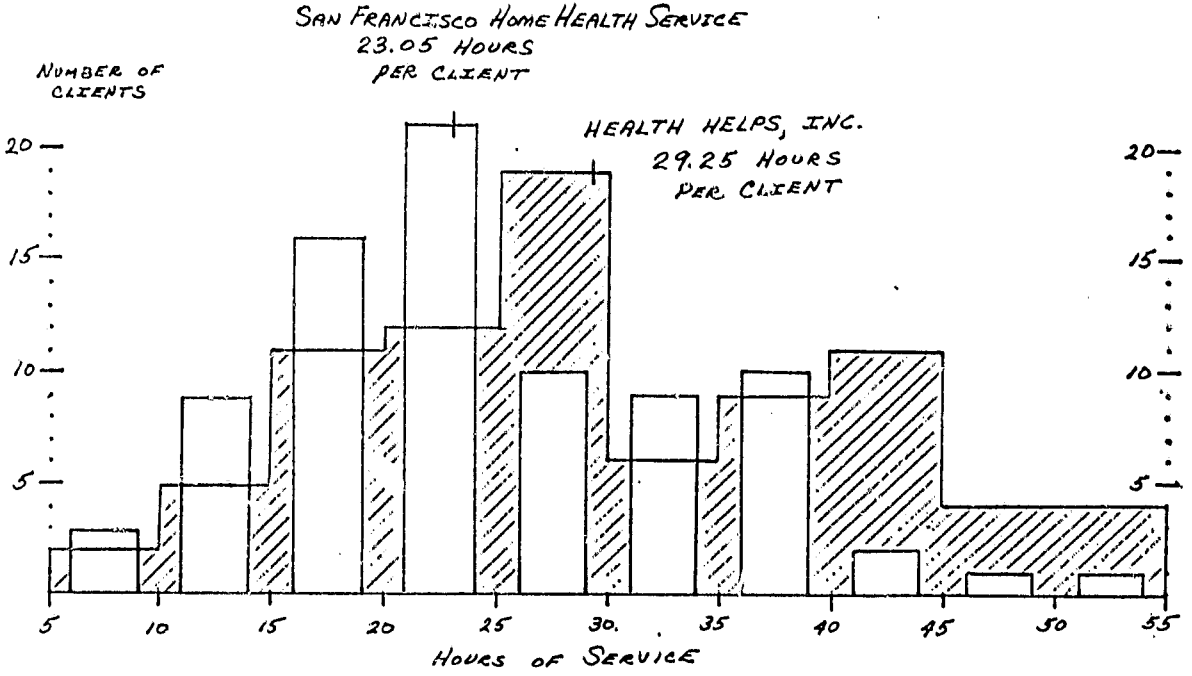
TABLE 3.—SUPERVISORS FOR HEALTH HELP, INC.

	(Payroll (78 homemakers)				Billing (314 patients)	
	Homemaker hours	Rate of pay	Supervisor hours	Rate	Homemaker hours	Supervisory visits
Austin	63	$2.60	(1)	$265.00	35	20
Cruel	114	3.35	(1)	75.00	105	13
Hector	20	2.75	24.5	2.90	16	26
Pearl	0	(2)	(1)	1,000.00	0	39

[1] Unknown.

[2] Not available.

Comparison of Utilization of Homemakers
For 83 Clients Transferred
From Health Help (July 1976 Service Records)
To San Francisco Home Health Service



Appendix 7

LETTER FROM JOHN P. BYRNE, PRESIDENT, NATIONAL ASSOCIATION OF HOME HEALTH AGENCIES; TO SENATOR FRANK CHURCH, DATED APRIL 5, 1977

NATIONAL ASSOCIATION OF HOME HEALTH AGENCIES,
St. Louis, Mo., April 5, 1977.

Hon. SENATOR FRANK CHURCH,
U.S. Senate, Russell Senate Office Building,
Washington, D.C.

DEAR SENATOR CHURCH: We have followed with interest the investigation of home health agencies conducted jointly by the Senate Special Committee on Aging and the House Ways and Means Committee. As the only national organization exclusively devoted to representing agencies which provide health-related services in the home, NAHHA is vitally concerned that incidents of fraud and abuse in the home health field be uncovered and that those involved by vigorously prosecuted. It is our best judgment that fraudulent practices are very much the exception, not the rule; nevertheless, evidence of such practices tends to reflect adversely on the entire home health field and we want to express our support for your activities, both in pressing for the enforcement of sanctions against violators and in taking positive steps to reduce the likelihood of future violations.

One current NAHHA initiative along these lines is the development of a strategy for objective, measurable standards for home health agencies. A NAHHA committee is currently drafting proposed standards to cover all aspects of an agency's operations, including such matters as the organization, governance and administration of the agency; patient care; rights of patients; staffing, financing and audits; maintenance of patient and financial records; and ongoing evaluation and accountability. The adoption and implementation of such standards would enable agencies to conduct periodic informal reviews of their own performance and provide a sound basis for outside assessments of agencies by accrediting organizations, governmental agencies and legislative bodies.

Along with the effort to develop standards for home health agencies, NAHHA has supported the inclusion of home health agencies in the certificate of need process mandated by the Health Planning Act of 1974. The requirement that such a certificate be obtained from local health planning bodies as a precondition to the establishment of new agencies or the expansion of existing ones is consistent with the congressional intent that comprehensive health planning be implemented at the local and State levels. Moreover, such a requirement should help to screen out those whose entry into the home health field is motivated primarily by a desire for a quick profit on a minimal investment, rather than by a commitment to provide patients with good health care and related services in a home setting.

Unfortunately, former HEW Secretary Mathews excluded home health agencies from the certificate of need regulations issued on January 13, 1977 (1-21-77 Federal Register, p. 4002-4032) despite the recommendation of the Public Health Service that such agencies be covered by the regulations. NAHHA has urged that these regulations be revised to include home health (see letter to Secretary Califano enclosed) and solicits your support in these efforts.

In conclusion, we want to stress that home health care is an integral and important part of the entire range of health services. It is not an "alternative to institutionalization" as is sometimes said—for the patient who needs treatment of a kind best provided in an institution, there is no successful alternative to the many thousands of patients, especially among the elderly, who are inappropriately institutionalized to receive health care that could as well be provided to them at home, often at less cost, if only they had access to home health services. We believe that most health agencies are dedicated to the task of making high quality health services available in the face of barriers imposed by inconsistent and sometimes conflicting State and Federal reimbursement programs. (For example, the care given a patient paid for under title XX of the Social Security Act is no different from that provided a Medicaid or Medicare patient under titles XVIII and XIX of the same act, but the title XX eligibility requirements are entirely different, the program administration is weaker, and the opportunities for fraud are greater).

We strongly support your efforts to uncover those in the home health field who have taken advantage of Federal health programs at the expense of the patient and the taxpayer. We look forward to working with you to implement antifraud measures and to remove unreasonable barriers to the availability of home health services.

Sincerely,

JOHN P. BYRNE, *President.*
ROBERT P. LIVERSIDGE, Jr.,
Chairman, Legislative Committee.

Appendix 8

TRANSMITTAL OF THE HEARING RECORD

DEPARTMENT OF JUSTICE,
CRIMINAL DIVISION,
August 1, 1977.

HON. FRANK CHURCH,
Chairman, Special Committee on Aging,
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: The materials concerning Peter Gottheiner which were provided to Mr. Jim Graham of the Fraud Section, Criminal Division, by your staff on June 3, have been reviewed and forwarded to the United States Attorney, Northern District of California, for further investigation.

Thank you for your assistance in this matter and your offer of future assistance.

Very truly yours,

BENJAMIN R. CIVILETTI,
Assistant Attorney General.
By JOHN C. KEENEY,
Deputy Assistant Attorney General.

Appendix 9

MEMORANDUM TO SAM GIBBONS, CHAIRMAN, HOUSE WAYS AND MEANS OVERSIGHT SUBCOMMITTEE; FROM JOHN MARKIN, OVERSIGHT SUBCOMMITTEE STAFF ASSISTANT, DATED APRIL 19, 1977

FINDINGS AND RECOMMENDATIONS RESULTING FROM OUR INVESTIGATION OF HOME HEALTH AGENCIES

As you know, I will be leaving the Oversight staff on April 17 to return to the General Accounting Office. I would like to take this opportunity to thank you and all of the other Oversight members and staff for allowing me to work with the subcommittee and gain such valuable experience. I have thoroughly enjoyed being associated with personnel who are so dedicated, able, and productive. I'm sure that under your direction, the Oversight Subcommittee during the 95th Congress will achieve even greater success than in the past in overseeing the Federal programs under the jurisdiction of the full committee. Again my thanks.

STATUS OF HOME CARE CASE (FLORA SOUZA)

On April 5, 1977, Val Halamandaris, associate counsel, Senate Special Committee on Aging, and I gave all of the detailed workpapers on the Home Kare, Inc. investigation to Neil Brown of the Program Fraud Unit, Criminal Division, Department of Justice. If you need any information regarding the status of Justice's investigation of Home Kare, Inc., you might want to call Mr. Brown on . . . In addition, Mr. Halamandaris can be reached on . . ., and you will be able to reach me at the General Accounting Office by calling the Human Resources Division on . . .

GENERAL FINDINGS OF INVESTIGATION INTO HOME HEALTH AGENCIES

From our investigation of proprietary and private, nonprofit home health agencies and through testimony at a hearing held on September 13, 1976, by the House Ways and Means Subcommittees on Health and Oversight and at additional hearings on March 8 and 9, 1977, conducted by the Senate Special Committee on Aging and the House Ways and Means Subcommittees on Health and Oversight, we found that:

(1) There has been a large growth in many areas of the country of proprietary and private, nonprofit home health agencies (HHA's) which generally serve only medicare patients;

(2) costs of similar home health services vary widely in the same city;

(3) overutilization of home health services is commonplace in many agencies;

(4) there have been excessive delays and failures on the part of the Department of Health, Education, and Welfare in providing guidance and controls on the growth and reimbursement of home health services;

(5) many HHA's station personnel in hospitals to act as discharge planners for the hospitals, at no cost to the hospitals, in order to solicit medicare patients;

(6) HHA claims for visits to patients that should have been denied for payment by fiscal intermediaries were, in fact, paid;

(7) patients indicated that the time spent with them by home health aides was less than the time specified on the HHA's records;

(8) agencies continue to provide medical services even though the patient no longer has a medical need for the case;
(9) some agency nurses make as many as 10 or 11 home visits in a day which means that the nurse is in the patient's home for only a short period;
(10) the current Bureau of Health Insurance (BHI) home health agency cost report form does not require enough of a detailed breakdown of HHA administrative costs;
(11) most HHA's have never undergone a full-scope field audit;
(12) considerable variation with respect to HHA claims review by fiscal intermediaries;
(13) many HHA patients are not homebound;
(14) many HHA administrators and owners claim numerous personal expense items to the Government such as meals, automobiles, boats, home telephones, newspapers, gasoline, apartment rent, etc.;
(15) intermediaries lack specific guidelines or regulations to back up their audit adjustments made to HHA cost reports;
(16) salaries for administrative personnel are much higher than those for comparable positions in most visiting nurse association HHA's;
(17) in some cases, patients' general medical conditions do not correspond to the conditions described in the patients' medical records prepared by the HHA (done to insure medicare coverage);
(18) HHA's with no medicare cost experience upon which an interim payment rate can be established are placed on the periodic interim payment method;
(19) physical therapy services are procured by HHA's at greater cost from related organizations through subcontracting rather than HHA's hiring their own therapists;
(20) medicare auditors are denied access to statistical and financial records of related companies with which the HHA does business;
(21) cost per patient varies widely in the same city;
(22) several members of a family operating several HHA's claim salaries from each facility;
(23) projected HHA budgets are given only a brief review by the fiscal intermediary, as a result overpayments to HHA's occur frequently;
(24) HHA owners claiming substantial salaries from several Federal health programs;
(25) conflict of interest on the part of fiscal intermediaries responsible for monitoring HHA's;
(26) medicare has had great difficulty in collecting overpayments to HHA's;
(27) physicians are paid fees for referring patients to a particular HHA (often disguised as medical director compensation);
(28) conflict of interest on the part of HEW employees being entertained by and receiving consulting fees from HHA's;
(29) HHA's switch intermediaries to those that deny fewer claims for payment and that have easier cost settlement procedures; and
(30) no BHI national policies or guidelines for dealing with HHA administrative costs.

LEGISLATIVE RECOMMENDATIONS

I agree with the following legislative changes in the basic structure of the medicare financing of home health activities suggested by Mr. Thomas Tierney, Director, Bureau of Health Insurance, on March 9, 1977.

(1) The Bureau of Health Insurance should be allowed to set up either a single national intermediary to deal with home health care providers or a series of regional intermediaries.
(2) Stiffen criminal penalties for fraud and abuse (similar to those in H.R. 3 and the Talmadge bill).
(3) Provide BHI, its agents, and others at interest at the Federal level with full authority to gain access to not just the records of the provider itself (HHA), but also the records of any interlocking activities of the provider.
(4) Develop legislation which would better define those services that can properly constitute home health care and be reimbursed as a part of the medicare program.

In addition, I would recommend that:

(1) In order for an HHA to become certified or recertified to participate in medicare it would have to document that a given percentage of its patients are other than medicare beneficiaries.

(2) Require all new HHA's to obtain a certificate of need from its appropriate area health systems planning agency.

ADMINISTRATIVE RECOMMENDATIONS

(1) Establish rigid national controls on HHA costs, including visits, administrative salaries, automobile leases, pensions, and all fringe benefits, etc.

(2) Set limits on the number of staff an HHA can employ in administrative positions.

(3) Issue national policy on management service fees reimbursed to HHA's and disallow all franchise fees.

(4) An HHA's initial full year cost report should undergo a full-scope field audit and every HHA should be audited in detail at least once every 2 years.

(5) Revise the current HHA cost reporting form to include a detailed breakdown of administrative costs.

(6) Require all HHA's to use the same method of accounting.

(7) Require that an HHA file 1 full year's cost report before allowing that agency to be reimbursed on the periodic interim payment method.

(8) Require each fiscal intermediary on a sample basis to conduct an HHA beneficiary contact program to determine if services billed were actually rendered.

(9) Develop minimum percentages of HHA services that have to be provided directly by the agency and cannot be subcontracted.

(10) Set a limit on the percentage of administrative and general costs for which medicare will reimburse an HHA.

(11) Prohibit reimbursement to advisory board members who are also owners or employees of the agency.

(12) HHA personnel should be restricted from acting as the discharge planner at hospitals and nursing homes.

(13) Prohibit HHA's from doing business with related organizations.

(14) Issue a list of home health services that are reimburseable under medicare and insure uniform application by all fiscal intermediaries.

○

END