United States General Accounting Office

GAO

Report to the Chairman, Subcommittee on Health and Long-Term Care, Select Committee on Aging, House of Representatives

January 1990

HEALTH CARE

Limited State Efforts to Assure Quality of Care Outside Hospitals

RESTRICTED——Not to be released outside the General Accounting Office unless specifically approved by the Office of Congressional Relations.

547723

GAO/HRD-90-53

GAO

United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-236203

January 30, 1990

The Honorable Edward R. Roybal
Chairman, Subcommittee on Health
and Long-Term Care
Select Committee on Aging
House of Representatives

Dear Mr. Chairman:

In this report, we respond to the request of the former Chairman, the Honorable Claude Pepper, for information on the state requirements relating to quality assurance for health care delivered by both freestanding providers and health maintenance organizations. We have included information on state quality assurance activities concerning (1) licensing, inspection, and enforcement for 16 types of freestanding providers and (2) inspection and enforcement activities for health maintenance organizations.

As arranged with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after its issue date. At that time, we will send copies to the Department of Health and Human Services and other interested parties.

Please call me on (202) 275-5451 if you or your staff have any questions about this report. Other major contributors are listed in appendix XIII.

Sincerely yours,

Janet L. Shikles

Janet L. Shikles
Director, Health Financing
and Policy Issues

Executive Summary

Purpose

Over the past two decades, medical and diagnostic procedures that traditionally have been done in a hospital are increasingly being done in "freestanding" facilities. These are facilities that provide such services as cardiac catheterization, testing of blood samples, and radiation therapy for cancer. Relocating complex and risky medical procedures from hospitals to freestanding facilities has prompted concern about quality assurance.

In response to this concern, the former Chairman, Subcommittee on Health and Long-Term Care, House Select Committee on Aging, asked GAO to determine how states license and inspect freestanding providers and otherwise ensure quality care. The Chairman also asked GAO to determine how and the extent to which states inspect health maintenance organizations (HMOs) to assure they provide quality care.

Background

Measures commonly used to promote quality are (1) licensing, which allows states to establish regulations covering providers, (2) inspection, which allows states to oversee providers' adherence to regulations, and (3) enforcement, which allows states to impose sanctions for deficiencies. (These measures cannot, of course, guarantee quality, but they do provide a foundation for quality care.)

In its study, GAO focused on state licensing, inspection, and enforcement for 16 types of freestanding providers (see p. 10), including ambulatory surgical centers, cancer treatment centers, and hospice care. GAO sent a questionnaire to health department licensing officials in the 50 states and the District of Columbia to obtain information on freestanding providers. GAO also did a telephone survey of the state officials responsible for regulating HMOs in the 50 states and the District of Columbia.

Information in this report on state licensing and inspection, including information on relevant state laws, is based on survey results received from states, reflecting activity through September 30, 1987, except as otherwise noted.

Results in Brief

States have been slow to license freestanding providers. In fact, states do not license or otherwise regulate most of the 16 types of freestanding providers in GAO's review.

For those freestanding providers that are licensed, however, states have imposed few sanctions for deficiencies identified during inspections.

State officials cited appeals processes and the lack of intermediate sanctions as impediments to imposing sanctions. In addition, state officials expressed concern about the adequacy of their oversight and licensing efforts.

Nevertheless, states' plans for expanding licensing requirements to unlicensed providers are limited. Because of minimal state regulatory efforts, consumers do not have adequate assurance that unlicensed freestanding providers are offering quality care.

GAO's Analysis

Limited State Licensing of Freestanding Providers

Nine of the 16 types of providers GAO studied were reported to be operating in more than 30 states; 3 of them (alcohol and drug abuse treatment centers, ambulatory surgery centers, and home health agencies) were typically required to obtain licenses. Licensing patterns were spotty for the other types—ambulatory care centers, ambulatory psychiatric centers, diagnostic imaging centers, hospices, independent clinical laboratories, and comprehensive rehabilitation centers.

Of the 45 states reported to have ambulatory care centers, 10 required licenses. Among 34 states reported to have diagnostic imaging centers, 3 required licenses. No state required licenses for pain control centers or cancer centers providing chemotherapy or radiation treatment, even though such centers were reported to be operating in from 14 to 18 states. (See pp. 17-19.)

State Sanctions Against Freestanding Providers Limited

Overall, states report licensing more than 23,000 freestanding providers. Out of this number, for the 12-month period ending September 30, 1987, 21 states reported imposing 165 sanctions against licensed freestanding providers for deficiencies identified during inspections. The remaining states reported not sanctioning any freestanding providers. Lengthy appeals processes and the lack of intermediate sanctions were cited as impediments to imposing sanctions.

The states imposed sanctions against six types of providers (alcohol and drug abuse centers, ambulatory care centers, ambulatory psychiatric centers, ambulatory surgical centers, home health care, and independent

clinical laboratories); most frequently, against independent clinical laboratories. Service restriction was the most frequently imposed sanction. (See pp. 24 and 25.)

States reported that the most effective sanctions were monetary penalties and service restrictions and the least effective, revocation, suspension, or other limits on providers' licenses. The most frequently mentioned impediment to imposing sanctions against providers was the time required to complete administrative or judicial hearings and appeals. (See pp. 24 and 25.)

State Concerns About Assuring Quality of Care for Freestanding Providers

Thirty-six state officials expressed concerns about assuring quality of care for freestanding providers. Typically, officials saw a need for (1) expanding licensing and (2) additional resources to carry out quality assurance programs. They also questioned whether staff working for freestanding providers have proper credentials and training. Still others expressed concern about the public's false presumption that freestanding providers are regulated. Concerns officials raised included:

- Treatment and procedures performed by freestanding providers without state or federal oversight, such as laboratories in supermarkets, may not be safe.
- Unless freestanding providers are regulated, the quality of care may not be as good as that provided in a hospital.
- More staff are needed to provide oversight of existing providers as well as for future ones.
- Professional and nonprofessional staff of freestanding providers may not be adequately qualified and credentialed.
- Staff lack training in infection control and emergency care in life-threatening situations (see pp. 25-27).

States Lack System to Address Complaints

Most states reported receiving complaints about the quality of care provided by freestanding providers, and almost half reported lacking systems for receiving and resolving such complaints.

Forty-two states reported receiving complaints during the 12-month period ending September 30, 1987. Complaints included

- insufficient and unqualified staff and inappropriate care,
- alleged poor quality of care and lack of attention to patient needs, and
- the staff's standards of medical practice (see pp. 27 and 28).

Limited Plans to Expand Licensing

Health department officials from only 13 states identified plans to license additional providers; those plans were generally limited to licensing one or two types of freestanding providers, typically those most frequently licensed by other states (see p. 28).

State Programs to Assure Quality of Care for HMOs Limited

Twenty-two states had on-site inspection programs for HMOs. Only two had imposed formal sanctions against HMOs during the 3-year period ending December 31, 1987: California prohibited the enrollment of new members and New York imposed fines. Sanctions were imposed because of poor or inadequate health care services or other quality-of-care-related deficiencies. Some state officials suggested that sanctions are often not needed because of (1) the willingness of HMOs to take corrective actions when deficiencies are identified and (2) the effectiveness of some state licensing programs. (See pp. 29-32.)

Recommendations

This report contains no recommendations.

Agency Comments

GAO did not obtain written comments on this report.

Contents

Tables

Figure

Abbreviations

GAO	General Accounting Office
HMO	health maintenance organization
HHS	Department of Health and Human Services

Introduction

Over the last two decades, efforts to control health care costs, rapidly developing technology, and increased competition have resulted in the rapid expansion of freestanding providers,[1] which offer specific health care services outside the traditional settings of hospitals, nursing homes, and physician offices. At the same time, health maintenance organizations (HMOs), which offer comprehensive health care services to members, have expanded rapidly as an alternative to the traditional fee-for-service method of paying for health care; their heavy emphasis on keeping patients out of hospitals has helped fuel an already growing ambulatory health care market.

Expressing concern about the quality of care provided by freestanding providers and HMOs, the former Chairman, Subcommittee on Health and Long-Term Care, House Select Committee on Aging, asked us to obtain information from the states on quality assurance requirements and practices for health care delivered by freestanding providers and HMOs. In subsequent discussions with the Subcommittee office, we agreed to focus on quality assurance in the states as it relates to (1) licensing, inspection, and enforcement for 16 types of freestanding providers and (2) inspection and enforcement for HMOs.

Growth of Freestanding Providers

Freestanding providers, offering alternatives to hospital-based or nursing home care, are reshaping the nation's health care system. These freestanding providers include the following:

Alcohol and Drug Abuse Treatment Center: A facility providing treatment, on an ambulatory basis, for drug and alcohol dependence. Such a facility is sometimes called a substance abuse service (or program) or behavioral health center.

Ambulatory Care Center: A facility providing primary or episodic care, usually during extended office hours, which may not require an appointment. This excludes a physician's office practice. Such a facility is sometimes called a primary care center or a walk-in clinic.

Ambulatory Psychiatric Center: A facility providing mental health services on an ambulatory basis. Such a facility is sometimes called an outpatient psychiatric center or a mental health clinic.

[1]The term freestanding providers is used throughout this report to include the 16 types of facilities and agencies that we studied that provide health care or services. (See pp. 10-12.)

Ambulatory Surgical Center: A facility providing surgical procedures that do not require an overnight stay, which may specialize in certain procedures, for example, cataract surgery or hernia repair.

Cancer Treatment Center (Using Chemotherapy): A facility providing diagnosis and treatment of cancer on an ambulatory basis, which uses chemotherapy.

Cancer Treatment Center (Using Radiation Therapy): A facility providing diagnosis and treatment of cancer on an ambulatory basis, which uses radiation therapy.

Cardiac Catheterization Laboratory: A facility providing cardiac catheterization—a diagnostic procedure involving the insertion of a catheter into the heart—on an ambulatory basis and not providing overnight accommodations.

Comprehensive Rehabilitation Center: A facility providing medical rehabilitation for a variety of disabilities, which uses coordinated multidisciplinary therapy performed by or under the supervision of a physician.

Diagnostic Imaging Center: A freestanding mobile or fixed facility providing radiologic diagnostic services using techniques that may include advanced imaging technologies. Some offer disease-specific services, for example, breast cancer diagnosis.

Emergency Center: A facility providing 24-hour emergency service with capability for emergency life support and stabilization. Such a facility is often called a freestanding emergency center.

General Diagnostic Center: A facility providing a variety of diagnostic procedures, usually on physician referral. Such a facility may specialize in urologic, cardiovascular, or gastrointestinal disorders.

Home Health Care Service: An agency providing services to treat patients at home for existing medical problems and usually requiring physician orders and professional assistance.

Hospice Care: An agency providing care for people who are terminally ill.

Independent Clinical Laboratory: A facility providing diagnostic testing of samples or specimens in a freestanding laboratory.

Pain Control Center: A facility providing a multidisciplinary approach to diagnose and treat chronic pain. Some may specialize in a single discipline or certain types of chronic pain.

Specialized Rehabilitation Center: A facility providing medical rehabilitation using a single-discipline therapy or multidisciplinary therapy and specializing in certain types of disabilities.

Freestanding providers have experienced rapid growth in recent years; projections are for continued growth. For example:

- The National Association for Ambulatory Care expected the number of ambulatory care centers to increase from 180 in 1980 to an estimated 5,500 in 1990.
- SMG Marketing Group, Inc., Chicago, projected an increase from about 784,000 procedures performed in 459 freestanding surgery centers in 1985 to over 1.9 million procedures in 829 centers in 1990.
- Medicare-certified home health agencies increased from 2,212 in 1972 to about 5,661 in 1988.[2]

A study prepared for the National Conference of State Legislatures predicted that by 1990, up to 40 percent of all diagnostic procedures and surgeries may be done outside hospitals.[3]

Growth of HMOs

Paralleling the growth of freestanding providers has been the growth of HMOs. They offer comprehensive health services to their members in return for a prepaid, fixed payment regardless of the quantity of services given to any particular member; frequently, HMOs contract with freestanding providers to provide services for their members. HMOs have a financial incentive to reduce overall health care costs so they emphasize preventive medicine and minimize the use of health services. Such an incentive, however, can also foster the provision of fewer services than needed, thereby compromising the quality of care.

The Health Maintenance Organization Act of 1973 (42 U.S.C. 300e et seq.) authorized a program to help develop new HMOs and expand existing ones by (1) providing financial assistance to and (2) requiring

[2]Medicare is a federal health insurance program that assists almost all Americans 65 years of age and over, as well as certain disabled people in paying for their health care costs.

[3]Barbara Yondorf and others, Hospital Cost Containment, a Legislator's Guide (National Conference of State Legislatures, May 1985), p. 169.

certain employers to offer their employees the option of membership in HMOs that demonstrate their qualifications to the Department of Health and Human Services (HHS) under the act. The act has led the way in alternatives to fee-for-service health care. By January 1975, 183 HMOs, with an enrollment of over 6 million, were operating in 32 states and the District of Columbia. By the end of 1987, 746 HMOs, with an enrollment of 31.8 million, were operating in all states except Alaska.

Quality Assurance Programs

Some health industry observers have raised concerns about the quality of care in the growing numbers of freestanding providers and HMOs performing complex medical procedures traditionally provided in highly regulated hospitals with specialized equipment and skilled staff. The concerns arise because of a perception that no one is taking steps to assure consumers that they will receive quality care from these freestanding providers.

Quality assurance can be broadly defined as activities to safeguard or improve the quality of medical care by assessing quality and taking action to correct any problem found. Examples of quality assurance activities include (1) regulating providers through licensing, (2) providing the necessary oversight to see that regulations are adhered to, and (3) imposing sanctions, if necessary, when providers fail to meet requirements. Although not covered in this report, accreditation of freestanding providers and HMOs by organizations, such as the Joint Commission on the Accreditation of Healthcare Organizations and the Accreditation Association for Ambulatory Health Care, is another example of an activity that can help assure consumers of quality care.

Quality Assurance Activities of State and Federal Governments

Quality assurance programs help ensure that patients receive quality care; the programs are intended to provide a process by which to evaluate such areas as the (1) appropriateness of patient care and services provided; (2) utilization of resources; (3) safety of patients; (4) conduct and performance of physicians and others providing patient care; (5) patient access to appropriate medical care; (6) outcomes of medical care rendered; and (7) licensing, training, and certification of physicians and other professionals providing direct medical care. Using the results of these evaluations, the programs are expected to make recommendations to health care providers for improvement in deficient areas.

State implementation of licensing programs helps meet a consumer expectation of quality care. The federal government, through the Medicare program, also helps meet this expectation by requiring the operation of quality assurance programs.[4] States usually operate licensing programs for physicians, hospitals, and HMOs. In addition, the Medicare program imposes quality standards for hospitals, HMOs, and physicians wishing to qualify for Medicare payments.

Provider Quality Assurance

Internal quality assurance programs for most health care providers participating in the Medicare program vary but typically include such things as a (1) written quality assurance plan describing the program; (2) system for resolving complaints of poor quality care; (3) system of peer review to independently review and verify the appropriateness and quality of the care being provided; and (4) credentialing process to systematically review and verify the licenses, education, and training of all applicants for appointment and reappointment.

Little information is available on the extent of state quality assurance programs of freestanding providers. Federal quality assurance standards have been established for five types of freestanding providers—ambulatory surgery centers, home health agencies, clinical laboratories, comprehensive rehabilitation centers, and hospices—choosing to participate in the Medicare program. HHS contracts with state health departments or other state agencies to do periodic inspections of these freestanding providers to determine compliance with Medicare requirements. There are no federal quality assurance standards for the other 11 types of freestanding providers (see p. 10), (except for physicians who are and other health professionals who may be individually licensed). These types of providers are essentially unregulated unless the state imposes quality assurance requirements through its licensing and inspection processes.

Objectives, Scope, and Methodology

The former Chairman, Subcommittee on Health and Long-Term Care, House Select Committee on Aging, asked us to obtain information on the extent of state quality assurance requirements and practices for health care services given by freestanding providers and HMOs. In subsequent

[4]Quality assurance programs also exist under the Medicaid program and the health programs of the Departments of Veterans Affairs and Defense. Medicaid is a federally aided, state-administered medical assistance program that serves needy people. The Health Care Financing Administration, within HHS, has overall responsibility for administering the program at the federal level.

discussions with Subcommittee staff, we agreed to focus on state quality assurance activities concerning

- licensing, inspection, and enforcement for 16 types of freestanding providers and
- inspection and enforcement for HMOs.

We agreed with Subcommittee staff to limit our work on HMOs to state inspection and enforcement activities because the staff already had information on quality assurance activities concerning licensing of HMOs.

To obtain the requested information about the 16 types of freestanding providers, we developed and mailed copies of a questionnaire to health department licensing officials in the 50 states and the District of Columbia (51 states), asking them to provide information about their licensing and regulatory programs. We asked the states to categorize their freestanding providers, using the broad definitions we gave them (see p. 10). Because our focus was on efforts states have taken on their own to regulate health care given by freestanding providers, we did not ask about possible state efforts on behalf of the federal government to assure that providers comply with federal law and regulation under the Medicare and Medicaid programs.

Regulatory Program for Freestanding Providers

The questionnaire for freestanding providers was divided into two parts. In part I, we asked specific questions about state licensing, inspection, and enforcement activities (as of Sept. 30, 1987) for each of the 16 types of providers. In part II, we asked general questions about these providers as a group, including questions about state oversight problems and concerns about the quality of medical care.

After pretesting the questionnaire, we mailed the final version on October 16, 1987. When responses were returned, we reviewed them for consistency and completeness before including them in our data base. When responses appeared inconsistent or incomplete, we telephoned state representatives and attempted to obtain the missing data or resolve any inconsistency. We did not, however, verify the data provided by the states.

Although all states responded to the questionnaire, they did not answer all questions. For example, 26 states either did not respond or were unable to say how much they had spent for licensing activities relating to freestanding providers during the most recently completed fiscal year

(see app. VII). Two broad categories of providers—alcohol and drug abuse treatment centers and ambulatory psychiatric centers—generally were not under the jurisdiction of licensing officials from the state health department. For these providers, over half (29) of the respondents referred us to another state regulatory agency, which we telephoned when necessary to obtain clarification of the responses.

Inspection and Enforcement Activities for HMOs

We conducted a telephone survey of HMO regulators in each state to determine whether states had imposed sanctions against HMOs because of deficiencies in the quality of health care they provided. We pretested the telephone survey by speaking (on the telephone) with the Chairperson of the Quality Assurance Committee, National Association of Health Maintenance Organization Regulators, a nonprofit association of state and federal government officials responsible for the regulation of HMOs. The pretest results were used to refine the questions and prepare an interview guide for use during our telephone survey. Through the telephone survey, we sought information about (1) the number of HMO plans and enrollees and (2) state inspection and enforcement activities relating to the quality of medical care provided by HMOs. When responses appeared inconsistent or incomplete we resolved discrepancies through discussions with state regulators. We did not, however, verify the data provided by the states.

Complete and accurate information on the number of HMO plans and enrollees was not always available, in part because (1) some HMOs were not timely in reporting this information to states and (2) HMOs used different reporting methods. For example, because some HMOs that operate in more than one state report total enrollment to each state, enrollment data are overstated. Likewise, HMO plans that serve residents of more than one state are usually counted by each state, resulting in overstatement of HMO plans. For six states that did not provide HMO enrollment data, we used data from a quarterly report of HMO growth and enrollment as of December 31, 1987.[5] We did not attempt to adjust or audit the HMO data reported to us by states or obtained from the report.

Our work, was done in accordance with generally accepted government auditing standards.

[5]Interstudy, The Interstudy Edge, Excelsior, Minn.: Spring 1988. Interstudy is an organization that specializes in HMO research.

States Have Quality Assurance Standards If They License Freestanding Providers but Licensing Is Limited

States frequently do not require freestanding providers to obtain a license to operate. If a license was not required, it was usual for the state to report not knowing whether a type of provider was operating or, if known to be operating, how many providers of this type were in the state.

States with licensing requirements, on the other hand, generally (1) establish minimum requirements for quality assurance, (2) conduct on-site inspections to determine compliance with such requirements, and (3) impose sanctions against those providers not in compliance. Of the more than 23,000 licensed freestanding providers, states reported imposing sanctions against 165 during the year ending September 30, 1987, as a result of deficiencies identified during inspections. Lengthy appeals processes and the lack of intermediate sanctions were most often cited as reasons why sanctions were not imposed against more providers.

Despite expressing concerns about the adequacy of their quality assurance efforts or identifying complaints of poor quality care or both, state plans for expanding licensing requirements were limited to one or two types of freestanding providers, typically those most frequently licensed by other states.

States Without Licensing Programs Have Little Knowledge of Freestanding Providers

States frequently reported limited knowledge of the types and numbers of freestanding providers. For 8 of the 16 types of providers studied, the majority of state officials responding to our questionnaire did not know whether certain types were operating or how many. Generally, states were able to provide data on the number of providers operating only for those types required to obtain a license. Of the 16 types of providers, the number required to obtain a license to operate ranged from 0 (in Iowa and Vermont) to 9 (in Massachusetts and Rhode Island).

State Mandatory-Licensing Programs

Of the nine types of providers known to be operating in more than 30 states, three—alcohol and drug abuse treatment centers, ambulatory surgery centers, and home health agencies—were required to have a license to operate in more than 70 percent of the states where they were operating (see table 2.1 and apps. I and II). The remaining six types of providers—ambulatory care centers, ambulatory psychiatric centers, diagnostic imaging centers, hospices, independent clinical laboratories, and comprehensive rehabilitation centers—were allowed to operate without licenses in 20 to 35 of the states where they were known to be

operating. Officials from these states were generally unable to tell us how many of the providers within each of these six types were operating (see app. III).

Table 2.1: Operating Status and Licensing Requirement Status for States by Type of Providers (As of Sept. 30, 1987)

	Status				
	Operating			Licensing requirement[a]	
Type of provider	Yes	No	Don't know	Yes	No
Alcohol and drug abuse center	50	1	0	42[b]	8
Ambulatory care center	45	5	1	10	35
Ambulatory psychiatric center	42	5	4	20	22
Ambulatory surgical center	50	1	0	41	9
Cancer treatment (chemotherapy)	14	23	14	0	14
Cancer treatment (radiation)	15	21	15	0	15
Cardiac catheterization lab.	11	30	10	2	9
General diagnostic center	22	19	10	3	19
Diagnostic imaging center	34	12	5	3	31
Emergency center	25	22	4	4	21
Home health care	51	0	0	38[c]	13
Hospice care	48	3	0	28	20
Independent clinical lab.	49	2	0	25	24
Pain control center	18	20	13	0	18
Rehab. center (comprehensive)	38	12	1	10	28
Rehab. center (specialized)	24	17	10	4[d]	20

[a]Applies only to those states in which the type of provider was reported to be operating.

[b]Only methadone treatment centers are required to be licensed in California and Ohio.

[c]Idaho requires home health care to be licensed only if operated for profit.

[d]Only cardiac rehabilitation programs are subject to licensing in North Carolina.

The other seven types of providers, although known to be operating in 11 to 25 states, were required to obtain a license in 4 or fewer states. For example, no states required cancer treatment centers (either radiation therapy or chemotherapy) or pain control centers to obtain a license to operate, although such providers were known to be operating in 14 to 18 states. Similarly, only 2 of the 11 states reporting the existence of cardiac catheterization laboratories required them to obtain licenses.

From the perspective of individual states, Montana and New York were the only ones that required each type of provider known to be operating in a state (five for Montana and eight for New York) to obtain a license. Four other states (Massachusetts, Nebraska, New Hampshire, and

Rhode Island) required all but one of the types of providers known to be operating (from 6 to 10) to obtain a license; New Jersey required 8 of the 10 types operating in the state to obtain a license. Usually, however, states were at the other end of the spectrum. For example, Iowa and Vermont did not require any of the types of providers operating (10 for Iowa and 6 for Vermont) to obtain a license, and 10 other states required 25 percent or fewer of the types of providers known to be operating to obtain a license (see apps. I and II).

Even when licensing was required, 12 states reported not implementing the requirements for certain types of providers, usually because regulations were new, had not been promulgated, or did not apply to existing providers. Other reasons included the nonavailability of funds and legal challenges.

Other State Licensing Programs

In addition to mandatory-licensing programs, 12 states reported having voluntary-licensing programs in which certain types of providers could participate. These programs cover

- 1,054 ambulatory psychiatric centers in eight states (see app. IV),
- 393 alcohol and drug abuse centers in four states (see app. IV),
- 35 independent clinical laboratories (Utah),
- 259 home health agencies (Indiana and Washington), and
- 15 hospices (Washington).

Indiana and Iowa had not implemented their voluntary licensing programs for hospices at the time of our review.

States Often Did Not Know Which and How Many Freestanding Providers Were Operating

States often did not know whether those freestanding providers that were allowed to operate without a license were operating. On the other hand, if states reported knowing that these providers were operating, they frequently did not know how many. In total, 26 states reported that they did not know whether one or more types of freestanding providers were operating in the state.

Hawaii did not know if 8 of the 16 types of freestanding providers were operating, followed by Washington, which did not know if 7 were operating. Fifteen states indicated that they did not know if one or two of the types were operating (see app. V). All states knew whether the five most frequently licensed types were operating: alcohol and drug abuse

centers, ambulatory surgical centers, home health care services, hospices, and independent clinical laboratories.

For those types of freestanding providers allowed to operate without licenses, states frequently reported knowing that they were operating but not knowing how many were operating. All but five states (Montana, Nebraska, New Hampshire, New York, and South Dakota) were unable to provide data on the number of providers operating for at least one type of provider they knew to be operating in the state (see app. VI).

Quality Assurance Requirements

To obtain a license, freestanding providers must meet certain quality assurance requirements established by the state. These requirements vary by type of provider and state: for the 13 types of providers with licensing requirements (see table 2.1), states reported 207 operational licensing programs; 73 percent of the programs require providers to have quality assurance plans; 74 percent, credentialing processes for nonphysician staff; 67 percent, credentialing processes for physicians; 58 percent, systems for resolving complaints; and 48 percent, peer review programs (see table 2.2).

Table 2.2: Licensing Programs With Quality Assurance Requirements by Type of Providers

Type of provider	Licensing programs with quality assurance requirements[a]	Requirement				
		Quality assurance plan	Peer review	Complaint system	Credentialing process	
					Physician	Nonphysician
Alcohol and drug abuse center	42	26	11	29	18	24
Ambulatory care center	9	5	4	7	7	7
Ambulatory psychiatric center	18	14	10	12	13	13
Ambulatory surgical center	38	29	23	21	36	31
Cardiac catheterization lab.	2	1	1	0	2	2
General diagnostic center	3	1	1	1	1	1
Diagnostic imaging center	3	2	1	2	2	2
Emergency center	2	2	1	1	2	1
Home health care	33	21	19	19	15	26
Hospice care	22	18	14	12	15	19
Independent clinical lab.	24	23	6	7	17	18
Rehab. center (comprehensive)	8	7	7	7	7	6
Rehab. center (specialized)	3	3	2	3	3	3
Total	**207**	**152**	**100**	**121**	**138**	**153**
Percent	**100**	**73**	**48**	**58**	**67**	**74**

[a]Some states that license freestanding providers have not issued regulations.

Inspections Generally Done on Schedule

States generally reported that they conduct on-site inspections of licensed freestanding providers at or near scheduled intervals, typically, at least annually. Such inspections generally include review of (1) patient records, (2) physician and nonphysician credentials, and (3) the provider's quality assurance program. Annual expenditures ranging from $0 to $12.8 million were reported by 25 states for their freestanding provider licensing activities (see app. VII).

The operational licensing program in each state requires on-site inspections, except for (1) Pennsylvania, which does not require them for home health care agencies, and (2) California, which does not require them for cardiac catheterization laboratories. Of the 205 on-site inspection programs identified,

- 198 include review of patient records,
- 157, physician credentials,
- 180, nonphysician credentials, and

- 152, implementation of the provider's quality assurance plan (see app. VIII).

For 10 of the 13 types of licensed providers, all states reported they require that at least a sample of patient records be reviewed during on-site inspections. However, a review of patient records is not required by 5 of the 24 states inspecting independent clinical laboratories, 1 of 32 states inspecting home health agencies, and 1 of 8 states inspecting comprehensive rehabilitation centers. Although requirements for inspection frequency vary by state and by provider type, requirements for annual inspections are common. For example, over 70 percent of the states require at least an annual inspection for alcohol and drug abuse centers, ambulatory surgical centers, and home health agencies. Although no state reported requiring on-site inspections at intervals greater than 24 months, regulations for some providers are not specific as to frequency (see table 2.3).

Table 2.3: Frequency of Required Inspections by Type of Providers

Type of provider	State inspection programs	Frequency required		
		3-12 months	13-24 months	Not specified
Alcohol and drug abuse center	42	31	8	3
Ambulatory care center	9	6	2	1
Ambulatory psychiatric center	18	8	8	2
Ambulatory surgical center	38	28	4	6
Cardiac catheterization lab.	1	1	0	0
General diagnostic center	3	2	0	1
Diagnostic imaging center	3	1	1	1
Emergency center	2	1	0	1
Home health care	32	24	0	8
Hospice care	22	15	1	6
Independent clinical lab.	24	15	6	3
Rehab. center (comprehensive)	8	3	3	2
Rehab. center (specialized)	3	1	2	0
Total	**205**	**136**	**35**	**34**

States reported that providers are inspected as frequently as, or more frequently than, required by state regulations, with few exceptions. Not all states, however, reported the frequency of their inspections for all types of providers, either because the information was not available or because no inspections had been conducted, for example:

- Adequate resources were not available to conduct the required biennial inspections of comprehensive rehabilitation centers (California).
- Funds were not available to implement the licensing program for home health agencies (Delaware).
- Regulations requiring inspections of alcohol and drug abuse treatment centers (South Dakota) and hospices (Massachusetts) were new and no inspections had been conducted.

The states reported meeting or exceeding the required inspection frequency 75 to 100 percent of the time, (see table 2.4). (We adjusted for those states that did not provide the information and excluded those states in which the frequency of required inspections was not specified.) For states whose regulations did not specify an inspection frequency for a particular type of provider, 21 of 34 states reported conducting inspections within a 12-month period; none reported an inspection interval that exceeded 24 months.

Table 2.4: States Setting Inspection Frequencies and Promptly Conducting Required Inspections by Type of Providers

	States	
Type of provider	**Number setting inspection frequency[a]**	**Percent conducting inspection promptly**
Alcohol and drug abuse center	37	89
Ambulatory care center	8	88
Ambulatory psychiatric center	15	87
Ambulatory surgical center	31	97
Cardiac catheterization lab.	1	100
General diagnostic center	2	100
Diagnostic imaging center	1	100
Emergency center	1	100
Home health care	23	87
Hospice care	15	93
Independent clinical lab.	21	81
Rehab. center (comprehensive)	4	75
Rehab. center (specialized)	2	100
Total	**161**	

[a]Excludes states that did not also provide data on whether they were conducting inspections.

States Report Few Sanctions Against Freestanding Providers

With more than 23,000 licensed freestanding providers in all states, 21 states reported imposing 165 sanctions against freestanding providers during the year ending September 30, 1987. Lengthy appeals processes and the lack of intermediate sanctions (see below) were cited as impediments to imposing sanctions.

Available Sanctions

Most states that require licensing for freestanding providers can revoke that license if providers do not comply with state requirements. State laws in Delaware and Idaho, however, do not authorize revoking the licenses of independent clinical laboratories. Eighty-two percent of the states also have authority to suspend licenses.

Authority to impose intermediate sanctions, such as restrictions on the services that can be performed and monetary penalties, is more limited. Of the states operating licensing programs for independent clinical laboratories, service restrictions are available to 67 percent and monetary penalties to 42 percent; these intermediate sanctions are available less frequently for other types of providers. For example, 6 of the 33 states that have operational licensing programs for home health care agencies are authorized to impose monetary penalties, and 5 of the 22 states that have operational licensing programs for hospices can impose service restrictions.

Sanctions Recommended and Imposed

States reported licensing more than 23,000 freestanding providers (see app. III). For the 12-month period ending September 30, 1987, 21 states reported imposing 165 sanctions:

- 23 license revocations,
- 5 license suspensions,
- 38 fines, and
- 99 service restrictions.

Independent clinical laboratories accounted for 116 of the 165 sanctions; 49 sanctions were reported against 5 other types of providers (see apps. IX and X).

Impediments to Imposing Sanctions

Officials of 17 states cited delays caused by the hearing and appeals processes as the primary impediment to imposing sanctions. For example, a Connecticut official reported that legal proceedings have proved

to be excessively time consuming, while a Florida official said that provider appeal rights can delay imposition of sanctions.

Officials of seven states cited the lack of intermediate sanctions as an impediment. These officials believe existing sanctions available to them are too severe or, in some cases, impractical. For example, a Nebraska official said the authority to impose intermediate sanctions would enable the state to regulate in a more reasonable manner than the more severe sanction of license revocation.

Officials in Delaware, Oklahoma, and South Dakota reported that political pressures or resistance by professional groups are impediments to imposing sanctions. Referring to political pressures, a South Dakota official added, "It is very difficult to close one [health care provider], even when it's bad."

Most and Least Effective Sanctions

We asked each state to describe the most effective and least effective sanctions available in the state. Twenty-eight states described the most effective sanctions; 25 described the least effective. Opinions were mixed. Officials in 10 states cited monetary penalties as most effective, but officials in 2 states—Rhode Island and Tennessee—believe these sanctions are least effective. Limits or restrictions on the procedures or services a provider may perform were viewed by 7 states as most effective; no state saw such restrictions as ineffective. Although 9 states believe revocation, suspension, or other limits on providers' licenses are the most effective sanctions, 21 believe such actions are least effective (see app. XI).

An Iowa official commented that licensing sanctions are ineffective because the legal protection afforded providers prevents revocation. A Colorado official said legal action is the least effective sanction because of the length of time and the multitude of appeals involved. An Illinois official noted that providers know few deficiencies warrant such drastic action as license revocation.

State Officials See Need for Additional Oversight

Officials of 36 states expressed concerns about the adequacy of their oversight of freestanding providers. Typically, these officials saw the need to expand regulatory oversight or provide additional resources to carry out oversight activities. Others, while not specifically citing the need for increased oversight, questioned whether staff working for freestanding providers have proper credentials and training. Still others

expressed concern about the public's false presumption that freestanding providers are regulated. The need for additional oversight was questioned, however, by officials from three states.

Officials of 18 states expressed concerns relating to the lack of regulatory oversight of most freestanding providers. For example, they expressed concern that:

- Treatment and procedures performed by freestanding providers without state or federal oversight, such as laboratories in supermarkets, may not be safe (Colorado).
- Without licensing, there is no review of the quality of care of freestanding providers (Florida).
- Unless freestanding providers are regulated, the quality of care may not be as good as that provided in a hospital (District of Columbia).

Officials of 9 states said that adequate resources were not available to carry out regulatory oversight activities for freestanding providers. For example, they told us that:

- Enough staff are never available to conduct inspections (Idaho).
- More staff are needed to provide oversight of existing providers, as well as future ones (South Dakota).
- Adequate funds are not available (Alabama).

Officials of eight states said that staff working for unregulated freestanding providers may not have proper credentials and training. They expressed concern, for example, that

- professional and nonprofessional staff of freestanding providers may not be adequately qualified and credentialed (District of Columbia, New Hampshire, Oklahoma, Texas);
- staff lack training in infection control and emergency care in life-threatening situations (Louisiana);
- nonprofessional staff may not be adequately trained and sufficient numbers of professional staff may not be available (Connecticut); and
- unqualified and unsupervised home health aides are being used (Rhode Island).

A Massachusetts official said that effective prelicensing evaluation and screening is needed to ensure the competence of freestanding providers, as well as their financial ability to provide adequate services and their overall fitness for licensing. State officials also expressed concern that

the public (1) needs to be better educated and (2) falsely presumes that freestanding providers are regulated. They said, for example:

- Consumers unknowingly receive substandard health care from unregulated freestanding providers (Texas).
- Consumers are at risk of not obtaining appropriate medical care because of the proliferation of freestanding providers and the resultant "confusion of choices" (Colorado).
- Consumers are often given medically unnecessary services (Maine).
- Consumers need better education about selecting health care providers (Arkansas).

Although most state officials expressed concern about the adequacy of their current quality assurance efforts, three states expressed opposing views:

- Consumers expect too much of the government, which lacks the funds to regulate all types of providers (Virginia).
- Studies are needed demonstrating the existence of quality-of-care problems before oversight is warranted (Iowa).
- Costs for regulating providers offering less than 24-hour care may not be justified (North Carolina).

Many States Lack Systems to Resolve Complaints

Regardless of licensing requirements, most states reported receiving complaints about the quality of care provided by freestanding providers, and almost half reported lacking systems for receiving and resolving such complaints. Forty-two states reported receiving complaints during the 12-month period ending September 30, 1987. Complaints included

- poor conditions of the providers' physical environment (Florida),
- insufficient and unqualified staff and inappropriate care (Texas),
- alleged poor quality of care and lack of attention to patient needs (Illinois), and
- the staffs' standards of medical practice (Illinois).

California estimated that it receives about 7,000 complaints each year related to the quality of care provided in all licensed facilities, including hospitals, nursing homes, and freestanding providers. A state official commented that the complaints range from cold food to wrongful death; the official indicated, however, that the state does not retain data for

complaints about the types of unlicensed freestanding providers. Therefore, he was unable to estimate the number of complaints received for freestanding providers.

Although California has a complaint system for licensed freestanding providers, 23 states reported no systems for resolving complaints about licensed or unlicensed freestanding providers. A Texas official, for example, indicated that although the state regularly receives complaints about care received from unlicensed providers, it was unable to provide specifics because the state does not keep records for unlicensed providers. A Colorado official recognized the need to build a case for regulation by documenting horror stories before going to the state legislature for authorization to license, but indicated that the state does not keep such records. The 28 states that reported having complaint resolution systems provided limited information concerning complaints.

States Have Limited Plans to Require Additional Types of Providers to Be Licensed

Despite concerns about the quality of care provided by unregulated freestanding providers, health department licensing officials from only 13 states identified plans to license additional providers; those plans were generally limited to licensing one or two types of freestanding providers, typically, those most frequently licensed by other states.

State Inspections and Enforcement Actions to Ensure That HMOs Provide Quality Care

On-site inspections of the quality of care provided by HMOs were being conducted in 22 of the 51 states as of December 31, 1987.[1] Although states generally had a variety of sanctions available during the 3-year period ending December 31, 1987, only two states—California and New York—had imposed sanctions against HMOs because of deficiencies related to quality of care. Some state officials suggested, however, that sanctions are often not needed because of the willingness of HMOs to take corrective actions when problems are identified and the effectiveness of some state licensing programs.

State Licensing of HMOs

States generally require an HMO to obtain a license (usually called a certificate of authority) to operate, and a growing number of states have enacted quality assurance requirements as part of their HMO licensing laws. Although primary responsibility for regulating HMOs is generally vested in a commissioner of insurance or similar official, quality assurance requirements are usually the responsibility of a department of health or similar state agency.

Section 1301(c)(6) of the Public Health Service Act (42 U.S.C. 300e(c)(6)) requires federally qualified HMOs (see p. 12) to have quality assurance programs. HHS regulations state that such programs must

- include a method for physicians and other health professionals to review health care delivery processes;
- systematically collect data on the services provided and patient outcomes, use the data to evaluate care given, and institute needed changes; and
- assure that hospitals and other health care facilities, through which they provide services, are certified under title XVIII of the Social Security Act.

HHS, as part of its federal qualification process, is responsible for a preliminary review of HMO quality assurance programs. Federal qualification is viewed by some as a quasi seal of approval, assuring that HMOs are fiscally viable and that minimum quality standards are being met.[2] Under the Medicare program, the federal government also contracts

[1]On-site inspections are conducted at an HMO's administrative office or principal place of business in a state and may include visits to HMO providers.

[2]Nancy M. Matlin, "HMOs: New Rules Aimed at Making Industry More Competitive," Child Health Financing Report, Vol. 6, No. 2, (Winter 1989), p. 5.

with peer review and quality review organizations to independently examine the quality of care in HMOs.

State Inspections of HMOs for Health Care Quality

Thirty-nine states reported that they are authorized to conduct on-site quality-of-care inspections, and such inspections are required in 28 of the 39. Yet, these inspections are actually conducted in only 22 states, of which 3 were not required. Collectively, these 22 states had 454 HMO plans with more than 23 million enrollees (see app. XII).

Of the 39 states that are authorized to conduct on-site inspections of HMOs, 17 had not conducted them at the time of our review. States offered varying reasons for this:

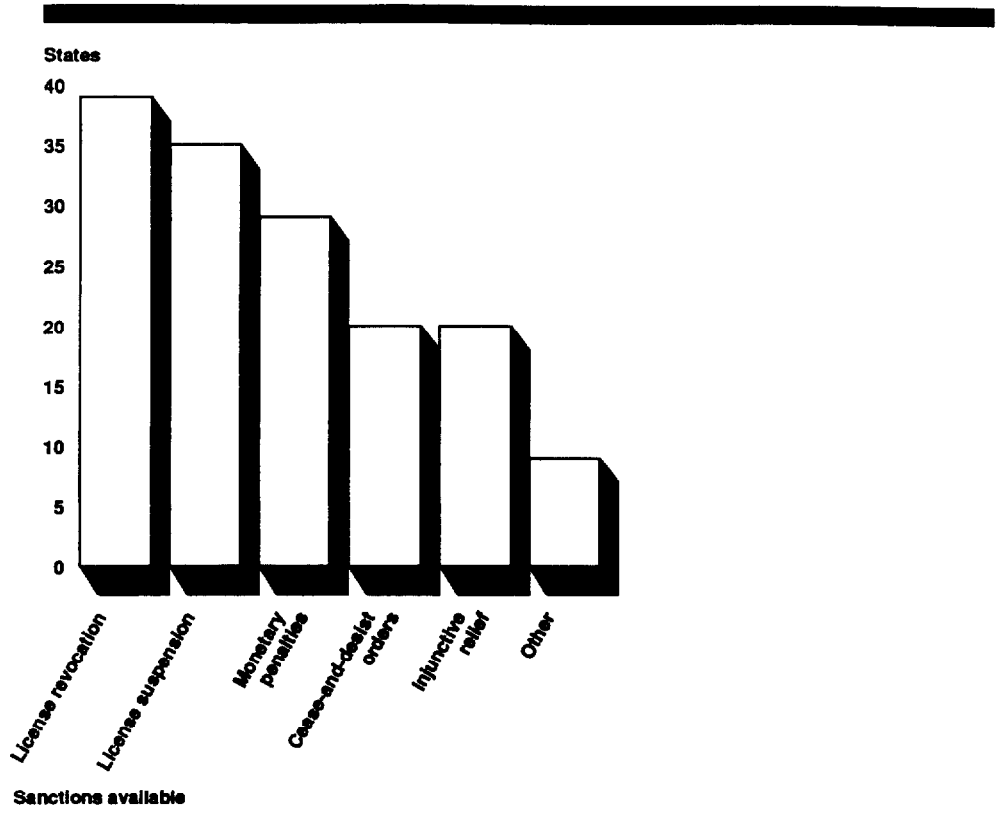
- In Montana, the state's only HMO was relatively new, and quality-of-care inspections were required only once every 3 years.
- In Alabama, the HMO law had been recently enacted, and inspections had not begun at the time of our work.
- In Utah, HMOs had not been a top priority, and the state did not have personnel to conduct quality-of-care inspections.
- In Colorado, the necessary personnel and funding to undertake quality-of-care inspections of HMOs were not available.
- In Louisiana, adequate procedures for conducting HMO quality-of-care inspections may not have been available.
- In Wyoming, on-site inspections were to be conducted if a problem arose, but no problems had been reported.

Officials from 12 states told us that (1) their laws and regulations do not specifically authorize on-site inspections of health care quality in HMOs and (2) they had not conducted such inspections. One of the 12 states—Alaska—has no HMOs. Two others—New Mexico and Wisconsin—reported that examiners at state insurance departments review HMO complaint files and quality assurance documentation during the course of periodic financial audits.

State Use of Sanctions for Enforcement

States have a variety of sanctions available to enforce the quality-of-care requirements in their HMO licensing law. For example (see fig. 3.1), of the 39 states authorized to conduct quality-of-care inspections, all can revoke and most can suspend a license; many can impose intermediate sanctions—such as monetary penalties or cease-and-desist orders—for failure to comply with state law or regulations.

Figure 3.1: Sanctions Available to Enforce Quality-of-Care Requirements for States Authorized to Inspect HMOs



During the 3-year period ending December 31, 1987, two states formally imposed sanctions against HMOs because of quality-of-care deficiencies. New York fined an HMO in late 1987 for failing to implement an approved quality assurance program; California prohibited three HMOs from enrolling new members because (1) the HMOs did not have sufficient providers to accommodate existing enrollees and (2) access to care was, according to that state, inadequate.

Eleven states told us that HMOs had been responsive to state demands for corrective actions and states had few problems obtaining compliance with quality-of-care regulations. Several states, including some of those discussed above, identified administrative enforcement measures that were effective in bringing HMOs into compliance without the need to impose sanctions.

Officials in two states (California and Rhode Island) identified adverse publicity of quality-of-care deficiencies as an effective enforcement measure. Because an HMO is dependent upon retaining existing premium-paying members while attracting new ones, any adverse publicity about the HMO can adversely affect it. A Rhode Island health department official told us that because the department's letters citing HMOs for failure to correct quality-of-care deficiencies become public documents, the department found that the threat of issuing such letters has resulted in timely corrective action by the HMOs.

Four states (California, Georgia, Illinois, and Pennsylvania) said that another effective enforcement measure is the refusal to approve new provider contracts or requests for changes in the geographic areas served by HMOs. Some HMOs seek to add new members by expanding the geographic areas that they serve. As more members are added, additional providers are usually needed. In Pennsylvania, for example, HMOs must obtain state permission before changing their service areas or adding new providers. A Pennsylvania official told us the state has used its approval authority as a tool to ensure compliance with quality-of-care regulations, refusing to approve HMO expansion plans until deficiencies are corrected.

Officials in two states (Iowa and North Dakota) told us that their requirements that HMOs pay the cost of inspections are effective enforcement measures. In Iowa, HMOs pay the cost of initial inspections. If an HMO fails to adequately correct identified deficiencies, it must pay for an additional follow-up inspection. Likewise, North Dakota officials advised us that the implied threat of additional inspections at the HMOs' expense has kept them in compliance.

Finally, some states indicated that well-planned licensing programs can decrease the need for sanctions. Of seven states conducting inspections and three states that did not, each state had denied a license requested by an HMO because of concerns related to quality of care. For example, an important protection, although not an enforcement measure against poor-quality health care, a Pennsylvania official told us, is denying or withholding approval for establishment of an inadequately planned HMO. California also saw the licensing program as an opportunity to avoid future problems.

Conclusions

Freestanding providers offer consumers alternatives to care traditionally provided in hospitals, nursing homes, and physicians' offices. With the expansion of the number of these providers comes a challenge to ensure that they will give quality health care. One way to do this is through licensing. States that license freestanding providers generally establish minimum quality assurance requirements, conduct on-site inspections to determine compliance with requirements, and impose sanctions against providers when necessary. This provides the consumer with some assurance that licensed providers are capable of giving quality care. States, however, have been slow to license freestanding providers; further, they have limited plans to expand licensing requirements. No one else currently fills the gap. Consumers, therefore, do not have adequate assurance that unlicensed freestanding providers are giving quality care.

States in Which Freestanding Providers Were Operating (As of Sept. 30, 1987)

State	Alcohol and drug abuse center	Ambulatory care center	Ambulatory psychiatric center	Ambulatory surgical center	Cancer treatment Chemotherapy	Cancer treatment Radiation	Cardiac catheterization lab.
Alabama	1	1	1	1	[a]	[a]	[a]
Alaska	1	1	1	1	[a]	[a]	[a]
Arizona	1	1	1	1	1	1	1
Arkansas	1	[a]	1	1	[a]	1	[a]
California	1	1	1	1	1	1	1
Colorado	1	1	1	1	[a]	[a]	[a]
Connecticut	1	1	1	1	[a]	[a]	[a]
Delaware	1	1	[a]	1	[a]	[a]	1
Dist. of Columbia	1	1	1	1	1	1	[a]
Florida	1	1	1	1	1	[a]	1
Georgia	1	[a]	1	1	1	1	1
Hawaii	1	1	[a]	1	[a]	[a]	[a]
Idaho	1	1	[a]	1	[a]	[a]	[a]
Illinois	1	1	1	1	[a]	[a]	[a]
Indiana	1	1	1	1	1	[a]	[a]
Iowa	1	1	1	1	[a]	[a]	[a]
Kansas	1	1	1	1	[a]	[a]	[a]
Kentucky	1	1	[a]	1	[a]	[a]	[a]
Louisiana	1	1	1	1	1	1	1
Maine	1	[a]	1	1	[a]	[a]	[a]
Maryland	1	1	1	1	[a]	1	[a]
Massachusetts	1	1	1	1	[a]	[a]	[a]
Michigan	1	1	1	1	[a]	[a]	[a]
Minnesota	1	1	1	1	[a]	[a]	[a]
Mississippi	1	1	1	1	[a]	[a]	[a]
Missouri	1	1	1	1	1	1	1
Montana	1	[a]	1	1	[a]	[a]	[a]
Nebraska	1	1	1	1	[a]	[a]	[a]
Nevada	1	1	[a]	1	[a]	[a]	1
New Hampshire	[a]	1	[a]	1	[a]	[a]	[a]
New Jersey	1	1	1	1	[a]	[a]	[a]
New Mexico	1	1	1	1	[a]	[a]	[a]
New York	1	1	1	1	[a]	[a]	[a]
North Carolina	1	1	1	1	1	1	[a]
North Dakota	1	1	1	1	[a]	[a]	[a]
Ohio	1	1	1	1	1	1	1
Oklahoma	1	1	1	1	[a]	[a]	[a]
Oregon	1	1	1	1	[a]	1	[a]

General diagnostic center	Diagnostic imaging center	Emergency center	Home health care	Hospice care	Independent clinical lab.	Pain control center	Rehab. centers	
							Comprehensive	Specialized
a	a	1	1	1	1	a	1	a
a	1	1	1	a	1	1	1	a
1	1	1	1	1	1	1	a	1
1	1	a	1	1	1	a	1	a
1	1	1	1	1	1	1	1	a
a	1	1	1	1	1	a	1	a
a	a	a	1	1	1	a	1	1
1	a	1	1	1	1	a	1	1
1	1	a	1	1	1	1	a	a
1	1	1	1	1	1	1	1	a
1	1	1	1	1	1	1	1	1
a	a	1	1	1	1	a	1	a
a	a	1	1	1	1	a	1	a
1	1	a	1	1	1	a	1	a
1	1	1	1	1	1	1	1	1
a	1	1	1	1	1	a	1	a
1	a	1	1	a	1	1	1	1
a	1	1	1	1	1	a	1	a
1	1	1	1	1	1	1	1	1
a	1	1	1	1	1	a	a	a
a	1	a	1	1	1	a	1	a
a	1	a	1	1	1	a	1	1
1	1	1	1	1	1	a	a	1
1	a	a	1	1	1	1	1	1
1	1	a	1	1	1	a	1	1
1	1	a	1	1	1	1	1	1
a	a	a	1	1	a	a	a	a
1	1	a	1	1	a	a	a	a
a	1	1	1	1	1	a	1	a
a	a	a	1	a	1	a	1	1
a	1	a	1	1	1	a	1	1
a	1	1	1	1	1	1	a	1
a	a	a	1	1	1	a	1	a
1	1	1	1	1	1	1	1	1
a	1	a	1	1	1	a	a	a
1	1	1	1	1	1	a	1	a
a	1	1	1	1	1	a	a	1
a	1	a	1	1	1	a	1	1

(continued)

State	Alcohol and drug abuse center	Ambulatory care center	Ambulatory psychiatric center	Ambulatory surgical center	Cancer treatment Chemotherapy	Cancer treatment Radiation	Cardiac catheterization lab.
Pennsylvania	1	1	[a]	1	[a]	[a]	[a]
Rhode Island	1	1	1	1	[a]	[a]	[a]
South Carolina	1	1	1	1	[a]	[a]	[a]
South Dakota	1	[a]	[a]	1	[a]	[a]	[a]
Tennessee	1	1	1	1	1	1	[a]
Texas	1	1	1	1	1	1	1
Utah	1	1	1	1	[a]	[a]	[a]
Vermont	1	1	1	[a]	[a]	[a]	[a]
Virginia	1	1	1	1	1	1	1
Washington	1	1	[a]	1	[a]	[a]	[a]
West Virginia	1	1	1	1	[a]	[a]	[a]
Wisconsin	1	[a]	1	1	1	1	[a]
Wyoming	1	1	1	1	[a]	[a]	[a]
Total	**50**	**45**	**42**	**50**	**14**	**15**	**11**

General diagnostic center	Diagnostic imaging center	Emergency center	Home health care	Hospice care	Independent clinical lab.	Pain control center	Rehab. centers	
							Comprehensive	Specialized
1	1	[a]	1	1	1	1	1	1
1	[a]	1	1	1	1	[a]	1	[a]
1	[a]	[a]	1	1	1	1	[a]	[a]
[a]	[a]	[a]	1	1	1	[a]	[a]	[a]
[a]	1	[a]	1	1	1	1	1	1
[a]	1	[a]	1	1	1	1	1	1
[a]	1	[a]	1	1	1	[a]	[a]	[a]
[a]	[a]	[a]	1	1	1	[a]	[a]	[a]
1	1	[a]	1	1	1	1	1	[a]
[a]	1	[a]	1	1	1	[a]	1	1
[a]	[a]	1	1	1	1	[a]	1	1
[a]	[a]	1	1	1	1	[a]	1	1
[a]	[a]	[a]	1	1	1	[a]	1	[a]
22	**34**	**25**	**51**	**48**	**49**	**18**	**38**	**24**

[a]This type of provider was either not operating in the state or it was unknown if this type of provider was operating (see app. V).

States in Which Freestanding Providers Operating Were Required to Be Licensed (As of Sept. 30, 1987)

State	Alcohol and drug abuse center	Ambulatory care center	Ambulatory psychiatric center	Ambulatory surgical center	Cancer treatment Chemotherapy	Cancer treatment Radiation	Cardiac catheterization lab.
Alabama	1	0	1	1	0	0	0
Alaska	0	0	0	1	0	0	0
Arizona	1	1	1	1	0	0	0
Arkansas	1	0	1	1	0	0	0
California	1[a]	0	0	1	0	0	1
Colorado	1	0	1	1	0	0	0
Connecticut	1	1	1	1	0	0	0
Delaware	1	0	0	1	0	0	0
Dist. of Columbia	0	0	0	1	0	0	0
Florida	1	0	0	1	0	0	0
Georgia	1	0	0	1	0	0	0
Hawaii	1	0	0	1	0	0	0
Idaho	1	0	0	0	0	0	0
Illinois	1	0	0	1	0	0	0
Indiana	1	0	0	1	0	0	0
Iowa	0	0	0	0	0	0	0
Kansas	1	0	1	1	0	0	0
Kentucky	1	1	0	1	0	0	0
Louisiana	1	0	1	1	0	0	0
Maine	1	0	1	0	0	0	0
Maryland	1	0	0	0	0	0	0
Massachusetts	1	1	1	1	0	0	0
Michigan	1	0	0	1	0	0	0
Minnesota	1	0	0	1	0	0	0
Mississippi	0	0	0	1	0	0	0
Missouri	0	0	0	1	0	0	0
Montana	1	0	1	1	0	0	0
Nebraska	1	1	1	1	0	0	0
Nevada	1	0	0	1	0	0	0
New Hampshire	0	1	0	1	0	0	0
New Jersey	1	1	1	1	0	0	0
New Mexico	0	0	0	1	0	0	0
New York	1	1	1	1	0	0	0
North Carolina	1	0	1	1	0	0	0
North Dakota	1	0	1	0	0	0	0
Ohio	1[a]	0	0	0	0	0	0
Oklahoma	1	0	0	1	0	0	0
Oregon	1	0	0	1	0	0	0

General diagnostic center	Diagnostic imaging center	Emergency center	Home health care	Hospice care	Independent clinical lab.	Pain control center	Rehab. centers	
							Comprehensive	Specialized
0	0	0	0	0	1	0	1	0
0	0	0	1	0	0	0	0	0
0	0	0	1	1	1	0	0	0
0	0	0	1	1	0	0	1	0
0	0	0	1	0	1	0	1	0
0	0	1	0	1	0	0	1	0
0	0	0	1	1	1	0	0	0
0	0	1	1	1	1	0	0	0
0	0	0	1	1	0	0	0	0
1	0	0	1	1	1	0	0	0
0	0	1	1	1	1	0	0	0
0	0	0	1	0	1	0	0	0
0	0	0	1[b]	0	1	0	0	0
0	0	0	1	1	1	0	0	0
0	0	0	0	0	0	0	0	0
0	0	0	0	0	0	0	0	0
0	0	0	1	0	0	0	0	0
0	0	0	1	1	1	0	1	0
0	0	0	1	0	0	0	0	0
0	0	0	1	0	1	0	0	0
0	0	0	1	1	1	0	1	0
0	1	0	0	1	1	0	1	1
0	0	0	0	1	1	0	0	0
0	0	0	1	1	0	0	0	0
0	0	0	1	0	0	0	0	0
0	0	0	1	0	0	0	0	0
0	0	0	1	1	0	0	0	0
1	1	0	1	0	0	0	0	0
0	0	0	1	1	1	0	0	0
0	0	0	1	0	1	0	0	1
0	1	0	1	0	1	0	1	0
0	0	0	1	1	0	0	0	1
0	0	0	1	1	1	0	1	0
0	0	0	1	1	0	0	0	1[c]
0	0	0	1	1	0	0	0	0
0	0	0	0	1	0	0	0	0
0	0	0	0	0	0	0	0	0
0	0	0	1	1	1	0	0	0

(continued)

State	Alcohol and drug abuse center	Ambulatory care center	Ambulatory psychiatric center	Ambulatory surgical center	Cancer treatment Chemotherapy	Cancer treatment Radiation	Cardiac catheterization lab.
Pennsylvania	1	0	0	1	0	0	0
Rhode Island	1	1	1	1	0	0	0
South Carolina	1	0	0	1	0	0	0
South Dakota	1	0	0	1	0	0	0
Tennessee	1	0	1	1	0	0	0
Texas	1	0	0	1	0	0	0
Utah	1	0	1	1	0	0	0
Vermont	0	0	0	0	0	0	0
Virginia	1	0	1	1	0	0	1
Washington	1	0	0	0	0	0	0
West Virginia	1	1	1	1	0	0	0
Wisconsin	0	0	0	0	0	0	0
Wyoming	1	0	0	0	0	0	0
Total	**42**	**10**	**20**	**41**	**0**	**0**	**2**

General diagnostic center	Diagnostic imaging center	Emergency center	Home health care	Hospice care	Independent clinical lab.	Pain control center	Rehab. centers	
							Comprehensive	Specialized
0	0	0	1	0	1	0	0	0
1	0	1	1	1	1	0	0	0
0	0	0	1	1	0	0	0	0
0	0	0	0	0	0	0	0	0
0	0	0	1	0	1	0	0	0
0	0	0	1	1	0	0	0	0
0	0	0	1	1	0	0	0	0
0	0	0	0	0	0	0	0	0
0	0	0	1	1	0	0	0	0
0	0	0	0	0	0	0	0	0
0	0	0	0	1	0	0	0	0
0	0	0	1	0	1	0	0	0
0	0	0	0	0	1	0	1	0
3	**3**	**4**	**38**	**28**	**25**	**0**	**10**	**4**

[a]Only methodone treatment centers are required to be licensed.

[b]Required to be licensed only if operated for profit.

[c]Only cardiac rehabilitation programs are subject to licensing.

Providers Licensed by States (As of Sept. 30, 1987)

State	Alcohol and drug abuse center	Ambulatory care center	Ambulatory psychiatric center	Ambulatory surgical center	Cancer treatment Chemotherapy	Cancer treatment Radiation	Cardiac catheterization lab.
Alabama	12	[a]	23	17	[a]	[a]	[a]
Alaska	[a]	[a]	[a]	3	[a]	[a]	[a]
Arizona	26	220	139	54	[a]	[a]	[a]
Arkansas	10	[a]	0	11	[a]	[a]	[a]
California	88[b]	[a]	[a]	46	[a]	[a]	1
Colorado	170	[a]	24	15	[a]	[a]	[a]
Connecticut	78	51	88	8	[a]	[a]	[a]
Delaware	8	[a]	[a]	0	[a]	[a]	[a]
Dist. of Columbia	[a]	[a]	[a]	12	[a]	[a]	[a]
Florida	460	[a]	[a]	45	[a]	[a]	[a]
Georgia	22	[a]	[a]	19	[a]	[a]	[a]
Hawaii	13	[a]	[a]	6	[a]	[a]	[a]
Idaho	49	[a]	[a]	[a]	[a]	[a]	[a]
Illinois	233	[a]	[a]	38	[a]	[a]	[a]
Indiana	190	[a]	[a]	18	[a]	[a]	[a]
Iowa	[a]	[a]	[a]	[a]	[a]	[a]	[a]
Kansas	185	[a]	30	9	[a]	[a]	[a]
Kentucky	75	9	[a]	19	[a]	[a]	[a]
Louisiana	73	[a]	42	25	[a]	[a]	[a]
Maine	21	[a]	25	[a]	[a]	[a]	[a]
Maryland	284	[a]	[a]	[a]	[a]	[a]	[a]
Massachusetts	117	84	127	6	[a]	[a]	[a]
Michigan	611	[a]	[a]	25	[a]	[a]	[a]
Minnesota	130	[a]	[a]	10	[a]	[a]	[a]
Mississippi	[a]	[a]	[a]	7	[a]	[a]	[a]
Missouri	[a]	[a]	[a]	20	[a]	[a]	[a]
Montana	8	[a]	5	8	[a]	[a]	[a]
Nebraska	20	246	71	2	[a]	[a]	[a]
Nevada	14	[a]	[a]	12	[a]	[a]	[a]
New Hampshire	[a]	18	[a]	5	[a]	[a]	[a]
New Jersey	44	49	0	12	[a]	[a]	[a]
New Mexico	[a]	[a]	[a]	3	[a]	[a]	[a]
New York	297	300	946	7	[a]	[a]	[a]
North Carolina	601	[a]	675	31	[a]	[a]	[a]
North Dakota	25	[a]	8	[a]	[a]	[a]	[a]
Ohio	11[b]	[a]	[a]	[a]	[a]	[a]	[a]
Oklahoma	55	[a]	[a]	12	[a]	[a]	[a]
Oregon	10	[a]	[a]	7	[a]	[a]	[a]

General diagnostic center	Diagnostic imaging center	Emergency center	Home health care	Hospice care	Independent clinical lab.	Pain control center	Rehab. centers	
							Comprehensive	Specialized
[a]	[a]	[a]	[a]	[a]	108	[a]	12	[a]
[a]	[a]	[a]	7	[a]	[a]	[a]	[a]	[a]
[a]	[a]	[a]	70	7	110	[a]	[a]	[a]
[a]	[a]	[a]	0	9	[a]	[a]	3	[a]
[a]	[a]	[a]	486	[a]	1200	[a]	4	[a]
[a]	[a]	32	[a]	25	[a]	[a]	3	[a]
[a]	[a]	[a]	117	2	109	[a]	[a]	[a]
[a]	[a]	0	0	4	17	[a]	[a]	[a]
[a]	[a]	[a]	0	0	[a]	[a]	[a]	[a]
43	[a]	[a]	395	32	350	[a]	[a]	[a]
[a]	[a]	0	73	22	123	[a]	[a]	[a]
[a]	[a]	[a]	16	[a]	31	[a]	[a]	[a]
[a]	[a]	[a]	13[c]	[a]	270	[a]	[a]	[a]
[a]	[a]	[a]	295	69	230	[a]	[a]	[a]
[a]	[a]	[a]	[a]	[a]	[a]	[a]	[a]	[a]
[a]	[a]	[a]	[a]	[a]	[a]	[a]	[a]	[a]
[a]	[a]	[a]	185	[a]	[a]	[a]	[a]	[a]
[a]	[a]	[a]	119	27	82	[a]	1	[a]
[a]	[a]	[a]	194	[a]	[a]	[a]	[a]	[a]
[a]	[a]	[a]	47	[a]	8	[a]	[a]	[a]
[a]	[a]	[a]	106	8	200	[a]	6	[a]
[a]	2	[a]	[a]	0	329	[a]	6	6
[a]	[a]	[a]	[a]	30	227	[a]	[a]	[a]
[a]	[a]	[a]	0	0	[a]	[a]	[a]	[a]
[a]	[a]	[a]	131	[a]	[a]	[a]	[a]	[a]
[a]	[a]	[a]	203	[a]	[a]	[a]	[a]	[a]
[a]	[a]	[a]	42	17	[a]	[a]	[a]	[a]
1	1	[a]	0	[a]	[a]	[a]	[a]	[a]
[a]	[a]	[a]	23	2	19	[a]	[a]	[a]
[a]	[a]	[a]	63	[a]	16	[a]	[a]	5
[a]	2	[a]	63	[a]	120	[a]	0	[a]
[a]	[a]	[a]	60	8	[a]	[a]	[a]	11
[a]	[a]	[a]	194	17	276	[a]	4	[a]
[a]	[a]	[a]	122	62	[a]	[a]	[a]	34[d]
[a]	[a]	[a]	34	2	[a]	[a]	[a]	[a]
[a]	[a]	[a]	[a]	0	[a]	[a]	[a]	[a]
[a]	[a]	[a]	[a]	[a]	[a]	[a]	[a]	[a]
[a]	[a]	[a]	73	1	50	[a]	[a]	[a]

(continued)

State	Alcohol and drug abuse center	Ambulatory care center	Ambulatory psychiatric center	Ambulatory surgical center	Cancer treatment Chemotherapy	Cancer treatment Radiation	Cardiac catheterization lab.
Pennsylvania	316	a	a	20	a	a	a
Rhode Island	51	21	8	4	a	a	a
South Carolina	56	a	a	8	a	a	a
South Dakota	9	a	a	5	a	a	a
Tennessee	126	a	220	30	a	a	a
Texas	250	a	a	90	a	a	a
Utah	60	a	11	6	a	a	a
Vermont	a	a	a	a	a	a	a
Virginia	75	a	0	10	a	a	1
Washington	46	a	a	a	a	a	a
West Virginia	14	0	35	0	a	a	a
Wisconsin	a	a	a	a	a	a	a
Wyoming	4	a	a	a	a	a	a
Total	**4,947**	**998**	**2,477**	**685**	**0**	**0**	**2**

General diagnostic center	Diagnostic imaging center	Emergency center	Home health care	Hospice care	Independent clinical lab.	Pain control center	Rehab. centers	
							Comprehensive	Specialized
[a]	[a]	[a]	302	[a]	4200	[a]	[a]	[a]
1	[a]	2	10	4	80	[a]	[a]	[a]
[a]	[a]	[a]	49	14	[a]	[a]	[a]	[a]
[a]	[a]	[a]	[a]	[a]	[a]	[a]	[a]	[a]
[a]	[a]	[a]	352	[a]	325	[a]	[a]	[a]
[a]	[a]	[a]	976	23	[a]	[a]	[a]	[a]
[a]	[a]	[a]	42	0	[a]	[a]	[a]	[a]
[a]	[a]	[a]	[a]	[a]	[a]	[a]	[a]	[a]
[a]	[a]	[a]	0	0	[a]	[a]	[a]	[a]
[a]	[a]	[a]	[a]	[a]	[a]	[a]	[a]	[a]
[a]	[a]	[a]	[a]	6	[a]	[a]	[a]	[a]
[a]	[a]	[a]	167	[a]	40	[a]	[a]	[a]
[a]	[a]	[a]	[a]	[a]	173	[a]	1	[a]
45	**5**	**34**	**5,029**	**391**	**8,693**	**0**	**40**	**56**

[a]Types of providers were not licensed by the states (see app. II).

[b]Only methadone treatment centers are required to be licensed.

[c]Required to be licensed only if operated for profit.

[d]Only cardiac rehabilitation programs are subject to licensing.

States With Freestanding Providers That Volunteer to Be Licensed to Meet Federal or State Funding Requirements

States	Alcohol and drug abuse centers	Ambulatory psychiatric centers
California	23[a]	381
Georgia	0	31
Illinois	0	200
Maryland	0	67
Mississippi	1	15
Ohio	350[a]	300
Texas	0	50
Vermont	19	10
Total	**393**	**1,054**

[a]These figures do not include methadone treatment centers, which are required to be licensed (see app. II and III).

States in Which the Operation of Freestanding Providers Was Unknown

State	Ambulatory care center	Ambulatory psychiatric center
Alaska	0	0
California	0	0
Colorado	0	0
Delaware	0	1
Dist. of Columbia	0	0
Florida	0	0
Hawaii	0	1
Idaho	0	1
Illinois	0	0
Indiana	0	0
Iowa	0	0
Kansas	0	0
Kentucky	0	0
Maine	0	0
Maryland	0	0
Michigan	0	0
Minnesota	0	0
Nevada	0	0
New Mexico	0	0
Ohio	0	0
Oklahoma	0	0
Tennessee	0	0
Texas	0	0
Washington	0	1
West Virginia	0	0
Wisconsin	1	0
Total	**1**	**4**

Cancer treatment		Cardiac catheterization laboratory	General diagnostic center	Diagnostic imaging center	Emergency center	Pain control center	Rehab. centers	
Chemotherapy	Radiation						Comprehensive	Specialized
0	0	0	1	0	0	0	0	1
0	0	0	0	0	0	0	0	1
1	1	1	1	0	0	1	0	1
1	1	0	0	1	0	1	0	0
0	0	0	0	0	1	0	0	0
0	1	0	0	0	0	0	0	1
1	1	1	1	1	0	1	0	1
1	1	0	0	0	0	1	0	1
1	1	1	0	0	1	1	0	1
0	1	0	0	0	0	0	0	0
1	1	1	1	0	0	1	0	1
1	1	1	0	1	0	0	0	0
0	0	0	0	0	0	1	0	1
0	0	0	1	0	0	0	0	0
1	0	0	0	0	0	1	0	0
0	0	0	0	0	0	1	1	0
1	1	1	0	1	0	0	0	0
1	1	0	0	0	0	0	0	0
1	1	0	0	0	0	0	0	0
0	0	0	0	0	0	1	0	1
1	1	1	1	0	0	1	0	0
0	0	1	1	0	0	0	0	0
0	0	0	1	0	1	0	0	0
1	1	1	1	0	1	1	0	0
1	1	1	1	1	0	1	0	0
0	0	0	0	0	0	0	0	0
14	**15**	**10**	**10**	**5**	**4**	**13**	**1**	**10**

States With Freestanding Providers in Operation That Were Not Required to Be Licensed (As of Sept. 30, 1987)

State	Alcohol and drug abuse center[a]	Ambulatory care center[b]	Ambulatory psychiatric center[c]	Ambulatory surgical center[d]	Cancer treatment Chemotherapy[e]	Cancer treatment Radiation[f]	Cardiac catheterization lab.
Alabama	0	1	0	0	0	0	0
Alaska	1	1	1	0	0	0	0
Arizona	0	0	0	0	1	1	1
Arkansas	0	0	0	0	0	1	0
California	1[g]	1	1	0	1	1	0
Colorado	0	1	0	0	0	0	0
Connecticut	0	0	0	0	0	0	0
Delaware	0	1	0	0	0	0	1
Dist. of Columbia	1	1	1	0	1	1	0
Florida	0	1	1	0	1	0	1
Georgia	0	0	1	0	1	1	1
Hawaii	0	1	0	0	0	0	0
Idaho	0	1	0	1	0	0	0
Illinois	0	1	1	0	0	0	0
Indiana	0	1	1	0	1	0	0
Iowa	1	1	1	1	0	0	0
Kansas	0	1	0	0	0	0	0
Kentucky	0	0	0	0	0	0	0
Louisiana	0	1	0	0	1	1	1
Maine	0	0	0	1	0	0	0
Maryland	0	1	1	1	0	1	0
Massachusetts	0	0	0	0	0	0	0
Michigan	0	1	1	0	0	0	0
Minnesota	0	1	1	0	0	0	0
Mississippi	1	1	1	0	0	0	0
Missouri	1	1	1	0	1	1	1
Montana	0	0	0	0	0	0	0
Nebraska	0	0	0	0	0	0	0
Nevada	0	1	0	0	0	0	1
New Hampshire	0	0	0	0	0	0	0
New Jersey	0	0	0	0	0	0	0
New Mexico	1	1	1	0	0	0	0
New York	0	0	0	0	0	0	0
North Carolina	0	1	0	0	1	1	0
North Dakota	0	1	0	1	0	0	0
Ohio	1[g]	1	1	1	1	1	1
Oklahoma	0	1	1	0	0	0	0
Oregon	0	1	1	0	0	1	0

General diagnostic center[h]	Diagnostic imaging center[i]	Emergency center[j]	Home health care[k]	Hospice care[l]	Independent clinical lab.[m]	Pain control center[n]	Rehab. centers	
							Comprehensive[o]	Specialized[p]
0	0	1	1	1	0	0	0	0
0	1	1	0	0	1	1	1	0
1	1	1		0	0	0	1	0
1	1	0	0	0	1	0	0	0
1	1	1	0	1	0	1	0	0
0	1	0	1	0	1	0	0	0
0	0	0	0	0	0	0	1	1
1	0	0	0	0	0	0	1	1
1	1	0	0	0	1	1	0	0
0	1	1	0	0	0	1	1	0
1	1	0	0	0	0	1	1	1
0	0	1	0	1	0	0	1	0
0	0	1	1[r]	1	0	0	1	0
1	1	0	0	0	0	0	1	0
1	1	1	1	1	1	1	1	1
0	1	1	1	1	1	0	1	0
1	0	1	0	0	1	1	1	1
0	1	1	0	0	0	0	0	0
1	1	1	0	1	1	1	1	1
0	1	1	0	1	0	0	0	0
0	1	0	0	0	0	0	0	0
0	0	0	1	0	0	0	0	0
1	1	1	1	0	0	0	0	1
1	0	0	0	0	1	1	1	1
1	1	0	0	1	1	0	1	1
1	1	0	0	1	1	1	1	1
0	0	0	0	0	0	0	0	0
0	0	0	0	1	0	0	0	0
0	1	1	0	0	0	0	1	0
0	0	0	0	0	0	0	1	0
0	0	0	0	1	0	0	0	1
0	1	1	0	0	1	1	0	0
0	0	0	0	0	0	0	0	0
1	1	1	0	0	1	1	1	1[s]
0	1	0	0	0	1	0	0	0
1	1	1	1	0	1	0	1	0
0	1	1	1	1	1	0	0	1
0	1	0	0	0	0	0	1	1

(continued)

State	Alcohol and drug abuse center[a]	Ambulatory			Cancer treatment		Cardiac catheterization lab.
		care center[b]	psychiatric center[c]	surgical center[d]	Chemotherapy[e]	Radiation[f]	
Pennsylvania	0	1	0	0	0	0	0
Rhode Island	0	0	0	0	0	0	0
South Carolina	0	1	1	0	0	0	0
South Dakota	0	0	0	0	0	0	0
Tennessee	0	1	0	0	1	1	0
Texas	0	1	1	0	1	1	1
Utah	0	1	0	0	0	0	0
Vermont	1	1	1	0	0	0	0
Virginia	0	1	0	0	1	1	0
Washington	0	1	0	1	0	0	0
West Virginia	0	0	0	0	0	0	0
Wisconsin	1	0	1	1	1	1	0
Wyoming	0	1	1	1	0	0	0
Total	**10**	**35**	**22**	**9**	**14**	**15**	**9**

General diagnostic center[h]	Diagnostic imaging center[i]	Emergency center[j]	Home health care[k]	Hospice care[l]	Independent clinical lab.[m]	Pain control center[n]	Rehab. centers	
							Comprehensive[o]	Specialized[p]
1	1	0	0	1	0	1	1	1
0	0	0	0	0	0	0	1	0
1	0	0	0	0	1	1	0	0
0	0	0	1	1	1	0	0	0
0	1	0	0	1	0	1	1	1
0	1	0	0	0	1	1	1	1
0	1	0	0	0	1	0	0	0
0	0	0	1	1	1	0	0	0
1	1	0	0	0	1	1	1	0
0	1	0	1	1	1	0	1	1
0	0	1	1	0	1	0	1	1
0	0	1	0	1	0	0	1	1
0	0	0	1	1	0	0	0	0
19	**31**	**21**	**14**	**20**	**24**	**18**	**28**	**21**

[a]Of the 10 states reporting the operation of alcohol and drug abuse centers that were not required to be licensed, none reported knowing how many were operating.

[b]Of the 35 states reporting the operation of ambulatory care centers that were not required to be licensed, Vermont reported knowing that 6 were operating.

[c]Of the 22 states reporting the operation of ambulatory psychiatric centers that were not required to be licensed, none reported knowing how many were operating.

[d]Of the 9 states reporting the operation of ambulatory surgical centers that were not required to be licensed, Maryland reported knowing that 31 were operating and Wyoming, 1.

[e]Of the 14 states reporting the operation of chemotherapy cancer treatment centers that were not required to be licensed, none reported knowing how many were operating.

[f]Of the 15 states reporting the operation of radiation cancer treatment centers that were not required to be licensed, Maryland reported knowing that 2 were operating.

[g]Of the 9 states reporting the operation of cardiac catheterization laboratories that were not required to be licensed, none reported knowing how many were operating.

[h]Of the 19 states reporting the operation of general diagnostic centers that were not required to be licensed, Minnesota reported knowing that 1 was operating; Mississippi, 4.

[i]Of the 31 states reporting the operation of diagnostic imaging centers that were not required to be licensed, Colorado reported knowing that 4 were operating; Iowa, 3; Maine, 4, Maryland, 97; Mississippi, 2; and Utah, 1.

[j]Of the 21 states reporting the operation of emergency centers that were not required to be licensed, Hawaii reported knowing that 2 were operating.

[k]Of the 14 states reporting the operation of home health care services that were not required to be licensed, Alabama reported knowing that 124 were operating; Colorado, 110; South Dakota, 25; Vermont, 17; and Wyoming, 32.

[l]Of the 20 states reporting the operation of hospice care services that were not required to be licensed, Alabama reported knowing that 7 were operating; Hawaii, 3; Maine, 23; Nebraska, 2; Pennsylvania, 75; South Dakota, 2; Wisconsin, 45; and Wyoming, 1.

[m]Of the 24 states reporting the operation of independent clinical laboratories that were not required to be licensed, Arkansas reported knowing that 46 were operating; Colorado, 65; the District of Columbia, 38; South Dakota, 6; and Vermont, 4.

[n]Of the 18 states reporting the operation of pain control centers that were not required to be licensed, Florida reported knowing that 18 were operating.

[o]Of the 28 states reporting the operation of comprehensive rehabilitation centers that were not required to be licensed, Alaska reported knowing that 1 was operating; Connecticut, 6; Delaware, 3; Florida, 120; Georgia, 5; Hawaii, 1; Illinois, 42; Iowa, 22; Mississippi, 4; Nevada, 1; New Hampshire, 3; Oregon, 6; and Virginia, 3.

[p]Of the 21 states reporting the operation of specialized rehabilitation centers that were not required to be licensed, Delaware reported knowing that 6 were operating; Georgia, 64; Oregon, 3; and Wisconsin, 23.

[q]Alcohol and drug abuse centers other than methadone treatment centers are not required to be licensed.

[r]Only if not for profit.

[s]Except for cardiac rehabilitation programs.

State Expenditures for Licensing of All Freestanding Providers (For States' Most Recently Completed Fiscal Year)

State	Expenditures
Alabama	$355,000
Alaska	[a]
Arizona	150,000
Arkansas	85,000
California	[a]
Colorado	10,000
Connecticut	[a]
Delaware	98,057
District of Columbia	[a]
Florida	[a]
Georgia	[a]
Hawaii	587,056
Idaho	[a]
Illinois	[a]
Indiana	[a]
Iowa	0
Kansas	[a]
Kentucky	[a]
Louisiana	66,000
Maine	[a]
Maryland	377,655
Massachusetts	[a]
Michigan	[a]
Minnesota	274,228
Mississippi	85,000
Missouri	77,165
Montana	156,444
Nebraska	[a]
Nevada	[a]
New Hampshire	[a]
New Jersey	[a]
New Mexico	[a]
New York	12,765,533
North Carolina	1,520,384
North Dakota	[a]
Ohio	0
Oklahoma	[a]
Oregon	53,500
Pennsylvania	1,219,428
Rhode Island	[a]

(continued)

State	Expenditures
South Carolina	[a]
South Dakota	[a]
Tennessee	[a]
Texas	600,000
Utah	300,000
Vermont	[a]
Virginia	247,100
Washington	57,000
West Virginia	290,000
Wisconsin	63,989
Wyoming	54,000

[a]State either did not report its expenditures or reported that its records did not separately identify that information.

States Requiring Review of Quality Controls During On-Site Inspections by Type of Freestanding Providers

Type of provider	States requiring on-site inspections	On-site inspections of quality controls			
		Review patient records	Review credentials		Verify quality assurance program
			Physician	Nonphysician	
Alcohol and drug abuse center	42	42	28	35	27
Ambulatory care center	9	9	8	8	6
Ambulatory psychiatric center	18	18	17	17	15
Ambulatory surgical center	38	38	36	35	28
Cardiac catheterization lab.	1	1	1	1	0
General diagnostic center	3	3	2	2	2
Diagnostic imaging center	3	3	3	3	3
Emergency center	2	2	1	1	2
Home health care	32	31	17	30	20
Hospice care	22	22	18	22	18
Independent clinical lab.	24	19	16	16	23
Rehab. center (comprehensive)	8	7	7	7	5
Rehab. center (specialized)	3	3	3	3	3
Total	**205**	**198**	**157**	**180**	**152**

Sanctions Recommended and Imposed on Freestanding Providers (During 12-Month Period Ending Sept. 30, 1987)

Sanction and provider type	Recommended	Imposed
License revocation:		
Alcohol and drug abuse center	5	1
Ambulatory care center	1	1
Ambulatory surgical center	2	3
Home health care	10	5
Hospice care	1	0
Independent clinical lab.	21	13
Subtotal	**40**	**23**
License suspension:		
Alcohol and drug abuse center	2	0
Ambulatory psychiatric center	2	2
Ambulatory surgical center	1	1
Home health care	1	1
Independent clinical lab.	4	1
Subtotal	**10**	**5**
Monetary fine:		
Alcohol and drug abuse center	2	3
Ambulatory care center	21	21
Home health care	1	0
Independent clinical lab.	4	14
Subtotal	**28**	**38**
Service restriction:		
Alcohol and drug abuse center	22	11
Independent clinical lab.	49	88
Subtotal	**71**	**99[a]**

[a]An imposed sanction may have been recommended during an earlier time period.

Sanctions Imposed on Freestanding Providers by States (During 12-Month Period Ending Sept. 30, 1987)

	Alcohol and drug abuse centers				Ambulatory care centers		
State	Revoke	Suspend	Fine	Service restriction	Revoke	Suspend	Fine
California	0	0	0	0	0	0	0
Connecticut	0	0	0	0	0	0	0
Florida	0	0	1	0	0	0	0
Georgia	0	0	0	1	0	0	0
Illinois	0	0	0	0	0	0	0
Kansas	0	0	0	0	0	0	0
Louisiana	0	0	0	0	0	0	0
Massachusetts	0	0	0	0	1	0	0
Michigan	0	0	0	0	0	0	0
Mississippi	0	0	0	0	0	0	0
Missouri	0	0	0	0	0	0	0
Montana	0	0	1	0	0	0	0
New Jersey	0	0	0	0	0	0	10
New York	1	0	1	0	0	0	11
Oklahoma	0	0	0	0	0	0	0
Oregon	0	0	0	0	0	0	0
Pennsylvania	0	0	0	0	0	0	0
Tennessee	0	0	0	0	0	0	0
Utah	0	0	0	10	0	0	0
Wisconsin	0	0	0	0	0	0	0
Wyoming	0	0	0	0	0	0	0
Total	**1**	**0**	**3**	**11**	**1**	**0**	**21**

Ambulatory psychiatric centers			Ambulatory surgical centers			Home health care			Independent clinical labs.			
Revoke	Suspend	Fine	Revoke	Suspend	Fine	Revoke	Suspend	Fine	Revoke	Suspend	Fine	Service restriction
0	0	0	0	0	0	0	0	0	0	0	0	10
0	0	0	0	0	0	0	0	0	0	0	0	5
0	0	0	0	0	0	0	0	0	0	0	10	40
0	0	0	1	0	0	0	0	0	0	0	0	0
0	0	0	0	0	0	0	0	0	4	0	0	20
0	2	0	1	0	0	2	0	0	0	0	0	0
0	0	0	0	0	0	1	0	0	0	0	0	0
0	0	0	0	0	0	0	0	0	3	0	0	0
0	0	0	0	0	0	0	0	0	2	0	0	1
0	0	0	0	0	0	0	1	0	0	0	0	0
0	0	0	0	0	0	1	0	0	0	0	0	0
0	0	0	0	0	0	0	0	0	0	0	0	0
0	0	0	0	0	0	0	0	0	1	1	4	3
0	0	0	0	0	0	0	0	0	0	0	0	0
0	0	0	0	1	0	0	0	0	0	0	0	0
0	0	0	0	0	0	0	0	0	0	0	0	5
0	0	0	0	0	0	0	0	0	1	0	0	3
0	0	0	1	0	0	0	0	0	0	0	0	1
0	0	0	0	0	0	0	0	0	0	0	0	0
0	0	0	0	0	0	1	0	0	0	0	0	0
0	0	0	0	0	0	0	0	0	2	0	0	0
0	**2**	**0**	**3**	**1**	**0**	**5**	**1**	**0**	**13**	**1**	**14**	**88**

State Opinions on Effectiveness of Sanctions

Sanction	States	
	Most effective	Least effective
Monetary penalties	10	2
Licensing actions	9	21
Service restrictions	7	[a]
Adverse publicity	2	[a]
Letter of dissatisfaction	[b]	1
Appointment of a "master"[c]	[b]	1
Total	**28**	**25**

[a]No state reported this sanction as "least effective."

[b]No state reported this sanction as "most effective."

[c]An officer of the court who assists the judge by undertaking various tasks.

HMOs, Enrollees, and On-Site Quality-of-Care Inspections by State (As of Dec. 31, 1987)

State	HMOs	Enrollees	On-site inspections		
			Required	Authorized[a]	Conducted
Alabama	13	144,132	1	0	0
Alaska	0	0	0	0	0
Arizona	17	992,109	0	1	0
Arkansas	7	10,172	1	0	1
California	61	7,700,000	1	0	1
Colorado	16	574,868	1	0	0
Connecticut	12	467,400	1	0	1
Delaware	7	123,800	1	0	1
District of Columbia	4	346,443[b]	0	0	0
Florida	34	1,144,066	1	0	1
Georgia	12	687,720	1	0	1
Hawaii	5	218,398[b]	0	0	0
Idaho	3	6,919	0	1	0
Illinois	45	1,676,164	1	0	1
Indiana	26	448,900	0	0	0
Iowa	12	236,143	1	0	1
Kansas	13	378,775	1	0	0
Kentucky	13	512,141	1	0	1
Louisiana	11	197,500	1	0	0
Maine	4	6,504[b]	1	0	0
Maryland	20	966,608	1	0	1
Massachusetts	21	1,229,677	0	0	0
Michigan	19	1,375,783	0	1	1
Minnesota	12	1,135,654	1	0	1
Mississippi	1	217	1	0	0
Missouri	20	417,281	0	0	0
Montana	1	5,000	1	0	0
Nebraska	7	69,443	1	0	1
Nevada	4	133,936	0	1[c]	0
New Hampshire	4	125,694	0	0	0
New Jersey	21	750,000	0	1	1
New Mexico	7	157,890	0	0	0
New York	29	2,128,841	1	0	1
North Carolina	11	337,705	0	0	0
North Dakota	6	84,677	1	0	1
Ohio	42	1,500,000	1	0	1
Oklahoma	11	165,020	0	1[c]	0
Oregon	14	514,940[b]	0	0	0

(continued)

State	HMOs	Enrollees	On-site inspections		
			Required	Authorized[a]	Conducted
Pennsylvania	28	991,542	1	0	1
Rhode Island	6	180,994	1	0	1
South Carolina	7	164,006	1	0	1
South Dakota	2	17,822	1	0	0
Tennessee	11	225,302	0	1	1
Texas	43	1,118,987	1	0	1
Utah	7	225,419	0	1	0
Vermont	3	11,541[b]	0	0	0
Virginia	19	358,129	0	1	0
Washington	18	470,362[b]	0	1	0
West Virginia	4	55,825	1	0	0
Wisconsin	31	1,021,582	0	0	0
Wyoming	2	3,185	0	1[c]	0
Total	**746**	**31,815,216**	**28**	**11**	**22**

[a]Authorized but not required.

[b]Interstudy, The Interstudy Edge, (Excelsior, Minn.: Spring 1988).

[c]Inspection required, but not on-site.

Major Contributors to This Report

Human Resources Division, Washington, D.C.	Jane L. Ross, Senior Assistant Director, (202) 275-6195 James R. Linz, Assistant Director Donald J. Walthall, Assignment Manager Michael O'Dell, Social Science Analyst
Dallas Regional Office	Donald Hass, Evaluator-in-Charge Isabella Seeley, Evaluator

Requests for copies of GAO reports should be sent to:

U.S. General Accounting Office
Post Office Box 6015
Gaithersburg, Maryland 20877

Telephone 202-275-6241

The first five copies of each report are free. Additional copies are $2.00 each.

There is a 25% discount on orders for 100 or more copies mailed to a single address.

Orders must be prepaid by cash or by check or money order made out to the Superintendent of Documents.