BY THE COMPTROLLER GENERAL

Report To The Congress

OF THE UNITED STATES

Health Costs Can Be Reduced By Millions Of Dollars If Federal Agencies Fully Carry Out GAO Recommendations

Because of the increasing costs of Government health programs--a subject of nationwide concern--GAO reviewed how agencies have implemented its recommendations to help control the costs of health programs.

GAO found that 84 of its reports issued from January 1974 through December 1978 on Federal and Federal/State health programs contained 262 cost-saving recommendations to the Congress and responsible Federal agencies. So far, 98 recommendations have been put into effect and savings of millions of dollars realized. However, 164 others have either not been carried out or only partially so. The Congress and the agencies should put into effect the outstanding recommendations. Millions more would be saved.

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COMPTROLLER GENERAL OF THE UNITED STATES
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To the President of the Senate and the
Speaker of the House of Representatives

This report discusses the extent to which the Congress and responsible Federal agencies have implemented our health program cost-saving recommendations made between January 1974 and December 1978. Although many of them have been fully implemented with millions of dollars in savings resulting, many others have been only partially implemented or not implemented at all. Millions of dollars in additional savings could be realized if actions are taken to fully implement those recommendations which still need action.

We are sending copies of this report to the Director, Office of Management and Budget; the Secretaries of Defense and Health, Education, and Welfare; the Administrator of Veterans Affairs; the Director, Office of Personnel Management; and other interested parties.

Comptroller General
of the United States

COMPTROLLER GENERAL'S
REPORT TO THE CONGRESS

HEALTH COSTS CAN BE REDUCED BY MILLIONS OF DOLLARS IF FEDERAL AGENCIES FULLY CARRY OUT GAO RECOMMENDATIONS

D I G E S T

The Congress and the Nation are concerned about the ever-increasing costs of health care in general and Federal health expenditures in particular. Over the years, GAO has issued many reports on Federal and Federal/State health programs which contained recommendations to reduce program costs or control cost increases. GAO believed that a review of the status of implementation of these recommendations would provide the Congress, its Committees, and the Federal agencies responsible for administering the programs an overview of what has been done and what more could be done to control Federal health expenditures. The Congress and the agencies could then take a fresh look at those recommendations which have not been fully implemented and reevaluate their positions on them.

During the years 1974-78, GAO issued 84 reports containing 262 cost control recommendations related to Government health programs. Of these, 98 have been fully or substantially put into effect by the Congress or the administering agencies, saving millions of dollars.

However, 164 recommendations have been carried out only in part or not at all. Additional savings of millions of dollars can be realized if these recommendations are implemented. GAO believes that the Congress and the responsible agencies should take the actions necessary to implement the outstanding recommendations.

Examples of savings realized from implementing GAO recommendations are:

--The New Orleans Naval Hospital was closed and leased to a private operator. Annual savings of $2.4 million in operating expenses were realized, plus increased revenues of about $1.8 million a year from the lease.

--The number of beds planned for Indian Health Service facilities in the Navajo area was reduced by 296, saving $8.4 million in construction funds and $2.8 million in annual operating costs.

--Increased loaning and reissuing of medical equipment by the Veterans Administration resulted in 42,000 items valued at over $7 million being loaned and, subsequently, recycled.

--The Congress amended the Medicare law to provide incentives to patients with end stage renal disease to dialyze at home and to remove a disincentive toward receiving a kidney transplant. Based on 1972 data, home dialysis was about $15,000 a year less costly than facility dialysis, and kidney transplants saved about $30,000 a year per patient over facility dialysis.

--Medicare and Medicaid fraud and abuse control programs were tightened.

--Over $1.3 million was recouped in Medicare and Medicaid duplicate payments to a large, publicly owned nursing home.

--Repeal of the law requiring subordination of Medicare to the Federal Employees Health Benefits program brought first-year savings estimated at $48 million.

--The Congress amended the law to control non-arms-length dealings among Health Maintenance Organizations and those who own or control them.

--Detection of lead poisoning through increased screening was strengthened. This should result in preventing cases of mental retardation and save the cost of treating patients.

See appendixes IV, V, and VI for all fully or substantially implemented recommendations.

Examples of substantial additional savings available by fully carrying out GAO recommendations either only partially or not implemented:

--There is a need for greater sharing of health resources among the health delivery systems of the Departments of Defense and Health, Education, and Welfare and the Veterans Administration. Every 1-percent reduction in these systems' costs, achieved by sharing, saves taxpayers about $70 million.

--When nursing home beds are unavailable to Medicare and Medicaid patients, they stay in more costly hospital beds. Data indicate that about $73 million in Ohio and about $216 million in New York is being spent on hospital services for such patients who could be served adequately by nursing homes if beds were available.

--About $53 million could be saved in fiscal year 1981 if States were permitted to award contracts competitively for Medicaid laboratory services.

--Payments to States for Medicaid administration should be based on performance standards. Better administration through increased State controls of fraud, abuse, and waste should generate large savings in program costs.

--Improvements in deinstitutionalizing the mentally disabled would save the Government millions.

See appendixes I, II, and III for all partially and not implemented recommendations.

Appendixes VII through XI list by agency those recommendations made to the agency head which have not been fully implemented.

Appendixes XII through XVI list by agency program those recommendations made to the Congress which have not been implemented.

Contents

ABBREVIATIONS

AFDC	Aid to Families with Dependent Children
CDC	Center for Disease Control
CSC	Civil Service Commission
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CHAMPVA	Civilian Health and Medical Program of the Veterans Administration
DOD	Department of Defense
FEHB	Federal Employees Health Benefits
GAO	General Accounting Office
HCFA	Health Care Financing Administration
HEW	Department of Health, Education, and Welfare
HMO	Health Maintenance Organization
HUD	Department of Housing and Urban Development
ICF	Intermediate Care Facility
IHS	Indian Health Service
OPM	Office of Personnel Management
OMB	Office of Management and Budget
PHS	Public Health Service
PSRO	Professional Standards Review Organization
SSA	Social Security Administration
SSI	Supplemental Security Income for the Aged, Blind, and Disabled
SNF	Skilled Nursing Facility
VA	Veterans Administration
VIP	very important person

CHAPTER 1

INTRODUCTION

Over the years, we have issued many reports on Federal and Federal/State health programs; these reports contained recommendations to reduce program costs or control cost increases. Because the Federal Government is very involved in the health care industry (it contributes about 30 percent of all health-related expenditures), actions on our recommendations can affect overall health expenditures, either positively or negatively. The Nation is concerned with the tremendous and ever-increasing costs of health care. Therefore, we decided to study the status of implementing our recommendations to find what had been accomplished and what more could be done. This report is a study of all of our cost control recommendations made between January 1, 1974, and December 31, 1978.

Chapter 2 discusses Federal programs which directly provide health care services to population groups through the health delivery systems of the Department of Defense (DOD), the Department of Health, Education, and Welfare (HEW), and the Veterans Administration (VA). These organizations' programs had estimated expenditures of about $7.4 billion in fiscal year 1978. Our efforts with direct care programs have been directed at two main areas:

--Preventing the construction or purchase of unneeded or oversized health facilities and equipment.

--Getting the different Federal health delivery systems to share resources whenever feasible, thereby eliminating or preventing unnecessary duplication.

Implementation of our recommendations by the Congress or the responsible agencies has saved many millions of dollars. However, many other recommendations have not been implemented, and additional large savings are possible. Appendix IV discusses all of our recommendations that have been fully or substantially implemented and the associated benefits from implementing them. Appendix I presents a comprehensive list of partially and not implemented recommendations and the basis for our recommendations.

Chapter 3 deals with Federal programs which pay for health care services for the aged, the disabled, the poor, and Federal military and civilian personnel and their dependents. Estimated program expenditures during fiscal year

1979 were $54.2 billion. Our efforts in these health financing programs have been primarily directed at assuring

--that providers are not overpaid for their services,

--that fraud and abuse against the programs are controlled, and

--that the States and contractors comply with Federal laws and regulations.

Again, the Congress and the responsible agencies have implemented many of our recommendations and saved millions of dollars but many recommendations remain to be implemented. Appendix V discusses the implemented recommendations and the benefits derived from the implementation. Appendix II provides information on all partially and not implemented recommendations.

Chapter 4 discusses our cost saving recommendations related to the grant and contract health programs of HEW's Public Health Service (PHS). In general, PHS programs use grants and contracts with non-Federal agencies and organizations to (1) provide health care services to underserved populations, (2) stimulate the development of alternative health delivery systems, (3) develop adequate or more cost-effective health resources, and (4) combat specific health problems (such as venereal disease and lead poisoning). Estimated PHS expenditures for fiscal year 1980 are $7.9 billion. Most of our cost control efforts related to PHS programs regard improving the efficiency and/or management effectiveness of PHS program management or of grantee/contractor operations.

Appendix VI presents our PHS program recommendations that have been fully or substantially implemented by the Congress or HEW and the related benefits. Appendix III discusses all recommendations not fully implemented.

SCOPE OF REVIEW

We reviewed all reports we issued between January 1, 1974, and December 31, 1978, which related to Federal and Federal/State health programs to identify recommendations

where the primary or secondary thrust 1/ was cost control. We then reviewed the responsible agency's statement of actions taken or planned (required by section 236 of the Legislative Reorganization Act of 1970) and other agency documents to determine what, if any, action had been taken to implement the recommendations. We also held discussions with responsible agency officials.

For recommendations to the Congress, we reviewed applicable laws and other congressional documents to determine what actions the Congress or its Committees had taken.

1/A recommendation with a secondary thrust of cost control would be, for example, a recommendation to improve the management of a program which, ultimately, was to control costs, and thereby improve the effectiveness of cost control.

CHAPTER 2

COST CONTROL IN THE FEDERAL DIRECT HEALTH CARE SYSTEMS

The Congress and Federal agencies have become involved in controlling the costs of the Government's various direct health care systems. Progress has been made in certain respects, but additional action by the Congress and the agencies can further reduce Federal health care costs without adversely affecting quality.

THE FEDERAL DIRECT HEALTH CARE DELIVERY SYSTEMS

DOD, VA, and HEW have the major responsibilities for directly providing health care to Federal beneficiaries. HEW fulfills its health care responsibilities through its Indian Health Service (IHS) and PHS direct health care systems, and St. Elizabeths Hospital (Washington, D.C.).

In the past 5 years, our audit efforts have been directed primarily toward the two largest Federal hospital and clinic systems--DOD and VA--and, to a lesser degree, the HEW direct health care systems. The following table illustrates the magnitude of these Federal health care systems:

Hospital and clinic system	Current number of		Estimated expenditures for direct health care (fiscal year 1978)	Total FY 1978	
	Hospitals	Clinics		Hospital admissions	Outpatient visits
			(millions)	(thousands)	
DOD	124	205	$2,440	770	39,261
IHS	49	101	467	78	3,125
PHS a/	8	27	169	33	1,723
VA	172	220	4,332	1,158	15,070
Total	353	553	$7,408	2,039	59,179

a/Excludes PHS Leprosarium in Carville, Louisiana.

DOD health care beneficiaries include active-duty military members and, when space, facilities, and staff are available, their dependents, retirees, and dependents of retired and deceased military members. DOD's health care delivery system is composed of three separate systems administered by the Surgeons General of the Army, Navy, and Air Force. The IHS system provides care to the American Indian and Alaska Natives, and the PHS system is primarily responsible for providing care to U.S. seamen, PHS commissioned officers, and Coast Guard personnel. VA health care beneficiaries include (1) veterans with service-connected disabilities, (2) veterans that have any other disability and are unable to pay for necessary hospital care, when space is available, (3) veterans whose discharge or release from active military duty was for a disability incurred or aggravated in the line of duty, and (4) any person who receives or is eligible to receive military retirement pay or disability compensation, when space is available. VA can also provide care to the spouses and children of veterans who were killed or totally disabled by a service-connected disability.

FEDERAL AGENCIES' EFFORTS TO BETTER USE MEDICAL RESOURCES

Until recently, each Federal agency planned its health delivery system in terms of having sufficient services for the beneficiaries for which the agency had primary health care responsibility without considering the needs and capabilities of other Federal agencies. DOD provided care to active-duty military personnel, VA to veterans, and HEW to persons eligible for IHS or PHS health care systems. A series of our reports 1/ covered the lack of sharing of resources.

1/We have issued the following reports on interagency sharing of Federal medical resources: "Sharing Cardiac Catheterization Services: A Way to Improve Patient Care and Reduce Costs" (HRD-78-14, Nov. 17, 1977); "Computed Tomography Scanners: Opportunity for Coordinated Federal Planning Before Substantial Acquisitions" (HRD-78-41, Jan. 30, 1978); "Legislation Needed to Encourage Better Use of Federal Medical Resources and Remove Obstacles to Interagency Sharing" (HRD-78-54, June 14, 1978); and "Federal Hospitals Could Improve Certain Cancer Treatment Capability by Sharing" (HRD-79-42, Feb. 7, 1979).

In February 1978 the Assistant Secretary of Defense (Health Affairs), the Surgeons General of the Armed Services, HEW's Assistant Secretary for Health, and VA's Chief Medical Director agreed that one approach to providing the highest possible quality of care with the greatest efficiency was to accept common goals and share resources. The Federal Health Resources Sharing Committee was established as a result of this commitment.

The Sharing Committee is to identify and promote opportunities for jointly planning and using the Government's health care resources. It provides a forum for agency medical representatives to cooperatively explore opportunities to share services and resources.

The Committee has a number of specific charges, including:

--Define and clarify the scope of joint planning and sharing.

--Advise Federal agency officials on cooperative opportunities and restraints.

--Identify and recommend legislative, regulatory, or other policy changes needed to enhance joint planning and sharing.

--Initiate, validate, and recommend coordinated programs that give the highest payoff in reducing unwarranted duplication or excess capacity, but avoid adversely affecting efficiency, effectiveness, readiness, or quality.

--Clarify and recommend costing and funding provisions for interagency sharing agreements.

--Establish subcommittees to explore joint planning and sharing arrangements in specific health care areas and develop criteria and standards, when appropriate.

As of June 1979 the Sharing Committee had established five subcommittees which were to (1) develop and propose guidelines and criteria for assessing and justifying the need for and appropriate location of specialized medical services, (2) develop and propose program utilization criteria, and (3) explore sharing opportunities in specific geographic areas. These five subcommittees are the

--Cardiac Catheterization Laboratory Subcommittee,

--Computerized Tomography Subcommittee,

--Cancer Treatment Facility Subcommittee,

--Dental Subcommittee, and

--Health Care Information Systems Subcommittee.

None of the subcommittees had issued a final report as of June 1979. However, the Cardiac Catheterization Laboratory and Computerized Tomography Subcommittees had drafted reports which were approved by the parent Committee. The Sharing Committee has submitted these reports to each member agency for their acceptance and/or comments.

Measuring the cost savings that coordinated planning or sharing in a particular geographic area would have is difficult, because the cost savings depend on agencies' willingness to implement such coordination. However, a recurring savings of about $70 million would result from every 1-percent reduction in Federal agencies' combined annual operating budget resulting from coordinated planning and sharing of resources among Federal agencies.

STATUS OF IMPLEMENTING OUR COST-RELATED RECOMMENDATIONS

In the past 5 years (calendar years 1974 through 1978), we issued 28 reports to the Congress, its Committees, individual congressmen, and agency officials containing 70 recommendations which, when implemented in their entirety, would reduce operating costs for the Federal direct health care systems. Three reports had recommendations to several Federal agencies, 12 affected only DOD, 11 affected VA, 1 affected IHS, and 1 concerned St. Elizabeths Hospital.

Of the 70 recommendations, 23 have been fully or substantially implemented, 11 have been partially implemented, and 36 have not been implemented. Of the 36 recommendations on which action has not been taken, 10 recommendations were not implemented because the Congress failed to act, 25 others because an agency (or agencies) failed to act, and 1 because both the Congress and an agency did not act. In some cases, the same or a similar recommendation was made in more than one report. Therefore, there is some overlap in these statistics.

SAVINGS FROM IMPLEMENTING OUR RECOMMENDATIONS

Savings (quantifiable and unquantifiable) resulted from fully or substantially implementing recommendations made in our reports. The Congress or the responsible agencies have fully or substantially implemented 23 of our cost control recommendations related to the Federal direct health care systems, and millions of dollars in savings have resulted. Appendix IV presents information on all of these recommendations. Some are:

--Using the planning criteria for sizing military hospitals of four beds per 1,000 active-duty members and their dependents would have resulted in the construction of a new San Diego Naval Hospital whose capacity would have been about 900 acute care beds; it would have far exceeded expected medical needs. We recommended that DOD withdraw its hospital sizing criteria and implement a planning methodology which utilizes average lengths of stay and uses figures to project acute care bed requirements. DOD has adopted the use of our model for sizing its hospitals and has incorporated recent refinements we made to the model during our review of VA's hospital sizing activities. DOD is planning to request funding for a new San Diego hospital containing 560 acute care beds. No cost estimates are available on either the savings in construction costs or annual operating costs directly attributable to DOD's use of our model in sizing the facility. (MWD-76-117, Apr. 7, 1976.)

--The New Orleans Naval Hospital was being greatly underused, and the potential for increasing its military use to a viable level was virtually nonexistent because of the small number of military beneficiaries in the New Orleans area. We recommended (1) discontinuing both inpatient and outpatient medical services at the facility, (2) implementing necessary action to provide outpatient care at another nearby Federal facility, and (3) evaluating thoroughly other potential uses for the naval hospital. DOD implemented our recommendations. As a consequence, operating expenses were cut by $2.4 million by closing the unneeded New Orleans Naval hospital. In addition, increased lease income of about $44 million to the Government is possible if the current lease of the facility to a private medical concern continues for a 25-year period. (HRD-78-71, May 15, 1978.)

--Providing care to civilian burn victims at the United States Army Institute of Surgical Research cost far more than the reimbursement rate of $168 per day, which was normally paid by the patient's health insurance. We recommended establishment and implementation of a reimbursement rate for civilian patients which more closely approximated the full cost of the care provided. In October 1978 DOD implemented a revised rate of $634 per day. This rate resulted in about $2.2 million in estimated annual increases in revenue. (HRD-77-156, Sept. 29, 1977.)

--A review of certain proposed IHS hospital construction projects in the Navajo area indicated that the methodology for determining the number of beds required at each facility would result in too many beds. Because IHS uses the same methodology to size other hospitals throughout its system, similar problems probably existed elsewhere. We recommended that the Senate Subcommittee on the Department of the Interior and Related Agencies (Committee on Appropriations) should delay recommending appropriations for any IHS hospital project until IHS could explain why expanding existing underused facilities was necessary. IHS has reduced the number of planned beds in the Navajo area from 849 to 553; this resulted in a $8.4 million savings in construction costs and a recurring annual savings of $2.8 million in operating costs. (HRD-77-112, May 31, 1977.)

--VA's program to furnish medical equipment (such as wheelchairs and hospital beds) was unnecessarily expensive. This exisited because the VA Central Office staff had not (1) adequately evaluated equipment activities in the field or (2) provided adequate guidelines to the hospitals on how equipment loan versus issue determinations should be made. We recommended initiating a systemwide study to determine the extent and effectiveness of VA's equipment-loaning activities. From fiscal year 1975 to fiscal year 1978, VA's increased emphasis on loaning equipment instead of purchasing it for permanent issue to patients resulted in 42,000 items valued at over $7 million being loaned and, subsequently, recycled to other patients. (MWD-75-104, July 21, 1975.)

ADDITIONAL SAVINGS AVAILABLE IF OUR RECOMMENDATIONS ARE IMPLEMENTED

Progress has been made in reducing Federal direct health care costs in the instances cited above; however, the Congress and the agencies could take additional cost reduction actions recommended by us. For example, the Congress has not enacted legislation requiring a greatly expanded and cost-effective interagency sharing program. Such legislation is needed to require interagency sharing (when appropriate) and to encourage the establishment of governmentwide implementing procedures. Such legislation should also encourage individual initiative without affecting any Federal agency's organizational or command structures. In addition, it should give increased management options to local Federal medical officials, to make the best use of the Nation's medical resources. (See p. 37.)

Because of the increasing concern about the spiraling costs of health care, legislation to establish a firm Federal policy to promote Federal interagency sharing and to remove restrictions on sharing some types of services would be both beneficial and timely. Enacting such legislation would also complement the national health priorities established by the National Health Planning and Resources Development Act of 1974 by providing the impetus and direction needed by Federal agencies to make interagency sharing a rule, rather than an exception. Enacting other suggested legislation to improve the recovery of certain medical costs by Federal agencies and to provide legislative authority for VA's personal care residence program should also reduce Federal direct health care costs. (See pp. 46 and 65.)

The Congress has not addressed the issue of whether future VA medical centers should provide sufficient capacity for treating veterans with nonservice-connected illnesses. In 1978 about 70 percent of the inpatient treatment workload and about 48 percent of the outpatient treatment workload in VA facilities was for nonservice-connected conditions. Reducing treatment for these types of illnesses would significantly reduce VA's future need for appropriations for construction projects. (See pp. 57 and 58.)

On matters related to individual agencies' actions, the Congress has not

--formally limited the number of computerized tomography scanners which can be purchased by Federal

agencies until agencies develop a coordinated plan for acquiring and using these specialized and very expensive medical resources, (see p. 35)

--changed the VA program funding method for providing medical treatment to Filipino veterans from a reimbursable contract to a fixed-sum grant, (see p. 56) and

--required VA to prioritize all new hospital construction projects on the basis of explicit, objective criteria before funding is approved (see p. 62).

The Congress still needs to act on these recommendations; action would save costs in various agencies' construction and operation and maintenance budgets.

Another example relates to the Office of Management and Budget (OMB), which has consistently stated that it would rely on its budget examiners to address interagency sharing of medical resources. OMB's traditional reliance on its budget examiners is inadequate, because each examiner reviews only one agency's budget request.

Generally, agency officials have begun to address (1) proper planning and sizing of health care facilities and (2) sharing Federal medical resources. For example, DOD and VA officials are working with us to refine their hospital sizing models to meet the unique characteristics of each of their respective systems. Likewise, DOD, HEW, and VA officials continue to participate in issues involving sharing of Federal medical resources by participating in the Federal Health Resources Sharing Committee. However, the increasing demands on the Sharing Committee and the growth of its subcommittees make it very difficult for the Committee to make any substantial progress because it lacks both staff and resources.

Appendix I details all of the cost-saving recommendations on the direct care programs which have not been fully implemented.

CONCLUSIONS

Millions of dollars have been saved by implementing our recommendations, and millions more could be saved if the Congress or the responsible agencies implemement our other recommendations. The Congress and the agencies should act on all of our outstanding recommendations.

CHAPTER 3

SAVINGS ACHIEVED, BUT MORE IS AVAILABLE IN THE HEALTH FINANCING PROGRAMS

The Federal Government has four health financing programs covering various groups. The largest--Medicare--covers most people over 65 years old, and many disabled people. The second largest--Medicaid--covers people who receive cash assistance under the welfare programs, and other low income people. The other two financing programs cover Federal employees--the Federal Employees Health Benefits (FEHB) program covers active and retired civilian employees and their dependents, and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) covers the dependents of active-duty military personnel, retired personnel and their dependents, and dependents of deceased personnel. In the 5-year period 1974-78 we issued 42 reports that contained recommendations to control the costs of one or more of the health financing programs. The Congress or the administering agencies have fully or substantially implemented 63 cost control recommendations, and this has saved many millions of dollars. However, 72 recommendations have not been implemented or have only been partially implemented, and full implementation would save more millions of dollars.

MEDICARE AND MEDICAID

Medicare and Medicaid are administered by HEW's Health Care Financing Administration (HCFA). 1/ Medicare, authorized by title XVIII of the Social Security Act (42 U.S.C. 1395), consists of two parts--Hospital Insurance (part A) and Supplemental Medical Insurance (part B). To qualify for part A coverage, a person must (1) be 65 years of age and entitled to Social Security or railroad retirement benefits, (2) have received Social Security disability payments for at least 24 consecutive months, or (3) have end stage renal disease and be covered by Social Security. Also, persons over 65 who are not entitled to free part A coverage can purchase coverage by paying a premium, currently $69 per month.

1/Before HCFA was established in 1977, Medicare was administered by the Social Security Administration and Medicaid was administered by the Social and Rehabilitation Administration. In this report, references to those agencies generally have been changed to HCFA.

Part A covers inpatient hospital services and posthospital extended care services--inpatient services in a skilled nursing facility and home health services. Part A is financed primarily with receipts from the Social Security payroll tax. Payments to health services providers are normally based on the provider's reasonable costs.

To qualify for part B coverage, a person must be entitled to part A or be 65 years of age and a citizen or resident alien for at least 5 years. Part B enrollees pay a monthly premium (currently $8.70) which is based on the actuarial value of the coverage. Initially the premium amount was set to cover half of the actuarial value but, because of a provision which generally limits the increase in the premium amount to the increase in the consumer price index, the premium amount currently covers about a third of the actuarial value. Federal general revenues are used to cover the remainder of part B costs. Part B covers physician, laboratory, X-ray, outpatient hospital, home health, and various other ambulatory services. Payments to health services providers under part B are generally based on reasonable charges.

Medicaid is a Federal/State program to provide health services to recipients of cash assistance under the welfare programs and other low income persons. All persons receiving cash assistance under the Federal/State aid to families with dependent children (AFDC) program are covered by Medicaid. Normally, persons receiving assistance under the Federal Supplemental Security Income (SSI) program for the aged, blind, and disabled, are covered by Medicaid but 14 States have eligibility criteria more restrictive than SSI's for these persons. States can also provide Medicaid coverage to persons who meet all of the eligibility requirements of AFDC or SSI except for income and/or resources but who cannot afford to pay for all their medical expenses. Thirty-three States have elected to cover such persons.

Federal law and regulations set the broad framework under which the States initiate, design, and operate their Medicaid programs. The Federal Government pays from 50 to 78 percent of the costs of medical services, depending on the State's per capita income, and varying percentages of State administration costs depending on the administrative function performed.

States are required to provide Medicaid recipients with inpatient and outpatient hospital services, laboratory and X-ray services, skilled nursing and home health services,

physician services, family planning services, rural health clinic services, and preventive health services for children. States can also cover any other medical or remedial services recognized under State law and approved by the Secretary of HEW. States determine how they will pay providers for services rendered but are prohibited from paying more than Medicare would pay for a given service.

FEHB

The FEHB program, administered by the Office of Personnel Management (OPM), 1/ provides health insurance coverage for current and retired civilian personnel and their dependents. Employees have the choice of enrolling and also can choose which insurer under the program they wish to utilize. The Government and the employee share in the premium payments with the Government's share set at 60 percent of the average of the premium charges for the highest level of benefits offered by the two Government-wide insurers, the two largest insurance plans sponsored by employee organizations, and the two largest comprehensive prepayment plans (similar to Health Maintenance Organizations) participating in the FEHB program. The Government's share is limited to 75 percent of a given plan's premium. The scope of services covered and the method of paying providers varies among the insurers. However, a relatively comprehensive range of services is covered by all insurers, and providers are usually paid on the basis of charges.

CHAMPUS

CHAMPUS provides financial assistance for medical care provided by civilian sources to dependents of active-duty members, retirees and their dependents, and dependents of

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1/Before establishment of OPM, the FEHB program was administered by the Civil Service Commission. In this report, references to the Civil Service Commission generally have been changed to OPM.

deceased members of the uniformed services. 1/ 2/ The program originated in 1956 with the Dependents' Medical Care Act (Public Law 84-569) and was expanded by the Military Medical Benefits Amendments of 1966, 10 U.S.C. 1071 et seq. (Public Law 89-614).

CHAMPUS benefits are divided into two categories--basic and handicap. Basic benefits apply to all beneficiaries and cover both inpatient and outpatient medical care, including such services as surgery, hospitalization, outpatient prescription drugs, X-rays, clinical laboratory tests, and psychiatric care. Handicap benefits apply only to spouses and children of active-duty members and cover rehabilitative services and care for the moderately or severely mentally retarded or seriously physically handicapped persons.

Costs of care are shared by the Government and beneficiaries. For basic benefits, dependents of active-duty members pay a total of $25 or $4.65 a day, whichever is greater, for inpatient care; other beneficiaries pay 25 percent of total charges. For outpatient care, there is a deductible of $50 for each beneficiary ($100 maximum deductible for each family) each fiscal year, after which dependents of active-duty members pay 20 percent and other beneficiaries pay 25 percent of the remaining charges. No limit is set on the Government payment under the basic program. For handicap benefits, active-duty members pay a specified monthly amount, ranging from $25 to $250, depending on the rank of the active-duty member, and the Government pays the remaining charges up to $350 a month. The active-duty member pays any charges exceeding these amounts.

1/The "uniformed services" are the Army, the Navy, the Air Force, the Marine Corps, the Coast Guard, the commissioned corps of the Public Health Service, and the commissioned corps of the National Oceanic and Atmospheric Administration.

2/There is a similar program funded by VA and administered by DOD referred to as the Civilian Health and Medical Program of the Veterans Administration (CHAMPVA). CHAMPVA covers the spouse and children of veterans who have a total and permanent service-connected disability or have died from such a condition. The dependents cannot be eligible for CHAMPUS or Medicare.

The Office for CHAMPUS, located at Fitzsimons Army Medical Center near Denver, administers the program under the policy guidance and operational direction of the Assistant Secretary of Defense (Health Affairs). The Office for CHAMPUS contracts with fiscal agents, such as Blue Cross and Blue Shield plans and Mutual of Omaha, to process and pay claims.

COSTS OF AND PERSONS COVERED BY THE HEALTH FINANCING PROGRAMS

The following table lists the number of persons covered by the health financing programs and the costs of the programs for fiscal years 1974 and 1979:

	Number of persons covered (millions)		Program costs (billions)	
Program	FY 1974	FY 1979 (note a)	FY 1974	FY 1979 (note a)
Medicare	23.0	26.9	$11.4	$29.7
Medicaid	24.7	22.9	b/9.8	b/20.9
FEHB	9.3	10.0	1.6	3.2
CHAMPUS	7.7	8.0	.5	c/.4
Total	64.7	67.8	$23.3	$54.2

a/Estimated.

b/Includes States' share of costs which amounts to about 45 percent of total costs.

c/One-time reduction due to change in method of reporting costs. Estimated costs for fiscal year 1978 are $0.8 billion.

Obviously, there has been a tremendous growth in these programs' costs. Some of the growth is explained by increased beneficiaries, some by increased numbers of services covered by them, and some by increased use of services. However, most of the increased costs was due to inflation and increased sophistication of services.

SAVINGS FROM IMPLEMENTING OUR RECOMMENDATIONS

The agencies responsible for administering the Federal Government's health financing programs have fully or substantially implemented many of our recommendations. This has

resulted in large program savings. Appendix V lists all recommendations that have been fully or substantially implemented and the benefits from implementing them. Some examples:

--We used a number of information systems containing data on personal income and/or benefits (such as from SSA, DOD, VA, and State labor departments), and found in two States that 14 of 50 sampled Medicaid recipients were ineligible. We recommended that HEW consider having the States use these income information sources when determining Medicaid eligibility and conducting eligibility quality control reviews. Most States now routinely use other income information systems--not only for Medicaid, but also for AFDC--and we believe this has contributed significantly to a decrease in the number of erroneous eligibility determinations. (B-164031(3), Sept. 20, 1974.)

--Many people who could have safely dialyzed at home were being dialyzed in facilities. Based on 1972 costs, dialyzing at home cost at least $15,000 a year less than dialyzing at a facility. We made two recommendations to HEW and one to the Congress to encourage renal disease patients to dialyze at home. Public Law 95-292 met the thrust of our recommendations by providing reimbursement incentives to patients to dialyze at home. (MWD-75-53, June 24, 1975.)

--HEW was not receiving information from the States that could be compared to determine which methods most effectively assured that third parties liable for paying for services provided to Medicaid recipients were paying for such services rather than Medicaid. We recommended that HEW require the States to make third party information comparable. HEW revised its Medicaid quality control procedures in 1978 so that they included determining and reporting whether liable third parties had paid for services provided to Medicaid recipients. The information provided in the quality control reports should help assure that States have more effective third party recovery and avoidance programs. HEW's Inspector General estimated in his March 1978 annual report that third parties are liable for about $330 million a year for services that are paid for by Medicaid. (HRD-77-73, May 2, 1977.)

--A large, publicly owned nursing home in Pennsylvania had received payments from both Medicare and Medicaid

for the same services. We recommended that HEW recover the Federal share of duplicate Medicaid payments and assure that duplicate payments stop occurring. HEW recouped about $1.3 million in duplicate payments covering a 4-year period. An HEW official stated that duplicate payments are no longer being made. (HRD-77-44, May 6, 1977.)

--Large differences in administrative costs-per-claim processed existed among CHAMPUS claim processors under cost reimbursement contracts. DOD had not requested proposals from additional firms to see if claims processing costs could be lowered, nor had it terminated the contracts of any high-cost processors. Further, DOD had not eliminated a duplicate claims review function. We recommended that DOD request proposals for claims processing, terminate inefficient processors, and eliminate the duplicate review. DOD implemented these recommendations by going to competitively bid, fixed price contracts for claims processing functions (estimated first-year savings--$7.6 million) and by increasing contract monitoring to help terminate or not renew poor performing contractors. Going to competitive contracts also eliminated the duplicate review. This new method of contracting should help assure that claims processing costs are reasonable and that poorly performing contractors are not allowed to remain in the program. (MWD-76-48, Nov. 21, 1975.)

--In response to a legislative mandate, HEW and OPM prepared a proposal for coordinating the Medicare and FEHB programs. Our analysis of the proposal showed that it did not fully meet congressional intent. One of our suggested alternatives was adopted when the Congress repealed the law requiring subordination of Medicare to the FEHB program. Repeal of the section resulted in first-year savings estimated to be $48 million. (MWD-75-99, Aug. 4, 1975.)

ADDITIONAL SAVINGS AVAILABLE FROM IMPLEMENTING OUR RECOMMENDATIONS

The Congress, HEW, DOD, and OPM have generally responded to our health financing program recommendations; however, some of our recommendations have not been implemented or have been only partially implemented. Full implementation of these

recommendations could save hundreds of millions of dollars. Examples of these recommendations are given in this section; a full listing of them, along with why we made the recommendations and what, if any, action has been taken on them, is presented in appendix II.

One major problem facing HEW, which would result in tremendous savings if it could be resolved, is the unavailability of nursing home beds to Medicare and Medicaid patients. We issued two reports on this problem: one on administratively necessary days (HRD-76-142, June 29, 1976, see p. 71) and the other on the effect of Medicaid payment rates on the availability of beds (HRD-78-98A, Oct. 23, 1978, see p. 76). Data from Ohio showed that at least $14 million per year was being spent for hospitalizing Medicaid patients who could be adequately served in nursing homes and at least $59 million a year for such Medicare patients. The relatively low Medicaid nursing home payment rates appeared to cause the problem. Nursing homes were unwilling to accept Medicare patients because they feared these patients would eventually become Medicaid patients. Similar data for New York showed that about $216 million a year was being spent on hospital payments for Medicare and Medicaid patients who could be adequately cared for in nursing homes. We believe that similar problems exist in other areas of the country because other States also have relatively low Medicaid payment rates. In the two reports we made recommendations designed to provide HEW with the data necessary for identifying where the problem exists and to have HEW then correct the problem. HEW has taken some actions but needs to do more.

States normally pay providers of Medicaid supplies and laboratory services amounts not exceeding usual and customary charges and, in some instances, such amounts are subject to maximum fee schedules. Competitive procurement could result in much lower prices. Also, States should not pay more than the lowest amount charged to other purchasers. We recommended that the Congress authorize the competitive procurement of laboratory services on an experimental basis, and that it limit Medicaid payments to a laboratory to the lowest charge to other purchasers. (HRD-78-60, July 6, 1978, see p. 101.)

As of August 1979 the Congress had not enacted such provisions but the Senate Committee on Finance had agreed to report to the Senate a provision authorizing competitive procurement experiments. The Congressional Budget Office estimated $53.1 million in savings in 1981 if competitive bidding for laboratory services is authorized under Medicaid.

The Medicaid Management Information System is supposed to enable the States to vastly improve their management of Medicaid. Public Law 92-603 requires HEW to pay 90 percent of the State's cost of developing a system and, after approval, 75 percent of the operating costs. The system's potential was not being realized by either the States or the Federal Government. None of the three State systems we reviewed fully complied with legislative requirements or implementing regulations, even though HEW approved them as being operational. This noncompliance stemmed from weaknesses in HEW's system approval process and system design criteria. We believe States should be reimbursed for operating a system that meets certain performance standards of efficiency and effectiveness--not for merely having an approved system. Increased administrative funding should be provided by HEW only for meeting performance standards which have a significant effect on the program (such as cutting costs or increasing service availability).

We believe the best method to ensure adequate State management is to establish performance standards for their systems, basing the amount of Federal sharing on compliance with such standards, and periodically evaluating systems to assure that they meet Federal requirements--and we recommended that the Congress amend the Medicaid law to so require. (HRD-78-151, Sept. 26, 1978.) While some savings in administrative costs might occur if our proposal is enacted, the potential for reducing program costs through better management is tremendous. Senate Bill 731, designed to implement our recommendation, was introduced on March 22, 1979, and referred to the Senate Finance Committee.

CONCLUSIONS

The Congress and the responsible agencies should take the actions necessary to fully implement the outstanding recommendations contained in appendix II. Such actions would save millions of dollars for the health financing programs.

CHAPTER 4

PREVIOUS RECOMMENDATIONS FOR CONTROLLING COSTS IN FEDERALLY ASSISTED HEALTH PROGRAMS

Since 1973, we have made numerous studies of programs administered by PHS. Many of these studies resulted in recommendations to the Congress or to the Secretary of HEW for action that would contain or reduce the amounts expended on these programs.

Most PHS-administered programs provide Federal financial assistance through grants and contracts; they have one or more of the following objectives:

--Building resources allocation systems throughout the Nation through (1) strengthening State and local planning, (2) developing health services capacity in communities where such a capacity is needed, and (3) integrating these services into the health care mainstream.

--Implementing an aggressive preventive health strategy through (1) preventive health services, (2) improving the nutritional status of Americans, and (3) monitoring and modifying the environment.

--Strengthening essential resources for a quality, cost conscious health care system by (1) stabilizing academic medical institutions, (2) replenishing the health staff pool, (3) providing biomedical, behavioral, and health services research, and (4) developing a modern health data bank.

Since 1973 PHS expenditures on its programs have increased considerably, and Federal outlays for fiscal year 1980 are expected to be about $7.9 billion. The agencies comprising PHS and carrying out the above activities include: Alcohol, Drug Abuse, and Mental Health Administration; Center for Disease Control; Food and Drug Administration; 1/ National Institutes of Health; Health Resources Administration; Health Services Administration; and the Office of the Assistant Secretary for Health.

1/For this report we did not review the status of implementation of our recommendations related to the Food and Drug Administration.

Although many of our reports dealt with actions needed for improving program effectiveness, many also identified opportunities and included recommendations for controlling unnecessary costs. Seldom did our audit effort provide sufficient information for placing a monetary value on the overall results achieved or potentially achievable by implementing our cost-saving recommendations. Also, implementing some of the recommendations for controlling unnecessary Federal program costs may result in a cost transfer to some other Federal program or result in additional costs to State or local agencies or the general public.

The recommendations for reducing PHS program costs can be categorized into four types of required action:

--Require grantees and contractors to change practices or procedures through issuing regulations, policies, or standards or through revising legislation.

--Help grantees and contractors become more efficient through technical assistance.

--Monitor grantees and contractors to assure compliance with efficiency requirements in laws, regulations, policies, or standards.

--Improve HEW's internal management to develop cost-saving remedies.

The following sections of this chapter provide examples of fully implemented recommendations and those that have been partially or not implemented. Appendix III details our cost-saving recommendations which have not been fully or substantially implemented, and appendix VI lists all such recommendations which have been implemented.

REDUCING COSTS THROUGH ISSUING REGULATIONS, POLICIES, OR STANDARDS OR THROUGH REVISING LEGISLATION

To better assure that Federal programs are administered efficiently, effectively, and economically--consistent with congressional intent--the enabling legislation sometimes specifies how various aspects of a program are to be administered. More frequently, however, Federal agencies must supplement the legislation by issuing Federal regulations, policy statements, and operational standards.

During several reviews of specific health programs we noted that program efficiency and effectiveness was impaired because programs operated for several years without issuing all regulations required by the enabling legislation or HEW policy. Therefore, as a separate study, we selected for review 14 regulations in various states of development. Of these regulations 12 were still not published 6 months after enactment of enabling legislation--as required by HEW policy. Publication was delayed because:

--Known policy issues were not addressed and resolved on a priority basis.

--Developing a regulation was delayed due to limited staffing and resources.

--Some offices ignored established processing dates and placed a low priority on reviewing proposed and final regulations.

--Responsible officials did not take effective measures when a proposed or final regulation was delayed for one or more of the reasons above.

Tardiness in publishing regulations can negatively affect program implementation. For example, the absence of regulations can prevent the implementation of new provisions that could produce savings. HEW estimated that, in fiscal year 1974, approximately $81.2 million in potential savings was lost because the final regulation putting cost sharing into effect under the Medicaid program was not published until over 15 months after enactment of enabling legislation.

We recommended (HRD-77-23, Feb. 4, 1977) that the Secretary of HEW work toward timely publication of regulations and, thus, more timely implementation of congressional intent. In May 1978 HEW formally adopted Operation Common Sense, a new procedure for developing and processing regulations. This procedure should help expedite issuing regulations. The Congress is also now beginning to include specific dates by which HEW has to issue regulations. However, the timely issuance of regulations depends on the availability of staff who can prepare and process draft regulations at the program level. HEW has yet to insulate this staff from other program duties--initial efforts in drafting are still delayed as a result.

As with the timely issuance of regulations, HEW's failure to provide timely policy statements or to establish standards for grantees and contractors can also negatively impair program implementation. Cost-saving opportunities may be lost, and inefficiencies in grantee and contractor activities can result in spending unnecessary grant and contract funds.

Our reviews sometimes identified opportunities to improve program efficiency and effectiveness by amending the authorizing legislation. For example, our 1978 report on administering the Health Maintenance Organization (HMO) program (HRD-78-125, June 30, 1978) pointed out that sound management of an HMO was critical to its success in controlling costs, budgeting for the future, and marketing its services. We recommended that the Congress amend the legislation by authorizing a program to train HMO managers. The Congress authorized such a training program in November 1978 and funded it in July 1979. After HMOs begin to employ competent, trained managers, HMOs should be able to better control current and future costs.

The Congress and HEW have taken action to fully or substantially implement many recommendations that cited the need for the issuance of regulations, policies, or standards or the revision of legislation.

An example of HEW's implementation of one of our recommendations relates to the health planning program. Limited progress was being made at the State and local level in establishing and fulfilling the responsibilities of health planning agencies. HEW had not developed (1) regulations and guidelines for implementing the health planning act or (2) national standards and criteria regarding supply and distribution of resources. We recommended that HEW promptly issue the regulations, guidelines, standards, and criteria. HEW has subsequently published many of these documents. This should help local and State health planning agencies fulfill their responsibilities in controlling against excess supply of health services and unneeded construction of health facilities. As a result, health care costs should be better controlled. (HRD-77-157, Nov. 2, 1978.)

REDUCING COSTS BY PROVIDING TECHNICAL ASSISTANCE

During many of our studies of health programs, we noted that changes in grantees' and contractors' practices and procedures would improve program efficiency and economy. In

some cases, the grantees and contractors lacked the technical skills to implement the changes. In other cases they frequently concentrated on providing the services to intended program beneficiaries but placed less concentration on their accountability responsibilities for assuring that the services are provided efficiently and that available revenues are collected from third party payors. Generally, the deficiencies could be corrected if the PHS agencies would provide technical assistance.

We have reported that grantees were not billing for services provided to enrollees of community health centers (HRD-77-124, June 20, 1978) and community mental health centers (B-164031(5), Aug. 27, 1974).

The centers should have billed

--the Medicare and Medicaid programs for services to their beneficiaries;

--private insurance firms for services to patients covered by such insurance; and

--patients, when their financial status showed an ability to pay for health care.

The centers sometimes lacked procedures to identify who should pay for care; in other cases, bills were sent to potential third party payors but the centers did not have followup procedures to assure collection. It appears that the Congress, to the extent possible, intended centers to become self-sufficient. Therefore, we recommended that HEW increase its efforts to assist the centers in developing billing and collection procedures. HEW has encouraged its grantees to collect funds from third party sources, but we have noted that not all potential collections are being received. As a result, cost to the grant programs of providing care through community health centers and community mental health centers may be higher than necessary.

An example of an implemented recommendation regards the lead poisoning prevention program. High levels of lead in the blood can cause mental retardation--HEW estimates that 600,000 children have elevated blood lead levels. Despite developing an inexpensive testing technique to identify elevated blood levels, lead poisoning screening was not done routinely. We recommended that HEW expand its lead poisoning prevention effort, encourage States to initiate screening efforts, and start a public education effort

on prevention. HEW distributed information on problems, risks, and new technology in testing for lead poisoning. Such efforts, by helping to prevent retardation, should reduce the need to spend health care funds for long-term institutionalization of the mentally retarded as well as for care that would be needed on an outpatient basis. (HRD-77-37, Oct. 3, 1977.)

COST SAVINGS THROUGH MONITORING COMPLIANCE

Issuing regulations and policy statements, developing operational standards, and providing technical assistance does not complete HEW's responsibilities for assuring that grantees and contractors are efficiently and effectively fulfilling their responsibilities. PHS agencies must also monitor grantees and contractors to better assure compliance with program directives and for prompt awareness of grantees' and contractors' deficiencies and difficulties. Such monitoring can take the form of fiscal and program audits and prescribed reporting of data by the grantees and contractors.

During our studies we found that, although adequate guidance and assistance had been given to grantees and contractors, the grantees and contractors had not implemented procedures to minimize program costs while maximizing program goals and objectives. For example, during our study of Federal efforts to care and treat the mentally disabled in communities rather than in institutions (a national goal established in 1963), we noted that neither HEW nor the States had instituted procedures to assure that the mentally disabled were placed in appropriate alternative community-based facilities. Such placement could reduce the cost of caring for and treating these patients. HEW regulations stipulated that placing Medicaid recipients in intermediate care facilities because community alternatives were unavailable was to be documented, and alternatives were to be actively sought. We recommended that HEW monitor and enforce compliance with this regulation. HEW has taken only limited action on this recommendation. (HRD-76-152, Jan. 7, 1977.)

CHANGES IN HEW MANAGEMENT COULD CUT COSTS

In some of our studies we observed that HEW needed to (1) alter its decisionmaking process, (2) study a significant policy issue, or (3) better coordinate its internal management activities. Such management actions may not only improve program effectiveness, but they may also reduce program costs.

In our study of the swine flu program, we found that HEW needed to establish key points when implementing any mass inoculation program. While the program is being developed and implemented, HEW should objectively reassess all facts and, based on such reassessment, determine if continuing the program without change is warranted. Our report (HRD-77-115, June 27, 1977) recommended that HEW establish key points in the program planning and implementation processes to formally evaluate and redetermine prior program decisions. HEW subsequently developed a time-phased plan for pandemic influenza programs that included key points for reconsidering decisions to proceed with an immunization program.

In another instance we noted that a grantee had earned interest income on grant funds, and we recommended that the grantee refund the interest to the Treasury. HEW determined that $62,170 was owed to the Government, and it requested a refund from the grantee. We also noted that another grantee had incurred costs for activities beyond the scope of the grant, and recommended that HEW disallow these expenditures and recover funds inappropriately expended. HEW has disallowed the costs, but efforts to collect appear to be fruitless. (HRD-78-61, July 20, 1978.)

HEW HAS NOT IMPLEMENTED OR ONLY PARTIALLY IMPLEMENTED MANY COST-SAVING RECOMMENDATIONS

Although HEW has fully or substantially implemented many of our recommendations for saving costs in the PHS health programs, more opportunities exist through implementing other recommendations. In some cases, implementation would reduce the Nation's overall health care costs. HEW has disagreed with some of our recommended courses of action and has taken no action. In others, we believe that HEW has not given proper priority to initiating our recommendations:

--In 1972 HEW initiated a nationwide gonorrhea control program which essentially had two components--screening programs to identify females with gonorrhea, and interviewing males reported to have gonorrhea to identify and treat their contacts. We believe that HEW has insufficient data for assessing its program's effectiveness. We recommended that HEW periodically review whether the gonorrhea control projects are cost effective. HEW did not accept this recommendation. Until such efforts are undertaken, HEW may be incurring costs without maximizing results. (B-164031(2), June 10, 1974.)

--HEW's approach to deinstitutionalizing the mentally disabled was disorganized--plans for community placement had not been made, no instructions had been issued to component agencies, and no organization had been assigned responsibility for overseeing deinstitutionalization. Deinstitutionalization normally is less expensive than caring for patients in institutions. Our report included recommendations to the Congress, OMB, the Department of Housing and Urban Development, the Department of Labor, and HEW to improve the plight of the mentally disabled. In many cases, implementing the recommendations could cut costs. HEW has initiated some efforts but more could be done to develop appropriate, less costly facilities and effectively implement utilization controls to insure care is provided at the lowest cost level of appropriate care. HEW has yet to assign responsibility for overseeing the deinstitutionalization program. (HRD-76-152, Jan. 7, 1977.)

CONCLUSIONS

A number of opportunities exist to control health costs through the grant and contract programs by implementing our recommendations. We believe the Congress and HEW should implement these recommendations, which are listed in appendix III.

APPENDIX I

STATUS AS OF JULY 1979 OF GAO RECOMMENDATIONS TO CONTROL UNNECESSARY COSTS IN THE FEDERAL DIRECT HEALTH CARE SYSTEMS WHICH HAVE NOT BEEN FULLY IMPLEMENTED

Purpose of recommendation	Recommendation number (note a)		
	Partially implemented	Not implemented by Agency	Not implemented by Congress
Improve planning for and determination of proper size of new or renovated hospitals	6a,10a	b/15a,19b	b/15b,17a, 17b,19a, 19b
Increase sharing of Federal medical resources	None	1a,1b,1c, 1d,1e,1f, 1g,2a,2b, 3a,3b,9a,9b	2c,3c
Reduce or eliminate ineffectively used and/or unnecessary hospital space	4a,4b	4c,4d	None
Reduce cost by substitution of lower cost care	18a,20a	16a	20b
Better use of specialized medical resources	None	12a,12b, 13a,13b, 13c	None
Other	5a,5b,11a, 11b,11c	7a,8a,8b	8c,14a, 14b

a/Reports are numbered sequentially after this summary table. The number indicates the report and the letter indicates the recommendation.

b/Recommendation was made to both the Congress and the Veterans Administration.

MULTIAGENCY REPORTS

1. TITLE: "Sharing Cardiac Catheterization Services: A Way to Improve Patient Care and Reduce Costs," HRD-78-14, Nov. 17, 1977.

FINDINGS:

Cardiac catheterization is a procedure used to diagnose possible heart conditions. It is primarily performed to determine whether a patient needs cardiovascular surgery. Cardiac catheterization is performed on an inpatient basis; the process involves inserting a thin, flexible tube (catheter) into a blood vessel in the patient's arm or leg and moving it through the vessel into the heart chamber. It is performed in 90 Federal hospitals.

There was a large variance in the number of cardiac catheterizations being performed in DOD and VA hospitals. Also, there was no relationship between the number of catheterizations performed in a hospital and the number of physicians performing them in that hospital. Physicians at the hospitals visited had different views on the number of catheterizations which should be performed to maintain quality. VA had established guidelines, but neither DOD nor HEW had such guidelines for their hospitals.

In each of the four geographic areas visited, there were opportunities to share cardiac catheterization and increase patient safety and reduce Government costs.

RECOMMENDATIONS: NOT IMPLEMENTED

The Secretaries of Defense and HEW and the Administrator of VA should

(a) jointly develop uniform Federal guidelines for the planning and use of Federal cardiac catheterization laboratories which associate the number of catheterization procedures to be performed with the number of physicians that should perform them,

(b) consider variances from those guidelines,

(c) jointly analyze the use levels at cardiac catheterization laboratories and adjust the manner in which this diagnostic service is provided so that it is in harmony with the established Federal guidelines

and on a joint shared basis in a single Federal facility,

(d) discontinue providing cardiac catheterization in Federal facilities in geographic areas where the Federal guidelines cannot be met, and obtain this service from nearby civilian hospitals.

The Secretary of Defense and the Administrator of VA should

(e) consolidate operations between DOD and VA hospitals in the Dayton, Ohio, area, Tucson, Arizona, area, Augusta, Georgia, area, and the Washington, D.C., area.

The Secretary of Defense should

(f) close the cardiac catheterization laboratory at the Malcolm Grow Hospital.

In January 1978 the Federal Health Resources Sharing Committee chartered a subcommittee to address cardiac catheterization capacity among and between DOD, VA, and HEW. The subcommittee was to address both the general items in recommendations (a) through (d) and the specific geographic areas in recommendations (e) and (f). The subcommittee report was accepted by the Sharing Committee at its April 1979 meeting, and it was subsequently distributed to DOD, VA, and HEW for comments.

The cardiac catheterization subcommittee report sent to the agencies contained 14 recommendations. Recommendations included:

--Adopt the National Guidelines for Health Planning (within 3 years after initiation of a unit, a minimum of 300 cardiac catheterizations performed annually on adults and/or a minimum of 150 cardiac catheterizations performed annually on children; no new cardiac catheterization unit opened in any facility without an open heart surgery capability; and no additional adult catheterization unit opened in an area unless more than 500 studies are performed annually or 250 studies annually for a pediatric cardiac catheterization unit) subject to exception and variances.

--Require physicians to perform a minimum of 50 procedures annually to maintain proficiency.

--Close any existing cardiac catheterization laboratory currently performing fewer than the recommended number of procedures (allowing for variances) which is not expected to perform at an acceptable level in 3 years.

--Adopt regulations to authorize and require the use of the closest Federal facility regardless of service affiliation when an inhouse capability is not available.

--Legislative and regulatory changes should be made as speedily as possible to facilite interagency reimbursement.

--Use excess Federal cardiac catheterization capabilities to treat Medicare, CHAMPUS, and CHAMPVA program patients.

As of July 1979, the final report prepared by the subcommittee had not been issued.

(g) The Director, OMB, oversee efforts to develop uniform Federal cardiac catheterization guidelines in an appropriate and timely fashion and to insure that Federal cardiac catheterization services are shared when it will improve patient care and result in reduced costs to the Government.

The OMB Deputy Director informed us on July 18, 1977, that OMB was in full accord with the need for Federal agencies to jointly develop and use cardiac catheterization resources. However, OMB believes it can most appropriately enforce the application of any Federal guidelines developed through the budget review process. OMB took the same position on two subsequent reports relating to sharing (see pp. 34 and 37). Therefore, the more formal oversight and coordination recommended was not accepted.

We believe OMB's reliance on its budget examiners to recommend the proper action for interagency sharing will be inadequate, because each examiner reviews only one agency's budget and does not routinely address the cost savings possible by sharing resources.

2. TITLE: "Computed Tomography Scanners: Opportunity for Coordinating Federal Planning Before Substantial Acquisitions," HRD-78-41, Jan. 30, 1978.

FINDINGS:

Computed tomography scanners are a major new technological development in radiology. This equipment overcomes two disadvantages of conventional X-ray methods. First, scanners eliminate overlaying structures from view and, thus, clarify the image. Second, scanners make small differences in density apparent. Also, compared with some other neurological diagnostic procedures, scanners present little risk to the patient and minimal discomfort.

Scanners cost from $300,000 to $700,000, and operation and maintenance expenses are estimated to be several hundred thousand dollars per year.

The Federal Government had 16 scanners in operation and planned to purchase 29 more. These 45 scanners would cost about $21 million.

Only limited criteria had been developed in the civilian and Federal sectors for determining the need for and location of scanners. There was little or no coordination between DOD and VA at either the headquarters or local hospital level regarding planning or sharing scanners. Scans can be provided on an outpatient basis and, therefore, the procedure lends itself to interagency sharing.

RECOMMENDATIONS: NOT IMPLEMENTED

(a) The Secretaries of Defense and HEW and the Administrator of Veterans Affairs should develop a coordinated Federal approach for planning and using computed tomography scanners.

On February 6, 1978, the Federal Health Resources Sharing Committee was charged with conducting a review of computed tomography scanner utilization by DOD, VA, and HEW. The subcommittee report was completed in September 1978 and sent to the agencies for their comments in January 1979 after receiving the approval of the Sharing Committee. The report recommended certain essential common points to be reviewed when justifying the purchase of any scanner:

--An organized radiology service department with certain essential qualified medical, surgical, technical, and clerical staff should be available.

--No significant or available excess capabilities in other nearby Federal health care facilities or in civilian communities at a more reasonable cost should be available.

--Consideration of the wartime contingency role of the health care facility should be considered and provided for.

--Coordination and sharing with all nearby Federal providers to share capabilities should take place, but not to the extent that quality of care would be compromised for purely economic reasons.

--Consideration should be given to a facility's role in a communitywide emergency medical service system and the coordination and notification of purchase of the scanner with the appropriate health service agency or planning agency.

VA and the Department of the Air Force indicated that the report findings and recommendations were acceptable. DOD and the Department of the Army had difficulties with the report in many specific respects--including the lack of specificity in the scanner purchase criteria. Neither the Department of the Navy nor HEW had submitted comments on the report as of April 1979. The subcommittee report is being revised, and it will be resubmitted to the Sharing Committee for acceptance and informal agency comments.

(b) The Director, OMB, oversee the efforts of DOD, VA, and HEW to develop a coordinated Federal approach for planning and using scanners.

The OMB Deputy Director stated on August 16, 1978, that the OMB budget examiners would carefully review the matters discussed in our report during the 1979 budget review process. This position was the same taken by OMB on the sharing of cardiac catheterization resources among Federal agencies. As stated previously, we believe OMB needs to act in this area.

(c) The Congress should consider limiting the number of scanners that can be purchased until the coordinated Federal approach is developed.

The Congress has not imposed any limitation on any Government agency which would prevent them from acquiring additional scanners. As a consequence, VA has firm plans to acquire five scanners for use in VA hospitals in fiscal year 1979.

3. TITLE: "Legislation Needed to Encourage Better Use of Federal Medical Resources and Remove Obstacles to Interagency Sharing," HRD-78-54, June 14, 1978.

FINDINGS:

The Congress has expressed its desire for greater sharing of the Nation's medical resources by enacting several laws to encourage regional cooperation in health care delivery. However, Federal agencies' participation in regional health planning groups established as a result of these laws has, for the most part, been only advisory.

No interaction is required among the Federal agencies responsible for the direct delivery of health care. Moreover, no laws clearly require Federal interagency sharing, although several permit Federal health facilities to share their capabilities with other agencies.

In fiscal year 1977, DOD, VA, and HEW collectively spent over $6 billion to provide medical care directly to eligible Federal beneficiaries and over $700 million for medical care provided in Federal facilities to eligible beneficiaries in the non-Federal sector.

Numerous opportunities for increased interagency sharing

--had not been considered by the agencies involved,

--were pursued but abandoned, or

--were only partially successful.

In most instances the following obstacles precluded attempts by or discouraged local Federal officials from completing satisfactory interagency sharing arrangements:

--The absence of a specific legislative mandate for interagency sharing and a lack of adequate headquarters guidance on how to share.

--Restrictive agency regulations, policies, and procedures.

--Inconsistent and unequal methods for agencies to be reimbursed for services rendered to other agencies' beneficiaries.

The net result was increased Federal expenditures to perpetuate the uncoordinated direct delivery of health care to Federal beneficiaries by various Federal agencies.

RECOMMENDATIONS: NOT IMPLEMENTED

(a) The Secretaries of Defense and HEW and the Administrator of Veterans Affairs direct the Federal Health Resources Sharing Committee to expeditiously seek solutions to the administrative obstacles within each agency which impede sharing.

Subcommittees established by the Federal Health Resources Sharing Committee consider, among other things, administrative obstacles which hinder sharing of services (such as patient movement, reimbursement, patient eligibility, etc.). No final subcommittee reports had been issued as of June 1979.

The major obstacles to interagency sharing--the issue of inconsistent and unequal methods for reimbursing agencies for services rendered to other agencies' beneficiaries--have been recently addressed. For example, the Federal Health Resources Sharing Committee, in its January and April 1979 meetings, discussed the possible need for new or modified reimbursement legislation authorizing direct reimbursement to the facility providing care. The Sharing Committee Chairman has suggested that each agency review all existing authorities for interagency sharing to identify obstacles and suggest remedies. Also, the VA Chief Medical Director requested that the VA General Counsel determine whether additional or modified legislation is needed to reimburse facilities for services rendered in sharing arrangements.

(b) The Director, OMB, establish a management group within the existing OMB organizational structure to work with DOD, HEW, and VA to coordinate the development of an effective interagency sharing program.

On March 21, 1978, OMB stated that it disagreed with the creation of such a group. OMB said it would rely on its budget examiners and other staff already working in the agencies affected by our report's recommendations when considering interagency sharing. As stated in regard to recommendations 1(g) on page 32 and 2(b) on page 34, we believe that establishing such a group is essential.

(c) The Congress should enact legislation to establish a greatly expanded and cost-effective interagency sharing program. Specifically, this legislation should

--establish a Federal policy that directs interagency sharing, when appropriate;

--authorize each Federal direct health care provider to accept all categories of eligible beneficiaries on a referral basis when advantageous to the Government and care of primary beneficiaries would not be adversely affected;

--eliminate all restrictions on the types of medical services which can be shared;

--authorize Federal hospital managers to enter into sharing arrangements, subject to headquarters veto only if judged not in the best interests of the Government;

--authorize expansion of services as necessary to use Federal medical resources in the most cost-effective manner;

--establish a policy requiring full use of available nearby Federal medical resources before using civilian or distant Federal medical resources;

--authorize the establishment of a method of reimbursement under which the providing Federal hospital would use any revenues received to offset any expenses incurred; and

--assign to OMB the responsibility to (1) coordinate the implementation of an effective interagency Federal medical resources sharing program and (2) report annually to the Congress concerning the progress being made toward increased sharing of these resources.

Although several congressional committees have expressed interest in the interagency sharing of medical resources, no legislation has been introduced or enacted. Such legislation is needed, in our opinion, in order to assure that the agencies involved take the necessary actions for coordinating and sharing resources, thereby helping contain health program and construction costs.

DEPARTMENT OF DEFENSE REPORTS

4. TITLE: "Military Hospitals Should Be: (1) Provided Criteria for Presidential and VIP Accommodations and (2) Instructed to Discontinue Separating Officer and Enlisted Patients," B-161475, Dec. 24, 1974.

FINDINGS:

We found that DOD had not established criteria for Presidential and other very important person (VIP) accommodations in military hospitals and had not instructed the military departments to discontinue separating officer and enlisted patients. Criteria concerning the establishment, size, and furnishing of Presidential suites were needed because of the military departments' varied practices in establishing such suites. Construction or modification costs to establish the six Presidential suites ranged from $500 to $215,000; cost of furnishings ranged from $1,800 to $25,000; size of the suites ranged from 600 square feet to 6,543 square feet. A new hospital, including a 2,800-square-foot Presidential suite, was being constructed at Walter Reed Army Medical Center in Washington, D.C. Because a 6,543-square-foot suite already existed at the National Naval Medical Center in Bethesda, Maryland, DOD needed to assess the need for more than one suite in the Washington, D.C., area.

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Because the military departments left the decisions on establishing and furnishing VIP accommodations to the discretion of hospital commanders, there was considerable variation about the definition of a VIP, the size and furnishings of VIP suites, and the number of beds maintained for VIPs. DOD needed to (1) determine if such accommodations were needed and (2) establish criteria governing them.

At the four Navy hospitals we visited, the separation of officer and enlisted patients generally resulted in more space, more expensive furnishings, and a higher ratio of nursing staff being provided to officers. Although DOD is opposed to separating officer and enlisted patients, it had not instructed the military departments to eliminate this practice in existing or future DOD hospitals.

RECOMMENDATIONS: PARTIALLY IMPLEMENTED

(a) Determine the need for other VIP accommodations in military hospitals. If there is such a need, develop criteria for establishing and furnishing them.

In response to our recommendation, DOD said that VIP accommodations are necessary under special circumstances to support officials who require isolation from the public or whose position would invoke sufficient public concern to require either press or special coverage by other agencies. In addition, DOD indicated that such facilities should be used by special patients who are not in a severe or acute phase of their illness and that may be able to carry out their official responsibilities while in the hospital. DOD established space planning criteria governing the size of VIP accommodations and describing the circumstances governing their establishment.

The criteria do not, however, provide hospital commanders guidance for determining who is entitled to VIP treatment, how many VIP rooms to establish, how to furnish the VIP rooms, or what staffing to provide. As a result, our April 17, 1979, followup report, "Military Hospitals Need Stronger Guidance on Presidential, VIP, and Officer Accommodations" (HRD-79-61), recommended that DOD develop more specific criteria for establishing and furnishing VIP accommodations. Because accommodations including such items as chandeliers, refrigerators, and separate kitchens are not needed to enable a VIP to continue functioning in an official capacity, we recommended that the VIP kitchen at Walter Reed

Army Medical Center be discontinued and that furnishings be limited to those needed to enable VIPs to function in an official capacity.

(b) Instruct the military departments to prohibit the separation of officer and enlisted personnel in their existing and future hospitals.

In response to our recommendation, DOD, in April 1976, directed the Navy to discontinue separating officer and enlisted patients in Navy hospitals. However, the Navy did not issue instructions to individual hospitals to discontinue this practice, and some hospitals continue it to varying extents. Our April 17, 1979, followup report recommended that DOD direct the Navy to prohibit the separation of officers and enlisted patients, and follow up to assure that the regulation is enforced.

RECOMMENDATIONS: NOT IMPLEMENTED

(c) Establish criteria regarding the number, size, and furnishings of Presidential suites and require DOD approval of the establishment of future suites.

DOD agreed with our recommendation, but has not developed criteria concerning the number, size, or furnishing of Presidential suites. According to a DOD official, DOD does require approval for any future Presidential suites by a DOD Hospital Planning Review Committee. However, because criteria have not been established, the committee has no basis for evaluating a proposed Presidential suite. In our April 1979 report we again recommended that DOD establish criteria regarding the number, size, and furnishings of Presidential suites and require both DOD and White House approval of the establishment or remodeling of Presidential suites.

(d) Assess the adequacy of the Bethesda Presidential suite to provide medical care to the President, and convert to other uses either the Bethesda suite or the planned Walter Reed suite, as appropriate.

In April 1975 DOD advised us that it agreed with our recommendation and that it planned to make the suite in the new Walter Reed hospital the only Presidential suite for health care. However, in May 1978, as the Presidential suite at the new Walter Reed hospital neared completion, DOD reversed itself, declaring that the Bethesda suite was

adequate for providing medical care to the President, and it would remain as the Presidential suite.

Although DOD plans to use the Presidential suite at the new Walter Reed hospital for other VIPs, it was planned and constructed as a Presidential suite. Hospital officials could not provide specific data on the cost of constructing the new Presidential suite, but based on the overall cost of about $109 per square foot for constructing the new hospital, the 2,831-square-foot suite cost about $310,000. In our April 1979 followup report we recommended that DOD convert the Presidential suite in the new Walter Reed hospital to other patient uses in lieu of using it as a VIP suite.

5. TITLE: "Questionable Use of the Domestic Aeromedical Evacuation System," MWD-75-45, Apr. 21, 1975.

FINDINGS:

Aeromedical evacuation is the airlift of patients under medical supervision to, between, and from medical treatment facilities. In 1973 DOD spent about $29 million to move about 49,000 patients in its worldwide system. Sixty-four percent of the costs and 88 percent of the patients moved were included in the domestic segment of the aeromedical evacuation system which we reviewed.

One primary responsibility of the Armed Services Medical Regulating Office is to move patients to the nearest uniformed service hospital facility if care is not available locally.

We found that about 97 percent of the 43,000 patients transferred in the domestic system were classified as "routine," 2 percent were classified as "priority," and only 1 percent were classified as "urgent." Responses to 214 GAO questionnaires to domestic users of the system showed that

--80 percent could have received the needed care at or near their originating facility or closer than those to which they were transferred,

--44 patients who could have used CHAMPUS were transferred by the system,

--37 active-duty patients were transferred from medical facilities shown to have the needed treatment capability, and

--90 active-duty patients were transferred to other than the closest military medical facility with the required capability.

Reasons for such transfers included

--to have the patient receive care in a facility affiliated with the patient's service and

--physicians wanted to refer patients to other physicians they knew and/or trusted.

The questionnaire responses also showed that transportation by means other than the aeromedical evacuation system appeared appropriate for about half of the 214 patients.

RECOMMENDATIONS: PARTIALLY IMPLEMENTED

(a) Insure that the Armed Services Medical Regulating Office promotes increased use of interservice patient transfers.

(b) Insure that the Medical Regulating Office limit long-distance transfers initiated solely by one physician directly to another physician to those instances which are necessary.

In DOD's comments on the report, DOD said that the Medical Regulating Office system had been modified to assure adequate support of patient flow within the DOD medical regions and to realize increased utilization of the nearest military hospital regardless of its military affiliation. This expansion of patient regulating or monitoring responsibilities was incorporated in a revised DOD directive giving new responsibilities to the Medical Regulating Office--including the requirement to move patients to the nearest uniformed-services facility possessing the appropriate specialty capability. All patient movements were to be monitored, according to DOD, by a monthly reporting system that would provide the visibility to management for assuring compliance with DOD policy. However, during the fiscal year 1978 appropriations hearings before the House Subcommittee on Military Construction it was disclosed that the Surgeons General of the military departments had incorporated many exceptions to the DOD policy for use in patient regulating and, in our opinion, the exceptions currently in use could result in inappropriate transfers.

6. TITLE: "Policy Changes and More Realistic Planning Can Reduce Size of New San Diego Naval Hospital," MWD-76-117, Apr. 7, 1976.

FINDINGS:

At the time of our review, DOD was undertaking an accelerated health facilities modernization program estimated to cost $2.9 billion when completed in 1980. The replacement of the San Diego Naval Hospital to the extent planned, at an estimated cost of about $223 million, was questionable because of other nearby underused Federal hospitals.

DOD's criteria for planning the size of military hospitals was four beds per 1,000 active-duty members and their dependents--the criteria did not reflect the actual or expected use patterns for proposed military hospital construction projects. If applied to the San Diego Naval Hospital, DOD's criteria would have resulted in the construction of a facility whose capacity would far exceed expected medical needs. We developed a hospital sizing model for acute care beds. Applying it to the San Diego facility eliminated 300 planned acute care beds.

RECOMMENDATION: PARTIALLY IMPLEMENTED

(a) Incorporate into the hospital sizing methodology a sufficient number of light care (non-acute care) facilities to meet special requirements of the military which result from the fact that patients cannot always return to their duty stations for a normal convalescent period.

In January 1979 DOD stated that many important issues involved in size, construction, and operation of light care units had not yet been fully resolved. DOD's progress in resolving the overall issue of light care units as of January 1979 was transmitted, as requested, to the Chairman of the House Committee on Appropriations. Subsequently, the Committee told DOD that it expects this issue to be fully resolved before approval of any hospital construction projects in the fiscal year 1981 budget request.

7. TITLE: Letter report concerning, "Army and Air Force Medical Education and Training Programs for Enlisted Personnel," HRD-77-89, May 17, 1977.

FINDINGS:

The Army's Health Service Command and the Air Force's Air Training Command are responsible for medical education and training programs. Both commands planned to spend a total of $1.8 million to replace certain radiological training equipment. Savings could be achieved by meeting radiological equipment needs with existing resources or by purchasing equipment with lower capabilities.

RECOMMENDATION: NOT IMPLEMENTED

(a) Direct the Army and Air Force to determine the type of X-ray equipment needed for radiology training courses with a view toward making optimal use of existing resources and not purchasing equipment in excess of that needed for training.

There was no corrective action taken by DOD, the Army, or the Air Force. DOD told us in May 1979 that it planned to send a memorandum to the Army and the Air Force, requiring action on this matter and feedback on the eventual position taken by the military departments. We estimated a total savings of about $400,000 if our recommendation had been implemented.

8. TITLE: "New Strategy Can Improve Process for Recovering Certain Medical Care Costs," HRD-77-132, Sept. 13, 1977.

FINDINGS:

When the Government provides medical care to people who are injured or suffer a disease because of another person's fault, it can then recover the cost of care from the person at fault. The Government recovered about $14 million in 1975; $11 million of this amount was collected by DOD.

The Federal Medical Care Recovery Act authorizes DOD to recover these medical care costs. The recovery process under the act is complex and time consuming.

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DOD could simplify the recovery process, improve its timeliness, and possibly increase the amount it recovers by first seeking reimbursement from an injured person's insurance company when possible.

Claims officers were not trying to identify or file claims with insurance companies unless recovery under the Federal Medical Care Recovery Act is impossible or unsuccessful. Where possible, recovery from insurance companies should be sought as the first course of action, rather than as a last resort, since this is not as cumbersome or as time consuming as recovery under the act.

RECOMMENDATION: NOT IMPLEMENTED

GAO made several recommendations directed at streamlining DOD's recovery process, the thrust of which were

(a) taking advantage, where possible, of existing avenues of recovery before pursuing claims under the Federal Medical Care Recovery Act and

(b) standardizing the administrative processes of the three military departments.

DOD disagreed with the principal recommendation--to seek reimbursement from other sources before pursuing claims under the act. DOD contended that attempts to file a claim against any injured military beneficiary's insurance company--as a first avenue of recovery--would be contrary to the intent of the act. Also, DOD disagreed with most of our recommendations to standardize the administrative processes of the three military departments. DOD's original position on our recommendations had not changed as of May 1979.

Based on a review of the legislative history of the act, we believe our recommended approach is in harmony with the Congress intent. The order that sources of recovery are tapped is not the primary concern in the legislative history. Instead, the act was intended to permit the Government to recover the medical care costs it incurred from the negligent acts of others.

(c) The Congress should enact legislation which would

--limit the ability of insurance companies to exclude reimbursement to the Government,

--clarify whether mandatory no-fault automobile insurance can be classified as insurance provided by law, and

--change CHAMPUS to require that insurance provided by law or through employment pay for medical care given to all eligible beneficiaries in civilian hospitals.

The Congress has not enacted any legislation to address these issues.

We note, however, that the Congress did act on a similar recommendation we made regarding the Medicaid program by enacting section 11 of Public Law 95-142, which provides that Federal funds cannot be used to pay for services under Medicaid which an insurer would have been liable for except for an exclusion in its contract of services covered by Medicaid. Also, legislation is under consideration which would make Medicare payment liability secondary to accident insurance policies. This provision was ordered reported by the Senate Committee on Finance in June 1979, and the Committee's staff estimated savings of $132 million in fiscal year 1980--the estimate increased to $187 million in fiscal year 1984. We believe enactment of our recommendations in HRD-77-132 would yield substantial savings for the other Government health programs.

9. TITLE: "Better Coordination Could Improve the Provision of Federal Health Care in Hawaii," HRD-78-99, May 22, 1978.

FINDINGS:

In Hawaii, three Federal agencies are responsible for providing health care to a beneficiary population which amounted to about 230,000 persons in fiscal year 1977. That care is provided by DOD, VA, and HEW.

The Tripler Army Medical Center is the only Federal hospital in Hawaii. A $120 million renovation and construction project was planned for this facility that would more closely meet the changing health care needs of the military, VA, and HEW beneficiary populations.

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Our review showed a need for better coordination among the military services and other Federal agencies in Hawaii to insure that better use is made of existing Federal health care facilities in the State. In addition, the Army, in its planning for the Tripler renovation, needed to (1) keep other Federal health care providers and State officials fully informed and (2) give full consideration to their concerns so that, when completed, Tripler would be more capable of serving as the State's only Federal hospital and as a useful partner in the State's health care community.

RECOMMENDATIONS: NOT IMPLEMENTED

(a) Insure that the DOD Health Council (1) provides direction, guidance, and feedback to the Mid-Pacific Review Committee concerning military health care activities in Hawaii and (2) directs the Committee to seek representation of VA and PHS as participating members.

The DOD Health Council has taken no action as of June 1979 on the first part of the recommendation. However, it was placed on the agenda for the July 1979 Defense Health Council meeting.

With respect to the second part of the recommendation, the Federal Health Resources Sharing Committee in March 1978 requested that local discussions be initiated among DOD activities, VA, and HEW to identify sharing opportunities locally and coordinate any necessary actions in this area. However, the subcommittee established to address this issue was not formed until January 1979. The subcommittee has not yet made their position known on this matter.

(b) Establish interagency agreements to permit VA's and HEW's dental patients to be treated routinely in all military dental facilities in Hawaii when such treatments would be advantageous to the Government and the individuals involved.

No interagency agreements have taken place as of May 1979. However, the Federal Health Resources Sharing Committee's Dental Subcommittee, established in March 1979, will address dental resources in Hawaii. The subcommittee will develop and propose guidelines and criteria for the interagency sharing of Federal dental resources to include facilities, equipment, and personnel.

INDIAN HEALTH SERVICE REPORT

10. TITLE: Letter report concerning: "Planned Number of Acute Care Beds for the Indian Health Service," HRD-77-112, May 31, 1977.

FINDINGS:

Our analysis was limited to the Navajo area. However, we developed sufficient information for questioning the appropriateness of the planned number of acute care beds throughout the IHS system because the same construction planning methodology is used throughout the system.

When evaluating the planned hospital projects for the Navajo area, we compared the current capacity of the six hospitals (as measured by (1) constructed beds and (2) staffed and available beds) to the trend in hospital use from 1966 to 1976. We found that HEW planned to build facilities which would result in 253 more beds than were currently constructed even though:

--There were over 150 constructed beds and 100 staffed and available beds more than needed to meet peak patient demands.

--Patient use of hospitals declined from 489 a day in 1966 to 329 a day in 1976, despite a 41-percent increase in population over the same period.

--The combined occupancy rate of the hospitals declined from 86 percent in 1966 to 59 percent in 1976. Federal regulations for Public Health Service grants, loans, and loan guarantees for construction and modernization of general hospitals provide for an 85-percent occupancy rate.

Our preliminary data indicated that similar conditions probably existed in other IHS areas, particularly in Aberdeen, Texas; Anchorage, Alaska; Oklahoma; and Phoenix; where major hospital construction was planned.

RECOMMENDATION: PARTIALLY IMPLEMENTED

(a) The Secretary, HEW, should provide adequate justification to the Congress explaining why expansion of existing underused facilities is necessary and, at a minimum, recognize the trend in the use of inpatient services.

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IHS reduced the number of beds planned for the Navajo area from 849 to 553. However, IHS has not yet developed a reliable method for forecasting the bed size of other IHS new and replacement hospitals. We believe the development of an overall IHS planning methodology would significantly reduce the construction costs of IHS-funded projects. The Congress agrees, and it has delayed appropriations for any IHS hospital projects not currently under construction.

ST. ELIZABETHS HOSPITAL REPORT

11. TITLE: "St. Elizabeths Hospital and District of Columbia Are Improving Their Mental Health Services," HRD-78-31, Sept. 27, 1978.

FINDINGS:

There has been a lack of effective joint planning, coordination, and agreement on how to best provide mental health services to District of Columbia residents. As a result, there are overlaps and gaps in services, in obtaining foster care, and in making nursing home placements. Furthermore, residents do not have equal access to all services. One main reason for these problems is that the District has not provided adequate resources to its mental health programs to meet all the requirements of a community-based mental health system.

Reorganization and program cutbacks have reduced many services. Some patients were not receiving the full range of services as originally intended, and the women's alcohol detoxification unit was understaffed. In addition, partial hospitalization services were generally inadequate in the District because sufficient funds and staff were not available at the District's community mental health centers.

We found that St. Elizabeths could provide patients with more appropriate, efficient, and effective care if improvements were made in central admissions, treatment programs, outplacement services, work schedules, medical records management, industrial and recreational therapies, and medical and surgical services.

For example, (1) some patients did not meet the admissions criteria, (2) many patients returned to inpatient status because outpatient services were inadequate, and (3) there was a questionable need for the extensive medical and surgical branch maintained at St. Elizabeths Hospital.

The hospital employs five full-time surgeons, four of whom averaged only one operation every 4 workdays during the first 6 months of fiscal year 1977. The chief surgeon performed no surgeries.

St. Elizabeths was providing a higher than necessary level of care to many of its patients, a great number of whom could have been cared for in nursing homes and foster care homes. However, adequate facilities of these types were not available in the community.

We also found that one of the two wards comprising the Combined Adult Inpatient Services unit which serves the three District-operated community mental health centers was filled with geriatric patients who should have been in nursing homes.

St. Elizabeths did not have an effective system for information gathering, planning, evaluating, budgeting, staffing, and training because of inadequate implementation of a decentralized management system and inefficient use of committees for making management decisions. The hospital decentralized the management system to 10 divisions in 1971. This was to give division directors control over their resources; however, few division staff members were trained to assume these responsibilities. In addition, the superintendent's office has not always provided sufficient guidance and monitoring of division activities.

The Division of Administration's staff had not performed many of its functions as efficiently or effectively as possible. We found problems in the areas of procurement, property control, control of patient funds, patient clothing and laundry systems, management of patient burials, maintenance of facilities, and employee housing. Some problems were created or heightened by insufficient communication with the clinical divisions.

RECOMMENDATIONS: PARTIALLY IMPLEMENTED

(a) Develop a more effective and integrated management system which allows optimum utilization of resources to meet clinical needs.

HEW stated that a contract completed in September 1978 has resulted in the design of a management information system which will update hospital management concerning available resources (fiscal and manpower), program goals and objectives, manpower, performance standards, and service needs. A second

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contract was let in September 1978 to implement that system and to integrate several existing and planned information systems. The work under this contract was in process as of July 1979.

(b) Reassess division functions and reassign those which could be better performed centrally and require more central monitoring of division administrative and clinical activities to determine which activities are effective and should be considered for use by other divisions and those which are ineffective and should be discontinued.

HEW stated that the division functions are being actively reviewed for potential realignment on a continuum of service model. Changes will be made in those areas where it is explicitly indicated that centralization is required for control and effectiveness. HEW said that, when implemented, central coordination, monitoring, and oversight of administrative and clinical activities will be substantially enhanced.

(c) Establish a system for accumulating maintenance cost and performance information and transforming the data into a work measurement and evaluation system, develop a facilities preventive maintenance system, and determine which functions could be performed less expensively if contracted to the private sector.

HEW stated in May 1979 that a system for accumulating maintenance cost and performance information is being developed. The hospital has also been pursuing application of OMB Circular A-76, "Policies for Acquiring Commercial or Industrial Products and Services for Government Use." Intensive reviews of the dietary, refuse collection, laundry, and housekeeping activities will be initiated in fiscal years 1979 and 1980 to determine whether it is more efficient to contract the work to the private sector.

We believe full implementation of these three recommendations will further contribute to reducing the costs and improving the quality of mental health services provided by St. Elizabeths Hospital.

VA REPORTS

12. TITLE: "Better Planning and Management Needed by the Veterans Administration to Improve Use of Specialized Medical Services," B-133044, June 19, 1974.

FINDINGS:

An evaluation of VA's management and planning of three specialized service programs--kidney transplants, supervoltage therapy, and hemodialysis--revealed that

--VA established specialized medical services which duplicated existing services without adequately determining patient need,

--VA did not adequately control the expansion of specialized medical service programs,

--one VA medical center spent $465,000 over 3 years to conduct a kidney transplant program, but only two transplants were performed during that period, and

--about 70 percent of the patients, according to VA physicians, being dialyzed in highly staffed hospital centers could have been treated in lower cost centers requiring less professional staffing.

RECOMMENDATIONS: NOT IMPLEMENTED

To avoid establishing unnecessary supervoltage therapy services:

(a) Evaluate existing facilities and decommission duplicative or underused facilities by consolidating services, where possible, at VA medical centers within metropolitan areas and closing underused services when they are available at other Federal or community hospitals in the area.

(b) Require that the justification for new equipment and facilities identify the (1) location and use of similar VA, other Federal, and community equipment and facilities within a prescribed distance and (2) patient demand for the services to be provided based on the veteran population served by

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the medical center, disease incidence statistics, and other relevant data.

VA agreed with our recommendations, and advised us in 1974 that it had begun to close some units and consolidate others. VA officials stated that adequate consideration had not been given to the availability of specialized medical resources in the community. They said more emphasis would be placed on planning in the future to minimize unnecessary duplication of resources, personnel, and facilities.

However, in a February 7, 1979, report entitled "Federal Hospitals Could Improve Certain Cancer Treatment Capability by Sharing" (HRD-79-42), we reported that VA, which was planning to establish five new supervoltage therapy departments by 1984 and to upgrade and modernize 17 other supervoltage therapy departments at a cost of $10.4 million, had not fully evaluated the sharing potential of this resource with other Federal agencies. Consequently, we recommended that the acquisition of new radiation therapy equipment within the Federal Government be deferred, to the extent possible, until the sharing potential at 23 locations we identified was fully evaluated. We also questioned the reasonableness of VA's utilization standard of 2,865 treatments a year for supervoltage radiation therapy equipment. This standard was low compared to both the DOD and HEW standards of approximately 6,000 treatments a year.

13. TITLE: "Many Cardiac Catheterization Laboratories Underused in Veterans Administration Hospitals: Better Planning and Control Needed," HRD-76-168, Feb. 28, 1977.

FINDINGS:

Many VA cardiac catheterization laboratories were underused. During fiscal year 1975, VA operated cardiac catheterization units in 67 hospitals at a cost of about $20.2 million. Of the 12 laboratories reviewed, 11 did not meet VA's minimum workload standard of 150 patients a year. VA established these laboratories without (1) developing enough information to determine if they were really needed or (2) determining whether other nearby VA facilities and laboratories could be shared. Several professional medical associations stated that the quality of care is reduced when patients are catheterized in underused laboratories.

We also reported that 8 of the 12 laboratories were located at medical centers where cardiovascular surgery was not regularly performed--even though both VA and the medical community agreed that this situation should not exist. VA may be exposing patients to unnecessary risks by performing these catheterizations in medical centers without emergency facilities.

RECOMMENDATION: NOT IMPLEMENTED

(a) Revise established procedures to require justification for new or modernized laboratories to include data on patients to be served, disease incidence statistics, and number of patients referred elsewhere.

VA concurred with this recommendation and indicated that new catheterization laboratories will be established only when specifically justified by patient care requirements and when they met Federal guidelines. Also, laboratories will be upgraded only when there is a sufficient workload of appropriate disease categories. As of April 1979, VA stated that new catheterization laboratories would be established only when specifically justified by patient care requirements and when they meet Federal guidelines.

As discussed previously (see p. 33), the Federal Health Resource Sharing Committee's Subcommittee on Cardiac Catheterization report, containing guidelines and criteria for this specialized medical resource, had not been issued as of June 1979.

(b) Close VA cardiac catheterization laboratories that are underused because of insufficient patient demand or because they duplicate services at nearby facilities.

VA has been evaluating the utilization of certain of its laboratories for several years. As of June 1979, none of the VA laboratories had been closed although several have operated below the VA utilization standard.

(c) Establish sharing or contractual arrangements to provide this medical service where laboratories are closed.

According to VA officials, when a VA laboratory is closed necessary steps will be taken to assure that cardiac catheterization care is provided to veterans who need it through transfer to other VA medical centers, to other Federal hospitals, or to private sector hospitals with sharing or contract agreements. VA stated that as of April 1979 sharing laboratory capabilities was still being explored, but no sharing agreements had been arranged. (The subject of sharing cardiac catheterization among Federal agencies is the subject of Report 1 (see p. 30).

14. TITLE: "Potential for Reducing U.S. Financial Support and Ending VA Involvement in Medical Program for Filipino Veterans," HRD-77-95, May 20, 1977.

FINDINGS:

VA conducts a medical care program in the Philippines, which was originally established as a temporary 5-year program in 1948. The program has been legislatively extended, funding has been changed from grants to reimbursable contracts, and benefits have been extended to include nonservice-connected illnesses. In 1976 about 96 percent of the care provided under this program was to treat nonservice-connected illnesses. By limiting care to service-connected illnesses and by funding through fixed-sum grants, about $1.7 million could be saved and the need for VA involvement would end.

VA believed that reducing the program would adversely affect U.S./Philippines relations and the quality of medical care. In our opinion, the reductions would be consistent with the intended temporary nature of the program, the Philippines' growing self-reliance, and the Philippines' increased ability to pay these costs.

RECOMMENDATIONS: NOT IMPLEMENTED

(a) We recommended that the Senate Subcommittee on HUD-Independent Agencies, Committee on Appropriations, take appropriate steps to not fund the medical care program after September 30, 1978.

Public Law 95-520 authorized a 3-year extension through September 30, 1981, for VA medical care to be provided to eligible Filipino veterans. As a result, the Congress provided VA with $500,000 for this program in fiscal year 1979 and authorized appropriations of $1.35 million in fiscal year 1980 for this program.

We believe our recommendation is still valid and that no further funding should be approved by the Congress for this program.

(b) Because of the U.S. commitment to provide medical treatment of Filipino veterans for service-connected illnesses, we recommended that the Senate Appropriation Subcommittee on HUD-Independent Agencies take action to change the basis of program funding from a reimbursable contract to a fixed-sum grant to provide annual funding for only service-connected care.

No actions have been taken to implement this recommendation to date. We believe that reducing the medical program and VA involvement would be consistent with

--the temporary nature of the program,

--the U.S. position that the Philippine Government would eventually assume full responsibility for the hospital,

--the Philippine Government's policy of increased self-reliance and nationalism,

--the U.S. and Philippine desires to move away from the "special relationship" of the past,

--the Philippine Government's increased ability to absorb program costs and maintain the hospital, and

--the U.S. policy of minimizing its presence abroad.

Therefore, we believe our recommendation should be acted on.

15. TITLE: Letter report on: "VA's Process to Determine Bed Size of New and Replacement Health Care Facilities," HRD-77-104, May 20, 1977.

FINDINGS:

Our report described the results of our analysis of the construction plans for the VA's Bay Pines, Florida; Little Rock, Arkansas; and Richmond, Virginia; medical centers. The total construction costs for these three hospitals were estimated to be $334.4 million.

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Using a computer-based model for determining the number of acute care beds needed in medical centers, our estimate of the number of beds required at the three medical centers was about the same as VA had estimated. However, our analysis showed that the mix of beds was improper--VA was planning too many acute care beds and too few nursing home care beds. There are significant cost differences in constructing acute care beds versus nursing home care beds, and costs could be reduced if the mix of beds was determined on the basis of our model. Furthermore, annual operating costs could be reduced over the life of the facilities.

RECOMMENDATIONS: NOT IMPLEMENTED

(a) Revise the bed mix of the three proposed facilities as developed by our model, and withdraw the VA current hospital sizing methodology and adopt the GAO hospital sizing model.

VA did not concur with our recommendation, and took the position that its estimates were considerably more comprehensive and specific than those provided in our model. VA stated that, in the absence of congressional direction to proceed otherwise and because of probable increased costs and penalties caused by planning delays, it would proceed with constructing the three medical centers as planned. The VA Administrator, however, stated that VA was prepared to work with us in developing a health care facilities planning model for future projects, which would incorporate VA's requirements.

VA agreed to carefully assess our model when developing estimates for hospital bed needs. Where the estimate derived from our model differed from VA's estimates using its own methods, VA would provide the Congress with a detailed justification explaining the differences. We have been working with VA to develop a bed estimating model to project the number and types of medical center beds needed by VA. Full agreement has not been reached on an appropriate model. We are continuing to work with VA.

(b) Congress should consider the extent to which VA medical centers constructed in the future should provide treatment for veterans with nonservice-connected illnesses.

No action had been taken on this recommendation as of June 1979. We believe the Congress should specifically delineate its intent on this matter to VA as soon as possible. Uncertainty within VA on this matter can cause future unnecessary costs to VA's health system.

16. TITLE: "Operational and Planning Improvements Needed in the VA Domiciliary Program for the Needy and Disabled," HRD-77-69, Sept. 21, 1977.

FINDINGS:

VA's domiciliary program provides housing, medical treatment, food, clothing, and other services to eligible disabled, ambulatory veterans residing in VA facilities called "domiciliaries." During fiscal year 1976 VA operated 18 domiciliaries and provided care to an average of 9,090 veterans each day. This program cost about $62 million--an average daily cost of $18.61 for each veteran.

Because of inadequate management by VA's central office, domiciliaries did not properly consider whether veterans should receive other types of care, did not normally identify veterans with potential to return to community living, and did not in many cases develop individualized restoration goals/plans involving community resources. Also, VA had not planned its proposed domiciliary construction and renovation program adequately. Planning should have included analyses of veteran demand, matched with available and projected VA resources. VA's projected demand based on population data was not adequate for supporting its planned multimillion dollar investment.

RECOMMENDATION: NOT IMPLEMENTED

(a) Before proceeding with VA's long-range construction plans (1) determine the extent to which existing domiciliary facilities can be modernized, (2) better define current domiciliary demand, (3) develop adequate information to project future domiciliary care demand, and (4) clearly define staffing and operating guidelines for new domiciliary facilities to assure that required services from nearby VA hospitals are received.

VA reported in April 1979 that our recommendations concerning modernization of facilities and an adequate projection of future demand for domiciliary care were being implemented. VA stated it had undertaken a major study to more accurately

identify the number of beds currently needed in all extended care programs. Also, a major survey of the domiciliary population and program was in progress. VA said that staffing and operational guidelines were being prepared. The staffing guidelines will not result in mandatory application by management at VA medical centers, but will state VA policy. Subsequent program reviews and analysis of automated information system reports by VA will indicate whether adequate staffing support is provided to domiciliaries.

Until these actions are completed, savings attributable to our recommendation cannot be estimated.

17. TITLE: "Constructing New VA Hospital in Camden, New Jersey Unjustified," HRD-78-51, Feb. 6, 1978.

FINDINGS:

As part of its construction program, VA planned to construct a new VA medical center in Camden, New Jersey. VA's methodology to determine the need for and size of the medical center was reviewed, and its assumptions in planning the hospital were found to be not valid. Consequently, the proposed medical center was not justified and, by not building it, VA could save about $70 million in construction funds and $32 million a year in operating expenses.

VA's justification for the new medical center used several invalid assumptions and invalid data purporting to show that admissions to the Philadelphia VA Medical Center were constrained by a low bed supply. Information we developed, however, showed that the Philadelphia VA Medical Center, located 7 miles from the site of the proposed Camden VA medical center, could support the 1985 medical and surgical requirements of veterans in the area. However, construction or acquisition of a new nursing home care unit in the Camden area may be needed.

RECOMMENDATIONS: NOT IMPLEMENTED

(a) We recommended that the Subcommittee on HUD-Independent Agencies, Senate Committee on Appropriations, require that VA justify all new hospital construction proposals in terms of priority on the basis of a clear and explicit set of objective criteria before funding is approved. VA should use the criteria to evaluate and compare the current level of adequacy of VA hospitals nationwide in meeting the medical needs of veterans.

This requirement had not been imposed on VA by the Subcommittee as of June 1979. Implementation of a priority system utilizing an explicit set of objective criteria would allow VA to explain why one location in the United States versus another location had a more immediate need for a VA facility. In this instance, VA could not explain, from a priority standpoint, the basis used to select the Philadelphia/Camden area for a new VA hospital rather than some other location.

(b) The Subcommittee on HUD-Independent Agencies not approve funding for construction of a new VA medical center in Camden.

In its fiscal year 1979 budget submission to the Congress, VA proposed that the Camden project be eliminated and indicated it planned to build an outpatient clinic in Camden and a nursing home care unit in Philadelphia. Although the Congress did not provide construction funds for the Camden facility, House and Senate Committee reports stated that VA should proceed with planning and design of a new hospital at Camden. In its fiscal year 1980 budget submission, VA requested $67.8 million to begin construction of a medical center.

We believe our prior conclusions are still valid and the construction of the proposed medical center in Camden remains unjustified.

18. TITLE: Letter report regarding: "Outpatient Surgery and Preadmission Testing Program in VA," HRD-78-85, Apr. 4, 1978.

FINDINGS:

The concept of outpatient surgery is not new, having been performed for many years in hospitals, generally as a part of emergency services. Outpatient surgery has been developed for patients who need minor surgery, using either local or general anesthesia, and who are able to go home the same day. Preadmission testing, screening, and presurgical workup prior to hospitalization is used to reduce preoperative hospital stays for elective surgery cases that cannot be handled as outpatient surgery. This concept can be used for diagnostic procedures as well as routine laboratory and X-ray examination required prior to surgery.

Opportunities exist, through increased use of outpatient surgery and preadmission testing programs, to eliminate the need to hospitalize some veterans and reduce the length of

hospitalization for others. As of May 1979 the average cost per patient day in a VA facility was $138, compared to an average outpatient cost per day of $41. Although some problems currently impede increased use of these programs, the reduction in hospital days and related costs that can be achieved make it essential that the program be more fully implemented.

Generally, the costs of providing outpatient care are lower than the costs of providing inpatient care. Therefore, any services VA provides on an outpatient rather than on an inpatient basis should result in a reduction of service costs. The resulting savings, whether in terms of money, staff time, or space, could then be used to treat more veterans with existing resources or to reduce the total costs of veteran care.

RECOMMENDATION: PARTIALLY IMPLEMENTED

(a) Develop a systemwide policy for outpatient surgery and preadmission testing, based on the results of VA studies, and implement the policy in all general medical and surgical hospitals in the VA system.

VA devised a pilot study to evaluate outpatient surgery in four affiliated hospitals. The pilot study was to determine whether high quality surgical procedures could be delivered in an outpatient setting. It was scheduled for implementation in November 1979. However, funds for the study have been delayed until at least fiscal year 1981. In the meantime, minor surgery outpatient operating rooms are, according to VA, being encouraged for renovation programs, for new hospitals, and for all ambulatory care programs where space, staff, and funds can support outpatient surgery.

According to VA, a study was undertaken during the first quarter of fiscal year 1979 to emphasize preadmission screening in 40 VA medical centers. VA expects to publish a policy letter directing maximum preadmission surgical workup as a result of this study.

19. TITLE: "Inappropriate Number of Acute Care Beds Planned by VA for New Hospitals," HRD-78-102, May 17, 1978.

FINDINGS:

VA's plans to construct replacement medical centers in Martinsburg, West Virginia; Portland, Oregon; Seattle, Washington; and Baltimore, Maryland; were evaluated. VA's proposed approach would result in the construction of (1) the wrong combination or mix of acute care beds and less critical care hospital beds and (2) too few lower cost options (such as nursing home care and outpatient facilities). VA's planning model relied on past experience in determining the types of beds needed, thereby maintaining the inefficient system of the past. Moreover, VA's model does not adequately consider expected changes in the size and age mix of the veteran population.

We developed a computer-based model which analyzed past practices and determined the different levels of care that should have been provided. In applying this model to projected veteran population data, we found that a different mix of medical facilities was needed from that proposed by VA to make available the range of health care options consistent with modern medical practice.

RECOMMENDATIONS: NOT IMPLEMENTED

(a) The Congress should require VA to justify and prioritize all new and replacement hospitals based on clear and explicit objective criteria before approving funding.

As of June 1979 the Congress had not imposed this requirement on VA. We believe this recommended action should be taken for the same reason the recommendation was made in an earlier report. (See p. 57.)

(b) VA and the Congress, when contemplating the construction of replacement hospitals, should, among other things, consider the extent to which VA should continue to provide treatment to veterans with nonservice-connected illnesses and the availability of beds in nearby community and other Federal hospitals because each could significantly affect future bed needs.

No action has been taken by the Congress or VA on these matters. We still believe that action by the Congress and VA is necessary. Currently, service-connected veterans receive top priority in admission to VA hospitals, while those with nonservice-connected illnesses are admitted only on a space available basis. The report of the Senate Committee on Veterans' Affairs on the Veterans' Omnibus Health Care Act of 1976 stated:

> "The VA hospital system, since its establishment more than 50 years ago, has had as its primary mission the provision of first class medical care to service-connected veterans. Its secondary mission has been to provide care for nonservice-connected veterans, but only to the extent that facilities are available so as to bring about a patient population size which would promote efficient utilization of resources."

Therefore, whether new and replacement facilities should be sized to accommodate the entire current workload of nonservice-connected illnesses on a space available basis needs to be addressed. It is unclear as to whether new VA hospitals should be sized to meet all, some, or none of this demand.

Also, while the Government bears the cost (construction, equipment, staffing, etc.) of new VA hospital beds, it is also sharing the increased costs resulting from excess community hospital beds. Many were constructed with Federal support; the unnecessary costs associated with excess bed capacity are paid for, in part, through Medicare, Medicaid, and other Federal health benefit programs.

20. TITLE: "Better Service at Reduced Costs Through an Improved 'Personal Care' Program Recommended for Veterans," HRD-78-107, June 6, 1978.

FINDINGS:

As part of providing outpatient care for veterans, VA operates a community care program in which veterans live in residences other than their own under VA supervision. Within the community care program, the personal care residence program functions as an alternative to long-term institutionalization of psychiatric, medical, and surgical patients. A personal care residence, or foster home, is a residence where a sponsor or caretaker provides or arranges

for varying degrees of personal supervision, personal care, and personal relationships for the veteran.

This program is not covered by specific legislation. VA operates the program under its broad legislative authority to provide medical care and treatment to eligible veterans. Veterans must pay for their own living arrangements. During fiscal year 1977, VA reported that the program was active at 129 VA hospitals and that about 20,000 veterans participated. VA costs to administer the program primarily included salaries, travel of staff, and ancillary hospital services.

We concluded that the personal care residence program is practicable and that VA has effectively used the program as an alternative to institutional care for patients. However, more can be done to expand the program and to assure adequate services and facilities for veterans in personal care residences.

RECOMMENDATION: PARTIALLY IMPLEMENTED

(a) Expand the use of the personal care residence program to all VA hospitals and other facilities capable of implementing the program.

In responding to our report in September 1978, VA agreed that the personal care residence program should be expanded. The VA Administrator stated that the program already had high priority in VA's psychiatric hospitals, and he strongly endorsed establishing the program in general medical and surgical hospitals. He said VA would continue to develop the program in those facilities which did not have one, but pointed out that activating new programs will depend on the availability of staff and the existing priorities at each facility.

In April 1979 VA stated that

--a program guide had been drafted and is being coordinated within the agency;

--VA is continuing to gather data on the existing program to use in monitoring and evaluating program effectiveness, and it expects to establish an automated management information system for this purpose in the near future; and

--VA completed a program survey in December 1978, and the findings will be used for further long-range planning.

APPENDIX I

RECOMMENDATION: NOT IMPLEMENTED

(b) The Congress should provide specific legislative authority (1) for VA's personal residence care program and (2) to pay for indigent patients' personal care when other funds are not available.

The Congress has not enacted such legislation. VA has developed a legislative proposal to the Congress which requests specific authority for the program and sufficient staff to operate it. The proposal is currently under review by OMB. However, VA does not concur with that portion of our recommendation which would provide VA with the authority to pay for personal care when other funds are not available. Any legislation resulting should incorporate our recommendations.

APPENDIX II

STATUS AS OF JULY 1979 OF IMPLEMENTATION OF GAO RECOMMENDATIONS TO CONTROL UNNECESSARY HEALTH FINANCING COSTS

Summary Table

Purpose of recommendation	Recommendation number (note a)		
	Partially implemented	Not implemented	
		Agency	Congress
Modify method of paying providers	26a,39a,39b	42f	39c,47a, 47b
Reduce unneeded utilization	36a,36b,42b	None	None
Emphasis on use of more cost-effective or lower cost providers	21a,24a,24b, 24c,24d,26b, 42a,42e,44a, 44b,44c	44d	None
Deter fraud, abuse, and waste	25a,30a,37a, 37b,42c,42d	25b,40c, 40d,40e, 40f	40a
Improve program management	22a,31a,33a, 34a,35b,45a	22b,38a, 38b,38c, 38d,40b	46a,46b
Reduce administrative costs	27a	27b	23a
Make collections	31b,31c,32a, 32b,34b,35c	None	None
Other	35a	29a,38e, 38f,38g, 40g,40h, 40i,40j, 40k,41a, 43a	28a,28b, 38h

a/The reports are numbered sequentially after this summary table. The number represents the report and the letter represents the recommendation.

MULTIPROGRAM REPORTS

21. TITLE: "Home Health Care Benefits Under Medicare and Medicaid," B-164031(3), July 9, 1974.

FINDINGS:

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 Congress and health professionals have realized that alternatives are needed to institutional care.

We found that home health care was not being used much under the Medicaid program because:

--Services covered under the States' programs varied significantly.

--Some States had adopted Medicare eligibility criteria which are more restrictive than intended by Medicaid.

--States' payment rates for home health care had not been adequate.

RECOMMENDATION: PARTIALLY IMPLEMENTED

(a) Encourage the States to establish payment rates for home health care at a level that will stimulate greater utilization of Medicaid home health care.

HEW emphasized the importance of realistic payment rates as a means of encouraging more frequent use of home health care services. A survey showed that more States were switching to the Medicare cost reimbursement system for determining the rate of reimbursement.

An Interagency Task Force on Home Health Services studied the methods of reimbursement for home health services by various State Medicaid agencies.

In 1970 15 States utilized a system of fixed fees, negotiated rates, or schedule of allowances to reimburse home health agencies.

HEW's April 1979 report to the Congress on home health care, required by section 18 of Public Law 95-142, stated that 24 States have adopted Medicare cost reimbursement

principles and that 2 States have cost reimbursement systems which differ from Medicare. The report also stated that most States which do not pay for home health services on a cost basis pay less than Medicare does--some States pay up to 50 percent less than Medicare. Thus, the low reimbursement problem still exists.

Paying reasonable rates for home health care encourages more home health agencies to participate in the program and, thus, reasonable rates make the service more available.

22. TITLE: "Need to More Consistently Reimburse Health Facilities Under Medicare and Medicaid," B-164031(4), Aug. 16, 1974.

FINDINGS:

There was no systematic exchange of audit information between the Medicare and Medicaid programs where a common audit agreement did not exist or where audits were not made by the same organization functioning as a Medicare intermediary and as a Medicaid fiscal agent. Thus, problems discovered by one program were not always communicated to the other.

Intermediaries, using the same published Social Security Administration (SSA) guidelines, made different interpretations about whether and how much of certain costs were allowable or reimbursable by Medicare. In some cases, the inconsistent treatment resulted in overpayments for several years. Of the 30 hospitals and skilled nursing facilities reviewed, we identified Medicare and Medicaid overpayments of $1,000 or more totaling about $648,000 at 18 institutions.

Although these overpayments had occurred for a variety of reasons, we noted instances where overpayments might have been avoided or discovered earlier by an intermediary had SSA's advice to one intermediary on a specific reimbursement question been made available to others.

RECOMMENDATION: PARTIALLY IMPLEMENTED

(a) Require a full exchange of Medicare and Medicaid audit information when no common audit agreement has been reached between a Medicare intermediary and a Medicaid State agency or its fiscal agent.

In responding to our recommendation for the full exchange of Medicare and Medicaid audit information, HEW stated:

> "Progress in persuading States to adopt the common audit has been due in large part to the fact that participation in common audits would be less costly to them than separate Medicaid audits or the charge that Medicare could impose for access to its hospital audit information. If we were to tell those States that have not yet agreed to the common audit that we will furnish Medicare audit information and results to them free-of-charge, it would be very unlikely that they would agree to join in the common audit and to share in the costs of those audits. Moreover, those States which already use the common audit would probably want to reconsider and perhaps abandon it. In short then, under present circumstances, we believe the common audit program and its continued use and growth is contingent upon our decision to charge State Medicaid agencies, that do not join in common audits, for any Medicare audit information they request."

Proposed legislation is currently under consideration by the Congress which would require States to have common audit agreements with Medicare. Also, such a provision was passed by both the House and Senate during the 95th Congress but a conference on the differing versions of the bills containing the provision was not held before adjournment. If our recommendation was implemented or the proposed legislation becomes law, the identification and recovery of overpayments to providers under both Medicare and Medicaid would be enhanced because both programs would have all the information available on the providers.

RECOMMENDATION: NOT IMPLEMENTED

> (b) HCFA should catalog and make available on request to intermediaries, Medicaid State agencies, providers, and the Provider Reimbursement Review Board all HCFA decisions or specific interpretations affecting determination of Medicare's share of hospital or skilled nursing facility costs.

HEW has taken no action to implement this recommendation because HEW disagreed with us about its usefulness. We still believe that implementation of the recommendation

--would help prevent varying interpretations of the Medicare law, regulations, and instructions;

--would better insure that institutions are treated equally under similar circumstances; and

--could result in savings to the Medicare program.

23. TITLE: "History of the Rising Costs of the Medicare and Medicaid Programs and Attempts to Control These Costs: 1966-1975," MWD-76-93, Feb. 11, 1976.

FINDINGS:

The primary reason for the $10.4 billion rise in the cost of Medicare and the $9.8 billion rise in Medicaid between fiscal years 1967 and 1975 was inflation (and probably the use of more extensive types of services) plus increases in the number of people covered by each program and in the use of services. In addition, covering additional types of services resulted in increased costs, especially for Medicaid.

We had made 83 recommendations in reports to the Congress, its committees and members, and the Secretary of HEW designed to control unnecessary Medicare and Medicaid costs. While in most cases HEW has taken at least some action to carry out these recommendations, many of them had not been fully implemented.

HEW had often been slow to implement by regulation laws passed by the Congress to help control Medicare and Medicaid costs.

In a prior report we discussed the unnecessary expenditure of administrative funds caused by the Railroad Retirement Board contracting for the processing of Medicare claims for railroad beneficiaries. Since railroad beneficiaries only represented about 4 percent of total Medicare beneficiaries, we questioned the use of a separate carrier for these beneficiaries. We estimated that $2.8 million in administrative costs could be saved if the railroad beneficiary claims were processed by the carriers used by SSA. Therefore, we recommended that SSA withdraw its delegation of authority to contract from the Railroad Retirement Board and arrange to have railroad beneficiaries' claims processed by the carriers handling all other Medicare beneficiary claims.

However, the Congress subsequently enacted a law (section 263(d)(5) of Public Law 92-603) which gave the Railroad Retirement Board the authority to contract with carriers. Therefore, SSA could not implement our recommendation.

The use of a separate carrier to process and pay claims for a special, small group of beneficiaries seems inherently duplicative in administrative costs.

RECOMMENDATION: NOT IMPLEMENTED

(a) The Congress should repeal the law authorizing the Railroad Retirement Board to contract with carriers.

The Congress has not acted regarding this recommendation. In our report to the Congress on Medicare claims processing (HRD-79-76, June 30, 1979), which Public Law 95-142 required us to prepare, we again made this recommendation. That report estimates annual savings of $6.6 million if railroad retirees use normal Medicare carriers.

24. TITLE: Letter report on: "Use of Administratively Necessary Days Under the Medicare and Medicaid Programs," HRD-76-142, June 29, 1976.

FINDINGS:

Administratively necessary days of hospitalization are those days spent in a hospital while awaiting transfer to a lower level of care--skilled nursing or an intermediate care facility. This occurs with patients who do not need to be hospitalized but do need institutional care. Although the percent of total Medicare and Medicaid hospital days classified as administratively necessary was small--varying from 0.5 to 2.6 percent in the three States surveyed--the cost of these days is high because of the large cost per hospital day. Medicaid costs were $1.3 million higher during a 6-month period in the three States than they would have been if the patients had been placed in the appropriate lower level of care during the administratively necessary days.

The Medicare and Medicaid programs were paying for thousands of days of care in hospitals when care in lower cost facilities was appropriate. Our review indicated that HEW officials did not know the number of such days paid for under the programs or the specific reasons for their approval. We believe that program officials should have this information and should determine whether more beds in lower cost

facilities can be made available to Medicare and Medicaid patients needing other than hospital care.

The three States reviewed used different reasons for approving administrative days. Medicaid did not have regulations or guidelines for approving administrative days, other than permitting payment for hospital care when a skilled nursing facility bed was not available. Medicare authorized payment for administrative days only when a patient required skilled care and a skilled nursing facility bed was not available.

We believe that there should be a standard system for reporting administratively necessary days and uniform criteria for authorizing payment under both programs. The States and fiscal intermediaries should be required to report to HEW the reasons for approving administrative days and the type of facility which could provide appropriate care.

We also believe that the issuance in final form of HEW's April 19, 1976, draft memorandum to PSROs on approving administratively necessary days should help identify administrative days. The data on administrative days should be evaluated to determine ways to reduce them. Also, the data on these days should be provided to appropriate health system agencies or other area health planning groups in geographic areas where a large number of administrative days might indicate a lack of beds in certain lower cost facilities.

A later review of Ohio's Medicaid program showed that hospitalization of patients who could be adequately cared for at a lower level of care was still a problem. (See pp. 76 and 77 for a discussion of this problem.)

RECOMMENDATIONS: PARTIALLY IMPLEMENTED

(a) Establish regulations identifying those situations where Medicaid payment for administratively necessary days is authorized, although acute hospital care is not medically necessary.

In most hospitals, PSROs are now responsible for determining the medical necessity of continued stays. PSROs are permitted to authorize payment for 3 additional days after the day it is determined that a patient no longer requires hospitalization, if these days are required for locating a bed for the patient at an appropriate level of care. Under these rules, a maximum of 3 administratively necessary days could be authorized for a patient. However, our work in Ohio

(see p. 76) and other data from New York (which indicate that 3,961 patients who could be cared for at lower levels of care were in hospitals on February 28, 1979) indicate that PSROs are approving, as medically necessary days, days that under previous terminology would have been called administratively necessary days. This results because, if a patient needs institutional care at a level below that of a hospital but a bed is not available at the lower level, it becomes medically necessary that the patient be hospitalized. Also, a number of PSROs, including the one in the District of Columbia, have indicated that the inability to find beds in nursing homes results in expenditures for unnecessary hospital days.

(b) Require the States and fiscal intermediaries to identify payments for all administratively necessary days and report the reasons for these days.

(c) Evaluate data collected on administratively necessary days to determine ways to reduce the delay between the time acute hospital care ends and the time a patient is placed in an available lower cost facility.

(d) Provide data on administratively necessary days to appropriate health system agencies or other health planning groups in geographic areas where a large number of these days might indicate a lack of beds in certain lower cost facilities.

In January 1979 PSROs were directed by HEW to begin collecting data on days authorized as medically necessary because Medicare and Medicaid patients were awaiting the location of an available bed at a lower level of care. These data are to be reported quarterly. Now that HEW is receiving this information, it should have the data necessary for implementing our recommendations in this report and the Ohio report (p. 77), which we believe will save hundreds of millions of program dollars.

25. TITLE: "Investigations of Medicare and Medicaid Fraud and Abuse--Improvements Needed," HRD-77-19, May 23, 1977.

FINDINGS:

Medicare abuse cases--mostly involving complaints about physicians who violate agreements to accept the amount allowed

APPENDIX II

by Medicare as the full charge, other improper billing practices, or unnecessary services--were usually closed when complaints were satisfactorily resolved.

Fraud cases--usually involving complaints about billings for services that were not rendered or about duplicate billings--received further investigation if the complaints appeared valid.

Medicare investigations were usually begun as the result of complaints; little work had been self-initiated.

No system setting out priorities had been developed for directing the investigations. HEW had a system that only ranked the importance of complaints to be investigated if there was a backlog.

HEW recognized the need for evaluating its work and for more self-initiated work, especially regarding fraud and abuse by hospitals, nursing homes, and home health agencies.

Most fraud complaints appeared to result from misunderstandings or honest mistakes. However, some fraud may have gone undetected because of inadequate investigations.

Some fraud complaints at HEW's San Francisco and Kansas City regional offices were closed prematurely because:

--No sampling, or inadequate sampling, was done to determine whether an improper billing was an error or was part of a pattern which could point to fraud.

--Investigations were inadequate.

--Contractors (private organizations helping to administer Medicare) tended to seek recovery of overpayments on specific complaints rather than to look for fraud.

Because HEW's sampling procedures did not require an adequate sample size, fraudulent practices could go undetected. A larger sample was needed.

Personnel conducting investigations generally did not have prior investigative training or experience. However, this did not appear to cause the inadequacies we noted. HEW recognized that personnel with specialized skills would be needed to expand its fraud and abuse effort.

The administrative system for controlling and reporting complaints was unduly burdensome. Adequate control over complaints could be maintained without keeping details on all complaints at the region and headquarters. About half of the Medicare fraud cases referred to U.S. attorneys had been prosecuted--usually successfully. However, U.S. attorneys were often slow in deciding whether or not to prosecute, and some decisions appeared to be based on factors other than the merits of the cases.

Medicare fraud cases usually involve elderly witnesses who may die, be ill, or forget facts by the time a trial is held. The defendants are usually respected members of the community. These factors may make U.S. attorneys reluctant to prosecute doctors for Medicare fraud.

The basic responsibility for Medicaid investigations has been left to the States. Limited reviews of Medicaid investigations in two States showed a wide variance in the emphasis placed on investigations.

California spent considerable resources on investigations; however, because of a large volume of cases and high production standards, self-initiated work was limited and recovery of overpayments, rather than prosecution, was stressed. Missouri's investigations were limited.

Medicare and Medicaid fraud and abuse investigations were not well coordinated. Medicare and the two States visited coordinated to some extent; however, Medicare and the Social and Rehabilitation Service (responsible for Medicaid at the Federal level before March 8, 1977) generally did not.

RECOMMENDATION: PARTIALLY IMPLEMENTED

(a) Work with Missouri Medicaid officials to establish a more active program for investigating Medicaid fraud and abuse.

Missouri's Medicaid agency does have an investigative unit. However, this unit does not meet the requirements of Public Law 95-142 for Medicaid fraud control units, which the Congress believes, and we agree, would result in a more effective antifraud program. According to HEW, as of July 1979 legislation was pending in Missouri which would permit the State to establish a fraud control unit.

RECOMMENDATION: NOT IMPLEMENTED

(b) Establish statistical sampling procedures that will better detect fraudulent billing practices.

A pattern of fraudulent billings must be established to develop a fraud case. For physician billings, HEW's sampling procedures provide for a sample of 10 beneficiaries to be contacted for a suspected fraud case; if no potential fraudulent billings are identified, no additional beneficiaries need to be contacted.

We believe this sample size is too small because fraud would not be detected unless a high percentage of the physicians' bills are fraudulent. HEW did not concur with this recommendation because of investigative staffing considerations and other reasons, and it has not changed the sample size requirement. HEW also said the 10-beneficiary sample size is not intended to be a universal procedure for all cases.

26. TITLE: "Ohio's Medicaid Program: Problems Identified Can Have National Importance," HRD-78-98A, Oct. 23, 1978.

FINDINGS:

Many Medicaid and Medicare patients who should have been transferred to skilled nursing facilities (SNFs) remained in hospitals primarily because SNFs were unwilling to accept them. There was general agreement that this problem occurs because the State's maximum rate of $26 per patient day was not enough to cover the cost of skilled care and, therefore, a SNF found it more profitable to fill beds with intermediate care patients, whose costs were adequately reimbursed by Medicaid. The availability of SNF services to Medicaid and Medicare patients in Ohio had been adversely affected because of the State's relatively low limits on SNF reimbursement. Medicare was affected because nursing homes feared Medicare patients would become Medicaid patients after using up their Medicare benefits of 100 days. Millions of dollars in extra program costs for hospital services resulted.

We believe that the same problem may exist in other States. Many States have placed relatively low upper limits on nursing home reimbursement rates; this could affect the States' and Medicare's abilities to transfer hospitalized recipients to SNFs when that level of care is appropriate.

Nursing homes were reluctant to accept Medicare patients because they feared these patients would eventually become Medicaid patients.

RECOMMENDATIONS: PARTIALLY IMPLEMENTED

(a) Assist Ohio in improving its reimbursement system for skilled nursing services in order to increase their availability after assuring an adequate utilization review program for SNFs is in place.

HEW responded to this recommendation by stating that, beginning in 1979, it would, through its Chicago Regional Office, provide technical assistance to Ohio to improve the State's skilled nursing facility reimbursement system in order to assure that sufficient beds are available and to assure that an adequate utilization review program is developed. When completed, these actions should result in an increased availability of skilled nursing facility services to Ohio Medicaid and Medicare patients and thereby save these programs millions of dollars per year in hospital costs.

(b) Determine if other States' reimbursement systems for skilled nursing care are resulting in problems like those in Ohio and assist any State with these problems in improving their skilled nursing services program.

HEW said that it plans to review States' reimbursement systems for skilled care to determine if they resulted in adequate reasonable cost-related payment rates and to determine the effect of State payment rates on such areas as provider costs, program expenditures, and patient care. HEW also said it plans to review selected States' reimbursement systems to determine if they result in problems similar to Ohio. Technical assistance will be provided to help States overcome any problems identified during the reviews. HEW said a Financial Review Section would be added (expected in May 1979) to its State Assessment Guide in order to assist with reviewing reimbursement systems for skilled nursing facilities.

When these efforts are completed they should result in greater availability of skilled nursing facility beds for Medicaid and Medicare patients and thereby reduce hospital costs for these programs by millions of dollars each year.

27. TITLE: "Opportunities to Reduce Administrative Costs of Professional Standards Review Organizations," HRD-78-168, Oct. 12, 1978.

FINDINGS:

Professional Standards Review Organizations (PSROs) are designed to assure that health care services provided under Medicare and Medicaid are delivered in the most effective, efficient, and economical manner possible. We reviewed recent increases in the salary schedules established for executive and medical directors (who are the top administrators of these organizations) and compared their current salaries with salaries of similar positions in the Medicare/Medicaid administrative complex.

Salary schedules issued by HEW in November 1977 to guide PSROs in establishing executive director salaries appeared inflated. Criteria and data on which the salary schedules were based do not appear to be consistent with the experience and backgrounds of most executive directors.

These positions seem to relate more closely to similar positions in nonprofit organizations. Salary increases based on rates paid to similar positions in nonprofit organizations would be about 8 to 10 percent lower than the current HEW salary schedules.

Current salary levels for PSRO executive directors generally are equal to, or higher than, salaries of similar positions in the Medicare/Medicaid administration complex.

We also noted similarities in the administrative hierarchy within each organization and concluded that opportunities exist in States with more than one PSRO to consolidate similar administrative functions which could result in cost savings.

Average total salaries paid to administrative staffs at 13 organizations were over $256,000. Because there are 164 organizations in the 21 States that have more than one PSRO, HEW will spend over $40 million for administrative staffs when these 164 organizations are fully operational.

Not all organization areas can or should be consolidated into a one-per-State situation, but it would seem that the potential for eliminating duplication and realizing the resulting savings could be significant if the total number

of organizations can be consolidated (even on a limited basis) or if sharing basic administrative support services such as data processing and data management could be accomplished.

RECOMMENDATION: PARTIALLY IMPLEMENTED

(a) Identify organization areas where administrative staff and functions can be combined, paying particular attention to situations where nonperforming PSROs are replaced, and encourage the sharing of support services.

HEW said it considers consolidating PSRO areas, and thereby administrative staff and functions, when it terminates PSROs that fail to perform and in instances where it is clearly demonstrated that, due to small size, a PSRO cannot be cost effective. HEW also said that it is encouraging PSROs to investigate the possibility of sharing administrative activities, and it cited examples in California and Maryland where PSROs have begun to consolidate data processing activities. Significant administrative cost savings should result if these actions prove effective in getting PSROs to share.

RECOMMENDATION: NOT IMPLEMENTED

(b) Rescind the executive director salary levels published by the Health Standards and Quality Bureau in November 1977, and establish new salary levels based on salaries paid comparable positions in nonprofit organizations.

HEW said it would not rescind the November 1977 salary levels because it believed PSRO executive directors were not being overpaid (as of June 1979) because of increases in all salary levels nationwide. HEW did say that it would reexamine PSRO salary levels by July 1979 to determine if business or nonprofit scales would be most appropriate. HEW also stated that it would abide by the President's wage guidelines by limiting the salary increases of all PSRO employees to an average increase of no more than 7 percent.

It is still our view that the use of the nonprofit organizations salary indexes would make the PSROs more compatible with the rest of the Medicare/Medicaid administrative complex handled by the private sector.

MEDICARE REPORT

28. TITLE: "Potential Effects of National Health Insurance Proposals on Medicare Beneficiaries," HRD-76-129, Feb. 24, 1977.

FINDINGS:

Many national health insurance proposals introduced in the Congress would affect Medicare's methods of reimbursing beneficiaries for their costs of medical care. This report looked at several prominent health insurance proposals and analyzed features of each and how they would affect Medicare's methods of reimbursement. We also analyzed the effect of each proposal on a number of beneficiaries.

Medicare's benefit structure is complicated, and beneficiaries do not understand it. Medicare's inpatient hospital benefits are based upon a benefit period or "spell of illness" which begins when a beneficiary is admitted to a hospital and ends when the beneficiary has been out of a hospital or skilled nursing facility for 60 consecutive days.

Medicare's hospital cost-sharing charges (which begin with the 61st day of hospitalization) and limitations on covered days have had a negligible effect on discouraging hospital use. Only about 2 percent of the hospitalized beneficiaries used more than 60 days in a benefit period. Less than 1 percent used more than 90 days.

The system has created administrative problems--for the Government, for intermediaries (such as the Blue Cross Association), and for hospitals--because of the need to determine the days used in a benefit period and when hospitals should charge for deductible amounts and cost sharing.

Provisions of various national health insurance proposals which would simplify the program include:

--Eliminating the inpatient hospital day limitations.

--Using credit cards. Providers would be paid by Medicare on behalf of beneficiaries, and Medicare would collect the beneficiaries' share of costs.

--Replacing the present inpatient deductible and cost sharing amounts with a fixed, daily charge to the hospitalized beneficiary.

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Proposals which would increase administrative problems and related costs include

--introducing various levels of cost sharing based on income and

--using credit cards to pay providers.

If Medicare cost sharing were based on individual or family income, then that income would have to be determined individually. The cost to make these determinations could be substantial.

Using credit cards for Medicare inpatient hospital services would involve about 6,900 hospitals and 8 million transactions. The accounting and collecting of the cost sharing for other services would involve over 400,000 physicians and other professionals, and 100 million transactions. Bad debts, under such an arrangement, could be substantial.

RECOMMENDATIONS: PENDING

(a) In its deliberation on national health insurance proposals for changing Medicare's benefit structure, we recommend that the Congress carefully explore whether the benefits of introducing an income test would justify the resultant added administrative problems and related costs.

(b) If cost sharing for inpatient hospital services is believed desirable, we recommend that the Congress provide for a fixed, daily copayment for inpatient hospital services.

The Congress has not as yet deliberated on national health insurance. Several committees have considered or plan to consider national health insurance proposals.

MEDICAID REPORTS

29. TITLE: "Medicaid Expenditures for Ineffective or Possibly Effective Prescription Drugs," B-164031(2), Feb. 15, 1974.

FINDINGS:

In December 1970 the Surgeon General requested all agencies within HEW to prohibit the use of Federal funds for ineffective and possibly effective prescription drugs, and in May 1972 we recommended that the use of Medicaid funds for them be prohibited. However, based on data for September 1973, we estimated that California, Ohio, and Texas were expending funds at an annual rate of about $8.3 million for drugs which the Food and Drug Administration had classified as ineffective or possibly effective.

In December 1974 the Chairmen of the Senate Committee on Finance and the House Committee on Interstate and Foreign Commerce sent letters to the HEW Secretary asking why our recommendations had not been implemented. The Secretary replied that regulations implementing the recommendation would be published shortly.

RECOMMENDATION: NOT IMPLEMENTED

(a) Expedite publication of regulations prohibiting the use of Federal funds for the purchase of ineffective and possibly effective drugs under Medicaid and establish procedures for providing the States and drug providers lists of drugs classified as ineffective or possibly effective and lists of all identical, related, and similar drugs.

Although HEW agreed with the recommendation, it has taken no action to implement the recommendation.

In the more than 7 years since our initial recommendation was made, most drugs have received final classification by the Food and Drug Administration, and those classified as ineffective have been removed from the market. However, final action has not been taken on all drugs, so our recommendation is still applicable. If our recommendation was implemented Federal Medicaid funds would be more effectively used and the health care of Medicaid recipients would be improved through the substitution of drugs having evidence of effectiveness for drugs having little or no evidence of effectiveness.

30. TITLE: "Improvements Needed in Medicaid Program Management Including Investigations of Suspected Fraud and Abuse," MWD-75-74, Apr. 14, 1975.

FINDINGS:

The system for paying claims under Medicaid in Illinois needed improvement. Manual processing, cumbersome work operations, and other management problems delayed payment to Medicaid providers for long periods. The following problems in the system needed correction:

--Lack of accountability of claims.

--Unnecessary manual processing.

--Ineffective use of computers.

--Inaccurate files of those eligible to receive Medicaid.

--Insufficient provider and employee training.

States are required to have utilization review systems for institutional and noninstitutional (physicians, pharmacists, etc.) services provided under Medicaid.

Illinois' utilization review system for noninstitutional services did not provide a continuous evaluation of the necessity for and quality of services provided under Medicaid. Illinois did not routinely generate or evaluate profiles of services received by patients and profiles of services furnished by providers.

According to Illinois officials, the State now routinely generates and evaluates needed profiles. They said that Illinois planned to implement a Medicaid Management Information System which should improve the State's capability to perform utilization reviews. The cost of developing and installing such a system will be funded primarily by the Federal Government.

RECOMMENDATION: PARTIALLY IMPLEMENTED

(a) Insure, before approving Medicaid Management Information Systems, that State proposals for such systems provide data needed to perform effective utilization reviews and provide for an efficient system for paying claims under Medicaid.

Our 1978 report on Medicaid Management Information Systems discusses many deficiencies in the areas covered by this recommendation. (See pp. 105 to 108.)

31. TITLE: "Need for Closer Monitoring by the Social and Rehabilitation Service of State Reimbursements of Hospitals for Inpatient Services Furnished Under Medicaid," MWD-75-78, May 9, 1975.

FINDINGS:

States were not complying with HEW regulations on reimbursements for inpatient hospital services, and HEW has not taken effective action to assure that States comply. At the end of 1972, 15 of the 28 States we were able to obtain information from had outstanding overpayments of $20.4 million, and 8 States had underpayments of $16.6 million. Also, 4 of the 29 States from which we obtained data on settlement procedures had never made final cost settlements, 8 States had not made tentative settlements, 2 States did not require hospitals to submit cost reports, and 14 States had either incomplete or no statistics on over- or underpayments.

RECOMMENDATIONS: PARTIALLY IMPLEMENTED

(a) More closely monitor State activities regarding reimbursement for inpatient hospital services by insuring that tentative and final settlements are made with hospitals as required by Federal regulations and, where appropriate, retroactive adjustments are made.

(b) Take action to recover amounts due the Federal Government because of States' failure to reduce Medicaid claims to consider the nursing salary cost differential.

(c) Insure that outstanding overpayments and underpayments discussed in this report are collected or paid.

In response to our recommendations, HCFA regional offices were instructed to assign a priority to reviewing State reimbursements for inpatient hospital services paid for by Medicaid and to inform HCFA when any overpayments or underpayments are collected or paid. In March 1979 HEW directed its regional offices to review during fiscal year 1979 (1) State collections of overpayments to providers and (2) the submission, audit, and settlement of hospital cost reports.

When these recommendations are fully implemented by HEW, it should help assure that hospitals are not over- or underpaid by the States and that States do not improperly claim Federal sharing. Implementation should also assist hospitals with outstanding underpayments by fully reimbursing them for the services provided.

32. TITLES: "Deficiencies in Determining Payments to Prepaid Health Plans Under California's Medicaid Program," MWD-76-15, Aug. 29, 1975.

"Information About The Foundation Community Health Plan, Sacramento, California," HRD-78-62, Mar. 6, 1978.

FINDINGS:

Our 1975 report stated that the Auditor General of the State of California reported in July 1974 that the State had made inappropriate payments under the Medicaid fee-for-service system totaling $4.2 million for services to recipients enrolled in prepaid plans during the period January 1, 1971, through December 31, 1973. The prepaid health plans were liable for these payments, so the State was paying twice for the services. He concluded that such payments resulted from inadequate procedures to assure that health care services for Medicaid recipients in prepaid health plans were provided and paid for by the plan. We concluded that, under the State's approved Medicaid plan, the Federal Government is not obligated to share in these duplicate payments, and HEW should make sure that it has not. Furthermore, any Federal sharing in duplicate payments should be recouped.

The 1975 report also pointed out that Federal and State regulations prohibit paying more to prepaid plans than the services would cost under the fee-for-service system. California's negotiated monthly rates for fiscal year 1973 and 1974 for the Community Health Plan of the Medical Care Foundation of Sacramento exceeded by $4.6 million the State's estimates of providing comparable services under the Medicaid fee-for-service system. The State could not document or substantiate the basis for its determination to pay higher rates to the Foundation Plan. Our analysis of the data available to the State at the time of its determination indicated that the State's conclusions were not valid. Therefore, we concluded HEW should determine the amount of Federal sharing in payments to the Foundation Plan that were in excess of amounts allowable under HEW regulations and recoup or withhold the excess amounts.

HEW, State, and Foundation Plan officials agreed that the State had not justified its payment of rates to the Foundation Plan that exceeded the estimated per-capita fee-for-service costs. In February 1976 HEW awarded a demonstration project grant to California to develop a rate-setting methodology for prepaid health plans and a model quality assessment and cost control system for use by State Medicaid agencies. One purpose of the grant was to determine if the Foundation had been overpaid.

Our 1978 report analyzed the results of the State's study. We concluded that the State had failed to justify paying rates to the Foundation exceeding those that would normally have been paid to a prepaid health plan. The burden of justification rests with the State when it decides to deviate from regular procedures and regulations, and the State has failed to meet this burden. Accordingly, we concluded that HEW should implement our prior recommendation and recoup the Federal share of all excess payments made to the Foundation through fiscal year 1975.

RECOMMENDATIONS: PARTIALLY IMPLEMENTED

(a) Recoup from California the Federal share of payments made to the Foundation Community Health Plan which exceeded those allowable under the State's normal payment procedures.

On May 30, 1978, the HCFA Administrator upheld a disallowance of $0.8 million for sharing excessive payments to the Foundation Plan. This disallowance was based on a State auditor study covering a different time period and using a different methodology than we used. California appealed the Administrator's decision to the HEW Grant Appeals Board on June 29, 1978. As of July 1, 1979, no decision had been rendered by the Board.

We determined that the Foundation Plan was paid $4.6 million during fiscal years 1973 and 1974 (Federal share of $2.3 million) in excess of what would have been paid using normal State procedures. We did not determine the amount of excess payments in fiscal year 1975 but recommended that HEW do so. HEW officials told us that, if the $0.8 million disallowance is upheld by the Board, HEW will make a further disallowance based on our recommendation.

(b) Determine the amount of duplicate payments to prepaid health plans and fee-for-service providers made by California and recover the Federal share of such duplicate payments.

The HEW Audit Agency determined that about $800,000 of these duplicate payments were made in 1975, and HEW disallowed the Federal share. The State appealed the disallowance to the HEW Grant Appeals Board on February 20, 1979, and as of July 1, 1979, no decision had been rendered.

33. TITLE: "Federal Payments Made for Medical Services Provided to Ineligible People Under Medicaid in Illinois and New York," MWD-76-45, Oct. 17, 1975.

FINDINGS:

Using automated information systems available at the Federal and State levels which included information on employee earnings and benefits, we tested whether persons whose medical bills were paid by Medicaid were actually eligible for Medicaid. We tested 586 paid claims in New York City and 548 paid claims in Illinois. Of these, 130 payments were made on behalf of people either totally or partially ineligible for Federal Medicaid benefits. In New York, the Federal Medicaid program was erroneously charged for:

--60 payments, totaling $199,945, for recipients who were ineligible for Federal participation. Most erroneous charges were caused by a computer program error that converted payments on behalf of State home-relief recipients to the Federal old-age assistance category. From July 1973 through July 1974 this error resulted in about $36 million in payments on behalf of home-relief recipients being improperly claimed; the Government's share was about $18 million.

--29 payments, totaling $21,534, to providers, on behalf of medically needy persons, without considering the recipients' obligation to pay some of their medical expenses.

--13 payments, totaling $5,450, on behalf of people whose incomes were higher than the reported amount and, thus, were ineligible for assistance.

In Illinois, the Federal Medicaid program was charged for payments made on behalf of 28 people who were ineligible because their actual incomes exceeded allowable amounts. In these cases the State's automated eligibility records showed incomes lower than each person's actual income.

During January 1974 providers received an estimated $2.8 million on behalf of beneficiaries ineligible for Federal participation in New York and Illinois.

New York City did not maintain the required internal controls over its Medicaid computer operations. Moreover, neither New York State nor HEW took the necessary steps to assure the City's compliance with its own internal control standards for automatic data processing systems. New York City was also not complying with Federal laws and regulations applicable to its spend-down program.

The quality control requirements applicable to the medically needy, instituted by HEW in 1975, should help States identify eligibility problem areas in their Medicaid programs. However, HEW should also encourage States with similar systems to follow Illinois' example and verify income by using available State Department of Labor data to facilitate the identification of ineligible Medicaid cases.

RECOMMENDATION: PARTIALLY IMPLEMENTED

(a) Require HEW regional offices to review the internal controls over States' Medicaid automated claims processing systems.

HEW said that it was reviewing State automated claims processing systems and providing technical assistance to States. HEW now conducts State Medicaid management assessments which address this area. HEW also said that its model Medicaid Management Information System, when implemented by the State, would correct the control problems presented in the report. Our 1978 report on State Medicaid Management Information Systems (HRD-78-151, see pp. 105 to 108) showed that problems still exist in State claims processing systems.

34. TITLE: "State Audits to Identify Medicaid Overpayments to Nursing Homes," HRD-77-29, Jan. 24, 1977.

FINDINGS:

Nursing homes submit reports of their costs for each year to agencies of their respective States. These reports are used to determine how much these homes will be reimbursed by Medicaid.

The most prevalent unallowable costs identified by State and our audits involved:

--Nursing homes failing to offset certain costs with related income. For example, a county-owned nursing home in New York failed to report $166,000 in income from Medicare for inhouse physician services to Medicaid patients, but claimed the full cost of the physicians' salaries as a reimbursable Medicaid expense.

--Costs not related to patient care. At one for-profit nursing home in Florida, for example, State auditors disallowed costs for luxury automobiles and travel expenses.

--Unsupported or "paper" costs. In Massachusetts, a city-owned nursing home claimed as a reimbursable cost a "paper" property tax bill from the city for $123,000 which was not actually paid.

In the 340 desk and field audits we analyzed, covering about $300 million in total costs submitted by nursing homes, the States did not allow about 3 percent--almost $9 million. An additional 2.4 percent of costs claimed by nursing homes (approximately $7 million), were not allowed because of State maximum payment limits, or ceilings. However, State audits uncovered allowable costs of over $2 million which had been understated by the nursing homes.

In addition, we performed field audits involving about $35 million in claimed costs and identified $0.4 million in costs erroneously claimed and $0.4 million in reported costs exceeding the applicable State ceilings for nursing home reimbursement. Our findings of erroneous costs were in addition to findings in State audits for those same nursing homes.

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Field audits were productive in identifying costs that were claimed by nursing homes that should be disallowed. Field audits were productive regardless of whether the home was nonprofit, for profit, or public. At the time of our visits in mid-1975 the States varied substantially in their field audit efforts.

--Florida had not issued any field audit reports on nursing homes since the State Medicaid program began in January 1970. By May 1976 Florida had issued audit reports on 23 of the State's 261 nursing homes.

--Massachusetts' policy was to field audit all nursing homes each year, but the State had a 2-year backlog.

--New York had completed field audits of only 98 of 540 skilled nursing facilities since the State Medicaid program began in May 1966. The State limited its field audits to for-profit skilled nursing homes.

In addition, law enforcement officials in Massachusetts and New York had used field audits to get several convictions of nursing home operators for fraudulently claiming costs to the Medicaid program.

On July 1, 1976, HEW issued regulations requiring all States to field audit all nursing homes over a 3-year period unless the State already has an acceptable field audit program.

The cost of State field audits will be justified if the States can prevent overpayments and recoup overpayments identified. Of the four States reviewed only Virginia appeared to have an effective program for recovering overpayments.

Massachusetts and New York had $13.6 million in overpayments outstanding and problems in recovering it. Florida had no recoupment program, had never recovered any payment from a nursing home for any reason, and yet claimed it could recoup overpayments.

Public Law 92-603, enacted on October 30, 1972, required States to reimburse nursing homes on a cost-related basis. The implementation of the cost-related reimbursement requirement undoubtedly will cause some States and the Federal Government to spend more money on nursing home services. However, the regulations contain features--such as authorizing reimbursement limitations and requiring field audits--

that could enable the States to reduce the financial burden of changing reimbursement systems.

RECOMMENDATIONS: PARTIALLY IMPLEMENTED

(a) Assess periodically whether each State identifies and reports promptly overpayments to nursing homes as required.

In fiscal year 1978 HCFA began conducting State management assessments--onsite reviews by HCFA staff of the major areas of Medicaid management. One of the areas normally covered by these assessments is payments for long-term care, including State audits, in order to assure that States follow appropriate procedures. These assessments should help HCFA keep abreast of the status of overpayments.

However, in an ongoing review we have identified millions of dollars of collections which States have made but failed to report to HCFA. Thus, it appears that reporting problems still exist.

(b) Deny Federal participation in overpayments when States do not establish an effective recoupment program promptly.

HCFA obtained an opinion from HEW's General Counsel which states that HEW can and, moreover, is required by law to disallow Federal sharing in payments made by the State which HEW determines to be overpayments, regardless of whether the State has recovered the funds. Action based on this opinion should implement our recommendation.

35. TITLE: "The Department of Health, Education, and Welfare Should Determine Whether States Are Billing the Government for Amounts That Should Be Paid by Medicaid Recipients," HRD-77-43, Feb. 3, 1977.

FINDINGS:

The medically needy may have all or part of their medical expenses paid by Medicaid. Those medically needy whose income and resources are above a State-prescribed level must first incur a certain amount of medical expense--the "spend-down" amount--before they can receive assistance under Medicaid. Federal regulations provide that the payment of this spend-down amount is a matter between the medically needy and the provider of medical assistance. These amounts are not eligible for Federal financial participation.

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New York and Illinois had been paying providers for, and claiming Federal financial assistance for, spend-down amounts which were the responsibility of medically needy recipients. Procedures existed in both States for establishing accounts receivable and attempting to collect spend-down amounts from the medically needy; however, the collections--which were credited to total Medicaid costs--represented only portions of the Federal Government's share of amounts improperly claimed. In addition, both States had made direct refunds for portions of the amounts incorrectly claimed; however, New York had made no refund for periods after September 1972 and Illinois continued to improperly claim Federal financial assistance for spend-down amounts which were the responsibility of medically needy recipients.

New York State had been improperly claiming Federal financial assistance for spend-down amounts relating to medical expenses incurred by the medically needy at municipal and voluntary hospitals in New York City. Such improper claiming amounted to about $1 million for voluntary hospitals during fiscal year 1975. Based on actual spend-down amounts billed by municipal hospitals for the 6-month period (October 1975 through March 1976) we estimated that improper Federal financial assistance to municipal hospitals for a 12-month period was about $3 million. A State Comptroller's report of November 26, 1973, estimated that, since the inception of the Medicaid program in 1966 through September 1972, the Federal Government had paid about $3.7 million for these ineligible costs. New York State subsequently adjusted its December 1973 quarterly expenditures claim by $3,701,500.

The HEW Audit Agency issued a report dated December 23, 1975, on the Illinois Medicaid program. The Audit Agency reported that the majority of the spend-down amount for medically needy recipients was not being applied toward their medical costs. Instead, the State was paying these costs and claiming them for Federal financial participation with only a reduction for amounts actually collected from the recipients. The HEW Audit Agency estimated that Illinois had claimed at least $626,000 in ineligible costs (Federal share $313,000) which should have been paid by medically needy recipients. This amount was recovered by HEW from the State. However, we verified that the State was continuing to improperly claim sharing and did not intend to correct the problem until its Medicaid Management Information System became operational, then expected in early 1978. As of April 1979 it was expected that the system would be operational sometime in fiscal year 1980.

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HEW discovered that New York and Illinois were billing the Federal Government for amounts that should be paid by medically needy recipients. As of June 1, 1976, 32 States and jurisdictions were providing assistance to the medically needy; 5 additional States had spend-down programs solely for the aged, blind, and disabled. Because of the substantial dollar value of the ineligible claims in New York and Illinois, we believed HEW should determine whether other States were billing the Federal Government for amounts that should be paid by medically needy recipients.

RECOMMENDATIONS: PARTIALLY IMPLEMENTED

(a) Assure that the Federal Government does not reimburse New York and Illinois for amounts that are not eligible for Federal financial participation.

(b) Evaluate the procedures of the other States and jurisdictions for billing for services provided to the medically needy, and where necessary, take actions to assure that the Federal Government does not reimburse States for amounts that are not eligible for Federal financial participation.

(c) Compute the amount of Federal financial participation claimed which should have been paid by medically needy recipients in Illinois, New York, and other States and adjust the States' claims for Federal financial participation.

HEW said that it would have its regional offices review and monitor actions taken by the States to correct deficiencies in claiming for Medicaid recipients with spend-down amounts. HEW also said that the Medicaid quality control procedures would provide data to the States to correct spend-down problems. In addition, the State Medicaid management assessment reviews normally cover the spend-down program, and HEW should uncover problems through these reviews. Finally, HCFA said it would request the HEW Audit Agency to determine the amount of improper claiming of Federal funds in New York and Illinois.

HEW told us that it has reviewed New York City's revised claims payment system and that it appears that the problem of accounting for spend-down amounts has been corrected. HEW said it will continue to monitor the situation. Also, the HEW Audit Agency determined that improper claiming of Federal funds cost the Government about $11 million from

October 1972 through April 1978. An HEW official said this amount was recouped from the State in March 1979.

Because Illinois was depending on installation of a Medicaid Management Information System to correct its spend-down problems and because implementation is not now expected until sometime in fiscal year 1980, Illinois may still have the problems.

Our recommendations will have been implemented when the actions taken by HEW and the States are completed. This should result in better control over the spend-down program and save substantial amounts for the Medicaid program.

36. TITLE: "Compliance with Medicaid Requirement that States Providing Long-term Care Have an Effective Program of Control Over Use of Such Services," HRD-77-56, Mar. 1, 1977.

FINDINGS:

Section 1903(g) of the Social Security Act requires States which provide long-term care under Medicaid to have effective programs to control the use of these services or else suffer a reduction in Federal Medicaid sharing in payments for long-term care.

On June 1, 1976, we reported to the HEW Secretary that, for Quarterly Statements of Expenditures submitted by States on or after July 1, 1976, which covered quarters beginning April 1, 1976, we would invoke the authority contained in the Budget and Accounting Act, as amended, and the provisions of 31 U.S.C. 82c by holding the appropriate accountable officer or officers of the Federal Government responsible if they made payments for long-term care which have not been supported by required showings of compliance with section 1903(g) and a statement by the HEW Secretary or her designee that these showings are satisfactory.

We continued to monitor compliance with section 1903(g), and this report presented our conclusions about the States' compliance with and HEW's implementation of the section's requirements.

HEW had taken action to make certain that States submit required certifications of compliance with section 1903(g) which are satisfactory to the Secretary. HEW reduced funds for Delaware when it did not submit the required certification.

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Accordingly, we believed that, since the States' submissions were satisfactory to the Secretary, payments for long-term care for the quarters starting April 1 and July 1, 1976, had been supported as required by section 1903(g)(1).

HEW also required States to submit lists of medical reviews and independent professional reviews made each quarter, which provides improved support that States are complying with section 1903(g)(1).

HEW's limited validation survey for fiscal year 1975 showed that 27 States had not performed all required medical reviews, and the Social and Rehabilitation Service's Administrator proposed, among other alternatives, that the Secretary reduce long-term care funds for these States by about $375 million.

In 1977 HEW's plans for future validation surveys represented a significant improvement over its fiscal year 1975 validation survey. These plans needed to be modified to include visits to institutions, including hospitals, as required by law.

RECOMMENDATIONS: PARTIALLY IMPLEMENTED

(a) Make certain that upcoming validation surveys include visits to institutions, including hospitals, on a sample basis as required by law.

HEW has not been consistent in implementing this recommendation. The validation survey for the quarter ended December 31, 1977, did not include onsite visits, while the survey for the quarter ended March 31, 1978, did. We believe it is important to perform onsite validation surveys in order to obtain all the information necessary for insuring that the requirements of the Act have been fully implemented by the States. This should help ensure that maximum benefits, including cost saving benefits, are received from utilization review efforts.

(b) Revise the regulations to require more specific information in medical review reports, independent professional review reports, and plans of care.

HEW has not as yet revised the regulations as we recommended. However, HEW is revising its regulations related to long-term care facilities. We were informed by an HEW official that HEW hopes to implement our recommendation during

this overall revision. The official said that drafting the revisions should be completed in 1980. If our recommendation is implemented, it should provide HEW with better information on which to base its determinations of the effectiveness of State long-term care utilization review.

37. TITLE: "Problems in Carrying Out Medicaid Recovery Programs from Third Parties," HRD-77-73, May 2, 1977.

FINDINGS:

States have been required to carry out third-party recovery programs under Medicaid since March 1968. Third parties--health or automobile accident insurance companies--may be liable to pay part or all of the medical costs of injury, disease, or disability of a Medicaid applicant or recipient.

The HEW Audit Agency and consultants repeatedly reported inadequacies in State recovery programs. Recommended improvements were not always made.

The six States reviewed used various procedures and approaches to identify liable third parties, to recover or avoid costs applicable to them, and to account for and report recoveries or cost avoidances. Only California, as a matter of policy, paid claims covered by other health insurance and assumed responsibility to collect from liable third parties. However, between April 1975 and July 1976, California collected only $3.5 million on billings of over $119 million to private health insurers--only about 2.9 percent of amounts billed.

On the basis of California's experience, we questioned the wisdom of States assuming such collection responsibility, unless such an approach is tested and its feasibility (compared to a policy of cost avoidance) is demonstrated.

In areas where SSA determines Medicaid eligibility for aged, blind, and disabled individuals, third-party information was provided for approximately 7 cents per name. The information, however, consisted of a simple yes or no as to whether third-party resources exist, so the State Medicaid agency must obtain more information on third-party resources.

For States that have contracted with HEW to make Medicaid eligibility determinations for the aged, blind, and disabled, we believe SSA should obtain whatever information is needed on third-party resources during the eligibility determination process to be compatible with the States' third-party recovery systems, if the States will use the information.

SSA and HCFA officials disagreed about the merits of SSA obtaining additional information about recipient insurance coverage at the time of Medicaid eligibility determinations.

RECOMMENDATIONS: PARTIALLY IMPLEMENTED

(a) Ask States having eligibility determination agreements with HEW to (1) identify the information they believe is needed from aged, blind, and disabled individuals during the eligibility process and (2) decide whether the information would be compatible with their third-party system and used in administering their programs. SSA should then provide the necessary information the States agree to use in their third-party systems.

HEW formed a task group to study what HEW could do to provide useful third-party information to the States. The study group has designed a survey form to send to the States to determine which types of data SSA could provide to the States. Action taken would be based on the results of the survey. As of June 1, 1979, the survey form had not been sent to the States.

If SSA provides the States with more and better information regarding third-party coverage for SSI recipients, State third-party recovery programs should be enhanced and significant amounts of savings should accrue.

(b) Require California to demonstrate the effectiveness of its health insurance collection policy as compared with States emphasizing cost avoidance. If the effectiveness of California's approach cannot be supported by empirical evidence, it should be abandoned or HEW should decline Federal financial participation on the uncollected claims for which third parties are liable.

HEW plans to initiate an evaluation of the economic benefits of the two methods of handling third-party

liability--making Medicaid payments and attempting to collect from the third party or requiring the provider to collect from third parties before billing Medicaid. As of June 1, 1979, this study had not begun.

Such a study would be the first step in implementing our recommendation. As discussed above, California had collected only about 3 percent of the $119 million it had billed to third parties.

38. TITLE: "Medicaid Insurance Contracts--Problems in Procuring, Administering, and Monitoring," HRD-77-106, Jan. 23, 1978.

FINDINGS:

Some States, trying to have better control over Medicaid costs, used insurance contracts 1/ for administering their Medicaid programs. However, the insurance contracts had not solved States' Medicaid funding and budgeting problems.

Many private firms have declined to participate in Medicaid programs under insurance contracts due to the lack of accurate, reliable program cost and utilization data, and to the inability to predict recipient eligibility. This made the venture too risky.

Several firms that did enter into insurance contracts experienced severe financial difficulties. They charged that inaccurate, unreliable, and incomplete Medicaid program data caused them to underbid. These firms then terminated their agreements, refused to extend them, or pressured the State to renegotiate the contract in the contractor's favor so that they could avoid losses and reduce their underwriting risk.

HEW reviewed and approved contracts for Federal financial participation; however, weaknesses in the review resulted in its approving

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1/Medicaid insurance contracts are contracts under which a State buys insurance coverage for some or all types of services provided under Medicaid. For a predetermined monthly per-capita payment, the insurer agrees to pay for all covered services received by eligible recipients.

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--one contract that contained a loss recoupment provision in violation of existing Federal regulations,

--one contract that included estimated costs of $3.7 million ineligible for Federal sharing, and

--Federal sharing at incorrect rates on costs of about $181,000 under two approved contracts.

HEW also failed to make certain that a State complied with conditions placed on approval of a contract.

In the procurement actions, States generally did not follow Federal Medicaid standards when obtaining their insurance contracts. Open and free competitive practices were not followed, contractors' proposals were not adequately evaluated, and contract negotiation records were not maintained. In addition, they did not evaluate various alternatives to insurance contracts, such as State administration and fiscal agent arrangements.

There had been little Federal contract monitoring and no contractor financial assessments because HEW regional officials responsible for administering Medicaid programs believed that these functions were State responsibilities. HEW got involved only if the States requested its involvement.

Most States, however, had not assigned sufficient staff for adequately performing these functions. They were relying on unverified financial and program data provided by contractors for assessing contractor performance, negotiating contracts, and determining the State and Federal Governments' share of contract savings. This information contained inaccurate and unreliable data. In some instances it did not fully disclose overall contract results, because some contract revenues and costs were excluded.

We reviewed the financial performance of one nonprofit contractor who had six Medicaid insuring agreements. Its affiliated, for-profit subcontractor realized an average profit of 32 percent of costs. Five of the six contracts included provisions whereby the State would share in contractor profits. However, since almost all profits accrued to the affiliated subcontractor, the States could not share them.

APPENDIX II

RECOMMENDATIONS: NOT IMPLEMENTED

(a) Require prior approval of changes to insurance-type contracts and that HEW officials not approve changes which would have the effect of eliminating or reducing the underwriting risk assumed by the contractor under the terms of the initial contract approved by HEW.

(b) Develop procedures which delineate the role and responsibilities of HEW regional offices in monitoring Medicaid insuring agreements so that the Federal interest is protected.

(c) Develop and submit to the appropriate HEW contract-approving authority an acceptable plan for monitoring Medicaid insurance contracts and evaluating contractors' financial performance under the contracts.

(d) Include language in Medicaid insurance contracts which would make the contractor and all subcontractors subject to Federal procurement standards (45 C.F.R. 74.150 et seq.) and Federal cost principles (45 C.F.R. 74.170 et seq.)

(e) Issue regulations prohibiting the use of percentage-of-revenue agreements between Medicaid contractors and their subcontractors.

(f) Issue regulations requiring that all subcontracts assigning substantial portions of the contractor's responsibilities to a subcontractor be submitted along with the contract at the time of request for contract approval.

(g) Revise Medicaid regulations to require (1) State insuring agreements to address interest earned or equivalent benefits to be accured by contractors on premium payments and accumulated reserves and (2) the consideration of such interest and benefits in establishing premium rates and profit-sharing arrangements.

HEW has not taken final action on these recommendations. However, a HCFA official stated that HCFA has drafted regulations addressing recommendations (a) and (d). These draft regulations had not been published for comment. Also, a bill

reported by the Senate Committee on Finance (H.R. 934) contains a provision prohibiting most percentage-of-revenue agreements under Medicaid.

We believe that all of these recommendations, if implemented, would improve Medicaid contracting which should help contain program costs.

(h) The Subcommittee on Health, Senate Committee on Finance, should develop legislation to amend the Medicaid law to preclude Federal sharing in the cost of Medicaid contracts where State laws have restricted competition or provided potential contractors with a competitive advantage.

No action has been taken on this recommendation.

We believe that such a provision, if enacted, would help assure that maximum competition for Medicaid contracts is obtained which should, in turn, help assure that reasonable contract pricing is obtained.

39. TITLE: "Savings Available by Contracting for Medicaid Supplies and Laboratory Services," HRD-78-60, July 6, 1978.

FINDINGS:

Under the Medicaid law, recipients are entitled to choose the provider of their health care services. In the past, this provision has been the basis for challenging State or local efforts to competitively contract or otherwise directly provide equipment items (such as wheelchairs and laboratory tests) because recipients would be limited in their selection of providers.

For example, in 1975 New York City attempted to contract on a competitive basis for exclusive Medicaid laboratory services which would have reduced its annual costs by about $5 million; however, the contracts were never executed because the project was enjoined in court under the freedom-of-choice issue. Also, the State of Washington's program to operate a medical equipment pool for the loan and reuse of such items by Medicaid recipients has been questioned.

We compared prices paid for eyeglasses, oxygen, and wheelchairs by various State and Federal agencies and found that competitive buying produced worthwhile savings.

--During 1976 California paid $7.2 million for Medicaid eyeglasses based on vendors' usual charges; however, based on Washington's competitively awarded contract prices the costs would have been about $3.9 million.

--During 1976 Oregon paid, on the average, $6.15 per 100 cubic feet of oxygen based on vendors' charges; however, under Washington's competitively awarded contract the comparable price was $3.70.

--Because California usually pays manufacturers' suggested list prices for wheelchairs, its purchases of such items generally averaged about 3 percent under the list prices. VA, through negotiated or competitive purchasing arrangements, acquires wheelchairs for its beneficiaries at prices ranging from 7 to 29 percent lower than list prices.

State Medicaid programs pay higher prices for clinical laboratory services than other purchasers even though Medicaid is a volume user.

New York, New Jersey, and Massachusetts paid $12.50, $7.50, and $10.00, respectively, for a battery of tests. Fees were generally based on what a private individual had to pay on the open market. At selected laboratories for the same tests, the Federal Government paid from $4.40 to $5.25, physicians paid from $5.20 to $7.00, and a New York City Family Planning agency, through direct contracting, paid $3.75.

HEW had taken initiatives to encourage savings in acquiring Medicaid supplies and laboratory services, including implementing the lowest reasonable charge criteria for laboratory services which are common to elderly Medicare beneficiaries. Under these criteria, payment under Medicare is limited to the lowest charge levels consistently and widely available within a geographic area. However, the lists of Medicare tests did not include some tests common to Medicaid.

Also, the Congress had been considering legislation which would (1) permit competitive bidding for Medicaid laboratory services on an experimental basis and (2) prevent Medicaid from paying a laboratory more than other purchasers for such services. We believed the Congress should enact such legislation.

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The issue of whether or not direct contracting by States, to minimize Medicaid costs, is consistent with the freedom-of-choice provisisons of the Social Security Act was unclear. However, in May 1977 during testimony before the Senate Subcommittee on Monopoly and Anticompetitive Practices of the Select Committee on Small Business HEW officials said that a State's right to purchase eyeglasses in volume from manufacturers, which were to be furnished to qualified providers, was not in conflict with a Medicaid recipient's right to free choice of providers.

RECOMMENDATIONS: PARTIALLY IMPLEMENTED

(a) Publish regulations which encourage States to purchase eyeglasses, oxygen, wheelchairs, and such common items of durable equipment through agreements with suppliers (by means of competitive bids or competitive negotiation) to the extent permitted by existing law.

On May 25, 1979, HEW published proposed regulations on reimbursement for hearing aids and eyeglasses which would require States to pay for these items on the basis of (1) provider acquisition costs, (2) a volume purchase plan, or (3) a combination of the two methods. HEW estimated that the revised regulations, when finalized, would save $5 million per year--which represents 5 percent of the amount expended for the items.

When these proposed regulations are finalized, HEW will have fully implemented our recommendation with respect to eyeglasses and hearing aids. However, as discussed in the report, the same principles could and should be applied to additional items to save additional millions of dollars.

In June 1978 the Senate Committee on Finance agreed to report to the Senate a provision which authorizes States to competitively award contracts for laboratory services and durable medical equipment. We support this legislation.

Furthermore, on October 23, 1978, HEW sent an information letter to the States which stated that, in HEW's opinion, States could centrally procure medical supplies through competitive bidding and require providers to obtain supplies from the selected suppliers. HEW said the States are free to require opticians, optometrists, and pharmacies to obtain their drugs, lenses, and frames from designated suppliers which have agreed with the States to furnish such supplies

for a specified price. This is because the law permits Medicaid recipients to choose freely among qualified providers, but it does not permit recipients to have any voice in the provider's choice of suppliers. The letter also stated that the States could purchase durable medical equipment and loan it to recipients while retaining title to it.

(b) Expand Medicare's proposed lowest charge regulations to include laboratory tests which are the most commonly ordered under Medicaid.

Medicare's proposed lowest charge regulations were published in final form on July 26, 1978, and cover 12 common laboratory tests and 2 items of durable medical equipment. Because of a requirement in the Medicaid law, these regulations also apply to Medicaid. On January 24, 1979, HEW published for comment a proposed list of seven additional laboratory tests commonly used under Medicaid which it intends to include under the lowest-charge-level criteria. HEW said it would periodically review other items and services for inclusion on the list. As of July 1, 1979, this proposal had not been finalized.

When HEW finalizes the January 1979 proposal, and as it includes additional items under the lowest charge level criteria, millions of dollars in savings should accrue over the years.

RECOMMENDATION: NOT IMPLEMENTED

(c) To remove any doubt that competitive purchases of Medicaid supplies are authorized, the Congress should amend the Medicaid law to specifically exclude eyeglasses, hearing aids, oxygen, and selected items of equipment from the freedom-of-choice provision.

The Congress had not enacted such legislation as of July 1, 1979. However, the Senate Committee on Finance agreed in June 1979 to report to the Senate a provision which would implement this recommendation.

40. TITLE: "Attainable Benefits of the Medicaid Management Information System Are Not Being Realized," HRD-78-151, Sept. 26, 1978.

FINDINGS:

HEW approved Medicaid Management Information Systems in Michigan, Ohio, and Washington. We reviewed these systems and found systems that were

--underdeveloped,

--underused, and

--not in compliance with all legal requirements.

The systems--integrated computer processing operations--are used by States to (1) process and pay bills for health care services given Medicaid recipients, (2) store and retrieve service and payment data for monitoring and analyzing program activity, and (3) generate management reports.

By law, HEW pays 90 percent of a State's cost to develop a system and, after approval, 75 percent of the operating cost. Since developing and operating systems involve large Federal expenditures--many through contractual arrangements--there is concern about whether these expenditures were justified and reasonable.

The full potential of the system was not being realized by either the States or the Federal Government. None of the three State systems we reviewed fully complied with requirements of legislation or implementing regulations, even though HEW approved them as being operational. This noncompliance stemmed from weaknesses in HEW's system approval process and system design criteria. A fundamental change in Federal administrative cost sharing is needed. States should be reimbursed for operating a system that meets certain performance standards of efficiency and effectiveness--not for merely having an approved system.

Increased administrative funding should be provided by HEW only for meeting performance standards which have significant program effects (such as cutting costs or increasing service availability).

Lack of a clear definition of the kinds of information systems' costs for which States can claim 75-percent sharing had caused confusion among both HEW and State personnel, and it had hampered HEW's ability to effectively monitor and control costs.

Likewise, HEW could not effectively monitor or control Medicaid administrative expenditures because of limitations in cost-reporting requirements.

HEW had not required States to develop or report the cost of operating information systems in detail. Without this requirement HEW cannot adequately compare costs among States. Further, costly or inefficient administrative procedures were obscured in the method of cost reporting, and the reasonableness of such procedures went unquestioned.

In contrast, HEW required its Medicare claims processing agents to report costs on a functional basis and had been able to identify agents whose costs were out of line.

The Surveillance and Utilization Review subsystem and Management and Administrative Reporting subsystem are integral parts of the information systems. The review subsystem should provide information that (1) assesses the level and quality of care provided to Medicaid recipients and (2) reveals and facilitates the investigation of suspected instances of fraud or abuse by Medicaid providers and recipients. The reporting subsystem should provide necessary information to support decisionmaking.

The review subsystem had accomplished neither of its purposes effectively. It was underdeveloped, ineffective in identifying potential misutilization, and of unproven value. States generally were not reviewing the quality of care provided Medicaid recipients as required, and the subsystem was not providing the data needed to help States do so. Overall, States were still using a trial and error approach to producing and/or using the subsystem and its reports.

States generally used outputs from the management reporting subsystem in the manner intended, and they were satisfied with the results.

We believed the review subsystem needed further development and a thorough evaluation to assure that its approach is sound and effective. An available alternative--Utah's Physician Ambulatory Care Evaluation program--was addressing

the quality-of-care issue, as well as limiting potential overuse of services.

The Medicaid information systems' data base was often incompatible with the mechanized payment systems used by Medicare carriers--thus hindering timely, accurate, and mechanized exchange of payment data. Because many people have both Medicare and Medicaid coverage, the lack of compatibility causes Medicaid administrative ineffectiveness and reduces control over the payment of Medicaid claims. To qualify for 75-percent funding, the systems are required by law to be compatible.

RECOMMENDATIONS: NOT IMPLEMENTED

(a) To enable HEW to better manage and control the information systems, the Congress should consider amending title XIX of the Social Security Act to require HEW to establish systems performance standards and to require that HEW periodically reevaluate approved systems to determine if they continue to meet Federal requirements.

A bill (S. 731) has been introduced which is intended to implement this recommendation. As of July 1, 1979, no action had been taken on S. 731. We believe that enactment of legislation as we recommended would have tremendous potential for cost savings by assuring that Medicaid information systems detect and prevent fraud, abuse, and waste in the Medicaid program.

(b) Develop written approval procedures for use by HEW personnel in approving State information systems, including specific criteria for testing the systems in operation to assure that minimum standards are met.

(c) Update the General Systems Design and the program regulation guide to reflect system experiences to date, with emphasis on greater uniformity and use of proven processing techniques in systems developed by the States.

(d) Assist the States in developing medically acceptable definitions of medical practice which correlate medical diagnosis, procedure, age, and/or sex so that States can use the computer to check billings for consistency among these factors.

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(e) Undertake a demonstration project to determine whether the review subsystem can be further developed and refined so that it is more effective.

(f) Continue development and evaluation of alternative utilization review systems, such as the Utah program.

(g) Clearly define the kinds of information systems' cost that HEW will reimburse at the 75-percent sharing level.

(h) Develop and implement a functional cost-reporting system for Medicaid claims processing, similar to that used under Medicare, to facilitate cost comparisons among the States.

(i) Develop a uniform identification numbering system for providers and recipients and adopt standard coding systems for medical procedures, diagnoses, drugs, and medical supplies for use by the Medicare and Medicaid programs.

(j) Provide liaison between States and Medicare carriers to resolve conflicts which preclude free exchange of payment data.

(k) Enforce the statutory requirement that Medicaid and Medicare information systems be compatible.

As of July 1, 1979, HEW had not submitted to the Congress its statement of actions taken or planned in response to these recommendations (required by section 236 of the Legislative Reorganization Act of 1970). Therefore, we do not know the official position on our recommendations. However, we did note that HEW proposed draft regulations on Medicaid information systems which addressed some of the recommendations, and it formed a task force on these systems which was to consider our recommendations. As discussed above, the potential for savings by implementing our recommendations is great.

CHAMPUS REPORTS

41. TITLE: "Department of Defense Charges to Military Dependents for Inpatient Care," B-133142, Apr. 10, 1974.

FINDINGS:

The CHAMPUS legislation requires that program beneficiaries participate in the cost of the program. For inpatient care for dependents of active-duty personnel, in civilian facilities, the cost share was originally set at $1.75 per day (the daily subsistence rate for military personnel in 1956) or $25.00 per admission, whichever was higher. The daily cost share rate is now increased periodically to coincide with the currently established subsistence rate ($4.65 for 1979). Although military pay and hospital costs have increased and the beneficiaries' daily share of inpatient costs has increased, no increase has been made in the $25 minimum.

RECOMMENDATION: NOT IMPLEMENTED

(a) DOD should initiate a study of the desirability of increasing the $25 minimum cost share for inpatient care for dependents of active duty members in civilian hospitals and, if it is concluded that an increase is justified, Congress should be given suggested legislation to do so.

We estimated in 1974 that increasing the minimum to $50 would result in program savings of $5.5 million annually. Because military pay and hospital costs have continued to increase and the daily cost share has been increased, we believe our recommendation continues to be valid.

The Office for CHAMPUS, which administers the program, is considering proposing legislation to change the CHAMPUS cost-sharing provisions to 10 percent of the costs of covered services with a maximum payment of $1,000 for any consecutive 12-month period. This would apply to all categories of beneficiaries and for both inpatient and outpatient care and handicap care. Although this change would result in active-duty dependents paying more for inpatient care (up to the limit), the change would increase program costs because it reduces the cost share for all other categories of dependents and places a maximum limit on the amount of cost share paid in a particular period. CHAMPUS estimated the increased costs to the program from the change would be around $80 million

annually. CHAMPUS officials stated that the proposal was in a very preliminary stage, and they did not know if or when it might be approved.

42. TITLE: "Management of the Civilian Health and Medical Program of the Uniformed Services Needs Improvement," MWD-76-48, Nov. 21, 1975.

FINDINGS:

This report followed up on five previous reports. In our report on the physician component of the CHAMPUS program, we found that

--greater use of the available capabilities of VA and military hospitals and lower cost civilian psychiatric facilities would cut Government costs;

--fiscal agents lacked utilization review guidelines for evaluating quality, quantity, promptness, or necessity of medical care; and

--CHAMPUS was using claims forms that did not provide for positive certification as to the possible existence of additional insurance coverage. In December 1973, of 524 claims returned by one fiscal agent, 39 percent had to be returned because of inaccuracies or omissions concerning other insurance.

We said that these three problems persisted in our followup report.

Also, controls over the issuance and recovery of identification cards were still inadequate. Also, no action had been taken to make arrangements to permit CHAMPUS beneficiaries to purchase lower cost medical equipment from Government sources rather than from civilian vendors. A subsequent review of payments made for care provided to dependents of active-duty personnel no longer eligible for such care because the active-duty member separated from the service showed that about $780,000 of such improper payments were made over a 26-month period.

RECOMMENDATIONS: PARTIALLY IMPLEMENTED

(a) Continue to study ways to achieve greater use of available Government facilities for both inpatient and outpatient psychiatric care of dependents, and

establish means to encourage use of lower cost civilian facilities whenever medically feasible.

(b) Provide utilization-review guidelines to fiscal agents, and review, approve, and monitor utilization-review systems.

(c) Revise the claim form to provide positive certification as to whether other insurance exists, and, if so, details on that insurance.

CHAMPUS has partially implemented these recommendations. For example, CHAMPUS now uses participation agreements with civilian facilities that require that CHAMPUS patients be charged the lowest rates charged to other agencies. Additionally, in January 1979 CHAMPUS issued instructions to implement in stages the professional review process for surveillance of long-term inpatient care. CHAMPUS also issued instructions requiring (1) preauthorization of all psychiatric inpatient admissions (with the exception of admissions to institutions that qualify as hospitals, infirmaries, or Christian Science sanitariums) and (2) recertification of all long-term inpatient care after 30 days. In regard to the claims forms revision, in 1978 CHAMPUS adopted a new form for professional services designed to provide CHAMPUS fiscal agents with information on whether beneficiaries have insurance coverage besides that which CHAMPUS provides.

Partial implementation of these recommendations has had positive effects, and further implementation of the recommendations is desirable. The participation agreements, for example, help assure that CHAMPUS pays lower charges, and the preauthorizations and recertifications help assure that CHAMPUS pays only for covered services. DOD has yet to take action on opportunities to use lower cost Government facilities. The claim form revision should help save money by enabling more effective coordination of benefits with other insurance companies. In addition to revising the claim form for professional services, CHAMPUS is revising its claim forms for other types of services (such as outpatient services), and these forms will also require information on other insurance coverage.

(d) Strengthen procedures to insure proper issuance and recovery of identification cards or establish other controls to guarantee that benefits are provided only to eligible beneficiaries.

(e) Make arrangements to permit CHAMPUS beneficiaries to purchase medical equipment from Government sources.

As of May 1979 DOD expected to issue in the near future revised procedures for issuing and controlling identification cards. The new procedures would be responsive to our recommendation and would, we believe, lessen the amount of improper payments resulting from inadequate identification card control.

CHAMPUS is drafting legislation to implement our recommendation on purchasing medical equipment from Government sources. It is not known if the legislation will be proposed. We found that medical equipment purchased by CHAMPUS beneficiaries was frequently available from Government sources at considerably lower prices than from civilian vendors. We believe that the potential for reducing CHAMPUS costs by purchasing medical equipment from Government sources still exists.

RECOMMENDATION: NOT IMPLEMENTED

(f) Limit total payments to physicians when CHAMPUS payments are combined with other insurance payments, to the reasonable charges for the services rendered.

As of May 1979 CHAMPUS was drafting implementing instructions for this recommendation, but it could not provide us an estimate of when the instructions would be issued. Limiting total payments to reasonable charges when more than one insurance entity is involved would help save the program money, and it would assure that patients or physicians were reimbursed for total reasonable charges.

43. TITLE: "Greater Assurances Are Needed That Emotionally Disturbed and Handicapped Children Are Properly Cared for in Department of Defense Approved Facilities," HRD-76-175, Oct. 21, 1976.

FINDINGS:

The CHAMPUS legislation provides that costs of care are to be shared by the beneficiary and the Government. Cost-sharing requirements are intended to provide some assurance that beneficiaries obtain only necessary care since they must share in the cost. Facilities' failure to collect the

sponsor's share not only eliminates the sponsor's incentive to be concerned about lengths of stays and appropriateness of admissions, but also may result in higher facility charges, which are passed on to CHAMPUS to compensate for amounts not paid by sponsors.

Many facilities we visited were not collecting amounts due from sponsors. Facility officials usually said that sponsors' shares were not collected because of financial hardship. However, facilities often made little effort to determine if sponsors could afford to meet cost-sharing requirements. Many facilities had no documentation to show that they had attempted to collect sponsors' shares.

The effect of not collecting sponsors' shares can be illustrated by a case at a facility which waived 60 percent of the sponsors' charges. This facility charged $370 per month per patient. If the facility had charged properly, a captain would have paid his full share of $45 and CHAMPUS would have paid $325. However, since the facility waived 60 percent of the sponsors' share, a captain paid only 40 percent of $45 ($18) and the facility billed CHAMPUS the maximum of $350 in order to recover as much of the unpaid amount ($352) as possible.

RECOMMENDATION: NOT IMPLEMENTED

(a) Require that facilities attempt to collect sponsors' shares as provided in the laws authorizing benefits and require the facilities to document such attempts.

Although DOD generally concurred with this recommendation, DOD said priority has been given to other program changes considered to be more important in view of the large decrease in the overall cost of the handicap program--from about $17 million in 1974 to about $1 million for fiscal year 1979. We believe the recommendation is still appropriate and could help contain CHAMPUS costs.

44. TITLE: "Savings to CHAMPUS from Requirement to Use Uniformed Services Hospitals," HRD-79-64, Dec. 9, 1978.

FINDINGS:

CHAMPUS saved over $30 million during the 12-month period following implementation of the requirement that beneficiaries residing within 40 miles of uniformed services

hospitals obtain available nonemergency inpatient care there, rather than at civilian hospitals. According to DOD, a serious shortage of military physicians limits the potential for significant additional benefits from the requirement. However, some further savings could be realized through improvements in administration of the requirement.

RECOMMENDATIONS: PARTIALLY IMPLEMENTED

(a) Clearly define what is meant by the excessive waiting time exception to the 40-mile rule and implement instructions for more strict and consistent application of the continuity-of-care reason for issuing nonavailability of care statements.

(b) Require periodic exchanges of medical capability listings between hospitals within overlapping 40-mile radii.

(c) Require case-by-case coordination between hospitals when availability of needed medical services for which a nonavailability statement is requested cannot be determined from medical capability listings.

DOD agreed with these recommendations and is drafting a document requiring the Navy to develop a program that will implement them throughout the uniformed services. Refinements to the 40-mile rule should save program funds as initial implementation of this rule did.

RECOMMENDATION: NOT IMPLEMENTED

(d) Establish procedures for approval by higher DOD levels, such as the Assistant Secretary of Defense (Health Affairs), of alteration to the 40-mile radii now decided upon by hospital commanders, to exempt certain beneficiaries from the requirement to obtain nonavailability statements.

DOD said it did not favor this recommendation because, among other things, local commanders had better knowledge of local conditions than did centrally located staff. We continue to favor implementation of this recommendation because we found instances where local commanders had altered the 40-mile radius in ways that did not appear to conform to the law or to DOD's instructions regarding excessive cost and limited access. Reviews of alterations to the 40-mile radius by higher commands would help assure compliance with

the intent of law, assure equitable treatment of beneficiaries, and assure maximum savings.

FEHB REPORTS

45. TITLE: "Information on Unresolved Audit Exceptions With Federal Employees Health Benefit Carriers," B-164562, Nov. 7, 1974.

FINDINGS:

As of August 31, 1974, Office of Personnel Management (OPM) audit exceptions to charges made by health insurance carriers for the FEHB program totaled about $10.1 million. Of this amount about $9.4 million related to Blue Cross/ Blue Shield plans; as of December 31, 1978, the Blue Cross/ Blue Shield amount was about $9.3 million.

We reported that OPM was negotiating with Blue Cross/ Blue Shield concerning the following problems identified by OPM's audit:

--The applicability of the Federal Procurement Regulations to OPM's contract with Blue Cross/Blue Shield.

--The extent of OPM's audit authority and responsibility.

--The resolution of Blue Cross/Blue Shield "national issues" that have applicability to many of their local plans.

--The allowability of charges to the FEHB program for State statutory reserve requirements.

--The appropriateness of accounting adjustments made in 1973 by Blue Cross/Blue Shield for prior years.

The resolution of these problems could significantly affect the allowability of certain charges against the FEHB program. Moreover, the course of OPM's audit activities depend heavily on the outcome of the negotiations concerning these problems--particularly those related to the applicability of the Federal Procurement Regulations to FEHB contracts and the extent of OPM's audit authority and responsibility.

RECOMMENDATIONS: PARTIALLY IMPLEMENTED

(a) This report contained no formal recommendations, but we suggested that the Subcommittee discuss several issues, including those stated above, with OPM. On May 19, 1975, the Subcommittee held hearings to discuss our report.

OPM stated in the hearings that $3 million of the $9 million of audit exceptions with Blue Cross/Blue Shield had been resolved. Furthermore, an administrative disputes process had been agreed to by OPM and Blue Cross/Blue Shield.

OPM (successor to CSC) officials told us in June 1979 that they had resolved the issue of prior-year accounting adjustments to their satisfaction.

Since the hearings, OPM has broadened its audit scope to include evaluations of some aspects of management as well as purely financial reviews. Although OPM and Blue Cross/Blue Shield have continued to discuss the issues of (1) applicability of the Federal Procurement Regulations, (2) resolution of the "national issues," and (3) allowability of charges to the FEHB program for State statutory reserve requirements, none of these issues has been resolved. In June 1979 OPM officials told us that several of the issues were being resolved, either through the Armed Services Board of Contract Appeals or by negotiation. There is, however, no specific timetable for resolution. OPM said that cases presented to the Board can take up to 4 years for resolution. Although the total amount of unresolved audit exceptions has fallen by about $200,000 since we issued our report, the amounts attributable to "national issues" and State statutory reserve requirements have risen from $3.9 million to $8.5 million.

46. TITLE: "More Civil Service Commission Supervision Needed to Control Health Insurance Costs for Federal Employees," HRD-76-174, Jan. 14, 1977.

FINDINGS:

Local Blue Cross/Blue Shield plans and Aetna (the two largest FEHB carriers) had frequently made payments that did not appear to be in accordance with contracts and/or carriers' policy requirements. Also, certain systems designed by the carriers to eliminate excessive payments were not always functioning properly.

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We reported, too, that the contracts negotiated by CSC provided no incentives for the carriers to control benefit payments and contained no provisions under which CSC, either through audit or other means, could exercise sufficient control over the allowability of benefits paid by the carriers. In this regard, CSC had experienced difficulties auditing certain carriers' activities under the FEHB contracts. These difficulties appeared to stem from the lack of a contractual basis for questioning--and perhaps disallowing--carriers' payments of benefits under the contracts, disagreements between CSC and at least one carrier--Blue Cross/Blue Shield--regarding the extent of CSC's audit authority, and CSC's apparent lack of the medical expertise needed to challenge carrier actions and to sustain audit findings concerning questionable benefit payments.

CSC needed to improve its efforts to assure that health insurance carriers controlled benefit costs which, for the two carriers, amounted to more than $1.4 billion in 1975. We recognized that, if CSC developed and applied strict cost-control provisions and enforced such provisions, enrollees could react adversely because they might incur liabilities for charges not paid by the carriers. However, without cost-control programs, the carriers would continue to provide benefits not covered under the contracts, which would result in higher premium costs for both the enrollees and the Government.

RECOMMENDATIONS: NOT IMPLEMENTED

(a) CSC should include in its contracts specific cost-control programs which the carriers must follow. We also recommended that if CSC did not adopt this recommendation, the Subcommittee on Retirement and Employee Benefits, House Committee on Post Office and Civil Service, should consider developing legislation to require CSC to include specific cost-control and/or incentive provisions in contracts with the FEHB program carriers.

(b) CSC should revise its health insurance contracts to provide incentives to the carriers to control costs. We also recommended that if CSC did not adopt this recommendation, the Subcommittee should consider developing legislation to provide CSC with some flexibility in contracting with Blue Cross/Blue Shield for the Service Benefit Plan.

CSC responded that our report stressed the control of FEHB health insurance costs and did not address the control of health costs. CSC stated that tighter claims administration would undoubtedly result in higher out-of-pocket health costs for Federal employees. CSC believed that the most productive form of health care cost containment would be the result of carefully developed benefit packages. CSC said it was continuing to attempt, in its contract negotiations with the carriers, to provide a health benefits plan design more conducive to reducing costs; for example, the use of free-standing facilities, surgi-centers, and dialysis centers, which provide care at less cost than inhospital care and the use of second surgical opinion programs.

CSC said it had considered including incentives in its contracts with carriers to stimulate more efficient contract administration, but no workable plan for doing so had been developed. CSC believed that it should not be necessary to provide any additional incentives to achieve contract compliance because carriers have a legal, contractual responsibility to administer the FEHB program in accordance with the terms of the contract. CSC believed it had the authority to exclude local Blue Cross or Blue Shield plans from participation in the Service Benefit Plan. CSC said it would continue to study the feasibility of including incentives in the contracts.

In a June 1979 meeting, OPM officials stated that they still believed that benefit package design was an important way to control health insurance costs. To date, no legislation which would require specific cost control and/or incentive provisions in contracts with the FEHB program carriers has been enacted.

OPM officials also stated that, while they had modified FEHB program contracts somewhat to provide incentives for more effective budget processes or claims processing, they still maintained that the contracts were not generally amenable to incentives to control benefit payments. Because OPM maintained it could exclude a particular local Blue Cross or Blue Shield from participating in the Service Benefit Plan, legislation was not needed to provide contracting flexibility.

We continue to believe that implementing these recommendations would help control costs in the FEHB program. The contracts with the two governmentwide carriers remain essentially noncompetitive, negotiated instruments. While the contracts set administrative expense limits, they contain no incentives or specific measures to help control benefit payments, which represent over 90 percent of the program costs.

47. TITLE: "Civil Service Should Audit Kaiser Plans' Premium Rates Under the Federal Employees Health Benefits Program to Protect the Government," HRD-78-42, Jan. 23, 1978.

FINDINGS:

Although the FEHB Act requires that rates charged under the health plans' contracts reasonably and equitably reflect the cost of benefits provided, OPM had not comprehensively audited the two California Kaiser plans' rates or determined whether these two plans' rates were reasonable and equitable. It is important that OPM determine if these two plans' rates are reasonable because they, along with the rates of four other plans, are used to calculate the Government's contribution to the FEHB program. A small rate error can have a large effect on the Government's cost; for example, a $2 error in the biweekly rate would have increased Government costs by $15 million in 1977.

We reported that one reason OPM auditors had not comprehensively audited the Kaiser plans may have been that OPM lacked criteria for evaluating the reasonableness of the Kaiser rates. Unlike many Federal employee health plans and the other four plans used in calculating the Government's contribution to the program, the Kaiser plans are community rated; that is, premium rates are based on projected health care experience (cost and utilization) of all groups expected to be enrolled in the plan, including non-Federal enrollees. The other four plans are experience rated; that is, premium rates are based only on the experience of the Federal participants. Although community rating is an accepted method of determining premiums and is required by the Health Maintenance Organization Act of 1973, it does result in non-Federal groups affecting the amount the Government and Federal employees pay for health insurance.

RECOMMENDATIONS: NOT IMPLEMENTED

We recommended that OPM

(a) develop criteria to evaluate the reasonableness and equity of rates of community-rated, comprehensive health plans like the Kaiser plans and

(b) comprehensively audit the California Kaiser plans to determine whether their FEHB program rates reasonably and equitably reflect the cost of providing benefits to FEHB participants.

APPENDIX II

OPM did not concur with our recommendation for a number of reasons, including the problems associated with auditing community-rated plans which would involve audit of records pertaining to plans other than the FEHB program. OPM stated it was referring most of the questions raised in the report about community rating to HEW because the question about community rating must be viewed from the standpoint of broader health policy. However, in a June 1979 meeting OPM officials said that, although they had not implemented our recommendations, their reviews of comprehensive, community-rated plans did include a determination of whether a claimed community rate was, in fact, a community rate.

We have recognized the difficulties associated with auditing the premium rate of a community-rated plan. In our report we said that community rating makes it more difficult to determine if a rate is reasonable and equitable, as the FEHB Act requires. Nonetheless, because the rates of the two California Kaiser plans are used in determining the Government's contribution to the FEHB program and because OPM has never made a comprehensive audit of these plans, we believe the recommendations should be implemented.

APPENDIX III

STATUS AS OF JULY 1979 OF IMPLEMENTATION OF GAO RECOMMENDATIONS TO CONTROL COSTS OF FEDERAL HEALTH ASSISTANCE PROGRAMS

Purpose of recommendation	Recommendation number (note a)		
	Partially implemented	Not implemented	
		Agency	Congress
Require grantees and contractors to change practices or procedures through issuing regulations, policies, or standards or through revising legislation	51c,51e,52d, 53a,53b,53c, 53d,53e,53f, 58a,59a,59b, 59c	52d,55e, 55f	52e,59d, 60a
Help grantees and contractors become more efficient through technical assistance	49a,49b,49c, 50a,50b,50c, 51d,52b,55a, 55b,58b	58g	None
Monitor grantees and contractors to assure compliance with efficiency requirements in laws, regulations, policies, or standards	48a,51a,51b, 52c,56a	58c,58d, 58e	None
Improve internal management of HEW to develop cost-saving remedies	52a,54a,55c, 57a	58f,58h	None
Other	57b	None	None

a/The reports are numbered sequentially after this summary table. The number indicates the report and the letter indicates the recommendation.

CHRONOLOGICAL LIST OF REPORTS

48. TITLE: "Review of Selected Communicable Disease Control Efforts," B-164031(2), June 10, 1974.

FINDINGS:

A nationwide gonorrhea control program was initiated in fiscal year 1972. The program guidelines require that grantees (1) establish screening programs for diagnosing the disease in females in a variety of health care settings and (2) interview males reported to have gonorrhea to identify and treat their contacts.

Because funds available for controlling gonorrhea are limited, it is vital that grantees maintain an appropriate mix between the two control approaches to realize the full advantage of each approach.

RECOMMENDATIONS: PARTIALLY IMPLEMENTED

(a) Periodically review the results being achieved under gonorrhea control projects to determine whether the projects are being carried out in the most advantageous way and, if not, require grantees to make changes in the projects.

CDC stated that its headquarters staff constantly monitors the results being achieved through gonorrhea control projects. CDC officials said that this monitoring permits evaluation of all the various methodologies being used and enables CDC to help grantees adjust methods in the most cost effective manner. We noted, however, that CDC had insufficient data to accurately assess the relative cost-benefits of each control program component. Therefore, it may not be maximizing the reduction of the incidence of gonorrhea to the extent possible and may not be using the most cost-effective process.

49. TITLE: "Need for More Effective Management of Community Mental Health Centers Program," B-164031(5), Aug. 27, 1974.

FINDINGS:

The National Institute of Mental Health, the States, and the Community Mental Health Centers needed to improve performance substantially in some program areas for continued

progress toward program objectives. These areas include centers' ability to operate without continued Federal assistance, monitoring and evaluation, and coordination of center activities.

We reported that, without continued Federal assistance, some services, especially those which provide little or no revenue, would probably be curtailed or eliminated at many centers. The alternative financial resources available could not realistically replace Federal funds in total. Insurance coverage for outpatient mental health services was usually quite limited. Some centers could increase revenues by improving their billing and collection systems, but the increase overall would probably not be substantial because of their patients' low income and limited insurance coverage.

Program evaluation efforts at most of the centers reviewed were almost nonexistent because the centers placed little emphasis on this activity, as did the National Institute of Mental Health during the early years of the program.

Evaluations made by private contractors for the National Institute were of little value because of problems with timeliness and quality of the work.

RECOMMENDATIONS: PARTIALLY IMPLEMENTED

(a) Provide technical assistance to the centers in developing self-sufficiency financial plans and in improving their billing and collection systems.

(b) Consider and, if deemed appropriate, work toward expanding coverage provided by third-party payment programs for mental health outpatient services and services provided by nonphysicians.

(c) Insure that program evaluation contracts are effectively monitored and that evaluation results are made available to centers.

The thrust of these recommendations was to provide the means necessary for centers to become more self-sufficient. HEW agreed with these recommendations and pointed out a number of actions it was taking in response to the recommendations. However, major legislative changes were made in the program in 1975. This legislation (which placed a number of additional requirements on grantees) and a lack of Federal

staff have hampered efforts to implement the recommendations. An HEW official stated that the staff needed to provide the required monitoring of grantees or to provide technical assistance is not available. These and other problems are discussed in another report on the centers issued on May 2, 1979 (HRD-79-38).

We believe that, had these recommendations been fully implemented, the centers could have received more third-party reimbursements, which would decrease the need for Federal funds and would bring many centers close to self-sufficiency.

50. TITLE: "Progress and Problems in Training and Use of Assistants to Primary Care Physicians," MWD-75-35, Apr. 8, 1975.

FINDINGS:

A new profession has been introduced into the health care system--the assistant to the primary care physician (commonly referred to as the physician extender). Physician extenders are trained to do tasks that must otherwise be done by physicians. The use of extenders permits physicians to better use their time and, therefore, can increase the availability of care and help control health costs. From 1969 to 1974 HEW funded about 100 training programs for physician extenders through grants to universities and other nonprofit organizations. We reviewed 19 of the 100 training programs. The program was not effective because of

--varied program concepts, training methods, and backgrounds of trainees resulting from the fact that HEW had essentially left program direction to individual program sponsors;

--confusion and variance at the State level over the legal status of physician extenders; and

--inadequate efforts within some programs to place physician extenders in geographical areas of greatest need.

RECOMMENDATIONS: PARTIALLY IMPLEMENTED

(a) HEW should work with the States to develop the necessary legislation to clearly define the role of physician extenders and provide a legal framework enabling them to carry out the duties for which they have been trained.

(b) HEW should also work closely with professional organizations and State licensure boards to determine the most appropriate manner of granting official recognition to physician extenders.

(c) To derive maximum benefit from physician extenders by deploying them to areas of health care shortages and to insure the mobility necessary for such deployment, HEW should work closely with the States in developing criteria specifying training and experience qualifications acceptable to all States.

The thrust of these recommendations was to have HEW define the role of physician extenders in the health delivery system and to have the States enact consistent laws that would enable extenders to fulfill that role, thereby realizing their potential access to care and cost control benefits. In commenting on the draft report, HEW concurred with the need for a clear definition of the role of physician extenders and stated that, in accordance with the Social Security Amendments of 1972 (Public Law 92-603) and the Health Training Improvement Act of 1970 (Public Law 91-519), a single set of standards was being developed to define the physician extender role. According to HEW, although the standards would guide the States with developing legislation, the jurisdictional authority for practice rests entirely with the individual States.

At that time, HEW also concurred with the recommendation that it work closely with professional organizations and State licensing boards to determine the most appropriate manner of granting offical recognition to physician extenders. It stated that such recognition would be provided by the national certifying examination, which provides assurance that extenders have the minimal degree of competence necessary for insuring that the public's health, safety, and welfare are reasonably protected.

In 1976, HEW's Division of Associated Health Professions awarded a contract to the American Academy of Physician Assistants. A major purpose of this contract was to analyze the tasks performed by physician assistants. HEW anticipated that the role delineation would establish the profession's perspective of practice in terms of performance requirements. HEW believed that the refinement of the extender's role would identify the level of competence needed by extenders and delineate how extenders can best be used by physicians.

In May 1979 HEW stated that its proposed regulations for implementing section 783(a)(1) of the Public Health Service Act, "Grants for Physician Assistant Training Programs," outline how programs receiving support under this section must train physician extenders. Grantees will be required to submit copies of all applicable laws and regulations pertaining to the practice of physician assistants in the State or States in which the extenders' supervised clinical practice will be conducted and in which graduates of the program will be encouraged to work.

We were also advised that HEW's Bureau of Health Manpower now works closely with professional organizations and individual program directors on State legislation and certification matters. In the future, HEW anticipates that the State legislation currently being collected through federally funded programs will be analyzed, and the best features will be documented and published for use by the States. This will be done in conjunction with the professional physician assistant organizations.

HEW is encouraging programs to work closely with the States in the development of the enabling legislation and regulations. However, HEW advised us that it has taken the position that licensure is a State prerogative and, therefore, active intervention in the process has been ruled out.

51. TITLE: "Improving Federally Assisted Family Planning Programs," MWD-75-25, Apr. 15, 1975.

FINDINGS:

Welfare caseworkers were not adequately complying with a requirement to offer family planning services to welfare recipients. HEW was not adequately monitoring State implementation of the requirement and, therefore, was unable to enforce a penalty provision for States failing to comply. Family planning projects had not established procedures for giving priority to low income persons. Coordination between local welfare offices and family planning projects was inadequate.

Family planning clinics were not maximizing potential revenues from fees or third-party payment sources, such as Medicaid. Some family planning clinics had high drop-out and broken appointment rates. Some clinics did limited or no followup.

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The average cost per patient visit varied substantially among family planning clinics. HEW had neither established criteria for family planning projects to measure the reasonableness of costs for services, nor performed sufficient audits to evaluate project efficiency.

HEW's national family planning reporting system was generally considered to be of little value. A number of projects did not report regularly. Reports submitted were often incomplete, inaccurate, and tardy.

RECOMMENDATIONS: PARTIALLY IMPLEMENTED

(a) Establish a system and provide adequate staffing to determine compliance and permit enforcement of the one percent penalty provision and require States to report information needed for determining compliance.

In February 1976 HEW issued instructions to its regional offices on reviewing State fiscal year 1975 family planning program activities. Regional office staffs reviewed family planning activities in all States and recommended penalties for three States. HEW decided no penalties could be imposed, however, because of questions concerning the validity of sampling procedures and the uniformity of the review process among the States. Unless HEW monitors State actions to provide family planning services to welfare recipients and has appropriate incentives to assure compliance, welfare recipients needing family planning services may not receive them.

(b) Establish criteria for use in monitoring and evaluating the costs and performance of family planning programs; an HEW audit effort should be increased and grantee responsibility for subcontractor operations clarified.

In March 1979 HEW established administrative efficiency indicators for ambulatory health care projects that have been in operation for at least 2 years. The average cost per medical encounter (excluding laboratory, X-ray, and pharmacy) should not exceed $24. HEW required family planning grantees to be responsible for subcontractor operations, but it made no systematic effort to increase its audit effort aimed at family planning program grantees. Such audits are needed to better assure cost-effective operation of the grantees.

(c) Direct projects to perform adequate and prompt followup on missed appointments and patient drop outs to assist in patient retention.

HEW recently completed a study of the reasons why adolescents discontinue seeking family planning services. Although the study revealed that HEW could not take action on many reasons, it plans to issue guidelines to grantees for addressing those reasons which could be affected by grantee efforts (such as information and education). HEW has also developed a model for analyzing patient flow. By reducing the time patients must spend at clinics, HEW hopes to encourage more patients to continue seeking services. To better assure that needed services are provided, HEW needs to expedite these efforts.

(d) Encourage States to establish coordination between local welfare offices and federally-assisted projects so that recipients interested in family planning can be identified, enrolled, and followed up to ensure that they receive desired services.

In response to our report, HEW said that it was emphasizing the importance of coordination between the State welfare departments and federally assisted family planning grantees. However, no recent specific HEW efforts to encourage such coordination could be identified. HEW cited the rapid turnover of caseworkers and updating caseworkers on the availability of family planning services as major obstacles to coordination. Coordination is essential to precluding duplication of effort and to better assuring that the intended program beneficiaries receive available services.

(e) Require family planning projects to establish procedures aimed at enrolling low income persons, especially welfare recipients.

HEW requires applicants to describe in their program plans how they intend to recruit and enroll clients. However, HEW has not issued requirements or instructions to family planning projects to develop procedures for enrolling welfare recipients. HEW interprets the priority requirement in legislation to mean that, if two persons request family planning services and a clinic can only serve one, the low income person gets priority. About 55 percent of all women served in 1976 were at or below poverty level incomes; 78 percent were at 150 percent or less of poverty levels. About 16 percent of all clients were reported to be welfare recipients, ranging from 4 percent in Nevada to 30 percent in Louisiana.

52. TITLE: "Returning the Mentally Disabled to the Community: Government Needs to Do More," HRD-76-152, Jan. 7, 1977.

FINDINGS:

Care and treatment of the mentally disabled in communities rather than in institutions has been a national goal since 1963. We reported that care and treatment of mentally disabled persons in communities can be an effective and less costly alternative to institutional care. However, many mentally disabled persons have been released from institutions before sufficient community facilities and services were available and without adequate planning and followup. Others enter, remain in, or reenter institutions unnecessarily.

There was no overall plan and management system to set forth specific steps needed to accomplish deinstitutionalization; define specific objectives and schedules; define acceptable community-based care; or provide central direction and evaluation. OMB, Federal regional councils, and the President's Committee on Mental Retardation are responsible for directing and coordinating the efforts of Federal agencies. The first two had not taken action on deinstitutionalization, and the President's Committee had been only partly effective in coordinating the work of Federal agencies.

HEW's approach to deinstitutionalization was disorganized:

--Plans to make community placement work had not been made.

--Instructions to constituent agencies had not been issued.

--No one organization had been assigned responsibility for overseeing deinstitutionalization.

Problems we identified with individual programs included:

--The developmental disabilities programs in the five States reviewed provided funds to develop and expand community resources and worked productively with other agencies. But success was not commensurate with need. Greater commitment and cooperation from federally supported State and local programs was needed.

--Increased services available from community mental health centers and clinics had not always reduced unnecessary admissions to mental hospitals or provided services to people released from mental hospitals. Medication was the only service provided to many patients. The mental health centers program has developed separately from the public mental hospital system, making integration of the two difficult.

--Lacking alternatives, local programs used money provided by the Medicaid program to place the mentally disabled in nursing homes. Many homes were not staffed or prepared to meet the special needs of the mentally disabled or were not the best setting for persons so placed. People were also placed in nursing homes or elsewhere without any release plans, with plans that did not identify all services needed, or without adequate provisions for followup services. HEW had started to improve the quality of care nursing homes provide, but it had not dealt specifically with the special needs of the mentally disabled in those homes.

--Medicare provides insurance for only limited outpatient care for the mentally ill. Because of this, many people may be placed unnecessarily in mental hospitals. HEW monitored State surveys of mental hospitals for compliance with Medicare standards (including those on discharge planning) but this was limited.

--Although Supplemental Security Income helped mentally disabled people return to communities, some of these people were placed in substandard facilities, placed without provision for support services, or placed inappropriately. Standards on group housing for Supplemental Security Income recipients were not required; this aggravated the problem. Supplemental Security Income payments were reduced or not authorized when public agencies helped maintain or operated community residential facilities for the mentally disabled.

RECOMMENDATIONS: PARTIALLY IMPLEMENTED

The report contains 57 recommendations to the Congress, OMB, HEW, HUD, and Labor on actions they could take to help resolve the problems involved in returning the mentally disabled to the community. Following are the recommendations

to HEW with direct cost implications which have not been fully implemented.

(a) Determine what changes need to be made in the Medicaid program or other Federal programs to give States incentive to (1) place mentally disabled and other persons needing housing, income maintenance, some supervision, and support services, but not always medical care, in the most appropriate setting and (2) avoid unnecessary placements in SNFs and ICFs.

(b) Require HEW agencies to help States develop alternative facilities or provide services to those persons identified by independent medical or professional review teams to be inappropriately placed or not receiving appropriate services.

(c) Monitor and enforce compliance with Medicaid regulations requiring that:

(1) States (1) document instances in which persons are placed in ICFs because of the unavailability of community alternatives and (2) actively seek alternatives.

(2) Federal Medicaid funds not be used for mentally ill persons under 65 in SNFs and ICFs considered to be institutions for mental disease.

(d) Require States to effectively implement utilization controls and make sure that they accomplish intended results through HEW's validation surveys.

In late 1977 HEW established a departmentwide task force on deinstitutionalization to address the problems identified and recommendations made in this report. The task force established liaison with other Federal agencies, including the Departments of Housing and Urban Development and Labor. In June 1978 HEW and HUD launched a joint demonstration program to provide housing and support services to chronic mental patients in communities. It was estimated that between 400 and 600 housing units would be developed under the demonstration program. In September 1978 the task force submitted an interim report and recommendations to the Secretary of HEW, but no action had been taken on a departmentwide basis.

Several HEW regional offices have initiated action to enforce a provision which precludes the use of Federal Medicaid funds to help pay for the cost of care for mentally ill persons under 65 in nursing homes considered to be institutions for mental diseases. For example, HEW has found a substantial number of mentally ill persons under 65 in several California nursing homes considered to be institutions for mental diseases, and as of May 1979 was quantifying the amount of Federal Medicaid funds it believes HEW should recover from the State. An HEW Region V Medicaid official said that his agency had identified such improper placements in three States, and it plans to determine whether the problem exists in other States in the region. An HEW Region X Medicaid official stated that one State in his region had recently agreed to return about $500,000 in Federal Medicaid funds improperly used for the care of mentally ill persons in a nursing facility considered to be an institution for mental diseases. Opportunities for cost reduction through appropriate placement of patients are being lost, and Medicaid funds are being used for unintended purposes.

RECOMMENDATION: NOT IMPLEMENTED

(e) The Congress should consider amending section 1833(c) of the Social Security Act to increase the amount of outpatient mental health coverage available under Medicare. This could be done by increasing the $250 limit, the percent of Federal reimbursement, or both, or by authorizing a combined limit on inpatient and outpatient mental health care to encourage outpatient care.

A number of bills have been introduced in the House and the Senate to increase Medicare reimbursements for outpatient mental health care. However, no action has been taken by the Congress to increase such benefits as of July 1979. The Government may, therefore, be incurring costs for institutional care for persons who do not need it.

53. TITLE: "Fundamental Improvements Needed for Timely Promulgation of Health Program Regulations," HRD-77-23, Feb. 4, 1977.

FINDINGS:

Some HEW programs operate for years without the regulations required by enabling legislation, the Administrative Procedures Act, or department policy. Of 14 regulations

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studied by us, none were published in the Federal Register within 6 months after enactment of enabling legislation, as departmental policy required. Publication was delayed for one or more of the following reasons:

--Policy issues were not addressed and resolved on a priority basis.

--Extended delays occurred in developing a regulation due to limited staff and resources.

--Some offices ignored established processing dates and placed a low priority on reviewing proposed and final regulations.

--Responsible officials did not take effective measures when a proposed or final regulation was delayed for one or more of the reasons stated above.

A delay in publishing regulations often results in delays in implementing the law. In many cases the provisions of the law were enacted to control program costs. Thus, potential cost savings can be lost.

RECOMMENDATIONS: PARTIALLY IMPLEMENTED

(a) Develop sufficient manpower and resources to participate in developing and processing regulations, as well as fulfilling other responsibilities.

HEW has established a Regulations Management Unit in its Executive Secretariat and comparable units in each agency's Executive Secretariat to oversee regulation development and processing. The number of staffmembers handling regulations in HEW's Office of General Counsel has increased as well in order to speed up HEW's ability to put regulations out quickly. HEW does not have full-time regulation writers within its agencies; however, the number of people working on regulation development within the agencies has increased.

(b) Request comments from appropriate congressional committees on proposed and final regulations published in the Federal Register.

According to the Deputy Assistant Secretary for Health Legislation, regulations which are known to be of particular interest to certain congressional committees are informally sent to the committees for comment before publication in the

Federal Register. Judgment dictates which regulations are forwarded for comment. A formal procedure does not exist whereby all regulations are routinely submitted for review.

(c) Require that the computerized system for monitoring processing of regulations within the Office of the Secretary be modified to include both developing and processing. Also, consideration should be given to delegating to responsible officials the authority to take effective measures, when necessary, to avoid delays in promulgating regulations.

HEW's computerized monitoring system for tracking regulations has been modified to include some information about the status of regulations during their development. Specifically, the system shows the date on which development was approved and the target date set for delivery to HEW's Executive Secretariat for review and approval. Summary statistics show the number of regulations that are overdue grouped by agency and type of regulation. However, the system does not show precisely where a regulation is in the development phase.

(d) Highlight revisions made on unresolved issues or questions on program criteria or proposed regulations so that subsequent review can focus on those provisions.

According to an official in HEW's Regulations Management Unit, critical issues or questions are highlighted when regulations are passed from one review level to the next. However, because the time lapse between reviews can be considerable (when revisions to a regulation are made after a public comment period, for example), it is generally not reasonable to expect a reviewer to focus only on changes without also reexamining the general context in which the changes are being made. This usually means that the entire regulation must be reviewed, at least briefly. Additional actions by HEW are needed to preclude delays in issuing regulations.

(e) The Congress should consolidate programs with similar objectives and place them in the same agencies so that a corresponding consolidation in implementing regulations would result.

The Congress has not consolidated HEW programs. However, HEW, through administrative actions, has reorganized some of its agencies. Medicare was placed with Medicaid under

HCFA. The Public Health Service has been reorganized so that all staffing programs are handled by the same bureau and all institutional programs by the same agency. Also, according to an official in HEW's Regulations Management Unit, as of May 1979 HEW was consolidating the administrative requirements for Public Health Service grant programs.

(f) The Congress should include in legislation requiring regulations a maximum time limit by which the Secretary must publish such regulations.

Since the report's issuance, some provisions enacted into law have included specific dates by which HEW is required to issue regulations. We believe that the Congress is moving in the proper direction. Compliance with the laws should provide opportunities for the agencies to improve program efficiency and economy.

54. TITLE: "The Swine Flu Program: An Unprecedented Venture in Preventive Medicine," HRD-77-115, June 27, 1977.

FINDINGS:

The swine flu program was the Federal Government's first attempt at immunizing the entire U.S. population. For any future immunization effort as large or as concentrated as the swine flu program, the many preventive health care questions that arose will likely have to be considered again. The solutions devised for the swine flu program were not intended as a pattern for future efforts. Many problems, including the continued absence of a reported outbreak of swine flu, were encountered but the program continued without reevaluation of the decision for mass innoculation.

HEW used only informal procedures to develop the consent forms used for the program, and it had no plan to assure that informed consent procedures and requirements were adequately implemented. Adequate form content and administration may protect the Government from liability suits based on inadequate vaccine risk-benefit statements in consent forms.

RECOMMENDATIONS: PARTIALLY IMPLEMENTED

(a) Develop criteria and standard procedures for drafting informed consent forms, and a plan to systematically assure that informed consent procedures and requirements are implemented at projects and clinics.

HEW has taken steps to improve procedures for developing consent forms. During the development of these forms--now called information forms--for the 1978-79 flu program, HEW obtained comments from health care providers who use the forms, the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, and others both inside and outside HEW. However, this procedure does not require HEW to respond to each comment and to revise all the forms on the basis of comments from groups outside the agency, when this is warranted. Also, HEW is not required by law or regulation to obtain comments from anyone.

For ongoing immunization programs, HEW has delegated to the States under program grants the duty to warn vaccinees of the potential benefits and risks of vaccination. Thus, the States must assure that the forms are properly administered. HEW periodically checks State procedures, but has made no plans for more extensive followup if another nationwide pandemic flu program occurs. HEW has agreed to give particular attention to developing better monitoring of State procedures for future programs. Such monitoring could better assure adequate form administration.

55. TITLE: "Preventing Mental Retardation--More Can Be Done," HRD-77-37, Oct. 3, 1977.

FINDINGS:

In November 1971 the President established a national goal to reduce by half the incidence of mental retardation by the end of the century.

Of the many causes of mental retardation which have been identified, we selected a few for which preventive techniques were available to determine what else could be done. Preventing mental retardation saves a great deal of money that would be spent for treatment, care, and education of retarded citizens by such programs as special education, rehabilitation services program, and Medicaid. Mental retardation caused by inherited metabolic disorders can often be prevented if the afflicted infant is identified and treated shortly after birth. Almost all States had programs for testing a blood sample from newborn infants to detect phenylketonuria. Improvements were needed in many of these programs to reach all newborn infants. Also, only a limited number of States were testing for six other treatable metabolic disorders which can be identified from the same blood sample.

Chromosome abnormalities are estimated to account for about 16 percent of the clinically caused cases of mental retardation. Down's syndrome, one of the commonest of such abnormalities, appears in about 5,000 births each year. Treatment of chromosome abnormalities is limited; thus, medical genetics concentrates on preventing retardation through genetic counseling and testing. However, only a small portion of those who could benefit from these services received them. Neither HEW nor the States attempted to find out if persons needing the service were screened or served. Geneticists interviewed generally thought that a disproportionately small number of those who obtain genetic services were from lower socioeconomic groups.

Federally funded family planning programs and possibly others could provide the needed outreach, identification, and services to lower income families. Federally funded maternity and infant care projects were referring high-risk clients for genetic services; however, the family planning programs generally did not.

Mental retardation caused by rubella and measles can be prevented by aggressive vaccination programs. But, because rubella and measles immunization levels were low, expanded efforts to immunize children and test women of childbearing age for susceptibility to rubella were needed. Better data were needed on immunity levels in local areas.

HEW estimates that 600,000 children have elevated blood lead levels. More widespread screening was needed to determine the extent of the lead poisoning problem. A recent breakthrough in testing techniques has made it possible to do more testing inexpensively. However, except in certain known high-risk areas, lead poisoning was not recognized as a problem, and screening was not routinely done. Reporting requirements were inadequate for determining the extent of screening or the results in locales where screening was done.

Mental retardation and other complications caused by Rh hemolytic disease can be prevented by identifying women with Rh negative blood types and providing them with immunoglobulin when they bear Rh positive children or have abortions. Although the extent of the problem was not known, many women apparently were not receiving the immunoglobulin.

States needed comprehensive systems for testing pregnant women for Rh incompatibility, reporting disease incidence, and reporting immunoglobulin utilization. Only five States

had mechanisms for fully monitoring Rh hemolytic disease, only seven required either premarital or prenatal blood typing, and only six had special programs for reporting immunoglobulin use. In lieu of State laws requiring such tests, the family planning programs could assist by including Rh blood typing as a routine part of family planning services.

RECOMMENDATIONS: PARTIALLY IMPLEMENTED

(a) Encourage and support expansion of newborn screening to include treatable metabolic disorders in addition to phenylketonuria.

(b) Encourage and assist States to cooperate to establish cost-effective regionalized metabolic screening programs.

HEW has encouraged the States to expand their newborn screening programs, and it awarded 21 screening grants and a grant to Colorado to establish a regional screening program. HEW will need to continue to encourage and assist the States with their newborn screening programs. Until the recommendations are fully implemented there will continue to be the loss of lives or unnecessary costs of care and treatment from a lack of detection of metabolic disorders.

(c) Instruct CDC to determine if the incidence of Rh disease is lower in States having mechanisms for monitoring Rh disease and immunoglobulin use. If such surveillance mechanisms are effective, encourage States to develop comprehensive systems to test all pregnant women for Rh incompatibility and report incidence of Rh hemolytic disease and use of Rh immunoglobulin to CDC, thereby establishing a national program for monitoring the incidence of the disease.

HEW agreed with this recommendation and pointed out that CDC is involved in the monitoring and surveillance of Rh disease. CDC offers consultation to States upon request by helping them determine the nature of the problem and offering possible solutions.

A CDC official advised us that CDC has increased its efforts by analyzing data and assisting States. CDC has not determined if the incidence of Rh disease is lower in States having mechanisms for monitoring Rh disease and immunoglobulin use. By not doing this, CDC may be losing an opportunity to demonstrate to other States the savings possible by improved mechanisms for monitoring Rh disease.

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RECOMMENDATIONS: NOT IMPLEMENTED

(d) Require federally funded family planning and other appropriate programs to include rubella susceptibility testing and immunizations, where appropriate, among their routine services.

HEW originally stated that the federally funded family planning program would include rubella susceptibility testing. However, HEW has since reversed its decision and will not require family planning grantees to routinely perform rubella susceptibility testing because of the cost, which ranges from $4 to $20. Also, HEW does not plan to require family planning grantees to provide rubella immunizations to adolescents. Providers must have parental consent before immunizing minors and, therefore, minors seeking family planning services would need to obtain parental consent, thus losing confidentiality. HEW will require family planning grantees to obtain and document immunization history and refer adolescents elsewhere for immunization. By not implementing this recommendation, more women will continue to be at risk of contracting rubella during pregnancy and having retarded children.

(e) Require federally supported family planning programs to include Rh blood typing as a routine part of family planning services.

Although HEW originally agreed with our recommendation and had planned to implement it, it has now decided that Rh blood typing will not become a routine part of family planning services. HEW officials advised us that Rh blood typing requires testing both male and female partners. Because many unmarried females frequently change partners and do not desire pregnancy, it would not be cost effective to require family planning grantees to provide this service to all clients routinely. Rh blood typing will be required for persons seeking infertility services and for women who want to become pregnant.

We continue to believe that, since family planning clients received blood tests as a routine service, blood typing could be done at very little additional expense. This information should be a part of a woman's basic health knowledge, especially since the chances are 85 to 95 percent that the male partner will be Rh positive. A CDC official stated that the greatest Rh problems occur after abortions. Therefore, since (1) most family planning clients do not wish to become pregnant, (2) almost 30 percent of clients are

teenagers, and (3) a high proportion of teenage pregnancies result in abortions, these clients would appear to need such information. We, therefore, believe our recommendation is still valid and should be completely implemented. By not implementing the recommendation, family planning clients may not be aware of the risks they may face.

(f) Direct federally supported family planning programs to routinely include screening for individuals who are "high risk" for genetic disorders and refer such individuals to diagnostic and counseling services.

HEW concurred in principle with our recommendation but stated that universal screening could not be mandated until more capacity for effective screening and counseling is available. Family Planning Program Guidelines recommend these as clinic services where available. We agree that identification of high risk clients may not be feasible if diagnostic and counseling services are not available; however, to the extent such services are available and referral services are not provided, high risk clients may continue to be unaware of the need for or availability of such services.

56. TITLE: "Review of Grant Funds Awarded to The Counseling Center, Bangor, Maine," HRD-78-33, Dec. 21, 1977.

FINDINGS:

We reviewed the use of Federal funds by the Counseling Center (a community mental health center) at the request of Senator William Hathaway. We found that the Center's financial management practices and procedures were inadequate--especially its timekeeping, payroll, and cost allocation systems. Prior to July 1977 the Center did not segregate grant revenues and expenses by program. The Center's timekeeping system was still not used to support its payroll at the time of our review.

We also found that the Center overcharged Federal grants by about $81,000 for the periods we reviewed. Most of the overcharge was caused by reporting as expenditures the amounts in the grant applications when the Center's actual expenditures were less.

RECOMMENDATION: PARTIALLY IMPLEMENTED

(a) Require that an audit be made of the grants not covered by our review and that the overcharges discussed in the report be recovered.

The HEW Audit Agency has begun reviewing all grants to the Center. Action to collect the overpayments identified in our review has been postponed until the current audit is completed. When the audit is completed, the overpayments will be collected.

57. TITLE: "Are Enough Physicians of the Right Types Trained in the United States," HRD-77-92, May 16, 1978.

FINDINGS:

No system exists in the United States for assuring that the number and type of physicians trained is consistent with or related to the approximate number needed. Instead, decisions on the types and sizes of graduate medical training programs are usually made by individual program directors in the hundreds of medical schools and hospitals located throughout the Nation based on the availability of funds, the need to provide balanced training within a medical school, and the patient care needs of training institutions.

Under the present medical education system, it appears that too many physicians are being trained within certain specialities (such as surgery, cardiology, neurosurgery, and urology) and too few are being trained as primary care physicians.

Moreover, considerable debate continues over whether a sufficient aggregate supply of physicians exists in the United States. Some believe there are not enough physicians in the Nation, while others believe the country may soon be producing more physicians than it needs.

In addition, VA by law is moving to increase the number of medical schools and the aggregate supply of physicians at a time when concern is growing that the United States may soon have too many physicians.

RECOMMENDATIONS: PARTIALLY IMPLEMENTED

(a) The Secretary, HEW, should meet with representatives of the Coordinating Council on Medical Education (CCME) and explore the possibility of its engaging in national studies of physician and physician extender manpower supply and requirements under a mutually agreeable contractual arangement. HEW's Graduate Medical Education National Advisory Committee should (1) play an active role in monitoring their progress and (2) review indepth the Coordinating Council's completed studies and provide the Secretary with its detailed comments and recommendations. At a minimum, these studies should involve the collection and analysis of the following types of data: morbidity and mortality information; number and type of patients seeking physician care in various specialties; number, ages, and geographic location of practicing physicians by specialty and subspecialty; numbers and types of procedures actually performed by physicians in various subspecialties; the ways various specialists interrelate; number of physician extenders and other types of paraprofessionals entering the medical field and the duties they perform; likely imminent changes in the various specialties because of technological breakthroughs; and reimbursement mechanisms, possible changes thereto, and their impact on physician specialty choices.

On March 17, 1979, HEW commented that it concurred in the need to work with the Coordinating Council on Medical Education, but it stated that, in HEW's view, the Coordinating Council is not the only appropriate source for conducting the studies and analyses needed to determine an appropriate supply of physician specialists. However, HEW stated it will continue to meet with the Coordinating Council on areas of mutual interest in exploring the Nation's need for physicians, and will obtain the assistance of the Coordinating Council, as well as other appropriate professional organizations, in the process related to this issue.

HEW, through its Graduate Medical Education National Advisory Committee, is currently engaged in conducting studies of the future supply and requirements for physicians and physician extenders (among other issues), and their final report, expected in 1980, will include recommendations and

short- and long-term strategies for changing medical manpower production. HEW agreed that it should solicit viewpoints of the Coordinating Council, as well as other interested bodies, in their process.

Until these studies are finalized, HEW cannot ensure that the number and type of physicians being trained in the United States are consistent with the approximate number needed.

(b) Until the overall need for additional physicians is more precisely determined, the Congress should explore whether it wants the Veterans Administration to continue providing Federal grants either to establish new medical schools or increase the capacity of existing ones, as provided under Public Law 92-541.

Commenting on the draft report, the VA Administrator stated that, after clearance is obtained from OMB, VA plans to request deletion under Public Law 92-541 for support of both new medical schools and the expansion of existing ones. VA did submit a legislative proposal to substantially amend extension of Public Law 92-541 authorities. Specifically, in its fiscal year 1980 budget submission, VA did not propose an extension of the legislative authority for this program--which expires on September 30, 1979. It is unclear at this time, however, what action the Congress will take in this regard.

Until this issue is resolved, VA's staff training programs may contribute to what many believe will be an excess supply of physicians in the United States. It should be noted that a similar recommendation to the Congress was made in another report, "The VA Health Manpower Assistance Program: Goals, Progress, and Shortcomings" (HRD-79-8, Mar. 6, 1979).

58. TITLE: "Are Neighborhood Health Centers Providing Services Efficiently and to the Most Needy?" HRD-77-124, June 20, 1978.

FINDINGS:

Centers are overstaffed for the number of patients being treated. This underuse of physicians, dentists, support personnel, and services is costing the six centers reviewed more than $1 million annually. HEW records indicate that many other centers have similar costly inefficiencies. Anticipated patient demand on which staff levels were originally based

has not materialized, and staffs have not been reduced to levels consistent with demand.

Demand for health services from the 112 neighborhood health centers funded by HEW is not likely to increase beyond present levels, and demand could decline because the population growth of the areas that the centers serve has either stabilized or other sources of health care have become available.

HEW has not made sure that centers are serving residents of medically underserved areas. HEW does not know the number and percentage of users of the centers who live in these areas.

HEW no longer requires centers to become financially self-sufficient. However, its emphasis on having centers obtain as much revenue as possible from non-Federal sources may be having an adverse effect on the main objective--serving the medically underserved. Some centers have dropped boundary and residency requirements to attract patients who can pay for their services.

The Public Health Service Act requires centers to provide preventive health care services. Patient responsiveness--the basic ingredient necessary for success--is lacking. Most patients use the health centers for curing illness, not for prevention.

RECOMMENDATIONS: PARTIALLY IMPLEMENTED

(a) Develop criteria for measuring the productivity of dentists.

HEW concurred with this recommendation, and it has stated that it established productivity criteria for dentists, a part of which is a new ratio of one dental provider for every 1,000 to 1,500 patients. HEW also stated it has begun testing the criteria.

We do not know if the ratio is appropriate, but HEW's study should provide an answer. When appropriate criteria is applied, dental provider staffing levels will be consistent with patient demand.

(b) Continue to encourage and assist centers to bill and collect money when it is due them and make sure that centers concentrate on serving the

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medically underserved rather than seeking to serve patients in other areas that do not have a shortage of personal health services simply to increase revenue.

HEW concurred with this recommendation. In fiscal year 1979 it plans to devote an estimated one-third of its technical assistance contract efforts for the centers to project financial management. Major emphasis will be on such things as the development of accounts receivable systems. This should improve collection efforts.

RECOMMENDATIONS: NOT IMPLEMENTED

(c) Better enforce compliance with existing productivity and staff size criteria.

Although HEW concurred with this recommendation and stated that it had changed its physician productivity indicator from 2.7 encounters per hour to 4,200 encounters per year, this change will not affect productivity and staff size. A physician working 220 days per year, 7 hours per day, and treating 2.7 patients per hour would have about 4,200 encounters per year and, thus, no real change has occurred in the staffing criteria. As a result, excess staffing levels and the resultant excess operating costs will continue. The unnecessary staffing costs could total as much as $4.2 million.

(d) In addition to using cost criteria to control supporting and general service costs, assure close evaluation of the reasonableness of such costs at each center in relation to the level of service provided.

HEW concurred and stated that the sum of administrative housekeeping and maintenance costs should not exceed 20 percent of total operating costs instead of the former 25 percent. HEW stated also that it changed the ratio of medical support staff to the number of physicians from 4 to 1 to 3 to 1. We have noted that, although both of these criteria imply a closer scrutiny to accomplish increased efficiency, certain cost elements previously included in calculating the 25-percent factor were excluded from consideration (HEW lowered the percent but also lowered the pool of cost elements to be considered in calculating the percent). We also noted that, in regard to the medical support staff to physician ratio, HEW similarly removed certain categories of staff

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from consideration in determining the number of medical support staff. Therefore, excess administrative housekeeping and maintenance costs continue.

(e) Compile and maintain records to identify the number of center registrants who live in medically underserved areas and identify centers whose registrant workload is not primarily from those areas.

(f) Stop funding centers which serve only or primarily people who do not live in medically underserved areas, particularly where the residents have access to other health care providers. Funds to centers should be reallocated to medically underserved areas whose residents will be the center's primary workload, so as to achieve the greatest coverage with resources available.

HEW does not concur with these recommendations. HEW contends that it would not be cost beneficial to promulgate a series of data gathering and maintenance requirements to verify that community health centers serve medicallly underserved areas. In addition, HEW contends that it should serve individuals in need of medical services regardless of whether or not they live in an area designated as medically underserved.

We believe that collection of such data would be cost beneficial in allocating available funds to meet the health needs of residents in underserved areas who have little or no access to health care. We also believe that such data will provide information to assure that the centers serve the population intended by the Congress.

(g) Have health centers promote participation of the center users in preventive health care services.

(h) Use some health centers as sites for demonstration projects authorized under the recently enacted National Consumer Health Information and Health Promotion Act of 1976.

HEW concurred with these recommendations when commenting on a draft of the report and stated that it plans to actively pursue these efforts. However, it has not initiated any action, and the benefits of preventive health services are not being realized to the extent possible.

We still believe it would be cost beneficial for HEW to concentrate the use of its resources for residents of those areas in which there is no or limited access to health services.

59. TITLE: "Can Health Maintenance Organizations Be Successful? An Analysis of 14 Federally Qualified HMOs," HRD-78-125, June 30, 1978.

FINDINGS:

Our review showed that, although relationships with related organizations may aid HMOs by providing financial assistance or entrepreneural initiative, the relationships may also present opportunities for abuse.

HEW was slow to issue final regulations and guidelines for implementing and enforcing requirements of the HMO Act, as amended. HEW also had not issued a formal, uniform loan policy for administering the loan program.

Bills pending in the Congress at the time of our review required HEW to determine Medicare and Medicaid payments to HMOs by estimating (1) the cost of providing Medicare and Medicaid services in the fee-for-service sector in each HMO's service area and (2) a community rate for each HMO, adjusted for age and sex characteristics. Our review questioned HEW's ability to make these estimates. In the first instance, HEW's Medicare and Medicaid cost data were as much as 2 years old. And in the second instance, HEW had not issued any guidelines to translate the act's community rating requirement into a rate structure. Also, HEW appeared to be unable to monitor the activities of HMOs serving Medicare and Medicaid enrollees because HEW had not developed an effective compliance function. We found inadequacies in planning, marketing management, financial management, and utilization control among developing HMOs.

RECOMMENDATIONS: PARTIALLY IMPLEMENTED

(a) Issue in final form all regulations and guidelines needed to administer the nationwide HMO program, more effectively and uniformly, particularly for compliance, open enrollment, community rating, and fraud and abuse.

HEW has made progress toward issuing final regulations and guidelines needed to administer the nationwide HMO program. For example, final regulations on monitoring HMOs in light of the HMO Amendments of 1976 were published on July 25, 1978. Also, HEW published an HMO Compliance Plan on February 1, 1979.

Proposed regulations were issued on September 11, 1978, concerning open enrollment and community rating, among other things. They were revised and published as interim regulations on July 18, 1979.

Guidelines on open enrollment were being revised, but according to an HEW official they could not be completed in conjunction with corresponding regulations because there were numerous, complex issues to be resolved. A policy paper on community rating has been approved by the HEW Office of General Counsel and will be available when the revised regulations are published to provide additional guidance on the subject. Regulations are being prepared concerning financial disclosure requirements, and the HMO Compliance Plan addresses the detection and correction of abuses such as unreasonable payments to parties in interest, unethical marketing practices, and the fraudulent diversion or misallocation of funds. According to an HEW official, HMO staff are working with staff from HCFA to develop standards for detecting unethical practices of HMOs serving Medicaid clients.

Despite HEW's progress, most regulations and guidelines needed to operate the HMO programs are still not final. Consequently, the program continues to lack clear, uniform guidance on matters vital to its efficient and effective operation.

(b) Issue a formal, uniform loan policy for administering the loan program.

HEW published the first part of a Loan and Loan Guarantee Manual on April 26, 1979. The first issuance contained chapters on general provisions for operating loans and loan guarantees, loan monitoring, and defaults and remedies. Chapters concerning special provisions for direct loans and loan guarantees, and general provisions for planning and initial development loan guarantees and for loans and loan guarantees to finance the acquisition and construction of ambulatory health care facilities, still remain to be published. HEW's target date for completing the manual was August 31, 1979. In the meantime, no consistent policy

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guidance will be available on the issues contained in the sections still unpublished.

(c) The Congress should defer action on proposals that would institute new methods to pay HMOs for services provided to Medicare and Medicaid clients because HEW has not (1) demonstrated that it can accurately determine fee-for-service costs per enrollee, (2) issued community rating guidelines, or (3) established an effective compliance function.

The HMO Amendments of 1978 require the Secretary to promulgate regulations regarding the enrollment of members who are entitled to Medicaid benefits. The HMO Offices' position has been that HCFA should assume lead responsibility for preparing the regulations. According to an HMO official, the two agencies have been cooperating on the project.

The 1978 amendments did not institute new payment methods for Medicaid clients. Also, as noted in connection with recommendation (b), HEW has prepared community rating guidelines and has improved its compliance function. However, the adequacy of its new compliance function has not yet been tested.

RECOMMENDATION: NOT IMPLEMENTED

(d) The Congress should defer action on proposals to increase total loans available to individual HMOs until HEW demonstrates that it can effectively administer the existing loan program by developing a formal uniform loan policy and establishing an effective compliance function.

The HMO Amendments of 1978 increased the ceiling on operating loans from $2.5 million to $4 million, and it authorized a new loan program for acquiring and/or constructing outpatient care facilities. Since our report was issued in June 1978, HEW has published a substantial part of its loan manual and has improved its compliance function. However, HEW still cannot assure that HMO loan funds are being used effectively and efficiently.

60. TITLE: "Status of the Implementation of the National Health Planning and Resources Development Act of 1974," HRD-77-157, Nov. 2, 1978.

FINDINGS:

The primary purpose of the National Health Planning and Resources Development Act are to (1) restrain increases in health care costs through preventing the construction of unneeded facilities and the unnecessary duplication of capabilities to perform expensive services and (2) increase access to the health care system. HEW was slow to promulgate and finalize program regulations and guidelines needed by local and State health planning agencies to carry out functions required by the act. In States having a statewide health system agency, conflicts were evident because both the State health planning agency and the health systems agency have similar responsibilities and cover the same geographic area. Also, considerable concern had been expressed about the compatability of the Act's two major goals--cost containment and increased access to health care.

RECOMMENDATIONS: NOT IMPLEMENTED

(a) The Congress should also amend the National Health Planning and Resources Development Act to provide for Health Systems Agency and State Health Planning and Development Agency review of proposed projects involving Federal health facilities and equipment and require their recommendations regarding the appropriateness of the projects be sent to the cognizant Federal agencies. Federal agencies should be required to provide these recommendations, along with their written responses, to congressional committees before any decisions are made to fund a project. Specific legislative language regarding these changes will be furnished to the appropriate committees upon request.

Attempts have been made by several Members of Congress to amend the act to provide for health systems agency review of changes to the Federal health system. Each of these attempts has been unsuccessful.

We still believe that this recommendation should be implemented and that it would have an effect on the cost of the health care system. It would potentially reduce duplication of services between the Federal and non-Federal sectors and result in a more efficient and economical overall health care system.

A LIST OF FEDERAL DIRECT HEALTH DELIVERY SYSTEM COST CONTROL RECOMMENDATIONS WHICH HAVE BEEN FULLY OR SUBSTANTIALLY IMPLEMENTED

Presented below is a list of our recommendations related to the Federal direct health delivery systems of DOD, HEW, and VA, which have been fully or substantially implemented by the Congress or the responsible agencies. The conditions which led us to make the recommendations and the benefits derived from implementation are also discussed.

(1,2) Planning for the proper size for proposed construction projects of military hospitals did not reflect the actual or expected use patterns. We recommended that the Congress provide policy guidance concerning (1) for whose use new military hospitals should be built (that is, active-duty personnel, retired personnel, and/or dependents) and (2) to what extent, if any, should DOD's beneficiary population be required to use excess acute care bed capacity at other nearby Federal hospitals. (MWD-76-117, Apr. 7, 1976) In July 1976 the Congress gave DOD certain guidance on how to determine the number of acute care beds needed for active-duty personnel and their dependents, the bed capacity for other eligible beneficiaries, and the coordination needed between the Federal and civilian health care systems. In another report (HRD-77-5, Nov. 18, 1976) we recommended that DOD act promptly to develop specific instructions to implement the congressional policy guidance. In February 1977 DOD instructed the respective military departments to size military medical facilities based on a hospital sizing model developed by us. Additional facilities were allowed for dependents of active-duty soldiers when other adequate health facilities were not available locally or when the marginal cost of providing inhouse care to these beneficiaries was favorable relative to costs under the health insurance program for dependents. Also, DOD reaffirmed its methodology for planning the bed capacity for retirees and their dependents. These actions by the Congress and DOD will have a significant and recurring long-range effect on the future construction costs of DOD health care facilities.

(3,4) There were indications that Puerto Rico and the Virgin Islands were getting a disproportionate share of VA's medical care resources. The VA medical program in these locations was largely benefiting veterans with nonservice-connected illnesses. Consequently, many patients with service-connected disabilities were in contract hospitals with little monitoring by VA to insure quality of care. We recommended that the Congress clarify its position on the type and extent of limitations which should be imposed on the use of contract hospitals in Puerto Rico and the Virgin Islands. The Congress enacted Public Law 95-520, which clarified its position on VA's authority to provide contract care for veterans and for nonservice-connected disabilities in Puerto Rico and the Virgin Islands. We also recommended that VA closely monitor the fee basis and contract hospital programs in Puerto Rico and the Virgin Islands to insure that veterans receive quality care and that VA paid only for services received. VA implemented this recommendation. These actions should help VA better plan health resources needed in Puerto Rico and the Virgin Islands. (HRD-78-84, Mar. 30, 1978.)

(5) Using the planning criteria for sizing military hospitals of four beds per 1,000 active-duty members and their dependents would have resulted in the construction of a new San Diego Naval Hospital whose capacity would have been about 900 acute care beds and would have far exceeded expected medical needs. We recommended that DOD withdraw its hospital sizing criteria and implement a planning methodology that utilizes average lengths of stay and that uses figures to project acute care bed requirements. DOD has adopted our model for sizing its hospitals, and it has incorporated recent refinements we made to the model during our review of VA's hospital sizing activities. DOD is planning to request funding for a new San Diego hospital containing 560 acute care beds. No cost estimates are available on either the savings in construction costs or annual operating costs directly attributable to DOD's use of the model in sizing the facility. (MWD-76-117, Apr. 7, 1976.)

(6-8) The New Orleans Naval Hospital was being greatly underused, and the potential for increasing its military use to a viable level was virtually nonexistent because of the small number of military beneficiaries

in the New Orleans area. We recommended (1) discontinuing both inpatient and outpatient medical services at the facility, (2) implementing necessary action to provide outpatient care at another nearby Federal facility, and (3) thoroughly evaluating other potential uses for the naval hospital. DOD implemented our recommendations. As a consequence, annual savings of $2.4 million in operating expenses were made possible by closing the unneeded New Orleans Naval Hospital. In addition, increased lease income of about $44 million to the Government is possible if the current lease of the facility to a private medical concern continues for a 25-year period. (HRD-78-71, May 15, 1978.)

(9) Military hospitals were dissatisfied with the quality of X-ray film stocked by the Defense Personnel Support Center. We recommended that DOD determine, with appropriate input from radiologists, the quality of film to be used and that it use large-volume, central procurement for X-ray film if money could be saved. DOD implemented our recommendation by entering into DOD-wide contractual agreements with several manufacturers of X-ray film. These central procurement/direct vendor delivery of X-ray film contracts resulted in annual savings of about $780,000, according to an estimate by an official of the Defense Personnel Support Center. (MWD-76-75, Jan. 15, 1976.)

(10) DOD's urinalysis testing program required individuals to provide urine samples under observation to be tested for the presence of certain drugs. The program was uncovering a relatively small number of illegal users. We recommended that DOD reevaluate its use of the random urinalysis testing program. In September 1976 the Congress directed DOD to discontinue its random urinalysis testing program. Recurring annual savings of millions of dollars occurred because DOD discontinued its random urinalysis testing program. (MWD-76-99, Apr. 8, 1976.)

(11) The cost of providing care to civilian burn victims at the U.S. Army Institute of Surgical Research was far greater than the reimbursement rate of $168 per day. We recommended establishment and implementation of a reimbursement rate for civilian patients which more closely approximated the full cost of the care provided. In October 1978 DOD implemented a revised

rate of $634 per day. This rate resulted in estimated annual increases in revenue of about $2.2 million. (HRD-77-156, Sept. 29, 1977.)

(12) A system of control and accountability over military drug inventories at the pharmacy level was necessary. Hospital managers then could safeguard assets which--although individually small in value--collectively represented a large investment by the hospitals and and DOD. We recommended that the military medical departments determine the adequacy of controls over their pharmacies' drug inventories and take steps to initiate control systems at those facilities where they were lacking. As a result, DOD has required the military departments to improve inventory control methods in military pharmacies. According to the Office of the Assistant Secretary of Defense (Health Affairs), compliance with this requirement is routinely being checked by internal audits and inspection reviews. This action should improve the control of and accountability for about 95 percent of the drugs dispensed in military pharmacies. (MWD-76-27, Oct. 28, 1975.)

(13) A review of certain hospital construction projects proposed for funding by IHS in the Navajo area indicated that the methodology used to determine the number of beds required at each facility would result in the construction of too many beds. Because IHS uses the same methodology to size other hospitals throughout its system, similar problems probably existed elsewhere. We recommended that the Senate Subcommittee on the Department of the Interior and Related Agencies, Committee on Appropriations should delay recommending appropriations of funds for any IHS hospital project until IHS could explain why expansion of existing underused facilities was necessary. IHS has reduced the number of beds planned for health care facilities in the Navajo area from 849 to 553. This action resulted in a $8.4 million savings in contruction costs and a recurring annual savings of $2.8 million in operating costs. (HRD-77-112, May 31, 1977.)

(14-18) St. Elizabeths Hospital had a wide range of program weaknesses caused by a lack of effective planning, coordination, and agreement on how to best provide mental health services to District of Columbia residents. We recommended specific changes in many

program areas. HEW, District of Columbia, and St. Elizabeths Hospital officials fully or substantially implemented several of the recommendations; this should improve the cost effectiveness of the operational management of St. Elizabeths Hospital. Included in these actions were:

(a) Completion of a cost-benefit analysis to determine if it would be more cost-effective to contract out at least some of the services. Contracting for certain services should save about $2 million annually.

(b) Establishment of criteria and guidelines for identifying patients ready for release to less costly community facilities.

(c) Completion of a comprehensive study of hospital procurement operations and subsequent implementation of certain improved procurement management actions.

(d) Increased efforts to comply with property control instructions.

(e) Increased rents for employee housing and performance of only authorized maintenance work. (HRD-78-31, Sept. 27, 1978.)

(19) In Hawaii, three Federal agencies (DOD, VA, and HEW) were responsible in fiscal year 1977 for providing health care to a beneficiary population of about 230,000 persons. The Army, in its planning for an estimated $120 million renovation and construction project at the Tripler Army Medical Center--the only Federal hospital in Hawaii--needed to improve its coordination with other health care providers in Hawaii. In this way, Tripler would be more capable of serving as the State's only Federal hospital and as a useful partner in the State's health care community. We recommended that the Army, in its plans for renovating the Tripler facility, keep other Federal and State health care officials appraised of the plans and give full consideration to their comments. Improved coordination among Federal agencies on this matter has progressed to the point that DOD has stated that the Tripler renovation will specificially provide for VA's needs. (HRD-78-99, May 22, 1978.)

(20) VA's program to furnish medical equipment (such as wheelchairs and hospital beds) was unnecessarily costly. This condition existed because the VA Central Office staff had not (1) adequately evaluated equipment activities in the field nor (2) provided adequate guidelines to the hospitals on how equipment loan versus issue determinations should be made. We recommended the initiation of a systemwide study to determine the extent and effectiveness of VA's equipment-loaning activities. From fiscal year 1975 to fiscal year 1978, VA's increased emphasis on loaning equipment instead of purchasing it for permanent issue to patients resulted in 42,000 items valued at over $7 million being loaned and subsequently recycled for use by other patients. (MWD-75-104, July 21, 1975.)

(21, 22) The VA domiciliary program provides housing, medical treatment, food, clothing, and other services to eligible disabled, ambulatory veterans residing in VA facilities called "domiciliaries." Because of inadequate management by the VA Central Office, domiciliaries did not properly consider whether veterans should receive another type of care. We recommended that VA domiciliaries be required to (1) properly apply VA's admission criteria, including consideration of alternatives to domiciliary admission for those not needing such care and (2) identify domiciled veterans with potential to return to community living and develop individualized restoration goals and plans requiring greater use of community resources. In December 1977, the VA Administrator stated that, in line with the start of a new concept in caring for aged veterans, VA domiciliaries would not only provide the support necessary for veterans to recover their independence, but it would also offer incentives for their return to the community. In this regard, he stated that veterans with sufficient income to defray costs would be using the community care (foster home) program as an alternative to domiciliary admission. In addition, he stated that the domiciliary program would emphasize rehabilitation rather than custodial care. (HRD-77-69, Sept. 21, 1977.)

(23) An evaluation of VA's management and planning of its kidney transplant program revealed that most VA kidney transplant units were underused during fiscal year 1972. One hospital, over a 3-year period, performed only two transplants. We recommended that

VA evaluate its entire kidney transplant program to determine the number and location of transplant centers and discontinue services which do not meet the VA workload criteria. VA terminated funding for the unit at the one medical center we had identified. Over a 3-year period, this medical center had received $465,000 for its kidney transplant unit. (B-133044, June 19, 1974.)

A LIST OF HEALTH FINANCING PROGRAM COST CONTROL RECOMMENDATIONS WHICH HAVE BEEN FULLY OR SUBSTANTIALLY IMPLEMENTED

Below is a list of our recommendations related to the health financing programs of DOD, HEW, and OPM which have been fully or substantially implemented by the Congress or the responsible agencies. The conditions which lead us to make the recommendations and the benefits derived from implementation are also discussed.

(1,2, 3) Home health care is a generally less expensive mode of care than institutionalization, and we found that the availability of this alternative to Medicare beneficiaries was being adversely affected because Medicare claims paying agents were retroactively denying payment for such services; that is, denying payment after the services had been provided because claims paying agents began to apply a stricter interpretation of program coverage requirements. We recommended three actions to reduce or eliminate the retroactive denial problem: (1) assure effective and uniform interpretation of existing home health care coverage guidelines, (2) assure more uniformity in the claims payment screening criteria for home health care, and (3) establish regulations for advance approval of home health care as authorized by the Social Security Amendments of 1972. HEW did promulgate the advance approval regulations and took some actions in response to the other recommendations. In following up on the retroactive denial problem area in 1977, we found that problems between intermediaries and providers on whether and to what extent home health services are covered have largely been resolved. Denials of claims were minimal. This should have resulted in increased availability of home health care to Medicare beneficiaries and, thereby, helped contain overall Medicare program costs. In 1974 about 333,000 Medicare beneficiaries received home health services, while during 1977 about 690,000 beneficiaries will receive home health care. (B-164031(3), July 9, 1974.)

(4) The potential for home health care to be an effective alternative to institutionalization of Medicaid recipients was not being fully utilized because HEW had not provided sufficient guidance to the States on the

program's objectives and scope. We recommended that HEW emphasize to the States that home health care should be used when it is less expensive than institutionalization and meets the patient's needs; HEW took action to do so. Medicaid payments for home health care increased from about $25 million in fiscal year 1973 to about $179 million in fiscal year 1977. We do not know how much institutional care was avoided by the increased use of home health care, but it is probably substantial. (B-164031(3), July 9, 1974.)

(5) Medicare intermediaries were allowing widely varying, and often excessive, amounts for compensation for health facility owners who worked at the facility because HEW had not adequately defined how such compensation determinations should be made. We recommended that HEW establish more definitive guidelines and criteria for intermediaries, and HEW did so. Determinations of reasonable owner's compensation should now be consistently and accurately made. (B-164031(4), Aug. 16, 1974.)

(6,7) A primary purpose of using HMOs under Medicaid was to decrease program costs; however, because of the methods used to determine HMO payment rates, there was no assurance that this purpose was being realized. We recommended that HEW provide guidance to the States on how to determine HMO rates, and that it require States to document the basis for HMO rates. We also recommended that HEW establish a surveillance mechanism to ensure that HMOs are not overpaid by Medicaid. In 1975 HEW issued regulations requiring States to document the basis for HMO rates, and in 1978 it provided States with guidance on how to determine appropriate HMO rates. The 1975 regulations also required States to obtain advance approval of HMO contracts exceeding $100,000. One of the items reviewed before approval is the reasonableness of the HMO rate. These actions should help assure that potential savings from using HMOs under Medicaid are realized. (B-164031(3), Sept. 10, 1974.)

(8) We used a number of information systems containing data on personal income and/or benefits such as those of SSA, DOD, VA, and State labor departments, and found that 14 of 50 Medicaid recipients were ineligible. We recommended that HEW consider having the States use these other income information sources when determining Medicaid eligibility and conducting eligibility

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quality control reviews. Most States now routinely use other income information systems not only for Medicaid but for AFDC, and we believe this has contributed significantly to a decrease in the number of erroneous eligibility determinations. (B-164031(3), Sept. 20, 1974.)

(9-16) We found that Medicaid's early and periodic screening, diagnosis, and treatment program--a preventive health program for children which was expected to lower, in the long run, overall Medicaid costs--was not working effectively. We made eight recommendations to improve the program, and HEW took actions to implement all of them. The benefits of preventive medicine are now being received by many more children. (MWD-75-13, Jan. 9, 1975.)

(17-19) Investigation of fraud and abuse in Medicaid and Medicare was not adequately coordinated at the Federal level. State Medicaid program management in general, and fraud and abuse control programs in particular, were not adequately monitored by HEW, nor did it provide adequate technical assistance to the States to help them correct problems. States did not coordinate their investigations with Medicare; and HEW was not penalizing States, as required by law, for failing to have effective institutional utilization review programs--a primary means of controlling program abuse. We made recommendations to correct all these problems. As a result, HEW has one unit within HCFA charged with fraud and abuse control for Medicaid and Medicare. HEW is also now conducting State Medicaid management assessment reviews and program integrity reviews to identify State management problems and to assist States in overcoming them. In addition, there is more coordination between State Medicaid investigations and Federal Medicare investigations. Finally, HEW now penalizes States not meeting utilization review requirements. All of these changes should improve the effectiveness of Medicare and Medicaid fraud and abuse control efforts and, thereby, control program costs. (MWD-75-74, Apr. 14, 1975.)

(20) Many members of hospitals' governing boards and key hospital employees had overlapping interests with firms the hospitals did business with, which could detrimentally affect hospital costs and general administration. We suggested that the Congress require

hospitals to publicly disclose any such overlaps of interest. Section 3 of Public Law 95-142 requires hospitals to disclose to HEW or the States information on dealings between hospitals and firms with which the hospital's board members and certain key employees are connected. Such additional information should make it easier for HEW and the States to determine the reasonableness of dealings between hospitals and these other firms. (MWD-75-73, Apr. 30, 1975.)

(21-23) Many people who could have safely dialyzed at home were being dialyzed in facilities. Based on 1972 costs, it was at least $15,000 a year less costly to dialyze at home than at a facility. We made two recommendations to HEW and one to the Congress designed to encourage renal disease patients to dialyze at home. Public Law 95-292 met the thrust of our recommendations by providing reimbursement incentives to patients to dialyze at home. (MWD-75-53, June 24, 1975.)

(24) Not enough cadaver kidneys were being donated to meet the demand for transplants. Also, because our other recommendation in the report designed to encourage transplants was implemented, the demand for cadaver kidneys should increase. We recommended that HEW take action to encourage more cadaver kidney donations. HEW took a number of actions to implement this recommendation. The number of cadaver kidney donations has increased about 18 percent from fiscal year 1976 to 1978. (MWD-75-53, June 24, 1975.)

(25) Patients whose kidney transplants failed after more than 12 months had to have a 3-month waiting period before they could become eligible again for Medicare. The patient was liable for the costs associated with the failure and any dialysis needed during the waiting period. This served as a disincentive toward patients obtaining transplants, which usually are a much less costly method of treating renal disease than long-term dialysis. We recommended that the Congress amend the law to remove this waiting period requirement. Public Law 95-292 did eliminate the waiting period for patients whose transplants fail, and this removes this disincentive toward transplants. (MWD-75-53, June 24, 1975.)

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(26, 27) HEW's claims processing unit for Medicare providers--the Division of Direct Reimbursement--had higher claims processing costs than private firms with which HEW contracts for this function, but that fact was obscured from management because the unit did not report all its costs and was not monitored as the private firms were. We recommended that the unit be required to report all its costs and that it be monitored in the same manner as private firms. Both recommendations were implemented and should lead to better cost control over the unit's activities. (MWD-76-7, Sept. 30, 1975.)

(28) Because Medicare providers under the hospital insurance program (part A) were free to choose which intermediary processes their claims, some intermediaries had only a few providers in a given geographic area, and this resulted in increased claims processing costs because of the need for field offices and distant travel. We suggested that the Congress amend the law to permit HEW to redesignate an intermediary when the provider's selection impedes efficient administration. Section 14 of Public Law 95-142 provides HEW with this authority, and this provision should help control Medicare's administrative costs. (MWD-76-7, Sept. 30, 1975.)

(29) The provision in the Medicaid law requiring effective State utilization review programs over long-term institutional care, or suffer a reduction in Federal sharing in the costs of such care, was virtually impossible to administer in a timely manner. We proposed changing the law to correct the problems we identified. Section 20 of Public Law 95-142 corrected the problems we identified, and the law now provides a more effective mechanism for ensuring that States have good utilization review programs. Good utilization review programs can help the States avoid millions of dollars in unnecessary payments for institutional services. (MWD-76-89, Jan. 26, 1976, and HRD-77-56, Mar. 1, 1977.)

(30) HEW had not excercised the authority the Congress had granted it to experiment with reimbursement methods for durable medical equipment. We recommended that the Congress require HEW to enter lease-purchase agreements with suppliers of durable medical equipment. Section 16 of Public Law 95-142 imposed this requirement on HEW. Use of lease-purchase agreements

should save several million dollars per year. (MWD-76-93, Feb. 11, 1976.)

(31, 32) Physicians were billing Medicare and Medicaid for tests performed by independent laboratories as if the physicians had performed the tests and marking up the amounts charged by the laboratories. Also, claims processing agents were allowing physicians much higher payments for laboratory services than those charged by independent laboratories. We recommended that HEW limit payments for laboratory services to the lowest levels at which such services are widely and consistently available in an area, as authorized by section 224(a) of the Social Security Amendments of 1972 and establish a policy and issue instructions on how claims processing agents for Medicare and Medicaid should treat physician markups. HEW, on July 26, 1978, published regulations, under the authority of section 224(a), limiting payment for 12 tests to the lowest charge level. HEW has also proposed expanding the numbers of tests covered under these regulations. Also, effective December 31, 1978, HEW told its claims processing agents to normally allow a maximum markup by physicians of $3 to cover drawing specimens and handling services. (HRD-76-121, Aug. 4, 1976.)

(33) HEW was not receiving comparable information from the States to use for determining which methods were most effective in ensuring that liable third parties, rather than Medicaid, were paying for services provided to Medicaid recipients. We recommended that HEW require the States to report such information. HEW revised its Medicaid quality control procedures in 1978 to include determining and reporting whether liable third parties had paid for services to Medicaid recipients. The information provided in the quality control reports should help ensure that States have more effective third party recovery and avoidance programs. HEW's Inspector General estimated in his March 1978 annual report that third parties are liable for about $330 million per year in services paid by the Medicaid program. (HRD-77-73, May 2, 1977.)

(34) A large, publicly owned nursing home in Pennsylvania had received payments from both Medicare and Medicaid for the same services. We recommended that HEW recover the Federal share of duplicate Medicaid payments and take actions to ensure that duplicate payments

stop occurring. HEW recouped about $1.3 million in duplicate payments covering a 4-year period. An HEW official stated that duplicate payments are no longer being made. (HRD-77-44, May 6, 1977.)

(35) Some Medicare fraud investigations were closed prematurely because of inadequate and incomplete investigations. We recommended that HEW strengthen the monitoring of investigations to prevent premature closure. HEW issued instructions to its regional offices on the number of fraud cases they were to send to headquarters for review to determine the adequacy of investigation. Both closed and pending cases are included in the review. This should help assure that Medicare fraud does not go undetected because of poor investigations. (HRD-77-19, May 23, 1977.)

(36) U.S. attorneys were often slow in deciding whether to prosecute cases referred by Medicare, and there were differences among U.S. attorneys on the basis for making prosecution decisions which were not always based on the merits of the case. We recommended that HEW discuss with the Department of Justice ways to obtain more timely prosecution decisions and to assure that Medicare fraud laws are uniformly applied across the Nation. HEW currently works much more closely with the Department of Justice on both Medicare and Medicaid fraud cases. Also, the Congress, through passage of the Medicare and Medicaid Anti-Fraud and Abuse Amendments (Public Law 95-142) emphasized to HEW and Justice its concerns in these areas. We believe these actions have led to much improved conditions between the two Departments and should result in better detection and prevention of Medicaid fraud. (HRD-77-19, May 23, 1977.)

(37) Personnel conducting Medicare fraud investigations generally did not have prior investigative training or experience. We recommended that HEW hire personnel with the skills needed to handle the complex types of fraud and abuse in the Medicare program. Both HCFA and HEW's Office of Inspector General have hired trained investigators to handle Medicare fraud cases. This should help assure that cases are properly developed. (HRD-77-19, May 23, 1977.)

(38) Medicare and Medicaid investigations were not well coordinated within HEW or between HEW and the States. We recommended that HEW delineate the responsibilities of its organizations involved in Medicare and Medicaid investigations, and that HEW establish procedures for working with the States. Since our review, HEW's Office of Inspector General has been established; this Office has operational responsibility for fraud investigations for Medicare and Medicaid. Also, under authority granted in Public Law 95-142, many States have established Medicare fraud control units. The combined result of these actions has been better coordination of Medicare and Medicaid investigations. (HRD-77-19, May 23, 1977.)

(39-41) HEW was not actively involved in the procurement by States of health-insurance-type contracts, under which contractors assume liability to pay for covered services provided to eligible recipients in return for a predetermined per-capita payment. There were weaknesses in State procurement practices. States made decisions to contract without analyzing alternatives, did not encourage maximum competition, minimally evaluated contract prices, and failed to document negotiations. Also, HEW had approved insurance contracts that did not meet all Federal requirements. We recommended that HEW (1) issue guidance to its regional offices on their role in assisting States in contracting and on how to evaluate whether States have met Federal requirements for contracting under grants, (2) notify the States of contracting assistance available from HEW and encourage them to use it, and (3) require States to document their rationale for determining that an insurance contract was the proper and efficient method for administering Medicaid. In February 1978 HEW issued to the States recommended procedures for obtaining approval of State contracts. This presents a checklist of items and provides both the States and the HEW regional offices guidance on what they should do when contracting for Medicaid. One of the steps is a justification of the need for the contract. HEW has also increased training of State and HEW personnel in contracting procedures and has emphasized the importance of sound contracting procedures. These actions should help ensure that Medicaid contracts are obtained at reasonable prices and that they meet all Federal requirements. (HRD-77-106, Jan. 23, 1978.)

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(42, 43) Although a primary benefit of Medicaid insurance contracts is the assumption of risk by the contractor, several State insurance contracts included provisions which reduced or eliminated contractor risk--this contradicts Federal requirements. Also, two contracts were prematurely terminated by the contractor to reduce anticipated loss, one contract was renegotiated to the contractors' advantage as an alternative to termination, two contracts continued language which contractors used to justify negotiation of contract amendments which reduced risk and favored the contractors, and one contractor was allowed to accumulate large reserves--which virtually eliminated risk. We recommended that HEW assure that future insurance contracts comply with Federal requirements and that they do not contain provisions permitting contractors to terminate or renegotiate contracts to reduce or eliminate contractor risk. HEW agreed with these recommendations and said it would monitor compliance when approving insurance contracts in the future. No Medicaid insurance contracts have been awarded since our report was issued. (HRD-77-106, Jan. 23, 1978.)

(44) Medicaid was not always informing Medicare of providers who had been terminated for improper activities. Thus, a provider could be excluded from the Medicaid program but continue to receive payments from the Medicare program. We recommended that HEW require provider termination information to be exchanged so that providers could be terminated from both programs when appropriate. Section 7 of Public Law 95-142 requires, in effect, that when a provider is convicted of a criminal offense against one of the programs, the provider must be terminated from both programs. (HRD-78-46, Mar. 10, 1978.)

(45) HEW was not assuring that its regional offices were making all scheduled reviews of State efforts to control Medicaid fraud and abuse, and its Chicago region had not done so. We recommended that every State's fraud and abuse control efforts be reviewed. HEW now conducts program integrity reviews which assess each State's fraud and abuse control program. This should improve the effectiveness of State control programs. (HRD-78-46, Mar. 10, 1978.)

(46, 47) A review of 114 randomly selected claims processed in fiscal year 1973 showed that 24 involved incorrect payments due to deficiencies in CHAMPUS-Europe's claims processing practices. Also, CHAMPUS-Europe had not (1) established a basis for determining the reasonableness of physicians' fees nor (2) implemented a plan for improving claims adjudication procedures and the approval process for handicap care. Our review of handicap program applications showed that the severity of handicaps was not generally supported by objective means such as intelligence or hearing tests. We recommended that CHAMPUS-Europe establish and use a reasonable charge system in Germany and the United Kingdom and that DOD monitor CHAMPUS-Europe's implementation of plans for improving the claims adjudication and handicap care approval systems. In 1976 CHAMPUS-Europe adopted a reasonable charge medical payment system for Germany and the United Kingdom based on those countries' national health insurance systems, and DOD began to closely monitor improved procedures for claim adjudication and approvals for handicap care. These improvements help ensure that CHAMPUS-Europe does not overpay providers of health services. (B-133142, June 19, 1974.)

(48) Although CHAMPUS does not provide benefits for over-the-counter drugs, we found that there was no requirement for claims which beneficiaries submitted to include the name of the drug purchased. We found instances where CHAMPUS had paid for prescriptions for over-the-counter drugs such as vitamins and cough syrup. We recommended that CHAMPUS require the name of drugs on claim forms and, beginning September 1, 1977, CHAMPUS began such a requirement. This should ensure that CHAMPUS does not pay for drugs not covered by the program. (B-133142, Nov. 11, 1974.)

(49-51) DOD had not adopted comprehensive, specific standards for classifying the severity of handicaps and, consequently, questionable cases were continuing to be approved for care under CHAMPUS. Policy decisions necessary for improving program management and control--for example, prohibiting payments for treatment methods determined to be unnecessarily costly--were being made in an untimely manner. Because a standard format for use by physicians in reporting diagnoses had not been

established, physician statements did not contain sufficient information to assess properly whether the beneficiary's condition qualified for CHAMPUS benefits. We recommended that DOD

--issue more comprehensive and specific standards for determining whether handicapping conditions qualify for program benefits,

--make prompter evaluations and decisions regarding proposals for program change and responses to requests for policy guidance, and

--develop a standard format for use by physicians when reporting diagnoses, to facilitate preparing a complete medical statement for use in approving benefits.

DOD implemented these recommendations or took alternative action to assure that benefits are provided only for conditions that qualify and to assure that the care provided is appropriate. (MWD-76-48, Nov. 21, 1975.)

(52-54) Large differences in administrative costs per claim processed existed among CHAMPUS claim processors under cost reimbursement contracts; DOD had not requested proposals from additional firms to see if claims processing costs could be lowered, nor had it terminated the contracts of any high cost processors; and DOD had not eliminated a duplicate claims review function. We recommended that DOD request proposals for claims processing, terminate inefficient processors, and eliminate the duplicate review. DOD implemented these recommendations by going to competitively bid, fixed price contracts for claims processing functions (estimated first-year savings of $7.6 million) and by increasing contract monitoring to enable termination or nonrenewal of poorly performing contractors. Going to competitive contracts also eliminated the duplicate review. This new contracting method should help ensure that claim processing costs are reasonable and that poorly performing contractors are not allowed to remain in the program. (MWD-76-48, Nov. 21, 1975.)

(55, 56) CHAMPUS fiscal agents used different methods for establishing and updating physicians' reasonable charge levels and, thus, these levels varied by agent. This resulted because of a lack of guidance from DOD. We recommended that CHAMPUS adopt comprehensive reasonable charge determination requirements like those under Medicare; that CHAMPUS supply fiscal agents guidance on implementing them; and that CHAMPUS increase monitoring of fiscal agents. All these actions have been taken, and significant savings should be realized. (MWD-76-48, Nov. 21, 1975.)

(57-61) Patients were being inappropriately placed in facilities and were staying in them too long under CHAMPUS' program for emotionally disturbed and handicapped children. Also, some facilities charged CHAMPUS patients more than they charged other patients. We recommended that DOD require (1) preadmission approval of psychiatric institutional cases, (2) improvement of the process for approving psychiatric care extending beyond 120 days' duration, (3) improvement of the approval process for handicap care by considering appropriateness of placement, proposed length of stay, and benefit to the patient, (4) that facilities have utilization review and discharge planning programs and involve parents in the treatment program, and (5) contractually binding participation agreements with facilities, which include negotiated payment rates. CHAMPUS instructions issued in June 1977 and March 1979 implemented the first four recommendations. CHAMPUS also now requires facilities to charge it the same as the general public or at the lowest rate charged to other agencies. Effective implementation of these actions should lead to more appropriate care for emotionally disturbed and handicapped children and help reduce program costs. (HRD-76-175, Oct. 21, 1976.)

(62) In response to a legislative mandate subordinating Medicare to FEHB, HEW and CSC prepared a proposal. Our analysis of the proposal showed that it did not fully meet the Congress' intent. We suggested two alternatives to the HEW-CSC proposal, one of which was adopted when the Congress repealed the subordination requirement. The first-year savings of this action were estimated to be $48 million. (MWD-75-99, Aug. 4, 1975.)

(63) States and carriers were confused about the applicability of State laws and regulations to FEHB contracts. We observed that State requirements could result in higher premium costs to the Government and to the plans' enrollees as well as a lack of uniformity of benefits. We recommended that the Subcommittee on Retirement and Employee Benefits, House Committee on Post Office and Civil Service, consider legislation to clarify whether it intended State requirements to alter contracts negotiated pursuant to the FEHB Act. Public Law 95-368 provided that FEHB program contracts would preempt State and local laws and regulations relating to the nature and extent of benefit coverage and payments. The cost savings resulting from this action have not been measured specifically, but one carrier estimated in 1975 that compliance with all State laws would increase its FEHB plan premiums by 5 percent. (MWD-76-49, Oct. 17, 1975.)

APPENDIX VI

A LIST OF FEDERAL HEALTH ASSISTANCE PROGRAM RECOMMENDATIONS WHICH HAVE BEEN FULLY OR SUBSTANTIALLY IMPLEMENTED

Presented below is a list of our recommendations on PHS's health assistance programs which have been fully or substantially implemented by the Congress or HEW. The conditions which lead us to make the recommendations and the benefits derived from implementation are also discussed.

(1) Most States procured vaccines for use in controlling various communicable diseases, and the amount paid frequently exceeded prices available to HEW. We recommended that HEW establish procedures that would allow States to purchase the vaccines at the prices available to HEW. HEW issued a memorandum urging States to take advantage of centralized procurement of vaccines. Within 1 year after issuing the memorandum, 31 States were participating. Nine of 10 States reviewed showed a combined annual savings of $336,000. (B-164031(2), June 10, 1974.)

(2) Not all HEW physician extender training programs developed mechanisms for placing graduates in health manpower shortage areas. Therefore, we recommended that physician extender training programs incorporate a method to place graduates in areas where health manpower is scarce. HEW was required to implement this recommendation for training programs because the Congress amended the authorizing legislation and stipulated that, as a condition of grant or contract award, appropriate mechanisms for placing the physician extenders must exist. Physician extenders should now be more fully utilized to assist physicians with providing care. (MWD-75-35, Apr. 8, 1975.)

(3) Welfare caseworkers were not always informing welfare recipients of the available family planning services. We recommended that HEW require States to adopt policies and procedures to assure that caseworkers inform the recipients. In July 1975 HEW issued program instructions to guide the States in this matter and, as a result, there is now more assurance that welfare recipients will be informed of the availability to them of the family planning program. (MWD-75-25, Apr. 15, 1975.)

(4,5) Family planning projects were not collecting fees from patients who, based on their income, were able to pay for services. Projects were not maximizing revenues from third parties such as Medicaid and Social Services (a Federal/State program which provides a wide range of services, including family planning services, to low income people). Also, because some States did not recognize projects as providers of services under the Medicaid program, projects could not bill Medicaid. We recommended that HEW intensify its assistance effort directed at collecting from patients and third parties and help resolve the problems that existed between the projects and the States. HEW attempted to eliminate the impeding obstacles, with beneficial results. For example, collections from Social Services programs have increased from 11.4 percent of total grantee revenues in 1975 to 17.5 percent in fiscal year 1978. Such efforts decrease the need for Federal funds to provide family planning services. (MWD-75-25, Apr. 15, 1975.)

(6) Our analysis of the swine flu program showed that such mass innoculation programs need to be reassessed at key points to determine if continuing the program without change is warranted. We recommended that HEW establish, for future programs, key points at which programs would be reassessed. HEW developed a time-phased plan for pandemic influenza programs; that should help prevent problems like those encountered in the swine flu program from occurring in future programs. (HRD-77-115, June 27, 1977.)

(7-9) High levels of lead in the blood can cause mental retardation, and HEW estimates that 600,000 children have elevated blood lead levels. Despite development of an inexpensive testing technique to identify elevated blood levels, lead poisoning screening was not done routinely. We recommended that HEW expand its lead poisoning prevention effort, encourage States to initiate screening efforts, and start a public education effort on prevention. HEW distributed information on problems, risks, and new technology in testing for lead poisoning. Such efforts, by helping to prevent retardation, should reduce the need to spend health care funds for long-term institutionalization of the mentally retarded as well as care that would be needed on an outpatient basis. (HRD-77-37, Oct. 3, 1977.)

(10) HMOs had established relationships with other entities through common ownership or control and had entered into other transactions that could adversely affect an HMO's fiscal soundness. We recommended that the Congress amend the legislation and require public disclosure of such relationships and transactions. The Congress subsequently amended the legislation. Now an HMO must provide the Secretary of HEW with financial and other information, including a financial statement when the HMO is related to an organization by common ownership or control. Penalties are provided for failure to file the required information in the time period specified by the Secretary. This should prevent self-dealing relationships which increase HMO costs and can threaten their viability. (HRD-78-125, June 30, 1978.)

(11) Sound management of an HMO is critical to its success in controlling costs, budgeting for the future, and marketing its services; properly trained HMO managers were needed. We recommended that the Congress authorize a program to train HMO managers. In November 1978 the Congress authorized such a program and funded it in July 1979. After HMOs receive the benefits of the newly trained managers, HMOs should be better able to control current and future costs. (HRD-78-125, June 30, 1978.)

(12) Limited progress was being made at the State and local level in establishing and fulfilling the responsibilities of health planning agencies. HEW had not developed (1) regulations and guidelines for implementing the health planning act or (2) national standards and criteria regarding supply and distribution of resources. We recommended that HEW promptly issue the regulations, guidelines, standards, and criteria. HEW has subsequently published many of these documents. This should help local and State health planning agencies fulfill their responsibilities in controlling against an excess supply of health services and the unneeded construction of health facilities. Health care costs should be better controlled as a result. (HRD-77-157, Nov. 2, 1978.)

A LIST OF RECOMMENDATIONS

TO THE SECRETARY OF HEW WHICH

HAVE NOT BEEN FULLY IMPLEMENTED

The number of the recommendation corresponds to the number assigned the recommendations in appendixes I, II, and III. For details on the recommendations and the status of implementation, see those appendices.

The Secretary of HEW should:

1(a) (With the Secretary of Defense and the Administrator of VA.) Jointly develop uniform Federal guidelines for the planning and using Federal cardiac catheterization laboratories which associate the number of catheterization procedures to be performed with the number of physicians that should perform them.

1(b) Consider variances from those guidelines.

1(c) Jointly analyze the use levels at cardiac catheterization laboratories and adjust the manner in which this diagnostic service is provided so that it is in harmony with the established Federal guidelines and on a joint shared basis in a single Federal facility.

1(d) Discontinue providing cardiac catheterization in Federal facilities in geographic areas where the Federal guidelines cannot be met, and obtain this service from nearby civilian hospitals.

2(a) (With the Secretary of Defense and the Administrator of VA.) Develop a coordinated Federal approach for planning and using computed tomography scanners.

3(a) (With the Secretary of Defense and the Administrator of VA.) Direct the Federal Health Resources Sharing Committee to expeditiously seek solutions to the administrative obstacles within each agency which impede sharing.

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9(b) (With the Secretary of Defense.) Establish interagency agreements to permit HEW's dental patients to be treated routinely in all military dental facilities in Hawaii, when such treatments would be advantageous to the Government and the individuals involved.

10(a) Provide adequate justification to the Congress explaining why expansion of existing underused Indian Health Service facilities is necessary and, at a minimum, recognize the trend in the use of inpatient services.

11(a) Ensure that St. Elizabeths Hospital develops a more effective and integrated management system which allows optimum utilization of resources to meet clinical needs.

11(b) Reassess division functions at St. Elizabeths Hopsital and reassign those which could be better performed centrally, and require more central monitoring of division administrative and clinical activities to determine which activities are effective and should be considered for use by other divisions and those which are ineffective and should be discontinued.

11(c) Establish a system at St. Elizabeths Hospital for accumulating maintenance cost and performance information and for transforming the data into a work measurement and evaluation system, develop a facility preventive maintenance system, and determine which functions could be performed less expensively if contracted to the private sector.

21(a) Encourage the States to establish payment rates for home health care at a level that will stimulate greater utilization of Medicaid home health care.

22(a) Require a full exchange of Medicare and Medicaid audit information when no common audit agreement has been reached between a Medicare intermediary and a Medicaid State agency or its fiscal agent.

22(b) HCFA should catalog and make available on request to intermediaries, Medicaid State agencies, providers, and the Provider Reimbursement Review Board all HCFA decisions or specific interpretations affecting the determination of Medicare's share of hospital or skilled nursing facility costs.

24(a) Establish regulations identifying those situations where Medicaid payment for administratively necessary days are appropriate, although acute hospital care is not medically necessary.

24(b) Require the States and fiscal intermediaries to identify payments for all administratively necessary days and report the reasons for these days.

24(c) Evaluate data collected on administratively necessary days to determine ways to reduce the delay between the time acute hospital care ends and the time a patient is placed in an available lower cost facility.

24(d) Provide data on administratively necessary days to appropriate health system agencies or other health planning groups in geographic areas where a large number of these days might indicate a lack of beds in certain lower cost facilities.

25(a) Work with Missouri Medicaid officials to establish a more active program for investigating Medicaid fraud and abuse.

25(b) Establish statistical sampling procedures that will better detect fraudulent billing practices.

26(a) Assist Ohio in improving its reimbursement system for skilled nursing services in order to increase their availability after assuring an adequate utilization review program for SNFs is in place.

26(b) Determine if other States' reimbursement systems for skilled nursing care are resulting in problems like those in Ohio and assist any State with these problems in improving their skilled nursing services program.

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27(a) Identify PSRO areas where administrative staff and functions can be combined, paying particular attention to situations where nonperforming PSROs are replaced and encourage the sharing of support services.

27(b) Rescind the executive director salary levels published by the Health Standards and Quality Bureau in November 1977, and establish new salary levels based on salaries paid comparable positions in nonprofit organizations.

29(a) Expedite publication of regulations prohibiting the use of Federal funds for the purchase of ineffective and possibly effective drugs under Medicaid and establish procedures for providing the States and drug providers lists of drugs classified as ineffective or possibly effective and lists of all identical, related, or similar drugs.

30(a) Insure, before approving Medicaid Management Information Systems, that State proposals for such systems provide data needed to perform effective utilization reviews and provide for an efficient system for paying claims under Medicaid.

31(a) More closely monitor State activities regarding reimbursement for inpatient hospital services by insuring that tentative and final settlements are made with hospitals as required by Federal regulations and, where appropriate, retroactive adjustments are made.

31(b) Take action to recover amounts due the Federal Government because of States' failure to reduce Medicaid claims to consider the nursing salary cost differential.

31(c) Insure that outstanding overpayments and underpayments discussed in this report are collected or paid.

32(a) Recoup from California the Federal share of payments made to the Foundation Community Health Plan which exceeded those allowable under the State's normal payment procedures.

32(b) Determine the amount of duplicate payments to prepaid health plans and fee-for-service providers made by California and recover the Federal share of such duplicate payments.

33(a) Require HEW regional offices to review the internal controls over States' Medicaid automated claims processing systems.

34(a) Assess periodically whether each State identifies and reports promptly Medicaid overpayments to nursing homes as required.

34(b) Deny Federal participation in Medicaid overpayments when States do not establish an effective recoupment program promptly.

35(a) Assure that the Federal Government does not reimburse New York and Illinois for amounts that are not eligible for Federal financial participation under Medicaid.

35(b) Evaluate the procedures of the other States and jurisdictions for billing for services provided to the medically needy and, where necessary, take actions to assure that the Federal Government does not reimburse States for amounts that are not eligible for Federal financial participation.

35(c) Compute the amount of Federal financial participation claimed which should have been paid by medically needy recipients in Illinois, New York, and other States and adjust the States' claims for Federal financial participation.

36(a) Make certain that upcoming Medicaid validation surveys include visits to institutions, including hospitals, on a sample basis as required by law.

36(b) Revise the Medicaid regulations to require more specific information in medical review reports, independent professional review reports, and plans of care.

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37(a) Ask States having Medicaid eligibility determination agreements with HEW to (1) identify the information they believe is needed from aged, blind, and disabled individuals during the eligibility process and (2) decide whether the information would be compatible with their third-party system and used in administering their programs. HCFA should then provide the necessary information the States agree to use in their third-party systems.

37(b) Require California to demonstrate the effectiveness of its health insurance collection policy under Medicaid as compared with States emphasizing cost avoidance. If the effectiveness of California's approach cannot be supported by empirical evidence, it should be abandoned or HEW should decline Federal financial participation on the uncollected claims for which third parties are liable.

38(a) Require prior approval of changes to a Medicaid insurance-type contract and that HEW officials not approve changes which would have the effect of eliminating or reducing the underwriting risk assumed by the contractor under the terms of the initial contract approved by HEW.

38(b) Develop procedures which delineate the role and responsibilities of HEW regional offices in monitoring Medicaid insuring agreements so that the Federal interest is protected.

38(c) Require States to develop and submit to the appropriate HEW contract-approving authority an acceptable plan for monitoring Medicaid insurance contracts and evaluating contractors' financial performance under the contracts.

38(d) Require States to include language in Medicaid insurance contracts which would make the contractor and all subcontractors subject to Federal procurement standards (45 C.F.R. 74.150 et seq.) and Federal cost principles (45 C.F.R. 74.170 et seq.).

38(e) Issue regulations prohibiting the use of percentage-of-revenue agreements between Medicaid contractors and their subcontractors.

38(f) Issue regulations requiring that all subcontracts assigning substantial portions of the contractor's responsibilities to a subcontractor be submitted along with the contract at the time of request for contract approval.

38(g) Revise Medicaid regulations to require (1) State insuring agreements to address interest earned or equivalent benefits to be accrued by contractors on premium payments and accumulated reserves and (2) the consideration of such interest and benefits in establishing premium rates and profit-sharing arrangements.

39(a) Publish Medicaid regulations which encourage States to purchase eyeglasses, oxygen, wheelchairs, and other common items of durable equipment through agreements with suppliers (by means of competitive bids or competitive negotiation) to the extent permitted by law.

39(b) Expand Medicare's proposed lowest charge regulations to include laboratory tests which are the most commonly ordered under Medicaid.

40(b) Develop written approval procedures for use by HEW personnel in approving State information systems, including specific criteria for testing the systems in operation to assure that minimum standards are met.

40(c) Update the General Systems Design and the program regulation guide to reflect system experiences to date, with emphasis on greater uniformity and use of proven processing techniques in systems developed by the States.

40(d) Assist the States in developing for use under Medicaid medically acceptable definitions of medical practice which correlate medical diagnosis, procedure, age, and/or sex so that States can use the computer to check billings for consistency among these factors.

APPENDIX VII

40(e) Undertake a demonstration project to determine whether the Medicaid information system's review subsystem can be further developed and refined so that it is more effective.

40(f) Continue development and evaluation of alternative utilization review systems for Medicaid, such as the Utah program.

40(g) Clearly define the kinds of information systems' costs that HEW will reimburse States at the 75-percent sharing level under Medicaid.

40(h) Develop and implement a functional cost-reporting system for Medicaid claims processing, similar to that used under Medicare, to facilitate cost comparisons among the States.

40(i) Develop a uniform identification numbering system for providers and recipients and adopt standard coding systems for medical procedures, diagnoses, drugs, and medical supplies for use by the Medicare and Medicaid programs.

40(j) Provide liaison between States and Medicare carriers to resolve conflicts which preclude free exchange of payment data.

40(k) Enforce the statutory requirement that Medicaid and Medicare information systems be compatible.

48(a) Periodically review the results being achieved under gonorrhea control projects to determine whether the projects are being carried out in the most advantageous way and, if not, require grantees to make changes in the projects.

49(a) Provide technical assistance to the community mental health centers in developing self-sufficiency financial plans and in improving their billing and collection systems.

49(b) Consider and, if deemed appropriate, work toward expanding coverage provided by third-party payment programs for mental health outpatient services and services provided by nonphysicians.

49(c) Insure that program evaluation contracts are effectively monitored and that evaluation results are made available to centers.

50(a) Work with the States to develop the necessary legislation to clearly define the role of physician extenders and provide a legal framework enabling them to carry out the duties for which they have been trained.

50(b) Work closely with professional organizations and State licensure boards to determine the most appropriate manner of granting official recognition to physician extenders.

50(c) To derive maximum benefit from physician extenders by deploying them to areas of health care shortages and to insure the mobility necessary for such deployment, work closely with the States in developing criteria specifying training and experience qualifications acceptable to all States.

51(a) Establish a system and provide adequate staffing to determine compliance and permit enforcement of the one percent penalty provision for failing to provide family planning services under Medicaid and require States to report information needed for determining compliance.

51(b) Establish criteria for use in monitoring and evaluating the costs and performance of family planning programs; HEW audit effort should be increased and grantee responsibility for subcontractor operations clarified.

51(c) Direct family planning projects to perform adequate and timely followup on missed appointments and patient dropouts to assure patient retention.

51(d) Encourage States to establish coordination between local welfare offices and federally assisted projects so that recipients interested in family planning can be identified, enrolled, and followed up to ensure that they receive desired services.

51(e) Require family planning projects to establish procedures aimed at enrolling low income persons, especially welfare recipients.

52(a) Determine what changes need to be made in the Medicaid program or other Federal programs to give States incentive to (1) place mentally disabled and other persons needing housing, income maintenance, some supervision, and support services, but not always medical care, in the most appropriate setting and (2) avoid unnecessary placements in SNFs and ICFs.

52(b) Require HEW agencies to help States develop alternative facilities or provide services to those persons identified by independent medical or professional review teams to be inappropriately placed or not receiving appropriate services.

52(c) Monitor and enforce compliance with Medicaid regulations requiring that:

(1) States (1) document instances in which persons are placed in ICFs because of the unavailability of community alternatives and (2) actively seek alternatives;

(2) Federal Medicaid funds not be used for mentally ill persons under 65 in SNFs and ICFs considered to be institutions for mental disease.

52(d) Require States to effectively implement Medicaid utilization controls and make sure that they accomplish intended results through HEW's validation surveys.

53(a) Develop sufficient manpower and resources to participate in developing and processing health program regulations, as well as fulfilling other responsibilities.

53(b) Request comments from appropriate congressional committees on proposed and final regulations published in the Federal Register.

53(c) Require that the computerized systems for monitoring processing of regulations within the Office of the Secretary be modified to include both developing and processing. Also, consideration should be given to delegating to responsible officials the authority to take effective measures, when necessary, to avoid delays in promulgating regulations.

53(d) Highlight revisions made on unresolved issues or questions on program criteria or proposed regulations so that subsequent review can focus on those provisions.

54(a) Develop criteria and standard procedures for drafting informed consent forms, and a plan to systematically assure that informed consent procedures and requirements are implemented at immunization projects and clinics.

55(a) Encourage and support expansion of newborn screening programs to include treatable metabolic disorders in addition to phenylketonuria.

55(b) Encourage and assist States to cooperate to establish cost-effective regionalized metabolic screening programs.

55(c) Instruct CDC to determine if the incidence of Rh disease is lower in States having mechanisms for monitoring Rh disease and immunoglobulin use. If such surveillance mechanisms are effective, encourage States to develop comprehensive systems to test all pregnant women for Rh incompatibility and report incidence of Rh hemolytic disease and use of Rh immunoglobulin to CDC, thereby establishing a national program for monitoring the incidence of the disease.

55(d) Require federally funded family planning and other appropriate programs to include rubella susceptability testing and immunizations, where appropriate, among their routine services.

55(e) Require federally supported family planning programs to include Rh blood typing as a routine part of family planning services.

55(f) Direct federally supported family planning programs to routinely include screening for individuals who are "high risk" for genetic disorders and refer such individuals to diagnostic and counseling services.

56(a) Require that an audit be made of the grants to the Counseling Center, Bangor, Maine, not covered by our review and that the overcharges discussed in our report be recovered.

57(a) Meet with representatives of the Coordinating Council on Medical Education and explore the possibility of its engaging in national studies of physician and physician extender manpower supply and requirements under a mutually agreeable contractual arrangement. HEW's Graduate ate Medical Education Nation Advisory Committee should (1) play an active role in monitoring their progress and (2) review indepth the Coordinating Council's completed studies and provide the Secretary with its detailed comments and recommendations. At a minimum, these studies should involve the collection and analysis of the following types of data: morbidity and mortality information; number and type of patients seeking physician care in various specialties; number, ages, and geographical location of practicing physicians by specialty and subspecialty; numbers and types of procedures actually performed by physicians in various subspecialties; the ways various specialists interrelate; paraprofessionals entering the medical field and the duties they perform; likely imminent changes in the various specialties because of technological breakthroughs; and reimbursement mechanisms, possible changes thereto, and their impact on physician specialty choices.

58(a) Develop criteria for measuring the productivity of dentists in neighborhood health centers.

58(b) Continue to encourage and assist neighborhood health centers to bill and collect money when it is due them and make sure that centers concentrate on serving the medically underserved

rather than seeking to serve patients in other areas that do not have a shortage of personal health services simply to increase revenue.

58(c) Better enforce compliance with existing productivity and staff size criteria in neighborhood health centers.

58(d) In addition to using cost criteria to control supporting and general service costs, assure close evaluation of the reasonableness of such costs at each neighborhood health center in relation to the level of service provided.

58(e) Compile and maintain records to identify the number of neighborhood health center registrants who live in medically underserved areas and identify centers whose registrant workload is not primarily from those areas.

58(f) Stop funding centers which serve only or primarily people who do not live in medically underserved areas, particularly where the residents have access to other health care providers. Funds to centers should be reallocated to medically underserved areas whose residents will be the center's primary workload, so as to achieve the greatest coverage with resources available.

58(g) Have neighborhood health centers promote participation of the center users in preventive health care services.

58(h) Use some health centers as sites for demonstration projects authorized under the recently enacted National Consumer Health Information and Health Promotion Act of 1976.

59(a) Issue in final form all regulations and guidelines needed to administer the nationwide HMO program, particularly for compliance, open enrollment, community rating, and fraud and abuse.

59(b) Issue a formal, uniform loan policy for administering the HMO loan program.

59(c) The Congress should defer action on proposals that would institute new methods to pay HMOs for services provided to Medicare and Medicaid clients because HEW has not (1) demonstrated that it can accurately determine fee-for-service costs per enrollee, (2) issued community rating guidelines, or (3) established an effective compliance function. (Note: implementation by HEW, not the Congress, has only been partial.)

A LIST OF RECOMMENDATIONS TO THE SECRETARY OF DEFENSE WHICH HAVE NOT BEEN FULLY IMPLEMENTED

The number of the recommendation corresponds to the number assigned in appendices I and II. For details on the recommendations and the status of implementation, see those appendices.

The Secretary of Defense should:

1(a) (With the Secretary of HEW and the Administrator of VA.) Jointly develop uniform Federal guidelines for planning and use of Federal cardiac catheterization laboratories which associate the number of catheterization procedures to be performed with the number of physicians that should perform them.

1(b) Consider variances from those guidelines.

1(c) Jointly analyze the use levels at cardiac catheterization laboratories and adjust the manner in which this diagnostic service is provided so that it is in harmony with the established Federal guidelines and on a joint shared basis in a single Federal facility.

1(d) Discontinue providing cardiac catheterization in Federal facilities in geographic areas where the Federal guidelines cannot be met and obtain this service from nearby civilian hospitals.

1(e) (With the Administrator of VA.) Consolidate operations between DOD and VA hospitals in the Dayton, Ohio, area; Tucson, Arizona, area; Augusta, Georgia, area; and the Washington, D.C., area.

1(f) Close the cardiac catheterization laboratory at the Malcolm Grow Hospital.

2(a) (With the Secretary of HEW and the Administrator of VA.) Develop a coordinated Federal approach for planning and using computed tomography scanners.

3(a) (With the Secretary of HEW and the Administrator of VA.) Direct the Federal Health Resources Sharing Committee to expeditiously seek solutions to the administrative obstacles within each agency which impede sharing.

4(a) Determine the need for other VIP accommodations in military hospitals. If there is such a need, develop criteria for establishing and furnishing them.

4(b) Instruct the military departments to prohibit the separation of officer and enlisted personnel in their existing and future hospitals.

4(c) Establish criteria regarding the number, size, and furnishing of Presidential suites and require DOD approval of the establishment of future suites.

4(d) Assess the adequacy of the Bethesda Presidential suite to provide medical care to the President, and convert to other uses either the Bethesda suite or the planned Walter Reed suite, as appropriate.

5(a) Insure that the Armed Services Medical Regulating Office promotes increased use of interservice aeromedical patient transfers.

5(b) Insure that the Medical Regulating Office limit long-distance transfers initiated solely by one physician directly to another physician to those instances which are necessary.

6(a) Incorporate into the hospital sizing methodology a sufficient number of light care (nonacute care) facilities to meet special requirements of the military which result from the fact that patients cannot always return to their duty stations for a normal convalescent period.

7(a) Direct the Army and Air Force to determine the type of X-ray equipment needed for radiology training courses with a view toward making optimal use of existing resources and not purchasing equipment in excess of that needed for training purposes.

8(a) and 8(b) We made several recommendations to streamline DOD's third-party recovery process for health services provided, the thrust of which were

--take advantage, where possible, of existing avenues of recovery before pursuing claims under the Federal Medical Care Recovery Act and

--standardize the administrative processes of the three military departments.

9(a) Insure that the DOD Health Council (a) provides direction, guidance, and feedback to the Mid-Pacific Review Committee concerning military health care activities in Hawaii and (b) directs the Committee to seek representation of VA and PHS as participating members.

9(b) (With the Secretary of HEW and the Administrator of VA.) Establish interagency agreements to permit VA's and HEW's dental patients to be treated routinely in all military dental facilities in Hawaii when such treatments would be advantageous to the Government and the individuals involved.

41(a) Initiate a study of the desirability of increasing the $25 minimum cost share for inpatient care for dependents of active duty members in civilian hospitals and, if it is concluded that an increase is justified, the Congress should be given suggested legislation to do so.

42(a) Continue to study ways to achieve greater use of available Government facilities by CHAMPUS patients for both inpatient and outpatient psychiatric care of dependents, and establish means to encourage use of lower cost civilian facilities whenever medically feasible.

42(b) Provide utilization review guidelines to CHAMPUS fiscal agents and review, approve, and monitor utilization review systems.

42(c) Revise the CHAMPUS claims form to provide positive certification as to whether other insurance exists and, if so, details on that insurance.

42(d) Limit total payments to physicians when CHAMPUS payments are combined with other insurance payments to the reasonable charges for the services rendered.

42(e) Strengthen procedures to insure proper issuance and recovery of identification cards or establish other controls to guarantee that CHAMPUS benefits are provided only to eligible beneficiaries.

42(f) Make arrangements to permit CHAMPUS beneficiaries to purchase medical equipment from Government sources.

43(a) Require that facilities caring for emotionally disturbed and handicapped children under the CHAMPUS program attempt to collect sponsors' shares as provided in the laws authorizing benefits and require the facilities to document such attempts.

44(a) Clearly define what is meant under CHAMPUS by the excessive waiting time exception to the 40-mile rule and implement instructions for more strict and consistent application of the continuity-of-care reason for issuing nonavailability of care statements.

44(b) Require periodic exchanges of medical capability listings between hospitals within overlapping 40-mile radii.

44(c) Require case-by-case coordination between hospitals when availability of needed medical services for CHAMPUS patients for which a nonavailability statement is requested cannot be determined from medical capability listings.

44(d) Establish procedures for approval by higher DOD levels, such as the Assistant Secretary of Defense (Health Affairs), of alteration to the 40-mile radii now decided upon by hospital commanders, to exempt certain CHAMPUS beneficiaries from the requirement to obtain nonavailability statements.

APPENDIX IX

A LIST OF RECOMMENDATIONS

TO THE ADMINISTRATOR OF VA

WHICH HAVE NOT BEEN FULLY IMPLEMENTED

The number of the recommendation corresponds to the number assigned in appendix I. For details on the recommendation and the status of implementation, see that appendix.

The Administrator of VA should:

1(a) (With the Secretaries of Defense and HEW.) Jointly develop uniform Federal guidelines for the planning and using Federal cardiac catheterization laboratories which associate the number of catheterization procedures to be performed with the number of physicians that should perform them.

1(b) Consider variances from those guidelines.

1(c) Jointly analyze the use levels at cardiac catheterization laboratories and adjust the manner in which this diagnostic service is provided so that it is in harmony with the established Federal guidelines and on a joint shared basis in a single Federal facility.

1(d) Discontinue providing cardiac catheterization in Federal facilities in geographic areas where the Federal guidelines cannot be met and obtain this service from nearby civilian hospitals.

1(e) (With the Secretary of Defense) consolidate operations between DOD and VA hospitals in the Dayton, Ohio, area; Tucson, Arizona, area; Augusta, Georgia, area; and the Washington, D.C., area.

2(a) (With the Secretaries of Defense and HEW.) Develop a coordinated Federal approach for planning and using computed tomography scanners.

3(a) (With the Secretaries of Defense and HEW.) direct the Federal Health Resources Sharing Committee to expeditiously seek solutions to the administrative obstacles within each agency which impede sharing Federal medical resources.

9(b) (With the Secretary of Defense.) Establish interagency agreements to permit VA's dental patients to be treated routinely in all military dental facilities in Hawaii when such treatments would be advantageous to the Government and the individuals involved.

12(a) Evaluate existing facilities and decommission duplicative or underused facilities by consolidating services, where possible, at VA medical centers within metropolitan areas and closing underused supervoltage radiation services when they are available at other Federal or community hospitals in the area.

12(b) Require that the justification for new supervoltage radiation equipment and facilities identify the (1) location and use of similar VA, other Federal, and community equipment and facilities within a prescribed distance and (2) patient demand for the services to be provided based on the veteran population served by the medical center, disease incidence statistics, and other relevant data.

13(a) Revise established procedures to require justification for new or modernized cardiac catheterization laboratories to include data on patients to be served, disease incidence statistics, and number of patients referred elsewhere.

13(b) Close VA cardiac catheterization laboratories that are underused because of insufficient patient demand or because they duplicate services at nearby facilities.

13(c) Establish sharing or contractual arrangements to provide this medical service where cardiac catheterization laboratories are closed.

15(a) Revise the bed mix of the three proposed facilities as developed by our hospital sizing model, and withdraw the VA current hospital sizing methodology and adopt the GAO hospital sizing model.

APPENDIX IX

16(a) Before proceeding with VA's long-range construction plans (1) determine the extent to which existing domiciliary facilities can be modernized, (2) better define current domiciliary demand, (3) develop adequate information to project future domiciliary care demand, and (4) clearly define staffing and operating guidelines for new domiciliary facilities to assure that required services from nearby VA hospitals are received.

18(a) Develop a systemwide policy for outpatient surgery and preadmission testing, based on the results of VA studies, and implement the policy in all general medical and surgical hospitals in the VA system.

19(b) VA and the Congress when contemplating the construction of replacement hospitals, among other things, should consider the extent to which VA should continue to provide treatment to veterans with nonservice-connected illnesses and the availability of beds in nearby community and other Federal hospitals because each could significantly affect future bed needs.

20(a) Expand the use of the personal care residence program to all VA hospitals and other facilities capable of implementing the program.

A LIST OF RECOMMENDATIONS TO THE DIRECTOR OF OPM WHICH HAVE NOT BEEN FULLY IMPLEMENTED

The number of the recommendation corresponds to the number assigned in appendix II. For details on the recommendations and the status of implementation, see that appendix.

The Director of OPM should:

46(a) Include in its FEHB contracts specific cost control programs which the carriers must follow. We also recommended that if OPM did not adopt this recommendation, the Subcommittee on Retirement and Employee Benefits, House Committee on Post Office and Civil Service, should consider developing legislation to require OPM to include specific cost control and/or incentive provisions in contracts with the FEHB program carriers.

46(b) OPM should revise its FEHB contracts to provide incentives to the carriers to control costs. We also recommended that, if OPM did not adopt this recommendation, the Subcommittee should consider developing legislation to provide OPM with some flexibility in contracting with Blue Cross/Blue Shield for the Service Benefit Plan.

47(a) Develop criteria to evaluate the reasonableness and equity of the FEHB rates of community-rated, comprehensive health plans like the Kaiser plans.

47(b) Comprehensively audit the California Kaiser plans to determine whether their FEHB program rates reasonably and equitably reflect the cost of providing benfits to FEHB participants.

APPENDIX XI

A LIST OF RECOMMENDATIONS TO THE DIRECTOR OF OMB WHICH HAVE NOT BEEN FULLY IMPLEMENTED

The number of the recommendation corresponds to the number assigned in appendix I. For details on the recommendations and the status of implementation, see that appendix.

The Director of OMB should:

1(g) Oversee efforts to develop uniform Federal cardiac catheterization guidelines in an appropriate and timely fashion and insure that Federal cardiac catheterization services are shared when it will improve patient care and result in reduced costs to the Government. (This involves HEW, VA, and DOD.)

2(b) Oversee the efforts of DOD, VA, and HEW to develop a coordinated Federal approach for planning and using computed tomography scanners.

3(b) Establish a management group within the existing OMB organizational structure to work with DOD, HEW, and VA to coordinate the development of an effective interagency sharing program.

A LIST OF RECOMMENDATIONS TO THE CONGRESS RELATED TO MEDICARE AND MEDICAID WHICH HAVE NOT BEEN IMPLEMENTED

The number of the recommendation corresponds to the number assigned in appendices II or III. For details on the recommendation and the status of implementation, see those appendices.

23(a) The Congress should repeal the law authorizing the Railroad Retirement Board to contract with carriers.

28(a) In its deliberation on national health insurance proposals for changing Medicare's benefit structure, the Congress should carefully explore whether the benefits of introducing an income test would justify the resultant added administrative problems and related costs.

28(b) If, in the Congress' deliberation on national health insurance, it decides cost sharing for inpatient hospital services is desirable, the Congress should provide for a fixed, daily copayment for inpatient hospital services.

38(h) The Subcommittee on Health, Senate Committee on Finance, should develop legislation to amend the Medicaid law to preclude Federal sharing in the cost of Medicaid contracts where State laws have restricted competition or provided potential contractors with a competitive advantage.

39(c) To remove any doubt that competitive purchases of Medicaid supplies are authorized, the Congress should amend the Medicaid law to specifically exclude eyeglasses, hearing aids, oxygen, and selected items of equipment from the freedom-of-choice provision.

40(a) To enable HEW to better manage and control Medicaid information systems, the Congress should consider amending title XIX of the Social Security Act to require HEW to establish systems performance standards and to require that HEW periodically reevaluate approved systems to determine if they continue to meet Federal requirements.

52(e) The Congress should consider amending section 1833(c) of the Social Security Act to increase the amount of outpatient mental health coverage available under Medicare. This could be done by increasing the $250 limit, the percent of Federal reimbursement, or both, or by authorizing a combined limit on inpatient and outpatient mental health care to encourage outpatient care.

53(e) The Congress should consolidate HEW programs with similar objectives and place them in the same agencies so that a corresponding consolidation in implementing regulations would result.

53(f) The Congress should include in legislation requiring regulations a maximum time limit by which the Secretary of HEW must publish such regulations.

A LIST OF RECOMMENDATIONS TO THE CONGRESS

RELATED TO DOD HEALTH PROGRAMS

WHICH HAVE NOT BEEN IMPLEMENTED

The number of the recommendation corresponds to the number assigned in appendix I. For details on the recommendations and the status of implementation, see that appendix.

2(c) The Congress should consider limiting the number of computed tomography scanners that can be purchased by the Federal health delivery systems until a coordinated Federal approach is developed.

3(c) The Congress should enact legislation to establish a greatly expanded and cost-effective interagency sharing program. Specifically, this legislation should

--establish a Federal policy that directs interagency sharing when appropriate;

--authorize each Federal direct health care provider to accept all categories of eligible beneficiaries on a referral basis when advantageous to the Government and care of primary beneficiaries would not be adversely affected;

--eliminate all restrictions on the types of medical services which can be shared;

--authorize Federal hospital managers to enter into sharing arrangements, subject to headquarters veto only if judged not in the best interests of the Government;

--authorize expansion of services as necessary to use Federal medical resources in the most cost-effective manner;

--establish a policy requiring full use of available nearby Federal medical resources before using civilian or distant Federal medical resources;

--authorize the establishment of a method of reimbursement under which the providing Federal hospital would receive any revenues received to offset any expenses incurred; and

--assign to the OMB the responsibility to (1) coordinate the implementation of an effective interagency Federal medical resources sharing program and (2) report annually to the Congress concerning the progress being made toward increased sharing of these resources.

8(b) The Congress should enact legislation which would

--limit the ability of insurance companies to exclude reimbursement to the Government,

--clarify whether mandatory no-fault automobile insurance can be classified as insurance provided by law, and

--change CHAMPUS to require that insurance provided by law or through employment pay for medical care given to all eligible beneficiaries in civilian hospitals.

A LIST OF RECOMMENDATIONS TO THE CONGRESS

RELATED TO PHS HEALTH PROGRAMS

WHICH HAVE NOT BEEN IMPLEMENTED

The number of the recommendation corresponds to the number assigned in appendices I or III. For details on the recommendations and the status of implementation, see those appendices.

2(c) The Congress should consider limiting the number of computed tomography scanners that can be purchased by the Federal health delivery systems until a coordinated Federal approach is developed.

3(c) The Congress should enact legislation to establish a greatly expanded and cost-effective interagency sharing, program. Specifically, this legislation should

--establish a Federal policy that directs interagency sharing, when appropriate;

--authorize each Federal direct health care provider to accept all categories of eligible beneficiaries on a referral basis when advantageous to the Government and care of primary beneficiaries would not be adversely affected;

--eliminate all restrictions on the types of medical services which can be shared;

--authorize Federal hospital managers to enter into sharing arrangements, subject to headquarters veto only if judged not in the best interests of the Government;

--authorize expansion of services as necessary to use Federal medical resources in the most cost-effective manner;

--establish a policy requiring full use of available nearby Federal medical resources before using civilian or distant Federal medical resources;

--authorize the establishment of a method of reimbursement under which the providing Federal hospital would receive any revenues received to offset any expenses incurred; and

--assign to OMB the responsibility to (1) coordinate the implementation of an effective interagency Federal medical resources sharing program and (2) report annually to the Congress concerning the progress being made toward increased sharing of these resources.

53(e) The Congress should consolidate HEW programs with similar objectives and place them in the same agencies so that a corresponding consolidation in implementing regulations would result.

53(f) The Congress should include in legislation requiring regulations a maximum time limit by which the Secretary of HEW must publish such regulations.

59(d) The Congress should defer action on proposals to increase total loans available to individual HMOs until HEW demonstrates that it can effectively administer the existing loan program by developing a formal uniform loan policy and establishing an effective compliance function.

60(a) The Congress should amend the National Health Planning and Resources Development Act to provide for Health Systems Agency and State Health Planning and Development Agency reviews of proposed projects involving Federal health facilities and equipment and require their recommendations regarding the appropriateness of the projects be sent to the cognizant Federal agencies. Federal agencies should be required to provide these recommendations, along with their written responses, to congressional committees before any decisions are made to fund a project.

APPENDIX XV

A LIST OF RECOMMENDATIONS

TO THE CONGRESS RELATED TO

VA HEALTH PROGRAMS WHICH HAVE NOT BEEN IMPLEMENTED

The number of the recommendation corresponds to the number assigned in appendices I or III. For details on the recommendation and the status of implementation, see those appendices.

2(c) The Congress should consider limiting the number of computed tomography scanners that can be purchased by the Federal health delivery systems until a coordinated Federal approach is developed.

3(c) The Congress should enact legislation to establish a greatly expanded and cost-effective interagency sharing program. Specifically, this legislation should

--establish a Federal policy that directs interagency sharing when appropriate;

--authorize each Federal direct health care provider to accept all categories of eligible beneficiaries on a referral basis when advantageous to the Government and care of primary beneficiaries would not be adversely affected;

--eliminate all restrictions on the types of medical services which can be shared;

--authorize Federal hospital managers to enter into sharing arrangements, subject to headquarters veto only if judged not in the best interests of the Government;

--authorize expansion of services as necessary to use Federal medical resources in the most cost-effective manner;

--establish a policy requiring full use of available nearby Federal medical resources before using civilian or distant Federal medical resources;

--authorize the establishment of a method of reimbursement under which the providing Federal hospital would receive any revenues received to offset any expenses incurred; and

--assign to OMB the responsibility to (1) coordinate the implementation of an effective interagency Federal medical resources sharing program and (2) report annually to the Congress concerning the progress being made toward increased sharing of these resources.

14(a) Because of the United States commitment to provide medical treatment of Filipino veterans for service-connected illnesses, the Senate Appropriations Subcommittee on HUD-Independent Agencies should take action to change the basis of program funding from a reimbursable contract to a fixed-sum grant to provide annual funding for only service-connected care.

15(b) The Congress should consider the extent to which VA medical centers constructed in the future should provide treatment for veterans with nonservice-connected illnesses.

17(a) The Subcommittee on HUD-Independent Agencies, Senate Committee on Appropriations, should require that VA justify all new hospital construction proposals in terms of priority on the basis of a clear and explicit set of objective criteria to evaluate and compare the current level of adequacy of VA hospitals nationwide in meeting the medical needs of veterans.

17(b) The Subcommittee on HUD-Independent Agencies should not approve funding for construction of a new VA medical center in Camden.

19(a) The Congress should require VA to justify and prioritize all new and replacement hospitals based on clear and explicit objective criteria before approving funding.

19(b) VA and the Congress when contemplating the construction of replacement hospitals should, among other things, consider the extent to which

APPENDIX XV

VA should continue to provide treatment to veterans with nonservice-connected illnesses and the availability of beds in nearby community and other Federal hospitals because each could significantly affect future bed needs.

20(b) The Congress should provide specific legislative authority (1) for VA's personal residence care program and (2) to pay for indigent patients' personal care when other funds are not available.

57(b) Until the overall need for additional physicians is more precisely determined, the Congress should explore whether it wants VA to continue providing Federal grants either to establish new medical schools or increase the the capacity of existing ones, as provided under Public Law 92-541.

APPENDIX XVI

A LIST OF RECOMMENDATIONS TO THE CONGRESS

RELATED TO THE FEHB PROGRAM

WHICH HAVE NOT BEEN IMPLEMENTED

The number of the recommendation corresponds to the number assigned in appendix II. For details on the recommendation and the status of implementation, see that appendix.

46(a) OPM should include in its contracts specific cost-control programs which the carriers must follow. We also recommended that, if OPM did not adopt this recommendation, the Subcommittee on Retirement and Employee Benefits, House Committee on Post Office and Civil Service, should consider developing legislation to require OPM to include specific cost-control and/or incentive provisions in contracts with the FEHB program carriers.

46(b) OPM should revise its FEHB contracts to provide incentives to the carriers to control costs. We also recommended that, if OPM did not adopt this recommendation, the Subcommittee should consider developing legislation to provide OPM with some flexibility in contracting with Blue Cross/Blue Shield for the Service Benefit Plan.

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