B-093180

UNITED STATES GENERAL ACCOUNTING OFFICE
REGIONAL OFFICE
ROOM 1903 JOHN F KENNEDY FEDERAL BUILDING
GOVERNMENT CENTER
BOSTON, MASSACHUSETTS 02203

February 1, 1971

Mr Millard P Nute
Regional Representative, Bureau of Health Insurance
Social Security Administration
Department of Health, Education, and Welfare
Boston, Massachusetts, 02203

Dear Mr Nute

In order to ascertain the manner in which Massachusetts Blue Cross, a fiscal intermediary under the provisions of Title XVIII of the Social Security Act, has been determining the reasonableness of cost of hospital services furnished to Medicare patients, we reviewed the procedures and practices used by Blue Cross in arriving at final settlements with hospitals and audited the statements of reimbursable costs of three selected hospitals Questions raised during our review of the cost statements for two of the selected hospitals, the Mount Auburn Hospital and the Cambridge Hospital, were discussed in our letter to you dated March 10, 1970

This letter is to advise you of certain questionable cost items found during our review of the cost statements of the Massachusetts General Hospital (MGH) in Boston, Massachusetts, for the year ended September 30, 1967 Based on our examination of hospital documents and records and the Blue Cross audit workpapers, we believe that costs charged to the Medicare program totaling about $319,600 appear to be questionable

The MGH is a privately incorporated non-profit teaching hospital that receives funds for patient care from patients and from third-party insurers, both governmental and commercial The hospital also receives funds through Government research grants and private contributions and endowments. About 27 percent of MGH costs are related to research and other non-patient care activities

MGH has about 1,070 beds For the fiscal year ended September 30, 1967, the hospital reported 367,874 inpatient days of which 108,021 or about 29 percent were for Medicare patients The cost statement submitted by MGH for the same period showed net costs applicable to Medicare patients of about $7 7 million. The net effect of adjustments made by the Blue Cross audit staff together with the use of later statistical data resulted in increased costs of about $200,000 as follows

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	Medicare costs claimed by hospital	Net increase[1]	Medicare costs allowed[2]
Medicare costs			
Inpatient	$7,694,681	$ 9,285	$7,703,966
Outpatient	676,461	365,835	1,042,296
Total	$8,371,142	$375,120	$7,746,262
Less Net deductibles and co-insurance billed to Medicare patients	671,620	175,655	847,275
Net Medicare costs	$7,699,522	$199,465	$7,898,987

[1]Details of the Blue Cross audit revisions can be found in the Blue Cross audit report to the Blue Cross Association, dated November 26, 1969

[2]The hospital protested certain of the Blue Cross disallowances. Each of the protests were upheld at either a local hearing of the Provider Appeals Review Committee or by the Blue Cross Association. Blue Cross has prepared an amended statement, and increased MGH's reimbursement by about $64,000.

Since the Medicare program absorbs about 28 percent of MGH's costs allocable to patient care, any overstatement of hospital patient care costs or any underallocation of hospital indirect costs to non-patient care activities results in an increase in costs to the Medicare program. We found that total hospital patient costs at MGH were overstated and indirect expenses allocated to non-patient care activities were understated resulting in about $319,600 of questionable costs to the Medicare program as shown below.

SCHEDULE OF QUESTIONABLE COSTS

Item	Dollar effect on reimbursable Medicare costs
1. Unallowable research costs included in patient care costs	$84,500
2 Certain employee health and welfare costs not allocated to non-patient care activities	34,000

3.	Part B professional component portion of fringe benefit and overhead costs related to physicians services not eliminated	41,800
4.	Endowment income from restricted donations not deducted from costs	1,000
5.	Income from Commonwealth of Massachusetts for alcoholism and VD clinics not deducted from related costs	15,500
6.	Administrative and general expenses allocated to non-patient care activities understated	46,900
7.	Allowance in lieu of specific recognition of other costs	3,900
8.	Excessive reimbursement for professional services of hospital-based physicians	92,000
	Total	$319,600

The MGH comptroller advised us that any increase in the total costs allocated to non-patient care activities would be inequitable and as a result he would not agree with any of our findings regardless of their individual merit The comptroller also expressed doubt that retroactive adjustments of costs to the Medicare program could be made after a final settlement has been reached between the hospital and the fiscal intermediary.

UNALLOWABLE RESEARCH COSTS
INCLUDED IN PATIENT CARE COSTS

Research salaries totaling $286,100 were improperly classified as patient costs thereby increasing Medicare costs by $84,500

Hospitals are reimbursed for the cost of physicians' services directly related to patient care under the Supplementary Medical Insurance Benefits for the Aged (part B) portion of the Medicare program, and for research through Government programs other than Medicare. At MGH the physicians who received compensation from the hospital prepared monthly effort reports indicating the time spent performing various functions Each doctor's salary was then allocated to these functions.

In fiscal year 1967 physicians' salaries were allocated as follows

Direct patient care		$909,900
Research administration	$ 79,200	
Research	206,900	286,100
Other hospital services.		
Teaching	560,000	
Department administration	416,400	976,400
Total		$2,172,400

Although hospital costs allocated to the Hospital Insurance Benefits for the Aged (part A) portion of the Medicare program were reduced by $909,900 for patient care that was billed separately on a fee for service basis under part B, we believe that the part A costs should also have been reduced by $286,100 for the time spent by hospital based physicians on hospital research activities.

SSA's Principles of Reimbursement for Provider Costs dated May 1966 and succeeding manuals provide that research costs, over and above usual patient costs, are not allowable. The pertinent SSA reimbursement principal provides in part that·

"Principle

Costs incurred for research purposes, over and above usual patient care, are not includable as allowable costs.

Comment

There are numerous sources of financing for health-related research activities. Funds for this purpose are provided under many Federal programs and by other tax-supported agencies Also, many foundations, voluntary health agencies, and other private organizations, as well as individuals, sponsor or contribute to the support of medical and related research. Funds available from such sources are generally ample to meet basic medical and hospital research needs

A further consideration is that quality review should be assured as a condition of governmental support for research. Provisions for such review would introduce special difficulties in the health insurance program.

Where research is conducted in conjunction with and as a part of the care of patients, the costs of usual patient care are allowable to the extent that such costs are not met by funds provided for the research." (underscoring supplied)

SSA reimbursement instructions define usual patient care as those items and services (routine and ancillary) ordinarily furnished in the treatment of patients by hospitals under the supervision of physicians. According to the SSA instructions, where research is conducted by a provider which does not involve patients, the research costs are not allowable. For research conducted with patients to be allowable, records must be maintained identifying patients in the research projects, patient charges and other statistical data necessary in the allocation and apportioning of costs. Records identifying research patients associated with the $286,100 of research costs were not maintained, and such costs should not be included in allowable costs.

CERTAIN EMPLOYEE HEALTH AND WELFARE COSTS NOT ALLOCATED TO NON-PATIENT CARE ACTIVITIES

Because an equitable share of employee health and welfare costs were not allocated to non-patient care activities, the costs charged to the Medicare program appear to be overstated by about $34,000

Under the step down method of allocating costs, employee health and welfare costs are allocated to patient care and non-patient care activities on the basis of salaries. We noted, with a few minor exceptions, that the salaries of non-patient care activities, however, were not included in the base for allocating some of these costs -- personnel department, staff health clinic, related depreciation and administrative and general expenses. As a result, the costs allocated to patient care were overstated by $122,500 and Medicare costs appear to be overstated, as shown below.

Employee health and welfare costs not allocated to non-patient care.	
Personnel Department	$101,300
Staff Health Clinic	216,500
Depreciation	2,600
Applicable Administrative and General expense	145,500
Total	$465,900
Percentage of gross salaries related to non-patient care	26.3%
Employee related services costs allocable to non-patient care activities	$122,500
Medicare percentage	27.77%
Overstatement of Medicare costs	$ 34,000

PART B PROFESSIONAL COMPONENT PORTION OF FRINGE BENEFIT AND OVERHEAD COSTS RELATED TO PHYSICIANS SERVICES NOT ELIMINATED

Hospitals are reimbursed by part B of the Medicare program for the patient care given by hospital based physicians. Therefore to determine a reasonable amount to exclude from hospital costs reimbursable under part A for this patient care that was billed separately, the costs of physician services related to individual patient care should be deducted from hospital costs.

In calculating its professional fee schedule used for billing part B, the hospital included 8 percent factors for both fringe benefits and hospital overhead expenses. However, in computing the cost of physicians' services to be deducted from hospital costs neither the hospital nor the Blue Cross auditors considered fringe benefit costs or hospital overhead associated with the physician salaries. As a result, the hospital's allowable patient costs were overstated by $145,600 of which $41,800 was charged to Medicare.

The Provider Reimbursement Manual, Section 2108, provides in part that.

> "The costs of the medical and surgical services furnished by the physician which are to be excluded from the provider's allowable costs include the applicable portion of the physician's salary and related fring benefits such as payroll taxes, vacation pay, meals, and other similar benefits furnished by the provider at no cost to the physician."

The Blue Cross audit staff bulletin on this subject (Bulletin No. 14), did not specifically state that fringe benefits related to part B salaries should be deducted from hospital costs. During our review at Mount Auburn Hospital a similar situation was found and brought to the attention of the Blue Cross Medicare audit department and a supplement to the staff bulletin was issued requiring that this be done.

In our opinion, the hospital overhead associated with physicians' salaries at M.G.H. should have been deducted from hospital costs because it was included in the professional fees established for billing part B of the program.

ENDOWMENT INCOME FROM RESTRICTED DONATIONS NOT DEDUCTED FROM COSTS

SSA's Medicare regulations provide that endowment income designated

by a donor for paying specific operating costs should be deducted from the particular operating cost or group of costs. The reason given for this cost principle is as follows:

> "Donor-restricted funds which are designated for paying certain hospital operating expenses should apply and serve to reduce these costs or group of costs and benefit all patients who use services covered by the donation. If such costs are not reduced, the provider would secure reimbursement for the same expense twice, it would be reimbursed through the donor-restricted contributions as well as from patients and third-party payers including the title XVIII health insurance program."

As discussed below, we believe that during fiscal year 1967 Medicare costs were overstated by about $1,000 because income of $3,588 restricted by the donors of the Training School for Nurses Fund was not deducted from nursing school costs

We also believe that the hospital and the Blue Cross auditors were mistaken in their classification of income from the George Robert White Fund as unrestricted. Although the unrestricted classification of this endowment income resulted in no increase in Medicare costs in 1967, Medicare costs have been overstated in other years as explained below.

Training School for Nurses Fund

The Training School for Nurses Fund was transferred to MGH by a decree of the Massachusetts Supreme Judicial Court, which states in part·

> "It is ordered, adjudged and decreed that the plaintiff corporation do forthwith turn over all the funds in its hands to the Trustees of the Mass. Gen Hosp. in trust to hold and safely invest the same and to apply the net income and profits arising from said fund to the instruction and training of nurses for the sick and that the M.G H. be authorized and directed to receive said funds and hold the same on the trust aforesaid."

The comptroller informed us that the fund had been supplemented by sundry other gifts, some of which may not have been restricted, thereby altering the restrictive nature of the fund. We do not believe that the provisions of the court decree can be changed because of these sundry gifts.

Combining the funds received by the court decree with another fund, the MGH Training School for Nurses Endowment Fund, was considered in 1949 but rejected At that time the assistant treasurer wrote to the hospital Chief Accountant as follows.

> "I think the chief, if not the only, reason for combining the funds is that they are parallel in purpose and would avoid some confusion if there were only one fund. As far as I can see the only way to do it would be to have the Deed of Gift of the Endowment Fund amended by votes of the Trustees and the Association. Such votes would necessarily provide that the combined fund should be operated under the terms of the above Court Decree. In other words the disposition of the income would be solely in the hands of the Trustees and limited to the instruction and training of nurses for the sick.***"

In our opinion the income from the Training School for Nurses Fund is restricted, and therefore should have been deducted from the nursing school costs.

George Robert White Fund

The George Robert White Fund was established by a gift in codicil 2, dated December 31, 1928, to the will of Harriet J Bradbury, Mr. White's sister. The principal of the White Fund as of September 30, 1967 was $4,119,730, and the income is about $330,000 a year. The donor provided that a permanent trust fund be established with the income used first for the maintenance and equipment of the George Robert White Building, and second, for the general purposes of the hospital. The hospital did not classify the income from the White Fund as restricted, in our opinion it should have been so classified.

In 1967 equipment purchased for the White Building exceeded the endowment income. However, in other years, the White Fund endowment income exceeded equipment costs, but the difference was not used to reduce hospital maintenance costs of the White Building, as shown in the schedule below

Fiscal Year	Endowment Income	Equipment and Construction Costs	Income Available for Maintenance
1966	$307,600	$278,700	$ 28,900
1967	320,900	325,900	-0-
1968	337,400	199,200	138,200
1969	356,500	274,100	82,400
		Amount available for maintenance	$249,500

Had the income in excess of equipment and construction costs been used to reduce maintenance expenses of the White Building, Medicare costs would have been about $60,000 less during the above four years, assuming that the 1967 Medicare rate of utilization of hospital facilities was representative of the utilization over the entire four year period.

Our opinion that the White Fund income should have been classified as a restricted endowment is supported by the terms of the donor's will and also by an interpretation of the will prepared by a law firm for the hospital. The will states in part that

> "The other half of all the rest and residue of my property I give to the Massachusetts General Hospital, a Massachusetts corporation an amount not less than One Million Five Hundred Thousand ($1,500,000) Dollars and not exceeding Two Million Five Hundred Thousand ($2,500,000) Dollars of this bequest to be used as soon after my death as the trustees of the hospital shall decide that a building of major importance to the hospital is needed for the construction of such building, which shall be known as the George Robert White Memorial Building in memory of my late brother and the remainder of said one-half (1/2) of the rest and residue or all of it not so used for construction, to be held by said Massachusetts General Hospital as a permanent trust fund to be known as the George Robert White Fund, the income of which only shall be used first for the maintenance and equipment of such building and second for the general purposes of the hospital."
> (Underscoring supplied)

In 1939 the law firm for the hospital made the following interpretation of the will.

> "The word 'maintenance' is 'a large term whose meaning depends on the surrounding circumstances and the connection in which it is applied.' 38 C.J. 338. As used in a will the interpretation should be in harmony with the broad intent of the testator if that intent can be determined. This testatrix clearly had in mind first and foremost an important building, fully equipped, and maintained by her gift as 'one of the main buildings of the Hospital' for 'use directly to the care of the sick.' Only as an alternative did she give income to general purposes. If the building should be erected then general purposes were expressly said to be of second importance to her It seems to be a fair assumption that this testatrix did not want the monument to her brother to be a drag on other hospital resources, but that she did want it to be a contribution to the Hospital itself in further aid of its work.

> These considerations lead me to the view that the word 'maintenance' is not to be narrowly construed to mean only the repairs and upkeep of the building structure itself, but that it may properly include at least the recurring expense for keeping the building ready for the use of sick people for which it was expressly intended, such as; repairs, care and cleaning, heat, light, and water.***"

The Comptroller advised us that he considers the fund income to be unrestricted and the word "maintenance" to mean capital expenditurres only. We believe that both the will and the law firm's interpretation indicate that the income from the fund is restricted for maintenance and equipment of the White Building.

INCOME FROM COMMONWEALTH FOR ALCOHOLISM AND VENEREAL DISEASE CLINICS NOT DEDUCTED FROM RELATED COSTS

The Commonwealth of Massachusetts reimburses cooperating hospitals for the net costs of operating alcoholism clinics and venereal disease (V.D.) clinics. In fiscal year 1967, MGH received $22,900 and $63,100 respectively from the State for its alcoholism and V.D. clinics.

The hospital did not reduce the cost of its outpatient clinics by these amounts, however, and as a result Medicare costs were overstated about $15,500. The Blue Cross auditors advised us that it was an oversight on their part and that the income should have been used to reduce the operating costs of the clinics.

ADMINISTRATIVE AND GENERAL EXPENSES ALLOCATED TO NON-PATIENT CARE ACTIVITIES UNDERSTATED

MGH elected to use the step-down method of cost allocation in its statement of reimbursable costs Under this method Administrative and General (A&G) expenses are allocated to patient and non-patient activities based on departmental costs, including depreciation expense Non-patient departmental costs were understated by $2,598,700 because depreciation expense, research and other contract expenses were omitted, and also because certain credits were deducted. As a result, the A&G expenses allocated to non-patient activities were understated and Medicare costs were increased by $46,900.

Depreciation of major movable equipment omitted

Depreciation of major movable equipment totaling $733,000 was not included in non-patient care costs, although this type of expense was included in patient care costs. To be equitable and reasonable in allocating A&G expenses, depreciation expenses should be treated consistently (included in the base for both patient care and non-patient care or excluded from both).

Had depreciation expense been treated consistently, additional A&G expense would have been allocated to non-patient care activities with a corresponding reduction in the amount allocated to patient care.

Research and certain contract expenses excluded

For 1967 the non-patient care cost base did not include research and other contract expenses of $787,000. We were not given any justification for this omission. An associate comptroller informed us that he believed similar costs were included in subsequent years

Credits deducted from direct costs

Certain credits, totaling about $1,078,700 were improperly deducted from non-patient costs in computing the base for allocating A&G expenses. Based on our analysis of these credits for one month, we believe they could be categorized as follows:

1. Miscellaneous revenue for professional services such as from laboratory tests - This revenue is similar to income from patient care which is not deducted from patient care costs in computing the base. To be consistent comparable non-patient income should not be deducted from non-patient costs.

2. Sundry gifts considered by the hospital to be unrestricted - Comparable unrestricted gifts related to patient care, such as funds from the Community Fund, were not deducted from patient costs.

3. Research grant holding account balances - When research grants were received, MGH transferred amounts for indirect costs to a holding account. The holding account was reduced monthly during the lives of the grants. In computing the amount of non-patient care costs for allocating A&G expenses, the balance in the holding account was deducted from non-patient care costs, resulting in an understatement of the A&G base.

ALLOWANCE IN LIEU OF SPECIFIC RECOGNITION OF OTHER COSTS

The amount charged to Medicare for the two percent allowance in lieu of specific recognition of other costs will be reduced by about $3,900 if all of the above questionable costs are resolved in favor of the Medicare program.

EXCESSIVE REIMBURSEMENT FOR PROFESSIONAL SERVICES OF HOSPITAL-BASED PHYSICIANS

MGH professional fees for radiological services were established at a level which we estimate yielded about $316,000 in excess of related costs during fiscal year 1967 We estimate that the Medicare portion of this excess was about $92,000. As set forth in more detail below, the reason for the excessive reimbursement was that the fee schedule used to bill part B of the Medicare program for radiology services was too high, and this should have been determined at the time the fee schedule was initially approved by Blue Cross.

Prior to Medicare almost all x-rays of service patients were read by house officers and x-rays of private patients were read by staff radiologists. House officers (residents and interns) are not authorized to bill on a fee-for-service basis under part B, instead their salaries are reimbursed to the hospital under part A Following the inception of Medicare, staff radiologists began reviewing house officers' reports and making second readings of service patient x-ray films

The hospital anticipated that income of $542,600 would be required to meet its professional component expenses and that 33 1/3 percent of the charges of staff radiologists would yield this amount. However, no consideration was given to additional revenue which would result from second readings by staff radiologists of non-Medicare service patient x-rays.

As shown below, although non-Medicare service patients accounted for 34 percent of the projected radiology workload, MGH anticipated that no professional component revenue would be generated from this work.

Type of patient	Percent of Workload	Gross Revenue	Professional Component Percent	Professional Component Amount
Private	47	$1,170,962	33 1/3	$390,321
Medicare service	19	456,862	33 1/3	152,287
Non-medicare service	34	848,458	-0-	-0-
	100	$2,476,282		$542,608

In July 1966 the MGH Radiological Associates was formed One of the purposes of this organization was to expedite the collection and distribution of fees received for professional services rendered by its members. During fiscal year 1967, the Radiological Associates gradually assumed the billing function, starting with private ambulatory patients. According to the Chief of Radiology a fee is charged whenever a staff radiologist makes a second reading of x-rays if the reading contributes to patient care. During the first 3 months of fiscal year 1967, when the hospital was doing most of the billing, all patients were charged for professional radiological services without distinction as to who performed the service - staff radiologist or house officer. Accordingly, at the time that the professional component factor (33 1/3 percent) was submitted to the intermediary for approval on November 29, 1966, there were indications that it was excessive because all patients were being billed.

Section 405.485 of the Principles of Reimbursement for Provider Costs and for Services by Hospital-Based Physicians provides that "Once the portion of a physician's compensation attributable to professional services to supplementary medical insurance beneficiaries has been determined, a schedule of charges can be developed To be deemed reasonable the charges should be designed to yield in the aggregate, as nearly as may be possible, an amount equal to such portion of his compensation." After giving consideration to estimated bad debts and collection costs we calculate that the approved fee schedule yielded $754,000, whereas related expenses amounted to $438,000, a difference of $316,000.

Hospital officials maintain that their part B charges are reasonable as compared to prevailing charges in the area They also stated that cash receipts for radiology approximate actual expenses and that there

was no excessive reimbursement. In their calculation of income, no consideration was given to cash collected by the hospital during the 3 months when the hospital did most of the billing, as contrasted to cash collected by the Radiological Associates, nor did they estimate the cash yield from outstanding receivables at year end, September 30, 1967.

During the audit of MGH's fiscal 1967 Medicare cost submission the Blue Cross auditors made no adjustment for the difference in radiology professional component income and expenses The SSA principles of reimbursement makes no specific provision for retroactive adjustment at the time of audit and final settlement for part B payments made to a hospital for the professional component of the compensation paid by the hospital to its hospital-based physicians However, in a letter to us dated April 30, 1970, you indicate that Section C, Article IV, of the Agreement between the Blue Cross Association and the Secretary of Health, Education, and Welfare, concerning the recovery of overpayments would apply to excessive part B payments to hospitals.

LACK OF COORDINATION BETWEEN HEW AND BLUE CROSS AUDIT STAFFS

The HEW Regional Audit staff and the Blue Cross Medicare auditors are not coordinating their audit effort or apprising each other of the results of their independent reviews. In large teaching hospitals, particularly, such coordination would be helpful because of the detailed reviews of research grants performed by the HEW audit staff.

The Boston Regional Office of the HEW Audit Agency and the Blue Cross Medicare Audit staff performed independent audits of MGH's fiscal 1966 and 1967 costs. The HEW Audit Agency submitted their report on indirect cost rates for research grants for both years on March 7, 1969. Although the Blue Cross auditors began their review of both years one month later, on April 7, 1969, they did not ask for the HEW audit report or workpapers.

The scope of both audits were duplicative in certain respects For example, both included tests of indirect costs and verifications of the apportionment of indirect costs between patient care and research activities. Also, both audit groups verified some of the same statistical data such as the square foot base used to allocate operation and maintenance of plant and housekeeping costs.

We reviewed the audit adjustments made by the HEW Audit Agency in their report. Although the 1967 Medicare reimbursement would not have been much different had these findings been considered by the Medicare auditors, there is no assurance that the result would be the same in other years or at other hospitals. We could not readily estimate the probable reduction in audit effort had the Medicare auditors made use of the HEW audit work.

We note that the HEW publication, "Audit Program for Hospitals Under the Health Insurance for the Aged Act, Title XVIII," provides that the scope of the Medicare audit should be determined in part by a review of audit reports prepared by the hospital staff, independent public accountants, or others. No mention is made of HEW Audit Agency work.

RECOMMENDATIONS

Our overall recommendation is that you instruct the fiscal intermediary to prepare a revised hospital statement of reimbursable cost giving consideration to the questions raised by us in this report. In addition, we are making the following specific recommendations.

1. Because there are 32 hospitals receiving funds from the Commonwealth of Massachusetts for their V.D. and/or alcoholic clinics (See Appendix I), we recommend that the BHI assure itself that appropriate adjustments are being made at these hospitals. It is estimated that the Commonwealth gives these hospitals about $420,000 a year for alcoholism clinics. We could not readily determine the amount given by the Commonwealth for V.D. clinics.

2. We understand that the Medicare part B fiscal intermediary is evaluating the reasonableness of MGH's radiology fee schedule, but that to this date no conclusions have been reached. We believe that the special nature of the MGH Radiological Associates should be considered in determining whether the Radiological Associates is a separate entity. All the earnings of the individual members are assigned to the hospital in return for which they receive salaries from the hospital The salary levels are governed by the fixed salary schedule of the Harvard Medical School faculty, rather than by the amounts of fees earned Under these circumstances we recommend that a cost rather than a reasonable charge criterion be used in evaluating the fee schedule

3. We recommmend that you advise SSA to notify its intermediaries and the HEW Audit Agency of the need for close liason to assure that duplication of audit effort will be minimized, and that the results of provider reviews will be exchanged.

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We would appreciate being advised at an early date of any action taken by you and Blue Cross. Copies of this letter may be furnished to the Blue Cross Association and to the local Blue Cross Plan for that purpose. If we can be of any assistance to you please let us know.

Sincerely yours,

Louis Lucas

for Joseph Eder
Regional Manager

LISTING OF ALCOHOLISM AND VENEREAL DISEASE CLINICS IN HOSPITALS REIMBURSED BY THE COMMONWEALTH OF MASSACHUSETTS

	Alcoholism Clinics	Venereal Disease Clinics
Beverly		
Beverly Hospital		x
Boston		
Beth Israel Hospital		x
Boston City Hospital	x	x
The Boston Dispensary		x
Massachusetts General Hospital	x	x
Peter Bent Brigham Hospital	x	x
New England Hospital	x	
University Hospital		x
Washington Hospital	x	
Brockton		
Brockton Hospital	x	x
Cambridge		
Cambridge City Hospital	x	x
Mount Auburn Hospital	x	x
Cape Cod		
Barnstable County Hospital	x	
Fall River		
St. Annes Hospital		x
Fitchburg		
Burbank Hospital	x	x
Greenfield		
Franklin County Public Hospital	x	
Lawrence		
Lawrence General Hospital	x	

LISTING OF ALCOHOLISM AND
VENEREAL DISEASE CLINICS IN HOSPITALS
REIMBURSED BY THE COMMONWEALTH OF MASSACHUSETTS

	Alcoholism Clinics	Venereal Disease Clinics
Lowell		
Lowell General Hospital	x	
St. Josephs Hospital		x
Lynn		
Lynn Hospital		x
New Bedford		
St. Luke's Hospital	x	x
Newton		
Newton-Wellesley Hospital		x
North Adams		
Division of Pittsfield General Hospital		x
Pittsfield		
Pittsfield General Hospital	x	
Berkshire Medical Center		x
Quincy		
Quincy City Hospital	x	
Salem		
Salem Hospital	x	
Springfield		
Springfield Municipal Hospital	x	
The Springfield Hospital		x
Waltham		
Waltham Hospital		x
Worcester		
St. Vincent Hospital	x	
Worcester City Hospital		x