REPORT TO THE CONGRESS

Opportunities For Improving The Southern Monterey County Rural Health Project King City, California B-130515

Department of Health, Education, and Welfare

Office of Economic Opportunity

BY THE COMPTROLLER GENERAL OF THE UNITED STATES

JULY 6, 1971

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

B-130515

To the President of the Senate and the
Speaker of the House of Representatives

This is our report on opportunities for improving the Southern Monterey County Rural Health Project, King City, California. Administration of the project has been transferred from the Office of Economic Opportunity to the Department of Health, Education, and Welfare.

Our review was made pursuant to the Budget and Accounting Act, 1921 (31 U.S.C. 53), and the Accounting and Auditing Act of 1950 (31 U.S.C. 67).

Copies of this report are being sent to the Director, Office of Management and Budget; the Secretary of Health, Education, and Welfare; and the Director, Office of Economic Opportunity.

Comptroller General
of the United States

COMPTROLLER GENERAL'S REPORT TO THE CONGRESS

OPPORTUNITIES FOR IMPROVING THE SOUTHERN MONTEREY COUNTY RURAL HEALTH PROJECT, KING CITY, CALIFORNIA
Department of Health, Education, and Welfare
Office of Economic Opportunity B-130515

D I G E S T

WHY THE REVIEW WAS MADE

The Comprehensive Health Services Program is intended to find ways to break the cycle in which sickness and poverty reinforce and perpetuate each other. This grant-in-aid program, under the Office of Economic Opportunity (OEO), is a component of the Community Action Program authorized by the Economic Opportunity Act.

Funding of the program and changes in administrative responsibility since its inception are as follows:

--For fiscal years 1965 through 1970, OEO obligated about $220 million. For fiscal year 1971 $99 million has been authorized.

--In December 1970 responsibility for 16 of 66 operational projects was transferred from OEO to the Department of Health, Education, and Welfare (HEW) which was to provide up to $30 million in fiscal year 1971 to support those projects.

The General Accounting Office (GAO) is making a series of reviews to determine (1) the extent to which the objectives of the program are being met and (2) how well (efficiently) the program is being administered.

This report presents GAO's findings on the Southern Monterey County Rural Health Project, King City, California. The project is one of the 16 projects transferred to HEW and one of the few OEO-initiated projects in which private medical groups are involved actively.

The project serves an agricultural area, and about 35 percent of those eligible to participate in the project are migratory workers. The project was funded by OEO beginning in July 1967. For fiscal years 1968 through 1970, OEO provided grants of about $3 million to the project. For fiscal year 1971 $1.5 million has been authorized.

During the period covered by GAO's review, OEO's grants for the project were awarded to the Monterey County Medical Society, composed of physicians who practiced in Monterey County. The medical society delegated administration of the project to the Southern Monterey County Medical Group, Incorporated, a private group which is the major provider of medical services to the project. In October 1970 a new corporation,

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Rural Health Project, Incorporated, was formed to administer the project in place of the medical group.

GAO was assisted in its review by a medical officer from the U.S. Public Health Service, who evaluated the quality of medical care provided to project enrollees and the adequacy of patient medical records.

FINDINGS AND CONCLUSIONS

The project met certain of its short-range objectives by

- --enabling low-income persons to receive needed medical care similar to that provided to higher income area residents,
- --providing employment and training to area residents,
- --making use of several existing area health care agencies and resources to provide needed services, and
- --employing new types of supporting health workers to serve its enrollees. (See p. 16.)

The individuals and families enrolled in the project generally were satisfied with the medical services provided to them. (See p. 19.)

The project's value would be enhanced if it were to

- --offer a more comprehensive range of services,
- --give its enrollees a greater opportunity to participate in the project's development and operations,
- --gain the support of area residents not enrolled in the project, and
- --devote more effort to developing a means for measuring its long-range impact on the health and economic status of its enrollees. (See pp. 17 and 18.)

GAO found that opportunities for improvement existed in several other aspects of the project. The need for some of these improvements was noted previously by an OEO evaluation team. As a result, some improvements had been made, but there was still a need for further actions, as follows:

Organization structure

The project's organizational structure needed to be changed because it did not provide controls necessary to ensure that project activities would be conducted effectively, efficiently, and free of potential personal and financial conflicts of interest.

Changes made in the project's organizational structure, including the establishment of a new administering agency in October 1970, to eliminate the close relationship that existed between the project and the medical group, should provide better control over the management of project funds and activities and should reduce the possibility of conflicts of interest. (See p. 24.)

Preventive care services

The project needs to (1) give more emphasis to providing, and encouraging its enrollees to seek, preventive medical care, such as physical examinations and immunizations, (2) maintain more adequate records of such care, and (3) undertake efforts to improve the environmental conditions which contribute to the enrollees' health problems. These activities, although difficult and often sensitive undertakings, are essential components of a comprehensive health services program. (See p. 25.)

Outreach services

The project's outreach program--a program to seek out and enroll the poor and to provide them with needed health care and information--could be more effective if the project were to overcome the medical group physicians' reluctance to involve nonprofessional home health aides in the program and if the project were to attract a sufficient number of public health nurses to staff the program.

After the close of GAO's fieldwork, the project installed a referral and follow-up system which, if made to work effectively, also could improve the outreach program. HEW should monitor the new referral and follow-up system to determine whether it is effective and should continue to assist the project to strengthen the program. (See p. 35.)

Evaluations and operational data

Officials at all levels would be able to better manage the project and to better assess its progress if they had available necessary operational data and adequate evaluations of the quality of medical care provided to enrollees and of the effectiveness of other aspects of the project.

OEO and project officials were taking action near the close of GAO's fieldwork to install a new information system which should assist in accumulating financial and operational data. The project, however, needs to develop systematic procedures for evaluating its effectiveness and for reporting the results of such evaluations to management. (See p. 40.)

Eligibility and use of existing resources

To ensure that project funds are used to the optimum benefit of the persons eligible to participate in the project and that existing agencies

and resources are utilized to the maximum feasible extent, the project needs to (1) strengthen its policies and procedures for determining eligibility for project services, (2) utilize all available county health services, particularly the county hospital, and (3) seek out and claim all reimbursements available from established health programs, such as Medicaid and Medicare, and from other funding sources, such as the county and insurance companies. (See pp. 41 and 52.)

Administration of project funds

In its review of project expenditures, GAO found that the following questionable payments had been made to the medical group.

--The project paid the medical group between $37,500 and $50,000 more than it should have under grant terms for medical services rendered to project enrollees. These overpayments occurred both because the medical group had billed the project at erroneous rates and because billings submitted by the medical group at the physicians' usual fees had been increased by project employees to higher rates. (See p. 61.)

--Through February 1970 the medical society authorized, and the project paid, about $98,350 to the medical group without OEO authorization and on a basis other than the OEO-approved fee-for-service basis. These payments were made to cover costs claimed by the medical group to have been incurred as a result of the project. The project did not adequately evaluate the validity of these claims, and the medical group was unable to provide GAO with adequate documentation supporting them. (See p. 64.)

Also GAO is questioning a number of the project's salary payments. (See p. 68.)

RECOMMENDATIONS OR SUGGESTIONS

The Secretary of HEW

--should require and assist the project to expand, improve, and more adequately document preventive health care services (see p. 32),

--should monitor the outreach program periodically and should continue to assist the project in its efforts to strengthen the program (see p. 35),

--should encourage and assist project officials to undertake systematic evaluations of project activities and to develop procedures for reporting results to management at all levels for planning purposes and for dissemination to other federally assisted projects (see p. 40),

--should require and assist the project to strengthen its policies and procedures for determining eligibility for project services (see p. 50); and

--should stress to the project its responsibility to make maximum feasible use of existing agencies and resources, including the county hospital (see pp. 55 and 60).

GAO also is recommending to the Secretary of HEW that project operations be more adequately monitored (see pp. 60, 63, and 72) and that actions be taken to correct the questionable administration of project funds and to determine the amounts of and recover unapproved and unauthorized payments. (See pp. 63, 67, and 72.)

GAO believes that HEW and OEO should consider certain of these recommendations for application to other comprehensive health services projects.

AGENCY ACTIONS AND UNRESOLVED ISSUES

HEW stated that GAO's recommendations for changes were well taken, that it would continue efforts to correct the deficiencies, and that it would provide assistance to strengthen all aspects of the project. HEW stated also that this report indicated areas in which the effectiveness and efficiency of similar programs could be improved. (See app. III.)

OEO indicated agreement with all but one of GAO's recommendations--that of using the county hospital whenever appropriate--and described actions which had been taken, prior to the transfer of the project to HEW, to improve some of the activities covered in this report. OEO incorporated in its response some of the project staff's comments. (See apps. IV and V.)

With respect to the use of the county hospital, OEO stated that the use of available hospitals must be considered in the light of individual cases and the prevailing conditions and that both the needs of the patient and the goals of the project should be taken into account.

OEO stated, however, that the project's policies and practices in this regard had been under a continuing review aimed at furthering the use of the county hospital when indicated and that some project patients had been referred to the county hospital.

GAO believes that, to conserve limited program funds and to ensure that, in accordance with congressional intent, the actual cost of institutional care would not be financed under this program except in highly unusual circumstances, a concerted effort should be made to identify all cases in which the use of the county hospital would be appropriate. (See p. 56.)

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MATTERS FOR CONSIDERATION BY THE CONGRESS

In view of the interest shown by members of Congress in antipoverty and health services programs, GAO is bringing its findings and observations to the attention of the Congress for information purposes and for consideration by committees having responsibility for these programs.

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ABBREVIATIONS

GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare
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CHAPTER 1

INTRODUCTION

The Southern Monterey County Rural Health Project, located in King City, began operation in July 1967. The project has been financed by the Office of Economic Opportunity under its Comprehensive Health Services Program through grants awarded to the Monterey County Medical Society.

Through September 30, 1970, the medical society, composed of physicians who practiced in Monterey County, delegated the responsibility for administering the project to the Southern Monterey County Medical Group, Incorporated, a private group practice which was the major provider of medical services to the project. On October 1, 1970, Rural Health Project, Incorporated--a new, private, nonprofit health organization--was named to replace the medical group as the project's administering agency. The medical society continued as the grantee and the medical group continued as the major provider of services. The project is one of the few OEO-initiated projects in which private medical groups are involved actively.

Effective December 14, 1970, the responsibility at the Federal level for administering the project, as well as 15 other operational OEO health services projects, was transferred from OEO to the Department of Health, Education, and Welfare in accordance with a Presidential directive.

The purpose of our review was to evaluate the effectiveness of the project's operations and the manner in which grant funds for the project were being administered. We were assisted by a medical officer from the U.S. Public Health Service, HEW, who evaluated the quality of some of the medical care provided and the adequacy of patient medical records. Our review covered selected operations of the project for the period July 1967 through May 1970.

COMPREHENSIVE HEALTH SERVICES PROGRAM

The Comprehensive Health Services Program, intended to find ways to break the cycle in which sickness and poverty reinforce and perpetuate each other, was authorized as a

specific component of the Community Action Program by the 1966 amendments to the Economic Opportunity Act of 1964 (42 U.S.C. 2701). In authorizing the program, the Congress broadened the neighborhood health center concept which had been supported by OEO in 1965 and early in 1966 under its authority to finance demonstration projects designed to test, or assist in, the development of new approaches or methods to combat poverty through community action.

The existing authority for the program, section 222(a)(4) of the act, as amended, states that the program is to aid in developing and carrying out projects focused on the needs of urban and rural areas having high concentrations or proportions of poverty and a marked inadequacy of health services for the poor. According to the act, the projects are to be designed to make possible, with the maximum feasible use of existing agencies and resources, the provision of comprehensive health services and the necessary related facilities and services.

The act states also that comprehensive health services are to include preventive medical, diagnostic, treatment, rehabilitation, family planning, narcotic addiction and alcoholism prevention and rehabilitation, mental health, dental, and follow-up services. The act states, however, that, in rural areas which lack elemental health services and personnel, less comprehensive services may be established first.

In addition, the act states that the services are to be made readily accessible to low-income residents of the area and are to be furnished in a manner most responsive to their needs and with their participation and that the services may be made available to all residents of an area on an emergency basis or pending determinations of eligibility. Wherever possible, the services are to be combined with, or included in,arrangements for providing employment, education, social, or other assistance needed by the families and individuals served.

Further, the act states that, before approving any project, the Director of OEO is to solicit and consider the comments and recommendations of medical associations in the area and is to consult with appropriate Federal, State, and

local health agencies. Also, the Director of OEO is to take such steps as may be required to ensure that the projects will be carried on under competent professional supervision and that existing agencies providing related services are furnished with all assistance needed to permit them to plan for participation in the program and for the necessary continuation of the related services.

Prior to its transfer of 16 projects to HEW on December 14, 1970, OEO had funded 66 comprehensive health services projects, of which 47 were in urban areas and 19 in rural areas, and had provided funds for planning 17 additional projects, including four in rural areas. The projects either fully or partially operational at that time were estimated by OEO to have over 650,000 enrollees; when fully operational the projects are expected to have over 1 million enrollees.

From fiscal year 1965, when the first OEO health services projects were funded as research and demonstration efforts, through June 30, 1970, OEO obligated about $220 million for the program. For fiscal year 1971 $99 million has been authorized. HEW is to provide up to $30 million in fiscal year 1971 to support the projects transferred to it.

RURAL HEALTH PROJECT

The project was established in July 1967 to demonstrate and evaluate the feasibility of providing comprehensive, effective, high-quality health care to low-income families through the purchase of services, on a fee-for-service basis, from an existing private group practice and other health care providers. The project's main offices are located in a motel in King City. (See picture, p. 14.)

The grantee for the project is the medical society. During the project's first 3 program years, the medical society delegated responsibility for administering the project to the medical group, which was the major provider of medical services to project enrollees. Effective October 1, 1970, a new, private, nonprofit health organization, Rural Health Project, Incorporated, was named to administer the project in place of the medical group. The new agency will contract with the medical group and other providers for necessary health services.

Financial assistance provided or authorized by OEO for the project's first 4 program years and the amounts of payments to providers for physician and hospital services rendered to project enrollees are as follows:

Program year	Period covered	Total amount	Payments to providers (note a)
1	7- 2-67 to 6-15-68	$ 704,399	$563,211
2	6-16-68 to 6-30-69	1,064,646	640,384
3	7- 1-69 to 6-30-70	1,194,791[b]	575,470[b]
4	7- 1-70 to 6-30-71	1,491,814[b]	651,625[b]

[a]The difference between the total amount and the amount of payments to providers represents primarily funds used for administrative expenses and for salaries and related expenses of public health nurses and nonprofessional aides who travel throughout the project's target area to seek out and enroll the poor and to provide them with health information and home health services.

[b]Amount authorized.

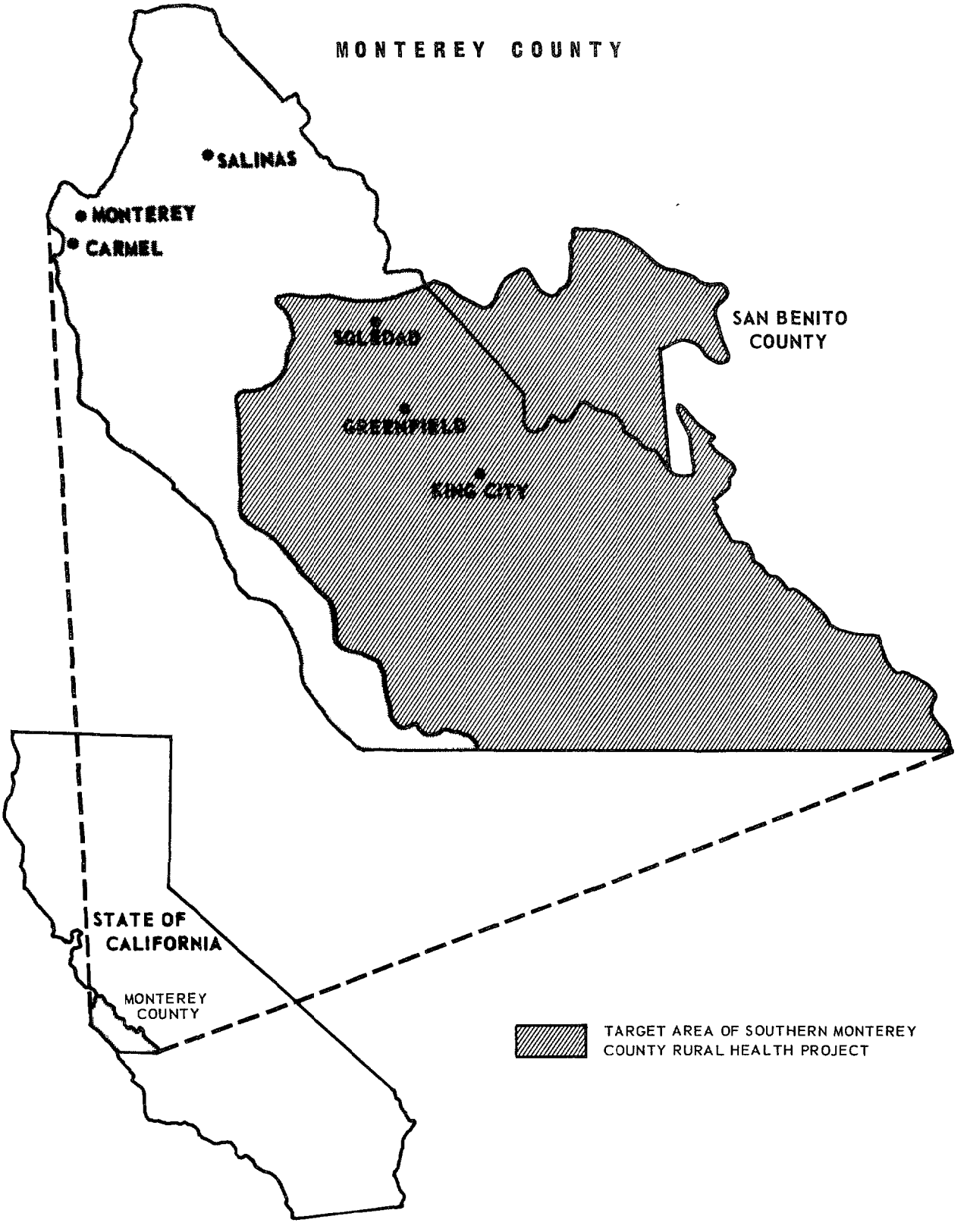
The project's target area covers approximately 2,100 square miles in the southern part of Monterey County. Persons living in part of neighboring San Benito County also are served. (See map, p. 12.) Employment in the area is agriculturally oriented, serving more than 230 corporate farms, processing plants, and food distributors. Much of the work is seasonal; employment expands during the peak harvest periods by about 6,000 persons, mostly migrant farm workers, to complement the resident population of about 15,000.

Project officials estimate that, at any given time, between 4,500 and 6,500 persons in the area, of whom the majority are from families whose members are employed either as field workers or as workers in related vegetable-processing activities, are eligible under the project for free health care. Project officials estimate also that about 35 percent of those eligible are migratory workers. The project's enrollees are predominantly Mexican and Mexican-American.

A project consultant reported that, at the time of enrollment, about 3 percent of the adults and 20 percent of the children who had enrolled during the project's first year had never visited a physician or, in the case of some adults, had not visited a physician since childhood and that about 35 percent of these adults and 77 percent of these children had never visited a dentist or had not visited a dentist since childhood. Other characteristics of the families and individuals enrolled in the project during the first program year are listed in appendix I.

MEDICAL FACILITIES AND SERVICES IN TARGET AREA

At the time of our fieldwork, the medical facilities in King City, which had a population of about 4,000 persons, included the (1) medical group's clinic (see picture, p. 14), (2) George L. Mee Memorial Hospital, a community, voluntary, nonprofit hospital, (3) Pioneer Hacienda Nursing and Convalescent Home, and (4) Home Health Care Agency. There were also one optometrist, three dentists, and a pharmacy.


MONTEREY COUNTY
SALINAS
MONTERREY
CARMEL
SOLEDAD
GREENFIELD
KING CITY
SAN BENITO COUNTY
STATE OF CALIFORNIA
MONTEREY COUNTY
TARGET AREA OF SOUTHERN MONTEREY COUNTY RURAL HEALTH PROJECT

Greenfield, a town 12 miles north of King City with a population of about 2,000, had a pharmacy and a suboffice of the medical group staffed by two physicians. Soledad, about 20 miles north of King City, was included in the project's target area from time to time. It had one physician and a pharmacy to serve a population of about 4,000. The facilities and services in King City, Greenfield, and Soledad are described more fully in appendix II.

Monterey County has offered to its residents various health services, such as immunization and tuberculosis clinics, public health nursing, both inpatient and outpatient care at the county hospital, and sanitation engineering services. Also, after the project was operational, the county began offering family planning services to county residents living outside the target area.

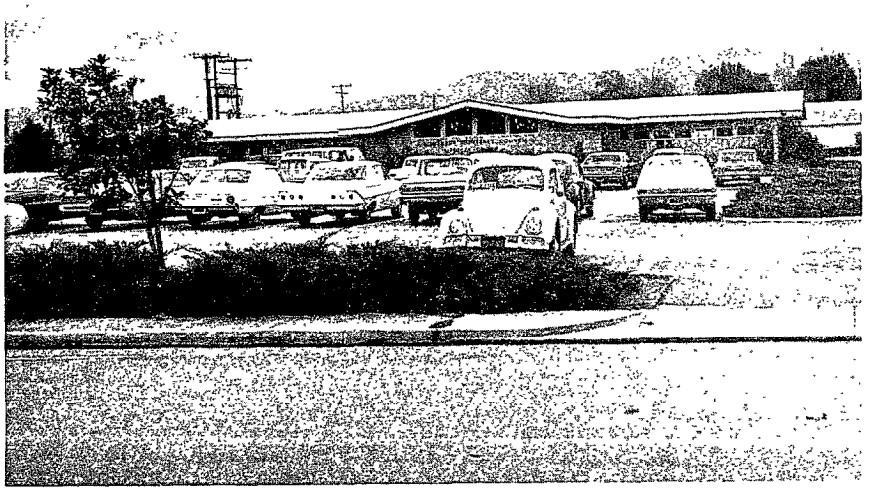
FEDERAL ADMINISTRATION OF PROJECT

The Director of OEO is responsible for administering and coordinating programs for combating poverty. He is responsible also for establishing basic policies governing OEO operations and programs and for planning, directing, controlling, and evaluating OEO programs. The Office of Health Affairs, a part of OEO's headquarters organization, is responsible for directing and coordinating all OEO activities concerned with health and medical activities, including the Comprehensive Health Services Program and the projects assisted under that program. For the 16 projects that were transferred to HEW, the Secretary of HEW has delegated authority for their administration to the Administrator of the Health Services and Mental Health Administration.

On September 30, 1970, we requested the comments of the Secretary of HEW, the Director of OEO, and the medical society on the matters discussed in this report. By letter dated November 17, 1970 (see app. III), the Assistant Secretary, Comptroller, HEW, stated that, although certain principal objectives had been achieved, changes were needed to meet other important objectives and to generally improve operations, as well as to take corrective actions.

He stated also that, since the project would be under the sponsorship of HEW, HEW would continue efforts which

RURAL HEALTH PROJECT OFFICES
KING CITY, CALIFORNIA



CLINIC OF SOUTHERN MONTEREY
COUNTY MEDICAL GROUP, INC.
KING CITY, CALIFORNIA

had been started to correct the deficiencies and would make every effort to provide assistance to strengthen all aspects of the project. He stated further that the timeliness of the report would allow HEW to take actions to improve the effectiveness and efficiency of similar programs.

By letters dated January 22 and February 22, 1971 (see apps. IV and V), the Deputy Director of OEO provided us with OEO's views. The Deputy Director stated that the comments received from the project staff had been reviewed by OEO.

We noted that selected comments from the project staff had been incorporated into OEO's comments. We have included, where appropriate, portions of OEO comments in the body of the report.

Because HEW is responsible for the project, recommendations in this report are being made to the Secretary of HEW.

CHAPTER 2

OPPORTUNITIES TO INCREASE PROJECT EFFECTIVENESS

Evaluating the effectiveness of a comprehensive health services project requires a measurement of how well the project has achieved both its long-range objectives and its short-term objectives. Long-range objectives comprise improving the health, social, and economic status of the project's beneficiaries and changing the system of providing health care, including changes in long-standing professional practices and in existing community attitudes. Short-term objectives comprise providing comprehensive, continuous, family-centered, accessible, acceptable, and high-quality health care to low-income individuals and families; using existing agencies and resources to the maximum feasible extent; and giving target-area residents an opportunity to be employed by the project and to participate in decisions concerning its operations.

The project has not operated long enough to fully measure achievement of its long-range objectives. It has operated long enough to measure the extent to which it has achieved some of its short-term objectives, the adequacy of its plans, the direction of its efforts toward achieving its long-range objectives, and the provisions it is making for permitting a more complete evaluation of the achievement of its objectives at some later date.

Our review, which included a review of patient medical records by a Public Health Service medical officer, showed that the project had enabled low-income persons needing medical care to receive care similar to that offered to higher income residents by a private group practice and by other providers, such as Mee Hospital and the nursing home. The project also had provided employment and training to target-area residents; had utilized several of the existing health care agencies and resources in the area; and had employed a pediatric nurse-practitioner and physician assistants, two of the newer types of supporting health workers, to serve its enrollees.

Opportunities existed, however, for improving the services offered to project enrollees and for improving other

aspects of project operations, such as its organizational structure, its preventive care and outreach activities, and project evaluations, to enhance its value as a health care provider and as an experimental effort. The need for some of these improvements, which would enable the project to more effectively meet its objectives and those of the Comprehensive Health Services Program, was disclosed previously by an OEO evaluation team. Although some actions had been taken by OEO and project officials and although some improvements had been made, further efforts were still needed to accomplish all the necessary improvements.

In commenting on a draft of this report, the Deputy Director of OEO stated that most of our conclusions and recommendations were in line with OEO findings but that the project's development, operations, and accomplishments must be considered in the context of:

--OEO's mission to develop and support innovative experimental projects, in this case within the framework of an existing private system of providing health care.

--The difficulties frequently encountered in developing health projects in rural areas, such as shortages of accessible medical resources and backup; long distances; inadequate transportation; and local attitudes adverse to new social programs, to persons on welfare, and to minority groups.

--The objectives of the Comprehensive Health Services Program to support local efforts that seek to learn how to reach the goals set by OEO's program guidelines under a variety of diverse conditions and circumstances.

IMPACT OF PROJECT

The project provided medical services which were generally accessible to the individuals and families that it had enrolled and with which the enrollees were generally satisfied. The project, however, did not offer a full range of comprehensive services. Also the enrollees were not given the opportunity to fully participate in decisions concerning

the project's development and operations. Further, the project had not gained the support of target-area residents not enrolled in the project, and it was not devoting much effort to developing a means for measuring its long-range impact on the health and economic status of its enrollees.

We recognize that the project has made medical services more readily available to low-income persons in the target area; but, in our opinion, the project has shown only limited improvement in methods of providing health care.

Services provided to target population

Project officials estimate that, at any given time, between 4,500 and 6,500 individuals eligible for enrollment in the project reside in the target area. From July 1967 through February 1970, about 3,000 families representing 10,319 individuals were enrolled in the project. Project records did not show the number of enrollees who had received services, but project officials estimated that about 60 percent of the individuals enrolled during the first 30 months of the project had received some medical care.

Mental health services were provided by a visiting consultant. Dental services were not provided during the project's first 3 program years because OEO would not approve the project's proposal to pay the local dentists for patients who missed their appointments.

Project officials informed us that the incidence of missed dental appointments by project enrollees would have been quite high because enrollees were reluctant to take time off from work to go to the dentist or to take a family member. For its fourth program year which began July 1, 1970, the project intended to routinely provide dental services--in the project's proposed dental trailer or, on a limited basis, in private dentists' offices--to eligible children between the ages of 4 and 14 years and to others on an emergency or follow-up basis.

Physician services at the King City clinic and the Greenfield suboffice and laboratory and X-ray services at Mee Hospital were offered from 9 a.m. to 5:30 p.m., 5 days a week. Evening clinic hours generally were maintained from

May through October at the King City clinic. Service after clinic hours and on weekends was available to enrollees at Mee Hospital's emergency room. Medical specialists and consultants from cities outside the target area visited the clinic on a scheduled basis. When requested, the project provided its enrollees with transportation to the medical facilities.

Our interviews with 52 systematically selected persons, each representing a family enrolled in the project, indicated that they were generally satisfied with the health care that they or their families had received through the project.

Quality of care provided

Members of an OEO evaluation team, on a 2-day visit to the project in March 1968, made a medical audit of the medical group's records on both private and project patients. The team also reviewed program operations, management and fiscal operations, community action, and the role of the medical society. The team stated in its December 1968 summary report that there was no essential difference in the medical care provided to private and project patients at the medical group's clinic and that, as far as the care went, it was good. The team reported, however, that certain additional medical services should have been provided and that some services that had been provided had not been needed.

The team reported also that the services of a pediatrician and an obstetrician particularly were needed. Subsequently, a pediatrician and a pediatric nurse-practitioner--the first in California--were hired. Physician coverage for adequate obstetrical care deemed essential by the OEO team, however, had not been provided up to the time that we completed our fieldwork.

The team reported further that improvements especially were needed in preventive health services and that the clinic staff's coordination with aides and outreach workers, or a team approach to care, was not evident from the records that it had reviewed.

In March 1970 the Public Health Service medical officer who assisted us in our review examined the clinic's records on 127 patients selected at random and found that most of the deficiencies cited by the OEO evaluation team still existed. The records examined included those of 78 project enrollees and 49 private patients.

Participation of the poor

The poor participated in the project through training and employment but were not given the opportunity to fully participate in decisions concerning the development and operation of the project, contrary to OEO guidelines. Project enrollees were not permitted to select representatives to the project's policymaking boards, nor were they given adequate opportunities to select representatives to the consumer advisory council, which was to be composed of target-area residents eligible for the project and which was to function in an advisory capacity on all aspects of the project. Of the 52 persons whom we interviewed, 33 stated that they had not been aware of the council or its meetings or that there was a lack of information about the council.

OEO informed us in January 1971 that the governing board of the new administering agency would consist of representatives of the project's enrollees as well as representatives of the medical society, the county's community action agency, the county supervisors, and Mee Hospital's auxiliary.

Support of general community

Project officials made only limited progress in obtaining support for the project from target-area residents who were not enrolled in the project. Generally, such residents were opposed to the project. Project officials told us that, to lessen the impact of this negative reaction, they had attempted to carry out the project in an inconspicuous manner. Medical group officials told us that the project had caused some ill feelings among its private patients and that, as a result, some of their patients were going elsewhere for medical treatment.

Long-range impact

Regarding the project's impact on the health and economic status of its enrollees, project officials have stated in project proposals that, over a period of time, declines in mortality and morbidity rates and in loss of work time and income can be expected to result from the operation of the project. Only limited data, however, was being accumulated by the project for measuring its impact in terms of these indicators.

ORGANIZATIONAL STRUCTURE CHANGED TO PROVIDE BETTER CONTROL OVER PROJECT ACTIVITIES

The OEO-approved organizational structure through which the project was administered during the period covered by our review did not provide the controls necessary to ensure that project activities would be conducted effectively, efficiently, and free of potential personal and financial conflicts of interest. Certain individuals who held major administrative and management positions with the project and/or whose salaries were paid in whole or in part by the project were

--major stockholders in, or persons who held key positions with or were employed by, organizations from which the project purchased services and space;

--persons closely related to those holding key positions with such organizations; or

--members of committees having major policymaking and evaluation responsibilities for project activities.

Following the conclusion of our fieldwork, a number of changes were made in the project's organizational structure, and on October 1, 1970, a new administering agency was designated to provide more extensive and effective program and management direction and control.

The act provides that, to receive financial assistance to carry out a project, the grantee observe, and require or encourage other participating agencies to observe, standards of organization, management, and administration which will ensure, so far as reasonably possible, that all project activities will be conducted effectively, efficiently, and free of personal or family favoritism. The grantee is to adopt, for itself and other agencies using funds or exercising authority for which it is responsible, rules designed to guard against personal or financial conflicts of interest.

In the original application for the project, the medical group stated that it intended to be the grantee. When the medical group was notified by OEO that it could not be

the grantee because it was a profitmaking enterprise, the medical society agreed to become the grantee and the medical group was designated as the administering agency. Under this arrangement the medical society was responsible for the project but the medical group controlled it.

The medical group is the major provider of medical services to the project, which also purchases medical services from Mee Hospital and the nursing home. During its first 3 program years, the project purchased medical services from these providers at a cost of about $1.8 million. For its fourth program year, the project budgeted about $650,000 for such services. In fiscal year 1969 project patients accounted for 34 percent of the medical group's work load.

From initiation of the project through the period covered by our review, the chairman of the board and medical director of the medical group was also the project director and a member of the project committee, the major policymaking body for the project. In addition, he was the medical director and a board member of Mee Hospital; the administrative officer of the nursing home; and a principal stockholder in a real estate investment company and a data processing center, which leased office space and sold data processing services, respectively, to the project. He also was a member of the eight-man health care projects committee of the medical society, which was responsible for overseeing project activities. As project director, he had primary responsibility for administration of the project, including the development of overall plans and of directions and procedures for implementing the plans.

During the same period the medical group's administrator was also the project's financial officer and a member of the project committee. In addition, he had an ownership interest in the data processing center and his wife was the administrator of the nursing home. As the project's financial officer, the medical group's administrator was responsible, with the project administrator, for coauthorizing all project expenditures.

Obviously, under such conditions the organizational structure did not provide the controls necessary to ensure

the most efficient use of OEO funds and the effectiveness of the project.

The project's April 1970 application to OEO for funding its fourth program year proposed that a new organization, to be known as Rural Health Project, Incorporated, be formed and be named as the administering agency in place of the medical group. In September 1970 OEO approved the proposed change, and on October 1, 1970, it was accomplished. Also we were informed by OEO officials in October 1970 that the project director and the financial officer referred to herein were no longer connected with the project.

Conclusion

The project's organizational structure through September 1970 raised questions of conflict of interest and did not provide the controls necessary to ensure the efficient use of project funds and the effective achievement of certain objectives of the Comprehensive Health Services Program and of the project.

The changes that were made in the organizational structure after September 1970 should provide better control over the management of project funds and activities and should reduce the possibility of similar questions arising regarding conflicts of interest.

NEED FOR IMPROVEMENT IN PREVENTIVE CARE SERVICES

The project needs to (1) give more emphasis to providing, and encouraging its enrollees to seek preventive care, such as physical examinations and immunizations, (2) maintain more adequate records of such care, and (3) undertake efforts to improve the environmental conditions which contribute to the enrollees' health problems. Preventive care services generally are recognized to be especially needed in poverty settings.

The initial application stated that the project would provide the medically indigent with comprehensive medical and surgical care, including preventive care services. Physical examinations were to be given to persons enrolling in the project, and the enrollees were to be encouraged thereafter to have periodic physical examinations. Also preventive care was to be practiced by emphasizing nutrition; immunization; and prenatal, postnatal, infant, and child care. Project enrollees were to be educated on preventive health measures and on environmental sanitation. Subsequent applications for funds to continue the project have repeated the need for, and the intention to provide, preventive health care.

Physical examinations

The project's records showed that, during the first 2 program years when 8,169 persons were enrolled, 2,058 physical examinations had been given to project enrollees. Information on all the 2,058 physical examinations was not readily available. The project's records, however, showed the following information on 842 physical examinations given to enrollees during the first 10 months of the second program year, during which time about 3,500 persons were enrolled for the first time.

Type of physical examination	Number
Complete examination of a new patient	448
Initial or subsequent examination for a problem	347
Complete reexamination	27
Annual physical examination	20
Total	842

The OEO evaluation report issued in December 1968 stated that it did not appear that the project had made a concerted or planned effort to give complete physical examinations to project enrollees during the early months of their care at the clinic but that components of such examinations had been given during enrollees' periodic visits. The report recommended that the project consider a policy of offering or scheduling complete physical examinations sometime within the first 3 months of enrollment for all patients planning to remain enrolled.

OEO health officials worked with the project staff to act upon the recommendation, but the Public Health Service medical officer, who reviewed patient records in March 1970, found that the problem still existed and that very few records showed that complete physical examinations had been given to project patients. He stated that the physical examinations that had been given usually had been requested by the patients' employers. He stated also that many patients had visited the clinic many times for various problems without ever having been given complete physical examinations.

The former project director told us that, because of the limited medical staff available, the project's goal of giving physical examinations to all enrollees could not be met. We were told that more physical examinations could be given if the project and the medical group had a system whereby physical examinations could be scheduled throughout the year.

Immunizations

It generally is recognized among medical professionals that immunizations are one of the most effective forms of long-term preventive care. One-time immunizations are considered effective in providing protection against certain diseases; a series of immunizations and periodic boosters usually are considered necessary for complete protection against other diseases.

Available records showed that many project enrollees had been given immunizations against such diseases as diphtheria, whooping cough, tetanus, smallpox, measles, and

polio but that the number of enrollees receiving the prescribed range and number of immunizations considered necessary for protection against certain of these diseases had been relatively low.

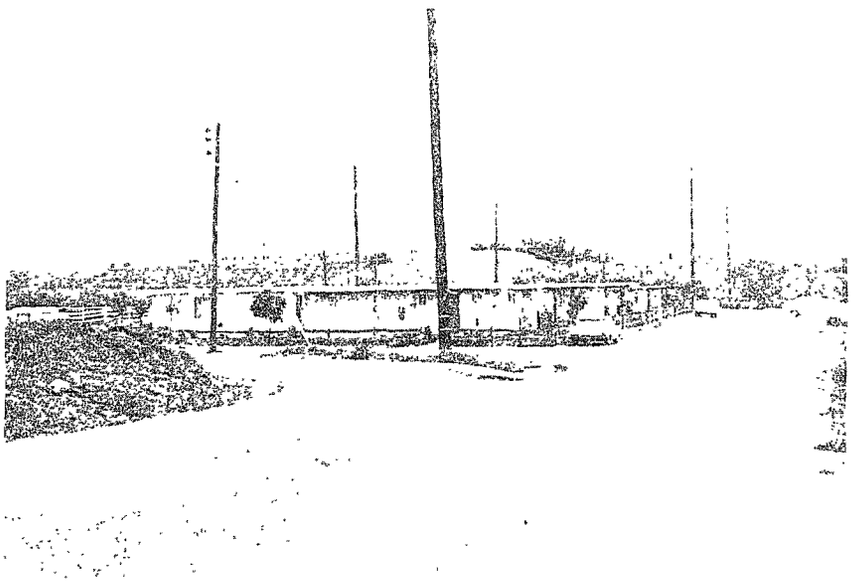
For example, the California State Department of Public Health recommends that, for protection from diphtheria and tetanus, a series of three combined shots (four for children under 5 years of age) be given during a 1-year period followed by a booster every 5 years for children and every 10 years for adults. For children under 5 years of age, a pertussis antigen for protection from whooping cough is to be added to the combined shots.

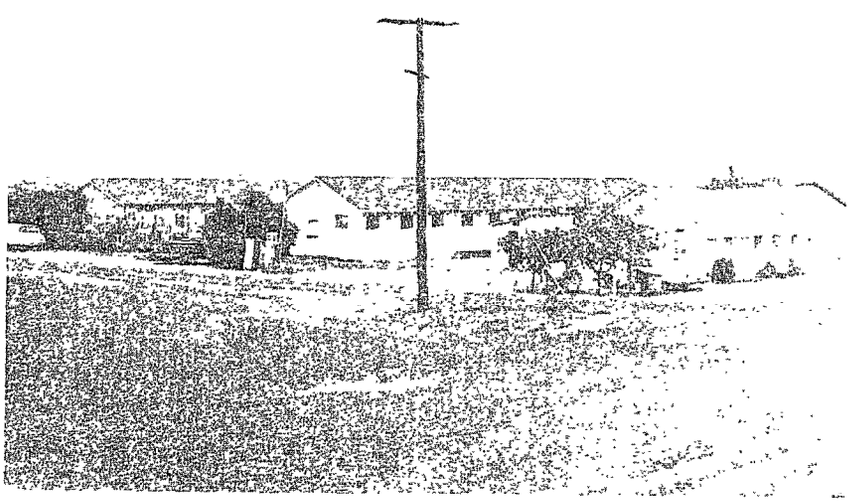
Project records showed that, during the first 2 program years when 8,169 persons were enrolled, 1,369 combined shots had been given for protection from these diseases. Of the 1,369 shots, 578 were given at mass immunization clinics and the remainder were given during normal office visits. Project records were not maintained adequately to determine which of the shots or boosters, except those given at the mass immunization clinics, had been given to each patient.

Further, the need for a more adequate immunization program was noted by the OEO evaluation team which reported that only two of the 21 children included in its review of pediatric care had received all the immunizations that should have been given. The team recommended that a patient immunization checklist be established, but such a checklist had not been established at the time of our fieldwork.

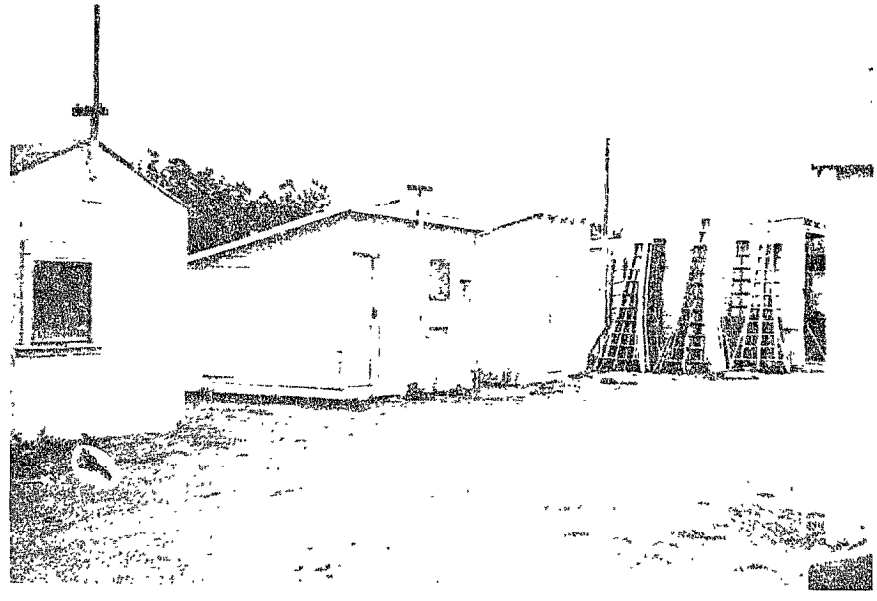
Sanitation and housing

Program guidelines state that sickness and poverty reinforce each other and that the poor usually live in conditions, such as crowded and unclean housing and inadequate heating and sanitary conditions, which undermine physical and mental health. Therefore, the guidelines state that the concern of the project staff for the health of the target population should include work with the community to promote needed changes in the target-area environment. Pictures of some of the farmworkers' labor camps and housing that we observed are on pages 28 and 29.





FARMWORKER LABOR CAMPS
NEAR KING CITY, CALIFORNIA



FARMWORKER HOUSING
NEAR KING CITY, CALIFORNIA

The project's health education supervisor told us that crowding and unsanitary conditions were a health problem in the target area. She said that the labor camps in the area originally had been set up for single men who came from Mexico to work under the bracero program--a foreign labor import program ended in December 1964, under which Mexican nationals entered the United States to work as agricultural laborers. Some of the buildings were erected during World War II. When the bracero program ended, families began to migrate into the area to work during the growing and harvest seasons; these families were housed in the same buildings that had been used by braceros. The supervisor stated that many labor camp owners required that a certain minimum number of workers live in each structure and that therefore many units and food preparation areas were shared by several families.

Project officials told us that they had not made any direct efforts to improve the environmental conditions of the target population because such efforts would risk confrontation with the ranchers and labor contractors. They said that any efforts to improve the poor conditions might result in loss of the project's access to the ranches and labor camps and in increased resentment of the general community toward the project, which would cause a further loss of private clinic patients.

A medical society official informed us that he did not believe that the project was qualified to handle the nonmedical aspects of health, such as sanitation and housing. The associate project director told us that the project had not become involved in the housing problem because no money had been budgeted for such activities.

Conclusion

Available project records indicated that physical examinations had been given to a large number of project enrollees but that the project's goal of providing initial and periodic physical examinations to all project enrollees had not been accomplished.

The project lacked the records necessary to determine the extent to which its enrollees had been protected against diseases through immunization. Available records indicated, and the OEO evaluation team pointed out, that the project had not given adequate emphasis to the development of an effective immunization program.

Project officials recognized that the poor environmental conditions in which a large segment of the target population lived were conducive to poor health, but they had not undertaken, as part of a preventive health program, systematic efforts to improve sanitation and housing.

We recognize that the poor traditionally have sought and used health services on an emergency basis or for specific illnesses and that changing their attitudes and practices is not an easy task. Also effecting improvements in environmental conditions that undermine physical and mental health is an expensive, difficult, and often sensitive undertaking. Providing preventive care services, encouraging the poor to use them, and attempting to improve environmental conditions, however, are integral and essential components of a comprehensive health services program.

Immunizations and early diagnoses through physical examinations are of great benefit in attempting to prevent disease and disability and can reduce the need for more costly care, such as hospitalization. Also improving the environmental conditions in which a person lives can have a major and long-range beneficial effect on his physical and mental health.

Therefore the project should

--give closer attention to preventive care services,

--encourage its enrollees to seek and use available health services on a regular and systematic basis rather than on the traditional emergency basis,

--maintain adequate preventive care records to show the care required and received by each project patient, and

--make an effort to improve the environmental conditions in which project enrollees live.

HEW should assist the project in these efforts and should encourage project officials to work with State and local agencies having responsibility for improving environmental conditions.

Recommendation to the Secretary of Health, Education, and Welfare

HEW, through the Health Services and Mental Health Administration, should require and assist the project to make a concerted and systematic effort to expand, improve, and more adequately document the preventive care services provided to its enrollees.

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The Deputy Director of OEO stated that OEO agreed with the recommendation and that substantial staff and consultant efforts had been aimed at helping the project to achieve its goals.

OUTREACH PROGRAM COULD BE MORE EFFECTIVE

Under the project's outreach program, public health nurses and nonprofessional home health aides were to travel throughout the project's target area to seek out the poor, encourage them to enroll, and provide them with needed health information and home health care. The health care aspects of the program were not very effective, however, because (1) the medical group physicians were reluctant to involve the nonprofessional home health aides in the health care system, (2) the project had been unable to attract a sufficient number of public health nurses to the area to staff the program, and (3) a referral system by which the physicians could routinely request the outreach workers to follow-up on patients in their homes had not been developed. The need for a more effective outreach program was reported previously by the OEO evaluation team.

Outreach services have been funded by OEO since initiation of the project. According to project proposals and OEO publications, outreach services are important in providing preventive and follow-up health care and education and in encouraging and assisting eligible persons in the target area to seek available services. Also the nonprofessional aides can contribute firsthand information on the problems of the target area and its people.

Further, using outreach workers for home follow-up efforts can reduce demands on the time of the more highly skilled members of the health care team and in some instances can reduce the patient's length of stay in a hospital or other institution by permitting him to remain at home or to return home sooner than otherwise would be possible. To be effective, outreach services should be adequately staffed and fully coordinated with the professional medical staff so that the physicians can use the outreach workers to contact and follow up on patients.

At the conclusion of our fieldwork, six of the 67 project employees--one public health nurse and five health education aides--were directly involved in outreach health services, such as visiting patients in their homes, conducting health education classes, and assisting at tuberculosis and immunization clinics. In addition, 12 employees--nine

community health aides and three drivers--provided non-health-related outreach services, such as determining eligibility, conducting a census, and providing transportation. A public health nursing program, essential to providing health-related outreach services, had not been initiated, however, because the project had been unable to attract a sufficient number of nurses. Also health teams had not been established, although the approved grants provided for such teams.

We were informed in our interviews with project employees, and the Public Health Service medical officer who assisted us in our review noted, that coordination between the professional medical staff and the project's outreach workers had been negligible. There appeared to be two major reasons for this. First, necessary mechanisms, such as a routine referral system by which the physicians could request outreach workers to follow up on patients, had not been developed. Second, the physicians would not have received fees for the time that they might have spent involving outreach workers in the health care system. Also the former project director informed us that the use of nonprofessionals to provide health care would have added to the risk of malpractice charges.

The OEO evaluation team reported that the project's outreach workers, although highly motivated, had been underutilized and that increased use of these workers for referrals and home follow-ups might have resulted in greater benefits to the patients. The team recommended to project officials that (1) the roles and functions of ancillary and paramedical employees, including the outreach workers, be reassessed so that their activities would be more effective and more closely related to physicians' activities and (2) an administrative program be undertaken to increase communication between the physicians and the paramedical employees.

We were informed by the former project director that each physician had determined the extent to which he relied upon the aides. We also discussed outreach efforts with several clinic physicians and other project officials, who agreed that the outreach concept had not been fully implemented.

Conclusion

The health care aspects of the project's outreach program were not very effective because (1) the physicians were reluctant to involve the outreach workers in the health care system, (2) the project had been unable to attract enough public health nurses to staff the program, and (3) a referral system had not been developed. In a draft of this report, we expressed the belief that OEO, which had responsibility for the project at that time, should make every effort to assist the project (1) to recruit the personnel required for an effective home health care program, (2) to include the outreach workers in the health care system, and (3) to increase the outreach workers' coordination with the professional medical staff. Accordingly, we made proposals to that effect.

OEO informed us in February 1971 that it agreed with our proposals and that the OEO staff had made continuing efforts to help the project strengthen its outreach services. OEO stated that the project staff recently had completed installation of a referral and follow-up system, that one facet of the system was the education of the medical professionals concerning the skills of the outreach workers, and that the outreach workers were being given additional training to enhance their skills.

We believe that HEW, to which responsibility for administering the project was transferred in December 1970, should monitor the project's recently installed referral and follow-up system from time to time to determine whether it is effective and should continue to assist the project in its efforts to strengthen its outreach program.

Recommendation to the Secretary of Health, Education, and Welfare

HEW, through the Health Services and Mental Administration, should monitor the project's outreach program periodically and continue to assist the project in its efforts to strengthen the program.

NEED TO IMPROVE PROJECT EVALUATIONS

Although an OEO team evaluated the project in March 1968, internal and external evaluations planned by the project either were not made or were limited in scope. The results of the evaluations that had been made by the project were not reported formally to officials responsible for administering the project. Also the project did not develop adequate procedures for accumulating, analyzing, and reporting base-line and operational data necessary for monitoring and evaluating--either by project officials or by others--its progress in carrying out approved plans and in achieving objectives.

Officials at all levels would be able to better manage the project and to better assess its progress if they had available necessary operational data and adequate internal evaluations of the quality of medical care provided to enrollees and of the effectiveness of such other aspects of the project as its accessibility, acceptability, comprehensiveness, enrollee involvement, and use of available manpower and existing resources.

Evaluations in themselves do not necessarily improve projects; however, if based on accurate and reliable data and if properly made and reported, they should apprise management of the achievements of a project and should pinpoint those aspects which could be improved. In addition, the results of evaluations of demonstration-type projects, such as this one, can be beneficial to other ongoing projects as well as to planning for new projects.

The Congress amended the Economic Opportunity Act in 1967 to require the continuing evaluations of antipoverty activities, including health projects. The initial application of the project--as a demonstration project--stated that project officials would arrange for a number of evaluations, including medical audits of the services provided.

According to the application, these evaluations and medical audits were to cover such aspects as the quality, adequacy, coordination, and continuity of health care; the completeness and clarity of medical records; the reasonableness of costs and charges; the extent of patient satisfaction;

and the adequacy of the overall program, including enrollment procedures, eligibility policies, scope of services, qualifications of staff, quality control measures, staffing patterns, accessibility, and relations between staff and patients. In addition, the application stated that the project would accumulate and analyze base-line and operational data, such as statistics on the incidence of disease, disability, and infant mortality; the number and characteristics of persons enrolled and treated; and the services provided.

The evaluations, according to the application, were to be made by a medical care consultant; the medical society; the medical staffs of the medical group, Mee Hospital, and the nursing home; and the consumer advisory council comprising project enrollees. These evaluations, with few exceptions, were not made or were limited in scope.

A limited evaluation was made by a medical group physician who had reviewed patient records during the initial stages of the project to determine their completeness and clarity. This evaluation was one of those provided for in the application. He told us that some of the records did not show such information as the patient's major complaint, the diagnosis, the treatment, and the physician's impressions. He said that he had attempted to encourage the other physicians to record this information but that his efforts had not been productive because the physicians would not cooperate. He stated that he had discontinued the review due to the lack of cooperation and to his increasing work load but that he was planning to resume the review with the assistance of the medical group's medical records supervisor.

Another medical group physician informed us that he had initiated a review of the length of patients' hospital stays because the amount of OEO funds that could be used for hospitalization was limited. The length of hospital stays was one of the aspects of the project bearing on costs and scope of services which was to be evaluated according to the application. The physician stated that he had not made any formal reports but that he had confronted the attending physicians in an effort to reduce the length of project patients' hospital stays.

He stated that, according to the statistics, his efforts had been successful. Our analysis of project records on hospitalization showed that the average length of hospital stay for project enrollees had decreased from 5.8 days during the period July 1967 through June 1968, to 4.3 days during the period July 1968 through June 1969, and to 3.7 days during the period July through December 1969.

The OEO evaluation team commented on the limited internal evaluations of the project's medical aspects. The team reported that little effort had beem made in internal medicine to set up formal case reviews or audit procedures. The team recommended to project officials that a medical audit and review committee be established for critical chart reviews and case studies and that an organized program be undertaken to encourage the improvement of medical practice.

The Public Health Service medical officer who assisted us noted that neither the medical society nor the medical group had made any quality control and program reviews above a perfunctory level. He stated that "The absence of ongoing internal reviews not only fails to monitor quality but also serves to isolate physicians from one another ***."

A medical society official told us that the medical society had not made onsite reviews of medical records which were planned but that, after January 1970, a committee of eight physicians was to begin such reviews. In May 1970 the official told us that these reviews had been initiated but that a formal system for reporting weaknesses to management for corrective action had not been developed. The project's budget for its program year which began July 1, 1970, included funds for activities to expand the medical society's medical audit and review functions.

Regarding the accumulation and analysis of base-line and operational data, the project's medical care consultant issued a report in March 1970 summarizing background information on persons who had enrolled in the project during its first program year. He disclaimed responsibility for the accuracy of much of the data, however, because of errors in interviewing, coding, card punching, or translation.

Also, in response to OEO requirements, the project submitted quarterly management reports to OEO showing operational data, such as the number and characteristics of persons enrolled and treated; the number of patient encounters with physicians, nurses, or other project employees; the number of referrals to other providers of service; and the number and type of X-ray examinations, laboratory tests, immunizations, and diagnoses.

The project's data processing supervisor, who was involved in preparing these reports from project records, informed us that the reports contained inaccurate and misleading information because necessary data had not been obtainable, had not been obtained, or had not been included in the reports. Project officials told us that they did not use the reports in their management of the project. OEO health officials informed us that the quarterly reports had proven to be almost worthless and that changes were being made in the report format and requirements.

The OEO evaluation team expressed concern over the lag in the project's data collection and processing system and recommended that the project staff pay more attention to the collection of data and give a higher priority to the development of computer programs for processing patient history and care data.

During the latter part of our fieldwork, OEO initiated action to install, with the aid of a contractor, a new information system for the project. In January 1971 OEO officials informed us that the system had been installed and that the project was reviewing bids for a local contractor to process the data. The new system, which also is being installed at several other OEO health service projects, is designed to provide financial and operational data on a uniform basis.

Conclusion

In addition to providing high-quality health care, the project is intended to demonstrate and test new and different ways of providing such care to the poor. Therefore it is essential that evaluations be made of project operations and of the extent to which the project is achieving its objectives.

Such evaluations, if based on accurate and reliable data and if properly made and reported, should be useful in improving project operations--such as the reductions in the length of patients' hospital stays achieved as a result of the medical group physician's review--and should be beneficial to other ongoing projects and to planning for new projects.

The new information system should assist in accumulating necessary financial and operational data. The project, however, needs to develop and follow systematic procedures for evaluating its effectiveness--including such aspects as the type and quality of care provided--and for reporting the results of such evaluations to management.

Recommendation to the Secretary of Health, Education, and Welfare

HEW, through the Health Services and Mental Health Administration, should encourage and assist project officials to undertake systematic evaluations designed for measuring the extent to which the project is meeting its objectives and to develop procedures for reporting the results to management at all levels for planning purposes and for dissemination to other federally assisted projects. The Deputy Director of OEO said that OEO agreed with our recommendation. In January 1971 OEO informed us that the project's budget for its fourth program year which began July 1, 1970, had included funds to expand the grantee's medical audit and review functions.

CHAPTER 3

POLICIES AND PROCEDURES GOVERNING ELIGIBILITY FOR PROJECT SERVICES SHOULD BE STRENGTHENED

The project's policies and procedures governing determinations of eligibility for project services should be strengthened to preclude (1) families whose incomes exceed applicable income limitations being determined to be eligible for free care, (2) inconsistencies in decisions regarding whether standards should be waived to permit certain individuals to receive free care, and (3) persons being provided with free care who, according to State standards, are considered to have sufficient financial resources to pay for certain portions of their medical care costs. In addition, project officials should continue the systematic efforts begun in January 1970 to help persons appearing to meet criteria for assistance under other programs to establish eligibility for such assistance.

Program guidelines provide that all persons receiving OEO-assisted health services meet a test of need by reason of circumstances of poverty and that only persons residing in the designated target area may receive regular care. The determination of eligibility is to be made in a manner that will maintain the dignity of the individual. Although determinations do not have to be made when the need for medical care is acute, determinations are to be made as soon thereafter as feasible.

In making eligibility determinations, the guidelines provide that each project establish income criteria and that one of the following criteria be applied:

1. OEO's poverty-line index.

2. Standards of the State Medicaid program.

3. Standards of other local antipoverty health and welfare programs which are integrally involved in the project's operations.

In addition, the guidelines state that persons who apparently meet the criteria for assistance under the State Medicaid or other public assistance programs and who are not so certified should be helped to establish eligibility for such assistance.

The project's applications, which were approved by OEO, stated that eligibility for services would be based on income and family-size standards of Medi-Cal--California's Medicaid program--and that calculations of income would be made on the basis of the 12-month period prior to the person's or family's date of application for enrollment. The applicants' representations of income were to be accepted without substantiating documentation.

Exceptions to the standards were to be made in cases of current destitution or very serious medical problems so that the family would not be forced into serious deprivation before being eligible for project services. Also persons potentially eligible for Medi-Cal benefits were to be encouraged to apply for such benefits.

NEED TO STRENGTHEN PROCEDURES USED TO ASCERTAIN FAMILY INCOME

Because project officials generally did not question or independently verify applicants' reported family incomes, families with incomes substantially over applicable income standards were enrolled in, and received free care from, the project.

Project officials informed us that information on a family's annual income generally was obtained from a responsible family member by a community health aide at the time of application or when a family's eligibility status was reevaluated. The family's annual income often was reported by the applicant as a single amount although members of the family may have worked for many employers. Project officials informed us that the reported income amounts rarely were questioned or independently verified.

To determine the accuracy of family incomes reported at the time of initial application or reevaluation of eligibility, we obtained income information for 86 families from

employers' records and other records. The number of family members in these families ranged from one to 14. For 17 families we were unable to obtain information on the incomes of all family members, although we did obtain information on the incomes of the members who appeared to be the principal wage earners.

In analyzing the available information for the 86 families, we found that 19 families each had an annual income exceeding the applicable standards by at least $1,000. Of these 19 families, 15 had reported incorrect incomes to the project interviewer; adequate information was not available in project records to enable us to determine the accuracy of reported incomes for the other four. Information on these 19 families is shown below.

Family	Number of persons	Actual income	Reported income	Income eligibility standard (note a)	Amount by which actual income exceeds: Reported income	Amount by which actual income exceeds: Eligibility standard
A	9	$14,616	$4,844	$5,220	$9,772	$9,396
B	9	12,386	5,173	5,220	7,213	7,166
C	14	12,014	5,600	6,540	6,414	5,474
D	9	10,377	4,760	5,220	5,617	5,157
E	2	7,760	4,151	3,372	3,609	4,388
F	11	6,931	(b)	5,748	(b)	1,183
G	7	6,817	1,500	4,692	5,317	2,125
H	8	6,653	(b)	4,956	(b)	1,697
I	5	6,515	4,000	4,164	2,515	2,351
J	8	6,435	(b)	4,956	(b)	1,479
K	6	6,225	4,000	4,428	2,225	1,797
L	4	6,126	(b)	3,900	(b)	2,226
M	2	6,186	3,400	3,372	2,786	2,814
N	3	6,030	3,500	3,636	2,530	2,394
O	4	5,734	4,000	3,900	1,734	1,834
P	1	5,030	1,650	1,944	3,380	3,086
Q	2	4,878	2,000	3,372	2,878	1,506
R	3	4,695	4,500	3,636	195	1,059
S	1	4,173	1,800	1,944	2,373	2,229

[a]Per Medi-Cal standard.

[b]Information not available.

Our analysis of the above differences showed that they generally had occurred because incomes of one or more family members had not been reported and/or only parts of some family members' incomes had been reported.

Project officials stated that their procedures for obtaining information on family incomes did not ensure complete disclosure of income and that families having incomes substantially above those allowed had been enrolled on the basis of erroneous statements, while families who were barely over the applicable income standards and who had correctly reported their incomes were generally not enrolled. The officials stated also that their policy of not questioning statements of income had evolved as a result of OEO's policy of not erecting barriers to needed health services.

UNIFORM CRITERIA TO BE ESTABLISHED FOR WAIVING INCOME STANDARDS

The project did not have uniform criteria to be used in determining whether, because of financial problems or medical needs, families whose incomes exceeded applicable income standards should be enrolled. As a result, some families in such situations were enrolled, while other families who appeared to have equally severe problems or needs were not enrolled. In addition, decisions to include or not include certain family members' incomes in the total family income were made on a case-by-case basis. Project officials informed us that uniform criteria for making such determinations would be established.

In implementing the policy of not forcing families into serious deprivation before extending aid, project officials, on a case-by-case basis, enrolled families with incomes exceeding applicable standards who were destitute at the time of application or who had very serious medical problems. During the second program year, for instance, 40 of the approximately 1,075 families who were initially enrolled reported incomes exceeding the applicable standards by $56 to $1,700. Enrollment of these families appeared to be warranted on the basis of their financial problems and medical needs. However, a number of families who appeared to have equally severe problems or needs were not enrolled.

In one case, for example, a four-member family applied for enrollment in the project on two occasions--in April 1969 when the father was hospitalized and in May 1969 when it was learned that he could not work for at least a year. On both occasions, the project determined that this family was not eligible because the father's reported income for the preceding 12 months had exceeded the applicable income standard by $600. In January 1970 the family again applied for enrollment in the project and was enrolled; by that time the father had worked only 3 of the preceding 12 months and not at all after May 1969 and his reported income for that period had been only $800.

Also eligibility determinations for families having several major income-producing members were not handled consistently. For example, in the case of a family of four--

which included two working sons aged 24 and 25, who lived at home--the reported total family income of $6,300 exceeded the standard of $3,600 by $2,700. The 24-year-old son who reported earnings of $3,500 was considered separately from the family and was determined to be ineligible. The combined reported income of the other family members, including the 25-year-old son, was then below the standard and they were determined to be eligible.

The supervisor responsible for eligibility determinations, who was hired in late 1969, took steps to apply uniform standards to those applications which required special attention. We also discussed this matter with the project administrator, who told us that he would take action to correct the inconsistencies in determining eligibility.

FREE CARE PROVIDED TO PERSONS WHO ARE ABLE TO PAY

Because it did not fully follow the eligibility standards it had adopted and because it did not maintain adequate records, the project enrolled and provided free medical care to some persons who, according to State standards, had sufficient financial resources to pay for certain portions of their medical care and for whom the State was responsible for paying the remainder.

Under Medi-Cal standards, persons needing financial assistance for medical care are placed in one of two groups. Persons who need full financial assistance are placed in group I, and persons who, because of their income and/or existing assets, need only partial financial assistance are placed in group II. For each person in group II, the State establishes, on a monthly or quarterly basis, an amount--or deductible--which the person must pay before Medi-Cal assistance can be received. The project, however, although it adopted Medi-Cal income standards as its criteria for eligibility, does not make a distinction between group I and group II persons.

Project records showed that at least 25 families were enrolled in Medi-Cal's group II and that these families had monthly or quarterly deductibles under that program ranging from $13 to $157. These families were enrolled in the

project and were therefore eligible for full financial assistance from the project for the cost of their medical care. Because of the fragmented billing records, we did not attempt to analyze each case to determine the full cost to the project for medical care provided to these persons.

In analyzing one case, however, we found that the patient was certified as eligible for Medi-Cal benefits effective May 1, 1969, at which time the State determined that the patient had the ability to pay the first $69 of his medical costs each month. During May 1969 the patient received medical services at the clinic that cost $94.50. In addition to paying the patient's $69 Medi-Cal deductible because a distinction had not been made between group I and group II persons, the project also paid the remaining $25.50 for which the State was responsible, because project records had not shown that this amount was in excess of the patient's deductible.

Project officials told us that it was their policy to pay all medical expenses of persons who met the eligibility requirements of the project. They stated that the person's deductible, which the project did not recognize, occurred because other health programs considered a person's assets, whereas the project based eligibility solely upon income.

NEED TO ENROLL PROJECT BENEFICIARIES IN MEDI-CAL PROGRAM

During its first 2-1/2 years, the project did not make a systematic effort or establish formal procedures to identify eligible families and aid them in enrolling in the Medi-Cal program. Because program funds cannot be used to finance services for which support is already available, program guidelines provide that OEO-assisted projects help persons who apparently meet the criteria for assistance under the State Medicaid or other public assistance programs, and who are not so certified, to establish eligibility for such assistance.

Because the project did not have the necessary records, we were not able to determine the total number of project enrollees who were eligible for Medi-Cal but who were not enrolled or the cost of medical services provided to these enrollees. We noted, however, in reviewing the applications of 211 families who were initially enrolled during the 3-month period ended March 15, 1969, that the applications of 44 families with dependent children indicated that the fathers of the families were unemployed at the time of application--one of the criteria for Medi-Cal eligibility.

Of these 44 families, eight had informed the project or the clinic that they were enrolled in the Medi-Cal program. The records for the other 36 families did not indicate that the project had made an effort to determine their Medi-Cal status and, if they appeared to be eligible but were not enrolled, to assist them in enrolling in the Medi-Cal program.

We discussed these 36 cases with county welfare department officials who, at our request, reviewed the department's files. They found that six of the families were enrolled at that time in the Medi-Cal program. Neither the project nor the medical group's clinic, however, had a record of their enrollment. The county officials stated that the remaining 30 families, on the basis of information in the applications for the enrollment in the project, appeared to have been eligible for Medi-Cal at the time that their applications for enrollment in the project were submitted. The officials were able to determine from their

files that 11 of these 30 families had been enrolled in the Medi-Cal program at one time or another.

Because project records were not always maintained on a family basis, we could not readily determine the total amount that the project had paid for medical services provided to these 36 families; however, in reviewing two cases we noted that the project had paid $276 for medical services provided to the families during the time that they were eligible for Medi-Cal.

The project hired a person with prior county welfare department experience, and in January 1970 he initiated a review of enrollee records to identify families potentially eligible for the Medi-Cal program. He identified 35 such families and took action to assist them in applying for the Medi-Cal program. Project officials informed us in November 1970 that the procedure had been continued in subsequent months.

Project and medical society officials informed us also that complying with Medi-Cal procedures and filling out application forms were complicated and time-consuming for the applicant because his eligibility had to be redetermined monthly. The officials stated also that the county welfare department would not identify for them the residents of the project's target area who were enrolled in the Medi-Cal program.

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Project officials told us that they would initiate action to correct the several weaknesses in determining eligibility that we had noted during our review. They pointed out, however, that the solution to these problems was not simple and that they had to consider OEO's policy of not erecting barriers to needed services as well as the more stringent State and county policies regarding free health care under the Medi-Cal program.

OEO health officials informed us that they recognized that the project might be paying for medical services rendered to persons eligible for Medi-Cal benefits but that the

difficulties and barriers in applying for the Medi-Cal program should also be considered.

CONCLUSION

The project did not establish adequate policies and procedures governing eligibility. Thus families whose incomes substantially exceeded established income limitations received free care; decisions on waiving standards in cases of need were inconsistent; and persons received free care who, according to State standards, had the means to pay for portions of their care. Also the project did not maintain records adequate for ensuring that the State was billed for medical care for which it had the responsibility to pay, and only a limited effort was made prior to January 1970 to assist persons potentially eligible for health programs to enroll in them.

We recognize that there are difficulties and barriers in applying for the Medi-Cal program and that, in making eligibility determinations for care under the project, some flexibility is needed so that persons who are destitute or who have very serious medical problems are not denied needed medical care. These considerations, however, were not germane to all the cases coming to our attention, nor should they be used by project officials as a basis for not making greater efforts to assist applicants in applying for enrollment in other health programs.

Appropriately applied eligibility standards provide equitable treatment not only for persons in similar economic circumstances but also for persons in varying economic circumstances within the overall eligibility limits. Enrolling ineligible persons or using project funds to pay for care which should be paid for by the individuals or by a third party diverts funds from the target population which the program was designed to serve.

RECOMMENDATION TO THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE

HEW, through the Health Services and Mental Health Administration, should require and assist the project to strengthen its policies and procedures for determining

eligibility for project services, to maintain records adequate to ensure that the State is billed for medical care for which it has the responsibility to pay, and to continue efforts to assist enrollees in applying for programs for which they are eligible.

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OEO agreed with our recommendation and stated that the revised eligibility procedures instituted during January 1970 were part of a concerted effort to improve the administrative procedures of the project.

CHAPTER 4

NEED TO INCREASE USE OF EXISTING RESOURCES

Because program funds may not be used to support health care services, facilities, or equipment for which support is available from other sources, the act and program guidelines provide that a project seek out and use existing resources to the greatest possible extent. Our review showed that the project had replaced some services that had existed in the target area prior to the project's being established and that the project needs to make additional efforts to obtain reimbursements from other sources responsible for making medical care payments. These matters are discussed below.

PROJECT HAS REPLACED COUNTY HOSPITAL SERVICES IN TARGET AREA

Rather than utilize existing services available at the county hospital--as required by the act, program guidelines, and conditions of the grant--the project substantially replaced the county hospital as a source of institutional care for its enrollees. The medical society submitted certifications to OEO that project services would be in addition to, not in substitution for, services previously provided without Economic Opportunity Act assistance.

The act requires that the Director of OEO satisfy himself, before approving assistance for such programs as the Comprehensive Health Services Program, that the services to be provided will be in addition to, and not in substitution for, services previously provided without Federal assistance. Further, the act and program guidelines call for comprehensive health services to be provided with the maximum feasible use of existing agencies and resources.

In accordance with the intent expressed by the Senate Committee on Labor and Public Welfare in its report on the 1966 amendments to the act which first authorized the Comprehensive Health Services Program, program guidelines provide that the actual cost of institutional care not be financed with program funds except in highly unusual circumstances.

The grant agreements state that program funds are the last-dollar source and that the project's agreements with public and private agencies which purchase or provide health services or supplies to low-income persons in the target area are to be designed so that the project does not bear health care costs which would otherwise be the responsibility of such agencies.

The county has the responsibility to provide medical care to county residents who do not have the ability to pay. In addition, the county has agreements with hospitals, including Mee Hospital in King City, under which the county provides reimbursement with certain limitations, for the cost of emergency care rendered to persons eligible for free county hospital care. The project, however, did not make appropriate use of the county hospital services and did not develop procedures to ensure that the clinic and Mee Hospital billed the county, rather than the project, for services which had been rendered to project enrollees but for which the county had been responsible for payment.

During its first 3 program years, the project spent, exclusive of clinic physicians' fees, about $627,000 for inpatient services provided to project enrollees at Mee Hospital. Project officials told us that patients were not referred to the county hospital because it was 50 miles distant, the patients would lose continuity of care, and the county had established a policy of billing patients for all services. Although these are mitigating factors, we believe that, in view of the costs incurred for hospital services and the provisions in the Senate report and program guidelines, these factors should not be the sole determinants of where a patient is provided with inpatient care.

The project provides transportation to the clinic and Mee Hospital for its enrollees, some of whom live 35 miles from King City. For nonemergency hospitalizations and those which are not of a highly unusual nature, transporting enrollees to the county hospital, a distance of 50 miles or less for most project enrollees, seems not be a major problem. We recognize that continuity of care is an appropriate and desirable objective, but we believe that such an objective must be balanced against the limited amount of program funds.

Regarding the county's policy of billing patients for all services, project officials told us that the county had an obligation to provide medical services to the needy but that liens were required by the county if the patient owned real property and that all patients not eligible for welfare were billed for services provided. These officials also said that the county tended to reduce its services to the extent that another activity was willing to provide them. These officials told us also that the county had expressed an unwillingness to pay for care provided to patients covered by the project.

We discussed with project personnel some cases in which it appeared that persons could have been referred to the county hospital. In two of these cases, which cost the project over $6,000, the persons were enrolled in the project after being admitted to Mee Hospital. Although project personnel agreed that the county hospital would have provided treatment in most of such cases, they stated that an effort had not been made to send these persons to the county hospital because the project would pay for the services.

OEO officials told us that these problems were symptomatic of OEO health service projects. They said that, where existing services in the target area are considered inadequate, OEO health programs should provide the services needed. They agreed, however, that reimbursements should be sought from other health programs whenever the responsibilities of such programs are being met by an OEO health program.

In responding to our request for the comments of his department and the county hospital on this matter, the Director of Public Health of the Department of Public Health, County of Monterey, by letter dated October 27, 1970, informed us that, notwithstanding the provisions of the act, it was, and continued to be, the county's understanding that the project was experimental and that it was intended to replace the modest program of health services that were being provided by the county to residents of the project's target area at the time the project was inaugurated.

The director stated, however, that the county hospital's contract with Mee Hospital for the provision of emergency hospitalization services still existed and that the county health department, which previously had conducted immunization clinics in the project's target area, supplied the materials for the conduct of the clinics but that the vaccine was administered by the project's representatives. He stated also that a representative of the county health department's nursing division previously had periodically visited persons in the area having a need for her services but that,with the advent of the project, such visits were stopped, since the county had determined that there was no longer a need for nurses' visits.

Conclusion

Rather than utilize existing available services--as required by the act, program guidelines, and conditions of the grant agreements--the project has paid for institutional care for its enrollees that traditionally has been provided by the county to those unable to pay for such care. Further, the project has not required the institutions providing the care--the clinic and Mee Hospital--to seek reimbursement for these services, contrary to the terms of the grants.

To limit the use of already scarce program funds, the project should attempt to fully utilize county hospital services and should require the clinic and Mee Hospital to seek reimbursements from the county for medical services which the county is responsible for providing.

Recommendation to the Secretary of Health, Education, and Welfare

HEW, through the Health Services and Mental Health Administration, should require the project to develop procedures to ensure that the county, rather than the project, is billed whenever appropriate for care rendered at the clinic and Mee Hospital and that the county hospital is utilized for nonemergency hospitalizations and those which are not of a highly unusual nature.

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The Deputy Director of OEO stated that OEO was in partial agreement with our recommendation. He stated also that, although substantial resistance had been encountered, efforts were being continued to obtain reimbursements from the county and others for care rendered at the clinic and Mee Hospital.

With respect to use of the county hospital, however, the Deputy Director stated that the appropriate use of the available hospitals must be considered in the light of the nature of individual cases and the prevailing conditions and that both the needs of the patient and the goals of the project should be taken into account. He stated further that the policies and practices of the project in this regard had been under a continuing review and discussion aimed at furthering the use of the county hospital when indicated. He stated, for example, that 68 project enrollees had been referred to the county hospital, 63 for outpatient care and five for inpatient care, between January and December 1970.

We realize that the nature of individual cases and the prevailing conditions must be considered in determining the use to be made by the project of the county hospital. We continue to believe, however, that consideration must also be given to the limited amount of program funds and the intent expressed by the Senate Committee on Labor and Public Welfare in its report on the program's authorizing legislation that the actual cost of institutional care not be financed under this program except in highly unusual circumstances.

The fact that some persons have been referred by the project to the county hospital indicates that utilization of the county hospital sometimes is appropriate. We believe, therefore, that a concerted effort should be made to identify those cases in which utilization of the county hospital would be appropriate and consistent with the provisions of the Senate report and program guidelines and to refer these persons to the county hospital for care.

IMPROVEMENTS NEEDED TO OBTAIN AVAILABLE REIMBURSEMENTS

The project did not establish procedures adequate for ensuring (1) that it would be adequately reimbursed during its first program year by other programs responsible for payment for services rendered to project enrollees and (2) that, during subsequent program years, claims would be submitted promptly by the clinic and Mee Hospital, before being submitted to the project, to other health programs or organizations responsible for paying for medical care. In addition, the project did not take steps to submit claims to, or to have the clinic and Mee Hospital submit claims to, private insurance companies and the county, which are responsible for payment for medical services rendered to some project enrollees.

As previously stated, the act and program guidelines require that health projects make maximum feasible use of existing agencies and resources and provide that program funds be used as a last-dollar resource. Both the guidelines and the conditions of the grant require that health projects make arrangements to obtain reimbursements for services which are provided by them but which should be paid for by other sources that are responsible for providing financial assistance for such medical care.

Due to a lack of reliable project records, we were unable to determine the full cost paid by the project for services provided to project enrollees who were eligible for financial assistance under other health programs, such as Medicare and Medi-Cal, or from other sources, such as private insurance companies and the county. It appeared, however, that savings of program funds could have been realized had the project fully utilized these other programs and sources.

During its first program year, the project paid the clinic and Mee Hospital for all services rendered to its enrollees. The clinic and Mee Hospital were to seek reimbursements from other health programs, primarily the Medi-Cal program, and remit the amounts so collected to the project. The project, however, did not maintain records to show the reimbursements due from the clinic and Mee Hospital,

and therefore it was unable to ensure that all amounts due were received. We were unable also to make this determination.

In October 1967 a medical society official suggested that the project establish procedures adequate for recording reimbursement receivables. The need for such procedures was discussed by the project's auditor in a letter dated March 12, 1968, to the medical society. Such procedures, however, were not established during the first program year.

Instead, project officials changed the existing reimbursement arrangements at the end of the first program year to provide that the clinic and Mee Hospital initially bill the other programs and bill the project only for those services and those enrollees not covered by the other health programs.

To determine whether the revised arrangements were working satisfactorily, we reviewed bills for $6,000 for services provided to 20 project enrollees (randomly selected) who were eligible for the Medi-Cal or Medicare programs at the time services were provided. Had adequate procedures been in effect, the project should not have paid any medical services provided to these persons if the services were covered by the other programs.

For 12 of the 20 persons, however, the project had been billed and had paid about $1,000 for drugs and for hospital and physician services which should have been paid for by the Medi-Cal or Medicare programs. The clinic's administrative personnel told us that these erroneous billings had been caused by the clinic's lack of current Medi-Cal and Medicare eligibility information and that project enrollees had not always properly identified themselves as being eligible for these programs.

Also some services which should have been paid for by Medi-Cal were paid for by the project because the clinic had not submitted the claims to Medi-Cal within the prescribed time limits. Again, because of the inadequate records, we were unable to determine the full amount of such payments.

Further, the project had not developed procedures adequate for obtaining, or for having the clinic and Mee Hospital obtain, reimbursements available from such sources as the county and private insurance companies. (The situation with respect to the county was discussed previously.)

Private insurance plans often cover at least part of the cost of medical services, the recovery of which would reduce the amount of program funds expended by the project. The project, however, made little effort to obtain reimbursements from private insurance companies. Although, because of inadequate records, we were unable to determine the full amount which the project might have realized from private insurance companies, we noted a number of cases in which project enrollees had been covered under private insurance plans but in which no effort had been made to seek reimbursement.

For example, in one case the project paid $775 for medical services provided to an enrollee whose husband was employed by a local business firm. We estimated that about $220 of this amount was recoverable under the firm's insurance policy which covered the family. The project's records, however, did not show that the family had private insurance coverage, and therefore a claim had not been made.

Project personnel informed us that, in the past, the methods used to identify those persons covered by private insurance plans had not been effective. They stated, however, that the project was making an effort to identify insurance coverage of project enrollees. They stated also that the project had determined that 65 of the approximately 235 local employers provided insurance coverage for their employees and that the project planned to take action to see that claims were directed to the insurance companies when appropriate.

Conclusion

The project did not establish procedures adequate for ensuring that all available reimbursements were obtained from other health programs and organizations responsible for payment for medical services rendered to project enrollees. As a result, program funds were used to pay for

services which should have been paid for by these other resources.

In previous reports to the Congress (B-130515, March 18, 1969, and B-130515, December 19, 1969), we stated that there was a need for OEO to assure itself that, in accordance with conditions of the grant, reimbursements available from other sources were obtained by health projects whenever possible. Accordingly, we recommended that the Director, OEO, through his cognizant program office, ensure that health projects claim reimbursements from third parties where appropriate.

In commenting on this matter in October 1969, OEO informed us that its health staff had been working with HEW and local officials in helping to complete arrangements to collect Medicaid, Medicare, and other reimbursements. OEO stated that the substantial resources devoted to this effort had resulted in the completion or development of arrangements for obtaining Medicaid reimbursement for 42 of OEO's then-existing 44 health projects, including its King City project.

The arrangements that have been made, however, are of little value if the health projects do not make vigorous, continuous, and timely efforts to seek out and obtain the available reimbursements.

Recommendation to the Secretary of Health, Education, and Welfare

HEW, through the Health Services and Mental Health Administration, should reemphasize to the project its responsibility to seek out and obtain reimbursements from third parties where appropriate and monitor the project's performance in this regard.

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OEO agreed with our recommendation and indicated that efforts to encourage and facilitate billing of Medi-Cal, Medicare, and other third-party sources had received substantial attention and would be continued.

CHAPTER 5

QUESTIONABLE ADMINISTRATION OF PROJECT FUNDS

The following questionable transactions came to our attention in our review of selected aspects of the administration of project funds.

PAYMENTS TO MEDICAL GROUP HIGHER THAN PROVIDED BY GRANT TERMS

The project paid the medical group an amount--estimated by us at between $37,500 and $50,000--for medical services rendered to project enrollees at rates higher than those provided by grant terms, because billings had been made at erroneous rates or because billings submitted at lower rates had been increased to maximum rates by project personnel. OEO began negotiating with the medical group in early 1970 for the repayment of a part of these overpayments. OEO informed us in January 1971 that the negotiations were continuing.

According to the approved grants, the fees paid by the project to the medical group and other providers of medical services were not to exceed, without the written approval of OEO, rates charged to private patients or rates under the Medi-Cal program, whichever were lower.

During the period covered by our review, the Medi-Cal program provided that payments for each medical procedure be based on the physician's actual fee, which was not to exceed a rate established by formula. The formula (California Relative Value Studies) provided for assigning a unit value to each medical procedure and for a conversion factor, expressed as a dollar amount, which might vary by county or area. The conversion factor for Monterey County was $6. The unit value, when multiplied by the conversion factor, resulted in the maximum rate allowed in the county under Medi-Cal for a given medical procedure.

For the 15-month period from June 1968 through August 1969, however, the medical group's bills to the project were based on a conversion factor of $7, or, in some cases, more than $7. The certified public accountant who reviewed the

second-year grant (OEO requires that grantee records be audited by independent accountants) reported to OEO in October 1969 that project administrative personnel had estimated that overpayments of between $30,000 and $40,000 had been made during the 12-month period ended June 30, 1969, because of the use of higher conversion factors. Therefore we estimate that, for the entire 15-month period, overpayments of between $37,500 and $50,000 were made by the project.

We were informed by the project's former financial officer, who was also the medical group's administrator, that billing the project at the higher rates had been an error but that the medical society, which was to review all charges to the project, had not informed him until June 1969 that the wrong conversion factor had been used.

Despite the medical society's notification, however, the project did not take action to have the medical group discontinue this practice or recover the overpayments. The project continued to make payments at the higher rates through August 1969. Early in 1970 OEO began negotiating with the medical group regarding the amount to be refunded. OEO informed us in January 1971 that the matter was still being negotiated.

Additional costs were incurred also because, during the period September through December 1969, the former project administrator instructed the project clerks to raise all medical group bills to the maximum amounts allowed by Medi-Cal. For example, a bill for $4 for a routine office call submitted by the medical group would be raised to $6, the maximum allowable for this type of service. The former project administrator told us that he had directed the increases because he believed that, since the medical group's billings could not exceed the maximum allowable rate, it should not bill at a lesser rate. According to our calculations, during the month of September these additional costs totaled about $630. We did not determine the amounts for the other 3 months.

We informed the former project administrator that the approved grant stipulated that the project pay the lesser of the physician's fee or the Medi-Cal rate, and in

January 1970 he instructed the staff to discontinue increasing the amounts billed. The project, however, had not made an effort, through the close of our fieldwork in May 1970, to obtain refunds from the medical group for these overpayments.

Conclusion

Because of noncompliance with the conditions of the grant, arbitrary administrative determinations, and the failure of the medical society to promptly carry out its responsibilities, the project paid the medical group more than it should have for medical services rendered to project enrollees.

Recommendation to the Secretary of Health, Education, and Welfare

HEW, through the Health Services and Mental Health Administration, should take action to determine and recover the full amount of the project's overpayments to the medical group for services rendered to project enrollees and make periodic reviews of project expenditures to ensure that billings are correct and that overpayments are avoided.

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The Deputy Director, OEO, stated that OEO agreed with our recommendation; that the project had sought to recover the excess payment to the medical group; and that OEO, pending the resolution of this matter, had withheld funds to the project.

PAYMENTS TO MEDICAL GROUP
NOT IN ACCORDANCE WITH GRANT PROVISIONS

Provisions of the grants limited the project's payments to the medical group to amounts billed under the fee-for-service concept unless otherwise authorized by OEO. Through February 1970, however, the medical society had authorized and the project had paid $98,350 to the medical group on other than a fee-for-service basis, and without OEO authorization, for costs which the medical group claimed it had incurred as a result of the project. These payments were made without an adequate evaluation by the project of the validity of the claims, and the medical group was unable to provide us with adequate supporting documentation for them.

The provisions of the grants required that all payments made by the project to the medical group be on a fee-for-service basis and that project funds be spent in accordance with the OEO-approved budget. The grants further stipulated that any proposed revisions in the budget items be submitted to OEO in writing and be approved by OEO in advance of the proposed expenditures. These stipulations were not met for the payments in question, nor was there any written justification showing the basis for the medical society's authorizing the payments.

Of the $98,350 in question, project records showed that the project had paid $31,000 on the basis of the medical group's claim that it had incurred losses due to hiring six physicians on a temporary basis in 1967 and 1968 to serve project patients at the clinic during evening hours. The remaining $67,350, according to the project's records, represented payments amounting to 20 percent of the medical group's indirect salary costs (salary costs of nonmedical or supportive personnel) from June 16, 1968, through February 28, 1970, to cover increased overhead costs claimed by the medical group.

Regarding the $31,000, we were informed by the project's former financial officer, who was also the medical group's administrator, that only two of the six physicians had staffed the evening clinic. Also the project had paid the medical group for the services of the six physicians on

a fee-for-service basis. Nevertheless the medical society authorized the entire $31,000 to be paid from project funds.

The project's former financial officer informed us that he had computed the loss of $31,000 on the basis of the difference between the six physicians' salaries plus related overhead costs and the total billings made for the services rendered by the six physicians to both project and private patients. He was unable to provide us with documentation supporting his computation. Also medical society officials did not have any records showing the basis on which the medical society had authorized this payment.

The only record provided to us of any discussion with OEO officials on the payment of the $31,000 was the former project administrator's memorandum of his telephone conversation with an OEO project analyst during the same week that the medical society had authorized the payment. This memorandum stated:

> "There is no objection to the principle of OEO paying for losses incurred by the Group through the hiring of short-term medical staff. *** [The OEO project analyst] pointed out the fee-for-service is supposed to cover such costs, but agreed that in some situations it might be reasonable to pay for losses directly. However, without specific authorization from OEO, funds spent for such a purpose would probably be disallowed."

Medical society and project officials were unable to provide us with any evidence that OEO had specifically authorized the payment.

Project and medical society officials also were unable to provide us with any evidence that the payments of $67,350 for claimed increased overhead costs had been discussed with or specifically approved by OEO officials.

In response to our written request for information on these payments, the medical society informed us by letter dated March 17, 1970, that:

"The approval to reimburse the Southern Monterey County Medical Group the $31,000 you questioned was based on direct out-of-pocket cost to the group. By terms of the grant we were required to maintain a night clinic and, to do this, physicians had to be brought in on whatever basis they were able to be obtained. It was the feeling of the Society's committee that this was a legitimate reimbursable expense and should be paid.

"The approval to reimburse the Medical Group 20 percent of their payroll costs was based on a review of their appropriate records, knowledge of time being spent by their staff, and consultation with the Group's consultant ***.

"Both of these matters were discussed verbally with [two OEO officials] ***.

"*** Expenditures such as the ones you are inquiring about were not anticipated, but we could find nothing within the grant conditions that excluded authorizing reimbursement for these costs."

To obtain additional funding for increased costs, the project, in its proposal for the third program year which began July 1, 1969, budgeted $76,500 to reimburse the medical group for increased overhead, based primarily on rising salary costs. OEO allowed the item to remain in the approved budget but attached to the grant a special condition which required specific OEO approval before payments could be made. The proposal did not disclose that the project had been making payments representing 20 percent of the indirect salaries to cover increased overhead or that it intended to continue making such payments.

On December 23, 1969, the former project director requested OEO's approval to pay the $76,500 to the medical group. On February 6, 1970, OEO authorized the release of $40,000, subject to future audit. In its letter, OEO agreed that it appeared that there had been an increase in the medical group's costs but stated that the documentation that had been provided was inadequate for determining the nature and magnitude of the increases.

OEO health officials informed us in May 1970 that they were not aware that payments for the short-term physicians and increased overhead costs had already been made or that the project was continuing to make payments for increased overhead costs based on 20 percent of indirect salaries.

Conclusion

The project's payments to the medical group for losses that it claimed it had incurred due to hiring physicians on a temporary basis and for overhead costs computed as a percentage of indirect salary costs were not in accordance with provisions of the grants, were not included in the approved budgets, or were not otherwise approved by OEO as required. In addition, the medical group did not furnish adequate justification to show that these costs were necessary and in direct support of the project.

Regarding the amount budgeted for the third program year to reimburse the medical group for increased overhead, the medical group should be required to furnish adequate data to substantiate that the costs claimed for reimbursement are necessary and in direct support of the project.

Recommendation to the Secretary of Health, Education, and Welfare

HEW, through the Health Services and Mental Health Administration, should require the medical group to reimburse the project for payments made on other than a fee-for-service basis that were not approved by OEO and to adequately support any claims for reimbursement of overhead costs charged to the grant during the third program year.

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OEO agreed with our recommendation and said that it had requested HEW to follow up on these matters.

QUESTIONABLE SALARY PAYMENTS

OEO funds were used to pay all or part of the salaries of certain persons although (1) the indicated portions of the persons' time spent on project activities had not been commensurate with the parts of their salaries paid with OEO funds, (2) persons whose full salaries had been paid with OEO funds had generated income for the medical group by treating private patients, or (3) the project had reimbursed the medical group on a fee-for-service basis for services rendered to project patients by these persons.

Former project director

For its third program year, the project budgeted,and OEO approved, funds of $24,000 for the former project director's salary on the basis that 80 percent of his time would be spent on project business. The amount had been increased from the project's first program year when the former project director had received no salary from the project but when 20 percent of his time was budgeted for project business. During the second program year, the former project director's budgeted salary of $14,400 was based on 40 percent of his time being spent on project business.

The former project director had not maintained records to show how much of his time he had spent on project business and how much he had spent carrying out the responsibilities of his positions with the medical group, Mee Hospital, and the nursing home.

The former project director informed us that much of the time he had charged to the project had been spent on speaking engagements and on writing articles for medical journals concerning the project. Project records showed that he had delivered a number of speeches but that much of the writing of the speeches and the journal articles had been done by another person who was paid about $2,700 from OEO funds for services provided from September 1968 to January 1970.

Associate project director

The project reimbursed the medical group during the third program year for two thirds of the salary that the medical group paid to one of its physicians who had acted as the project's part-time associate project director. The associate project director informed us that he did not keep time records but that he scheduled about 16 hours of his regular workweek for project business. He told us that he spent the remainder of his time seeing both project and private patients on a fee-for-service basis at the medical group's clinic, working at the clinic on an on-call basis, and visiting patients at Mee Hospital.

In addition to paying the medical group for two thirds of his salary for administrative duties, the project also paid the medical group on a fee-for-service basis for services rendered by him to project patients at the clinic.

Secretary to former project director

The project paid the entire salary of $7,000 of the former project director's secretary, although, according to the former project director, the secretary had spent a portion of her time on nonproject business. The project's former financial officer told us that the secretary's entire salary had been charged to the project to help cover added overhead costs incurred by the medical group due to the project.

Former financial officer

During the second and third program years, the project budgeted and OEO approved payments of $15,375 to reimburse the medical group for 50 percent of the salary that the medical group paid to its administrator, who also had acted during that time as the project's financial officer. The percentage had been increased from the 20 percent for the first program year in which 10 percent of his salary had been OEO-funded and 10 percent had been provided as a contribution to the project.

The former financial officer informed us that he had not maintained records of the time he had spent on project

business but that project-related work had taken a significant amount of his time. Medical group records showed that about 35 percent of the medical group's patients were project enrollees.

Pediatrician

OEO approved the use of grant funds to pay the salary of a pediatrician who worked at the medical group's clinic from October 1968 to November 1969. The pediatrician, whose total salary for the employment period was about $17,000, treated both private and project patients. The medical group billed both private patients and the project for her services on a fee-for-service basis. Over the period of her employment, the total billings by the medical group for her services amounted to about $31,000, of which, at the time of our fieldwork, the medical group had reimbursed the project about $2,600.

After we inquired into this matter, the project was reimbursed an additional $12,500 for a total of $15,100 or about half the pediatrician's total billings.

Physician assistants

OEO funds also were used to pay the salaries of two physician assistants who worked at the clinic. One was employed from October 15, 1968, to October 31, 1969, at a total cost to the project of $8,125. The other, initially employed on August 5, 1969, was receiving a salary of $1,250 a month at the time of our fieldwork.

These physician assistants worked at the medical group's clinic and treated both private and project patients. The medical group billed both private patients and the project for their services on a fee-for-service basis. The project was not reimbursed for time spent by these assistants in treating private patients, and although it was paying the assistants' full salaries, the project paid the medical group on a fee-for-service basis for services they had rendered to project patients.

The medical society advised OEO in October 1969 of the employment of the second assistant and indicated that the

medical group would pay a portion of his salary. An OEO official, however, approved the use of OEO funds to pay the full salary of the assistant. Provision was not made for the project to be reimbursed for the billings generated by the assistant.

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OEO health officials informed us that they had approved the payment of the former project director's salary for the third program year on the basis of his administrative responsibilities and his value to OEO in publicizing the Comprehensive Health Services Program and the project. OEO officials stated, however, that it did not appear that the former project director had fully met his administrative responsibilities with respect to the operations of the project.

OEO officials informed us that they were not aware of the differences between the parts of salaries paid from OEO funds and the portions of time spent on project activities by the associate project director, the former project director's secretary, and the former financial officer or that the project was being charged on a fee-for-service basis for services rendered to project patients by persons whose salaries were being paid, in whole or in part, with OEO funds.

Regarding the salary of the second physician assistant being paid entirely with OEO funds with no provision for the project's being reimbursed for services provided by him, the OEO official who approved the arrangement stated that he had done so because of OEO's interest in developing new roles in the health field.

Conclusion

Grant funds were used to pay all or part of the salaries of certain persons employed by the project without regard to the time they actually had spent on project activities and, except for one case, without having reimbursed the project for the time these persons had spent rendering services to nonproject patients. In addition, the project paid the medical group on a fee-for-service basis for services rendered to project patients by persons whose

salaries were being paid, in whole or in part, with grant funds.

Also OEO's approval of the project's paying the entire cost of the salary of the second physician assistant with program funds without requiring reimbursement for services rendered by him is contrary to program guidelines which provide that health projects must obtain reimbursements whenever possible.

Recommendations to the Secretary of Health, Education, and Welfare

HEW, through the Health Services and Mental Health Administration, should determine and recover from the medical group for the cases cited above (1) the amount of the differences between the part of salaries paid and the part of the salaries that should have been paid on the basis of the amount of time actually spent on project activities, (2) the reimbursements due the project for services rendered to non-project patients by persons whose salaries were paid, in whole or in part, with program funds, and (3) the amounts paid the medical group on a fee-for-service basis for services rendered to project patients by persons whose salaries were paid, in whole or in part, with program funds.

HEW should also provide for more adequate monitoring of project operations to preclude such situations from occurring in the future.

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The Deputy Director of OEO, in his comments, stated that OEO agreed with our recommendation and that it had requested HEW to follow up on these matters.

CHAPTER 6

SCOPE OF REVIEW

Our review was concerned primarily with the policies, procedures, and practices followed in the administration of the project in King City. We were assisted in our review by a United States Public Health Service medical officer who reviewed the medical records to evaluate the quality of medical care and treatment.

We reviewed the basic legislation authorizing the program and various OEO policy and guidance publications and documents. We examined pertinent records and documents and interviewed officials at OEO's headquarters, Washington, D.C., and at the offices of the medical society, the project, the medical group, and the community action agency, all of which are located in Monterey County. We also interviewed 52 project enrollees.

APPENDIXES

CHARACTERISTICS OF PROJECT'S FIRST-YEAR ENROLLEES (note a)

	Number (note b)	Percent
AGE:		
Under 19	2,142	53
19 to 54	1,433	36
Over 54	460	11
ETHNIC GROUP:		
Mexican-American	2,094	54
Mexican	1,184	31
White	558	14
Black	7	
Other	41	1
BIRTHPLACE:		
Mexico	1,150	30
California	1,139	29
Texas	991	25
Other	603	16
RESIDENCE IN TARGET AREA--ADULTS ONLY:		
Under 12 months	460	30
12 to 23 months	184	12
Over 23 months	905	58
CITIZENSHIP STATUS--ADULTS ONLY:		
Citizen of United States	987	60
Not Citizen of United States	651	40
EDUCATION--ADULTS ONLY:		
None	208	13
1 to 6 years	743	47
7 to 8 years	258	16
9 to 11 years	242	15
12 years or over	127	8
MONTHS WORKED IN LAST YEAR:		
Male head of household:		
None	86	12
1 to 7 months	152	22
8 to 12 months	468	66
Female head of household:		
None	108	45
1 to 7 months	68	28
8 to 12 months	63	26

[a]This data was extracted from a study, prepared by a project consultant, entitled "One Thousand and Nine Poor Families," March 1970.

[b]The number of enrollees in related categories, such as those showing adults only, may not agree in total because the necessary data may not have been obtained for each enrollee or because errors may have occurred in translating or coding the data.

APPENDIX II

MEDICAL FACILITIES AND SERVICES

IN KING CITY, GREENFIELD, AND SOLEDAD

MEDICAL GROUP'S CLINIC

The medical group's clinic, built in 1963, is located in King City in an attractive, air-conditioned, modern, single-level structure. It houses a private group practice composed of nine physicians.

The practice was initially established in 1945 as a father-and-son partnership. It was incorporated in October 1969 with an executive committee of three physicians; the seven permanent physicians at that time were the shareholders.

On April 1, 1970, the physician staff included a surgeon, an internist, a pediatrician, and six general practitioners. In addition, during the project's first 3 program years, several full-time and part-time physicians joined and left the medical group. Several medical specialists and consultants from cities outside the target area visit the clinic on a scheduled basis.

GEORGE L. MEE MEMORIAL HOSPITAL

Mee Hospital, which was built in 1962 adjacent to the clinic and which was accredited by the Joint Commission on Accreditation of Hospitals, is the only hospital within 45 miles of King City. Mee Hospital, which averaged about 50-percent utilization during the 4-year period 1966 through 1969, provides basic inpatient care as well as outpatient, laboratory, and X-ray services.

PIONEER HACIENDA CONVALESCENT AND NURSING HOME

The nursing home is a 25-bed facility licensed by the State. It is located in King City 3 blocks from the clinic-hospital complex. It has consistently been fully utilized and most of its revenue has come from sources other than the project.

HOME HEALTH CARE AGENCY

This agency is located in King City adjacent to the project offices. It was originally established under the project in April 1968 and had one registered nurse to provide home health care. It was taken over by the medical group in early 1969, but, due to continued losses from its operation, it was transferred back to the project in April 1970. At that time, it was staffed by a registered nurse, a home health aide, and a secretary.

GREENFIELD MEDICAL FACILITY

The medical group's suboffice, located in Greenfield, was opened in 1951. It is staffed by two general practitioners, one of whom serves as the anesthesiologist at Mee Hospital. At the time of our review, the other practitioner was president of the medical society.

SOLEDAD MEDICAL FACILITY

In January 1968 the project opened a suboffice in Soledad. Due to staffing difficulties, it was necessary to close it in the latter part of the second program year. Soledad residents were excluded from the project for the first 5 months of the third program year, after which the project decided to provide transportation for eligible Soledad residents to the clinic at King City. Also the project made arrangements with a private physician in Soledad, who was not affiliated with the medical group, to provide care to project patients on a fee-for-service basis.

APPENDIX III

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY
WASHINGTON, D.C. 20201

NOV 17 1970

Mr. Philip Charam
Associate Director
Civil Division
United States General Accounting
Office
Washington, D.C. 20548

Dear Mr. Charam:

We appreciate the opportunity to review the draft report on the GAO's review of the operations of the Southern Monterey County Rural Health Project, King City, California, funded by the Office of Economic Opportunity under the Comprehensive Health Services Program. You may know that this and 15 other comprehensive health services projects will be transferred from the OEO to this Department as of December 14, 1970.

We noted that while certain principal objectives had been achieved, changes were needed in order to meet other important objectives and to generally improve operations as well as to take corrective actions. The recommendations of the GAO for changes are well-taken. Since the project will be under the aegis of the HEW soon, we will continue efforts which have been started to correct the deficiencies and will make every effort to provide assistance to strengthen all aspects of the project. Further, the timeliness of this report indicates areas in which we can take action in order to improve the effectiveness and efficiency of similar programs.

Please send us a copy of the final report when it is released.

Sincerely yours,

James B. Cardwell
Assistant Secretary, Comptroller

EXECUTIVE OFFICE OF THE PRESIDENT
WASHINGTON, D.C. 20506

OFFICE OF ECONOMIC
OPPORTUNITY

JAN 22 1971

Mr. Henry Eschwege
Associate Director
United States General Accounting
Office
Washington, D.C. 20548

Dear Mr. Eschwege:

As requested in your letter of September 30, 1970, we have reviewed in detail the draft report on the Southern Monterey County (California) Rural Health Project. We have also provided copies to the Rural Health Project staff and have received and reviewed their comments.

Comments on the draft report are enclosed. These statements include both general observations and comments on particular points.

We would be pleased to discuss any of these comments further with G.A.O. staff.

Thank you for your assistance.

Wesley L. Hjornevik
Deputy Director

APPENDIX IV

Comments on GAO Draft Report, "Opportunities for Improving Services to the Poor and Administrative Efficiency of the Southern Monterey County, California, Rural Health Project."

GENERAL COMMENTS

The development and operations of the Rural Health Project, Inc. (RHP) must be considered within the context of OEO's mission to develop and support innovative experimental Comprehensive Health Services Programs. In the case of RHP, this effort is being attempted within the framework of an existing private delivery service. The Monterey County Medical Society and the Southern Monterey County Medical Group are among the few private medical groups in the country to join actively in the experiment to develop new methods of health care so as to incorporate the poor into the health service system on an equal basis. The Society, the Group, and the original Project Director have shown courage and leadership in their work in this area and have progressed significantly in learning from these early endeavors. [See GAO note 1, p. 84.]

In addition, the activities and accomplishments of the RHP should be considered in the context of the difficulties encountered in the development of health projects in all rural areas throughout the country. Conditions frequently encountered in these types of undertakings include shortages of accessible medical resources and back-up, pressure of patient loads, insufficient supply of health personnel, long distances, inadequate transportation, difficulty of recruitment of skilled staff, and local attitudes adverse to new social programs, to persons on welfare, and to minority groups. [See GAO note 1, p. 84.]

Most conclusions and recommendations of the GAO report are in line with OEO findings. The success of the RHP, however, must be viewed in terms of the

objectives of the CHS Program - to support local efforts that seek to learn how to reach the goals set by the Program Guidelines under a variety of diverse conditions and circumstances. The Program Guidelines for Comprehensive Health Services set goals against which the progress and problems this project has experienced should be measured, rather than as established standards to which the project must correspond immediately.

The RHP has made important gains and shows significant promise in identifying and documenting existing health problems and establishing new and more responsive methods of care in a privately owned medical group practice which serves persons of differing income and cultural backgrounds. Learning has been linked with the experimentation and service delivery; some of thelearning has been positive and some negative.

The work of the RHP has received recognition from many professional groups. An evaluation of the RHP by an eleven man evaluation team from the California Medical Association is attached [see GAO note 1, p. 84].

The draft GAO Audit Report also documents, [see GAO note 1, page 84] some of the accomplishments of the project. Progress is noted in two areas of need for many people who had never had access to them before: quality medical care and permanent employment with an adequate income.

The comments [see GAO note 2, p. 84] of the audit report must especially be viewed in light of the conditions discussed above. The provision of comprehensive services in a remote rural area is a matter of such complexity that full accomplishment is only possible in terms of many years of effort. Progress has to be measured in the light of small steps toward constructuring a unified program, such as employment of a pediatrician, utilization of a nurse

practitioner, initiation of a physician's assistant, development of dental services, consideration of a drug formulary, and many other significant gains. Each of these steps moves towards the goal of comprehensive services once the problem was identified, the need assessed, and implementation of a solution begun. As a particular short-term goal (i.e., a pediatrician attracted to the area, a major accomplishment in itself) is accomplished, an important new capability is established which leads to the resolution of other problems.

The complexities involved in stimulating and facilitating changes in the existing system of delivery of health care services is staggering, especially when the project is a limited experimental one. Participation of poor consumers in planning and operations is one of the key elements of this complexity and has been encouraged in line with the Guidelines towards which OEO and RHP are attempting to work. The RHP consumers have progressively developed an increasing voice in the project; the degree of that voice has undergone continual redefinition and meaningful expansion during the short three years of the Project.

[See GAO note 3.]

GAO notes:

1. Deleted material referred to exhibits accompanying the Deputy Director's letter which were considered in the preparation of our final report but which are not reproduced herein.

2. Deleted page references refer to pages of draft report.

3. Deleted material pertained to specific comments by OEO which were considered in the preparation of our final report but which are not reproduced herein.

EXECUTIVE OFFICE OF THE PRESIDENT
WASHINGTON, D.C 20506

OFFICE OF ECONOMIC
OPPORTUNITY

FEB 22 1971

Mr. Henry Eschwege
Associate Director
United States General Accounting
Office
Washington, D.C. 20543

Dear Mr. Eschwege:

In line with the request by your staff, there are forwarded additional comments on each of the specific recommendations included in the draft GAO Report on "Opportunities for Improving Services to the Poor and Administrative Efficiency of the Southern Monterey County, California, Rural Health Project".

Sincerely,

Wesley L. Hjornevik
Deputy Director

COMMENTS OF [illegible] ON EXCERPTS OF GAO DRAFT REPORT ON RURAL HEALTH PROJECT

[See GAO note 1, p. 87.] Subject	Comment
Preventive Health Services	Agreement. Substantial staff and consultant efforts have been aimed at aiding Project Personnel to achieve these goals.
Outreach	Agreement. Continuing staff efforts have sought to help Project personnel to strengthen these services.
Evaluation	Agreement. [See GAO note 2, p. 87.] substantial progress has been made in this regard.
Eligibility	Agreement. Revised eligibility procedures were instituted during January, 1970, as part of a concerted effort to improve the administrative procedures of the project.
Hospital Care	Partial Agreement. Continuing efforts have been made to obtain County and other reimbursements for care rendered at the clinic and Mee Hospital but substantial resistance has been encountered. [See GAO note 2, p. 87.] it is believed the appropriate use of the available hospitals must be considered in light of the nature of individual cases and the prevailing conditions, taking into account both the needs of the patient and the goals of the project. The policies and practices of the Rural Health Project in this regard have been under continuing review and discussion which has aimed at furthering the use of the County Hospital when indicated; for example 68 project patients were referred to the County Hospital between January, 1970 and December, 1970. 63 were outpatients, 5 were inpatients.
Reimbursements	Agreement. Efforts to encourage and facilitate billing of Medi-Cal, Medicare, and other third party sources have received substantial attention. [See GAO note 2, p. 87.]

[See GAO note 1.]

Subject	Comment
Overpayment for services	Agreement. The Rural Health Project has sought to recover the excess payment to the Medical Group. OEO has withheld funds to the Project awaiting the resolution of this matter.
Overpayment for salaries and indirect costs	Agreement. The Public Health Service, Department of Health, Education and Welfare, to whom responsibility for administration of this grant was transferred on December 14, 1970, has been requested to follow up on these items.
Advance Payments	[See GAO note 3.]
Salary Payments	Agreement. The Public Health Service has been requested to follow up on these matters.

[See GAO note 3.]

GAO notes:

1. Page references which referred to pages of the draft report were deleted.

2. Deleted material referred to portions of the Deputy Director's letter of January 22, 1971, which were considered in the preparation of our final report but are not reproduced herein.

3. Deleted material pertained to matters included in the draft report which are not included herein.

APPENDIX VI

PRINCIPAL OFFICIALS OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE AND THE OFFICE OF ECONOMIC OPPORTUNITY RESPONSIBLE FOR THE ADMINISTRATION OF ACTIVITIES DISCUSSED IN THIS REPORT

	Tenure of office	
	From	To
DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE		
SECRETARY OF HEALTH, EDUCATION, AND WELFARE:		
Elliot L. Richardson	June 1970	Present
ASSISTANT SECRETARY FOR HEALTH AND SCIENTIFIC AFFAIRS:		
Roger O. Egeberg, M.D.	July 1969	Present
ADMINISTRATOR, HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION:		
Vernon E. Wilson, M.D.	May 1970	Present
OFFICE OF ECONOMIC OPPORTUNITY		
DIRECTOR:		
Frank C. Carlucci	Dec. 1970	Present
Donald Rumsfeld	May 1969	Dec. 1970
Bertrand M. Harding (acting)	Mar. 1968	May 1969
R. Sargent Shriver	Oct. 1964	Mar. 1968
ASSOCIATE DIRECTOR, OFFICE OF HEALTH AFFAIRS:		
Carl A. Smith, M.D. (acting)	May 1971	Present
Thomas E. Bryant, M.D.	Sept. 1969	Apr. 1971

OFFICE OF ECONOMIC OPPORTUNITY

ASSISTANT DIRECTOR, OFFICE OF HEALTH AFFAIRS (note a):				
Thomas E. Bryant, M.D. (acting)	Jan.	1969	Sept.	1969
Joseph T. English, M.D.	Mar.	1968	Jan.	1969
Julius B. Richmond, M.D.	July	1966	Mar.	1968
ASSISTANT DIRECTOR FOR COMMUNITY ACTION PROGRAMS (note a):				
Theodore M. Berry	Apr.	1965	Sept.	1969
PROJECT MANAGER, HEALTH SERVICES, COMMUNITY ACTION PROGRAM (note a):				
Gary D. London, M.D.	Apr.	1968	Aug.	1969
John Frankel, D.D.S.	July	1966	Apr.	1968

[a]In a September 1969 major reorganization of OEO, these offices were terminated as organizational entities. At that time, the various health activities of OEO, including the Comprehensive Health Services Program, were combined in a new Office of Health Affairs and the majority of other Community Action Program activities were shifted to a newly created Office of Operations.

U.S. GAO, Wash., D.C.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

OFFICE OF THE SECRETARY

WASHINGTON, D.C. 20201

OCT 22 1971

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Honorable Elmer B. Staats
Comptroller General of the United States
General Accounting Office
Washington, D.C. 20548

Dear Mr. Staats:

The Secretary has asked that I reply to the report of the General Accounting Office entitled "Opportunities for Improving the Southern Monterey County Rural Health Project, King City, California." As requested, we are enclosing the Department's comments on the findings and recommendations in your report.

If you would like any additional information or if we can help in any way, please let us know.

Sincerely yours,

James B. Cardwell
Assistant Secretary, Comptroller

Enclosure

COMMENTS ON THE GENERAL ACCOUNTING OFFICE
REPORT TO THE CONGRESS, ENTITLED
OPPORTUNITIES FOR IMPROVING THE SOUTHERN MONTEREY COUNTY
RURAL HEALTH PROJECT, KING CITY, CALIFORNIA

GAO Recommendation: HEW should require and assist the project to make a concerted and systematic effort to expand, improve, and more adequately document the preventive care services provided to its enrollees.

HEW Comment: We concur. Arrangements have been made for staff at the HEW Regional Office in San Francisco, California to provide the necessary consultive services to Project officials to carry out this recommendation.

GAO Recommendation: HEW should monitor the project's outreach program periodically and continue to assist the project in its efforts to strengthen the program.

HEW Comment: We concur. The Medical Project Officer at the regional office has established a schedule for reviewing the effectiveness of the outreach program and its relationship to medical services being rendered.

GAO Recommendation: HEW should encourage and assist project officials to undertake systematic evaluations designed for measuring the extent to which the project is meeting its objectives and to develop procedures for reporting the results to management at all levels for planning purposes and for dissemination to other federally assisted projects.

HEW Comment: We concur. As pointed out in the GAO report, funds were provided by OEO as of July 1, 1970, to increase the capability of Project officials to review and evaluate the adequacy of their operations. A computer system has been designed for this purpose by an outside contractor. This system, when fully de-bugged, will be the basis for a complete management evaluation and reporting system of the project's operations. We plan to have HEW regional staff participate in this work during its later stages.

GAO Recommendation: HEW should (i) reemphasize to the project its responsibility to seek out and obtain reimbursements from third parties where appropriate and (ii) monitor the project's performance in this regard.

HEW Comment: We concur. Third party reimbursement guidelines are presently being developed nationally which state: "Except under extenuating circumstances with justifications documented and approved by DHEW, 314(e) grants may not be charged for covered services rendered to individuals eligible under third party insurance or prepayment financing arrangements except for the cost to the grantee which is in excess of the reimbursable amount."

We plan to monitor the extent that projects such as this one go against third parties for reimbursement of medical expenses by reviewing and analyzing a monthly closing statement to be submitted to the HEW regional office. The requirement for this type of report is now being developed as a condition of award for all projects of this nature.

GAO Recommendation: HEW should take action to determine and recover the full amount of the project's overpayments to the medical group for services rendered to project enrollees and make periodic reviews of project expenditures to ensure that billings are correct and that overpayments are avoided.

HEW Comment: We concur. The Regional Office will, within the next sixty days, determine and recover appropriate project overpayments to the medical group. Periodic reviews of project expenditures are being made by the Regional Office to ensure that billings are correct and that overpayments are avoided.

GAO Recommendation: HEW should require the medical group to reimburse the project for payments made on other than a fee-for-service basis that were not approved by OEO and to adequately support any claims for reimbursement of overhead costs charged to the grant during the third program year.

HEW Comment: We concur. After detailed and lengthy negotiations, including an audit by the Southern Monterey County Medical Society, a fee schedule was accepted by the Medical Group for future reimbursements. Collection of prior payments made on other than a fee-for-service basis and not approved by OEO will be discussed with the medical group in the near future.

An audit by an independent accounting firm supported the center's claim for reimbursement of overhead costs charged to the grant during the third program year. An evaluation of this report is now in process.

GAO Recommendation: HEW should require and assist the project to strengthen its policies and procedures for determining eligibility for project services, to maintain records adequate to ensure that the State is billed for medical care for which it has the responsibility to pay, and to continue efforts to assist enrollees in applying for programs for which they are eligible.

HEW Comment: We concur. Project personnel are revising the guidelines concerning eligibility for project services. These guidelines will bear a direct relationship to Medicaid standards on eligibility. In addition, they will incorporate a sliding scale of payment for borderline or "near poor" as well as for other types of prospective patients.

A new accounting system has been installed at the project. One of its features is that it assists in identifying project patients whose medical bills may be paid partially - or in full - by third parties, such as the State or commerical insurance firms. The public accounting firm that installed this system plans to review it in the near future for adequacy and effectiveness.

As recommended, Project Officials will continue the systematic efforts begun in January 1970 to assist project enrollees in applying for assistance under the State Medicaid or other public assistance programs for which they appear to meet the criteria.

GAO Recommendation: HEW should require the project to (i) develop procedures to ensure that the county, rather than the project, is billed whenever appropriate for care rendered at the clinic and Mee Hospital and (ii) assure that the county hospital is utilized for nonemergency hospitalizations and those which are not of a highly unusual nature.

HEW Comment: We concur. HEW regional office officials have stressed to project officials that in most instances the county and not the project is responsible for paying the cost of medical services provided project participants at the clinic or at the (local) Mee hospital. It was pointed out, that as mentioned by GAO in their report, program funds are the last-dollar source for payment of such expenses, and are not to be used for this purpose except in highly unusual circumstances. In addition, project officials were notified that the amount of the current year's grant award which may be used for such payments of hospitalization expenses has been reduced - and that next year's award will have no funds for payment of such expenses.

The Regional Health Director has notified project officials that the county hospital will have to be used for all nonemergency hospitalization required for those people not eligible for care under any other hospitalization plan such as Medicare, Medicaid or private health insurance.

GAO Recommendation: ... group for the cases cited above (1) the amount of the differences between the part of salaries paid and the part of the salaries that should have been paid on the basis of the amount of time actually spent on project activities, (2) the reimbursements due the project for services rendered to non-project patients by persons whose salaries were paid, in whole or in part, with program funds; (3) the amounts paid the medical group on a fee-for-service basis for services rendered to project patients by persons whose salaries were paid, in whole or in part, with program funds.

HEW should also provide for more adequate monitoring of project operations to preclude such situations from occuring in the future.

HEW Comment: In regards to the OEO overpayments, these amounts were in negotiation between the medical group administrator and OEO. HEW will, within the next sixty days, continue these negotiations and make appropriate collections. However, additional overpayments to the Medical Group should be prevented under HEW because of accounting systems installed by a national CPA firm, and an agreed rate between the center and the medical group.