Senate Hearings

Before the Committee on Appropriations

District of Columbia Appropriations

Fiscal Year 1977

94th CONGRESS, SECOND SESSION

H.R. 15193

PART 2 (Pages 959–1373)

ZERO-BASE REVIEW
of the Health Delivery System

SPECIAL OVERSIGHT HEARING
of the Department of Human Resources

DISTRICT OF COLUMBIA APPROPRIATIONS FOR FISCAL YEAR 1977

HEARINGS

BEFORE A

SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS UNITED STATES SENATE

NINETY-FOURTH CONGRESS

SECOND SESSION

ON

H.R. 15193

AN ACT MAKING APPROPRIATIONS FOR THE DISTRICT OF COLUMBIA FOR THE FISCAL YEAR ENDING SEPTEMBER 30, 1977, AND FOR OTHER PURPOSES

Printed for the use of the Committee on Appropriations

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ZERO-BASE REVIEW
of the Health Delivery System

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DISTRICT OF COLUMBIA APPROPRIATIONS FOR FISCAL YEAR 1977

TUESDAY, AUGUST 10, 1976

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, D.C.

The subcommittee met at 10:02 a.m., in room 1114, Everett McKinley Dirksen Office Building, Hon. Lawton M. Chiles (chairman) presiding.

Present: Senators Chiles and Mathias.

NONDEPARTMENTAL WITNESSES

OPENING REMARKS OF SENATOR CHILES

Senator CHILES. This morning the subcommittee begins a zero-base review of the health care delivery system that operates in the District of Columbia. In order to conduct such a review, it is necessary to discuss the health care resources that exist in the private sector as well as those resources made available by the city. We cannot only look at the city's health care system to make a complete determination of how well the health needs of District of Columbia citizens are being met. We also cannot make a complete review of the city's budget request for health care services without looking at the total health care system that operates in the city.

While it is a government responsibility to help insure that low-income people are not denied quality health care treatment because of their economic status here in the District of Columbia, it is also the city's responsibility to help insure that this is done in a cost-effective manner to insure the wise use of the taxpayers' money.

Low-income persons in need of medical services once had no significant alternatives to city health facilities. City owned and operated health facilities were, therefore, a necessity in order to insure that the poor received adequate health care.

ACCESS TO PRIVATE SECTOR SERVICES

The medicaid and medicare programs, section 1604 of the Public Health Service Act and the District medical charities program, give low-income persons the freedom to use private sector services which appear to be in ample supply. Low-income people are no longer absolutely required to depend on city health facilities, but many can now select services based on quality and other considerations to suit their needs.

These facts suggest the need for a zero base review of the city's present health care delivery system. A related issue that will be considered at this hearing will be the need for the city to implement a billing system to charge those individuals who are not poor and do have the ability to pay.

Presently, services are provided free at neighborhood health centers to all individuals regardless of their income. In earlier hearings on the fiscal year 1977 budget in April, I expressed the view that the city can no longer afford to give free health services to District of Columbia residents who are not indigent and who do have the ability to pay. The subcommittee was given assurances that corrective action would be taken, but still all services are being given away free.

We are fortunate this morning to have Mayor Washington with us. It is always a pleasure to have the Mayor before the subcommittee. The subcommittee is also pleased to have Mr. Yeldell and Mr. Coppie with us, who always provide the subcommittee with excellent testimony. The city's very fine cooperation in assisting us with this special review is appreciated.

We are also looking forward to receiving testimony from a number of public witnesses with special knowledge and expertise in various aspects of the District's health care system. These public witnesses include representatives from Group Hospitalization, Inc., the District of Columbia Medical Society, the Municipal Research Bureau, and Arthur Andersen & Co.

Senator Mathias is on the floor right now. He has an opening statement. I guess we will reserve his statement until he comes.

The subcommittee will begin hearing testimony from Mr. Wilson, vice president of public affairs at Group Hospitalization, Inc.

Mr. Wilson.

GROUP HOSPITALIZATION, INC.

STATEMENT OF BARRY P. WILSON, VICE PRESIDENT, PUBLIC AFFAIRS, GROUP HOSPITALIZATION, INC.

HEALTH CARE PLANNING AND SERVICES

Mr. WILSON. Thank you, sir.

Mr. Chairman, my name is Barry P. Wilson, and I am vice president of public affairs at Group Hospitalization, Inc., the Blue Cross plan which serves about 1.6 million residents of the Washington, D.C., metropolitan area.

I have furnished a full statement with supporting materials to you, and the following represents a brief summary of that statement.

GHI's interest in health care planning and in the rational development of health care services throughout the metropolitan area is of long standing, for reasons which we feel are readily apparent. In serving about 1.6 million participants or about half the population of the Washington area, GHI contracts with 30 area hospitals, including 15 in the District of Columbia, while Medical Service of the District of Columbia, our companion Blue Shield plan, contracts with about 5,000 area physicians, including more than 2,400 in the District.

The subcommittee has asked me to describe the current availability of hospital and related health care facilities in the District and the

metropolitan area, to state projections for these items through 1980, and discuss the implications of these trends.

The picture is not appealing. And it will grow progressively worse unless coordinating action is taken to arrest present trends. GHI believes the region will have an excess of 1,700 acute care hospital beds by 1980.

Those beds will require capital expenditures of at least $120 million to be built, and about $70 million a year to maintain. They will be a critical factor in hospital costs which will average $450 per patient-day by the end of 1980. Yet proposals for still more hospital beds are under active consideration in all parts of the metropolitan area.

REGIONAL HEALTH CARE CENTERS

Today, the District of Columbia is the center of a metropolitan health service area which includes both the Maryland and northern Virginia suburbs. The District is the site of regional health care centers which provide a range of tertiary and specialized services which thus far are unduplicated in the suburbs.

These regional centers include the three university medical centers at George Washington, Georgetown, and Howard, the Washington Hospital Center and Children's Hospital.

In 1973, nearly 47 percent of Maryland suburban residents who needed hospitalization were treated in District facilities. In 1973, about 16 percent of northern Virginia hospital patients were also cared for in the District.

And in general, District hospitals have not been overburdened by that mission. Over the past several years, the bed occupancy rates of 15 District of Columbia facilities have averaged only about 80 percent, despite occupancy levels of more than 90 percent in the 2 hospitals in the city's Southeast quadrant.

VIRGINIA AND MARYLAND OCCUPANCY LEVELS

While hospitals in northern Virginia have average occupancy rates of only about 80 percent, hospitals in suburban Maryland have been experiencing occupancy levels of 90 percent or more for the last several years.

Dramatic changes can be foreseen. Despite recent metropolitan population estimates which show that population has either stabilized or is actually declining in the District and some suburban areas, the community is about to receive a complement of over 2,000 additional hospital beds—beds approved based upon population projections of the 1960's.

But the real crisis will come about as the result of hospital construction in the Maryland suburbs. A new 200-bed hospital opened there 1 year ago, and on their way by 1978 or 1979, are over 1,600 more beds. Suburban Maryland is in the process of nearly doubling its beds from 2,200 1 year ago to almost 4,000 by 1980.

Maryland patients have used the equivalent of 1,700 District beds each year. GHI believes that as the 1,600 new suburban Maryland beds become available, already low occupancy rates at District of Columbia hospitals will be driven down so far that some District of Columbia facilities will be forced to reduce service or close entirely.

Further consequences can be expected: Needlessly incurred debt service and the expense of staffing underutilized facilities; the programs of the District's university and other regional medical centers, which depend heavily on revenues from routine use of medical-surgical beds, will be seriously injured; unneeded hospital beds will drain away health manpower resources, forcing up salaries and overall hospital cost.

Failure to constrain hospital bed supply will discourage the development of less costly modes of care, including long-term home care and ambulatory care.

Mr. Chairman, in recent years GHI has repeated these same warnings many times but with only limited effect. Hundreds more hospital beds are under active consideration; proposals for unneeded open-heart surgery units are being put forward; 20 or more computerized axial tomography scanners at $400,000 to $500,000 each, acquired without controls.

GHI believes the combined capacities of existing, expanded, and new metropolitan hospitals will far exceed the need for acute patient care.

STATE OF HEALTH CARE PLANNING

The subcommittee has asked me to comment on the current state of health care planning in the District. It is difficult to discuss the planning for one regional jurisdiction without also discussing the others. This was a basic point in public meetings held in 1975 by the Metropolitan Washington Council of Governments, to discuss health service area designation under Public Law 93–641.

GHI argued hard in these meetings for designation of the entire Washington standard metropolitan statistical area as a single health service area. We believed it to be the intent of Congress in the new law to keep SMSA intact for health planning purposes. However, the effort failed.

The Washington metropolitan area used to have four health planning bodies in the District, Montgomery County, northern Virginia, and southern Maryland. Regulations under Public Law 93–641 seem to require metropolitan coordination. Health planners representing the District and the three suburban health service areas are meeting together to attempt to hammer out a coordination agreement.

But, meanwhile, Maryland and Virginia have certificate-of-need laws with a detailed public review and comment process. The District does not have a comparable process. Certificate of need is issued by the Director of the District of Columbia Department of Human Resources, who may consult with a health planning advisory committee.

Further, the District has neither a formal nor detailed plan for the development of health care services and facilities in the city, nor effective criteria against which proposals for such services and facilities can be evaluated. Hospital proposals in the District utilize a formula provided under the old Hill-Burton plan. This formula derives bed need determinations by relating to the existing use of beds.

But even when the misleading Hill-Burton calculation is employed, it shows an excess of 560 acute care hospital beds in the District, and proposals for 450 more hospital beds remain under consideration.

Very briefly, there is GHI's evaluation of the status of local health care.

PRIVATE SECTOR CAPABILITY

Finally, the subcommittee has requested my comments on the extent to which I believe that the private sector has the capability and capacity to provide the services now provided by the District of Columbia Government. GHI believes the capabilities and capacities of private hospitals in the District is enormous, and hospital construction in the Washington suburbs will make much greater amounts of this capacity available to District residents in the very near future, if it can be captured in time. If our unused capacity is permitted by inaction to dissipate, it may be lost forever.

I think the District must begin immediately to focus on private health care needs of the city and to design the methods of meeting those needs. A vital question for the private hospitals and physicians will be whether they will be able to recover the full cost of care for the District's patients.

If the help of the private sector is sought, it will be up to the District and Federal Government to assure those doctors and hospitals that their efforts will not be rewarded with financial deficit.

IMMEDIATE ACTION ESSENTIAL

It presently operates in favor of an arrangement made with the private sector. I think this action would be premature. We must know what is being done before we decide what should be done. But quick action is needed. We cannot wait for all the pieces of the legislative health plan puzzle to be in place. These kinds of things are needed now.

First, the District should accelerate its efforts to develop an effective certificate-of-need law and set up a State health planning agency under Public Law 93–641.

Second, the District of Columbia Department of Human Resources should convene representatives of private hospitals in the District to study existing and projected capacities and capabilities of those facilities and needs of District of Columbia residents.

Third, a survey of District-operated facilities should be undertaken by the General Accounting Office to evaluate cost effectiveness of these public facilities.

And, fourth, the District should intensify its role in establishing an effective mechanism for the coordination of health care planning through agreements at both State and local levels.

PREPARED STATEMENT

Mr. Chairman, I will do my best to furnish additional information. My prepared statement is available to be inserted in the record at this point.

Senator CHILES. So ordered.

[The statement follows:]

Mr. Chairman, my name is Barry P. Wilson and I am vice president, public affairs of Group Hospitalization, Inc., the Blue Cross Plan which serves the Washington, D. C. metropolitan area. My responsibilities at GHI include our Plan's activities in the areas of health care planning and research, and I very much appreciate the opportunity the Subcommittee has given me to present some observations on the status of health services development and health care planning in the District of Columbia and the Washington metropolitan area.

GHI's interest in health care planning and in the rational development of health care services throughout the metropolitan area is of long standing, for reasons which we feel are readily apparent. In serving about 1.6 million participants, or about half the population of the Washington area, GHI contracts with 30 area hospitals, including 15 in the District of Columbia, while Medical Service of D. C., our companion Blue Shield Plan, contracts with about 5,000 area physicians, including more than 2,400 in the District. Benefits payments by both Plans exceeded $323,558,779 in 1975.

Additional responsibilities for GHI include functioning as Operations Center for the Government-wide Service Benefit Plan, the program which is underwritten by all Blue Cross and Blue Shield Plans across the nation and in which about six million federal employees and dependents are enrolled.

Our local Plan responsibilities further include serving as fiscal intermediary under Part A of Medicare for 26 hospitals in our service area, as well as 13 skilled nursing facilities and eight home health agencies. Our companion Blue Shield Plan, Medical Service, is Medicare Part B carrier for the Washington metropolitan area.

I have listed these responsibilities only to illustrate the impact which Blue Cross and Blue Shield operations have upon the provision of health care services throughout the Washington metropolitan area. But that impact is more than economic; we believe that our Plans have a deep obligation to do all we can to assure our subscribers that the health care services they

need are available, reasonably accessible, and of uniformly high quality. At the same time, we have a responsibility to assure subscribers that their subscription dollars will not be wasted on unnecessarily duplicative facilities and equipment, or on unnecessary or inappropriate services.

We believe that GHI's interest and involvement in health care planning is by now familiar to most providers and planners of health care services in this area. In the years between 1962 and the passage of the National Health Planning and Resources Development Act (P. L. 93-641) of 1974, GHI furnished a total of $140,000 to help support the activities of local areawide health planning agencies. In 1966, we sponsored an independent survey of metropolitan health care service and facility resources and needs, and made the survey results available to providers, planners and local governments throughout the community. And in 1973, the GHI board of trustees authorized the expenditure of up to $490,000 to support the development of the Metropolitan Washington Council of Governments' Health Information System, to give health care planners and providers the data they need to plan effectively. GHI funding for maintenance and improvement of this vital health data resource totaled $120,000 for the 1976 and 1977 fiscal years.

In 1971, the GHI board of trustees adopted a statement of policy which pledged GHI support of health care planning on a metropolitan areawide basis, as opposed to fragmented subregional planning. Under this policy, GHI reserves the right to contract only with those providers of health care services which can demonstrate, to the satisfaction of the GHI board, clear evidence of community need for the services they propose to develop. This policy has made it necessary for GHI staff to review carefully all proposals for the development of major health care services and facilities in the metropolitan community, and our staff has been deeply involved in the health planning review and comment process in every part of the metropolitan area. We have undertaken our own independent research and study to comment usefully on these projects, and where we have found ourselves in

clear disagreement with planning decisions at the state level, we have formally appealed and argued those decisions.

We believe that GHI's efforts in this arena have been helpful and constructive, and we plan not only to continue them, but to intensify them. We believe that the interests of our 1.6 million participants -- and the interests of the entire community -- are at stake.

These, then, are our credentials for discussion of the issues on which the Subcommittee has asked for our comments. The remainder of this statement will focus on those issues.

Mr. Chairman, the Subcommittee has asked me to describe the current availability of hospital and related health care facilities in the District and the metropolitan area, to state projections for these items through 1980, and to discuss the implication of these emerging trends on the health care facilities in the District of Columbia.

The picture is bleak. And we believe it will grow progressively less attractive, unless comprehensive, coordinated action is taken to arrest the trend we now see. Briefly, that trend is this: based upon our overall review of approved hospital bed construction in the Washington metropolitan area, the region will have an excess of 1,700 acute care hospital beds by 1980. Those beds will require capital expenditures of at least $120 million to be built, and about $70 million a year to maintain. They will be a critical factor in hospital costs which will <u>average</u> $450 per patient day by the end of 1980. The same costs <u>currently</u> average about $200 per patient day. Yet proposals for still <u>more</u> hospital beds are under active consideration in all parts of the metropolitan area, including the District.

A little historical perspective on this situation may be helpful. Over the years, the District has been the natural center of a metropolitan health service area which includes both the Maryland and Northern Virginia suburbs. This came about not only because of rapid population growth evolving from

the D. C. "center," but also because the District is the site of regional health care centers which provide a range of tertiary and specialized services which thus far are unduplicated in the Maryland and Virginia suburban jurisdictions. These regional services include the three university medical centers at the George Washington, Georgetown and Howard universities, together with the Washington Hospital Center, with its specialized burn and trauma services, and Children's Hospital, the recognized regional pediatric center.

With this range of specialized services, and with its totals of about 5,200 acute care hospital beds and about half of the metropolitan area's private physician offices, it follows that suburban patients have been heavily dependent on District facilities and services. In 1973, nearly 47% of Maryland suburban residents who needed hospitalization were treated in District facilities, In 1973, about 16% of Northern Virginia hospital patients also were cared for in the District. But despite the existence of nearly 5,000 hospital beds in the suburban areas, District patients have not generally sought care in suburban hospitals. On the contrary, in 1973, only 2,200, or 3%, of District hospital patients were cared for in suburban facilities.

Clearly, then, District facilities have been able to meet the inpatient needs not only of District residents, but of a high proportion of suburban residents as well. And in general, District hospitals have not been over-burdened by that mission; over the past several years, the bed occupancy rates of 15 D. C. facilities have averaged only about 80%, despite occupancy levels of more than 90% in the two hospitals in the city's Southeast quadrant.

At the moment, the status of the acute care hospital bed complement in the metropolitan area, then, appears reasonably good. In general, this is because there has been a ten-year "breathing space" -- a period of time since the mid-1960's in which new hospital bed construction has generally taken

place only in the Northern Virginia suburbs. Population growth seems very nearly to have caught up with the number of hospital beds available. While hospitals in Northern Virginia have average occupancy rates of only about 80%, hospitals in suburban Maryland have been experiencing occupancy levels of 90% or more for the last several years.

But dramatic changes are about to take place. Despite recent metropolitan population estimates which show that population has either stabilized or is actually declining in the District and some suburban areas, the community is about to receive a complement of over 2,000 additional hospital beds -- beds proposed and approved based upon the optimistic population projections of the 1960's -- beds that, for the most part, the community no longer requires.

In Northern Virginia, a new hospital with a 230-bed capacity will open next month in southern Fairfax County, and in another part of the same county, still another hospital may still be built, despite major efforts to head it off. In the District, where the new Howard University Hospital recently opened and Georgetown University Hospital has undergone some expansion, a 60-bed expansion has been approved for Hadley Hospital in the Southeast. The Hadley expansion appears needed, but GHI is more doubtful about proposals to the District for a new 250-bed hospital in Northeast and a new 200-bed Group Health Association hospital elsewhere in the D. C.

But the real crisis will come about as the result of hospital construction in the Maryland suburbs. A new 200-bed hospital opened there a year ago, and on their way by 1978 or 1979 are over 1,600 more beds -- five or perhaps six new hospitals, and expansion of two existing facilities. Suburban Maryland is in the process of nearly doubling its present complement of hospital beds, from 2,200 a little over a year ago to at least 4,000 by the end of the decade.

The threat to District hospitals of the Maryland construction is readily apparent. Suburban Maryland patients have used the equivalent of 1,700

District hospital beds each year. With 1,600 new beds opening in Maryland, to what extent will they continue to use District facilities? GHI believes that in view of the generally stable metropolitan area population, there is a serious danger that as the suburban Maryland beds become available, the already low occupancy rates in D. C. hospitals will be driven down further -- driven down so far, in fact, that it will not be economically feasible to keep many existing beds open, and some D. C. facilities will be forced either to reduce services or close entirely.

And further consequences can be expected, along the following lines:

. As I have indicated, the region's expected 1,700 excess beds will cost $70 million a year simply to maintain, and the community will have to continue that bill each year for many years to come -- for beds it doesn't need.

. Health care costs will continue their steep rise, not only because of inflation, but because of needlessly incurred debt service and staffing for duplicative, underutilized facilities.

. The programs of the District's university and other regional medical centers -- which depend heavily on revenues from routine use of medical-surgical beds -- will be seriously injured.

. Already scarce health manpower resources will be drained away by unnecessary and duplicative facilities and services, in a wasteful "competition" for patients. Higher salaries, generated by the scarcity of trained personnel, will drive up health care costs still further, and personnel shortages will threaten the quality of care.

. Failure to constrain hospital bed supply within rational limits will discourage the development of less costly,

alternative modes of care, including skilled nursing care and post-acute hospital care; home care programs; and ambulatory care centers.

- Low hospital occupancy rates and the continuing requirement for patient revenues will work against some hospitals' efforts to develop effective patient care evaluation and discharge planning programs, and ultimately may increase both the rate of patient admissions and the average length of stay.

Mr. Chairman, I have outlined this dangerous situation -- as GHI views it -- at the request of the Subcommittee, and I hope it is helpful. Frankly, GHI has repeated these same warnings many times in recent years, but with only limited effect. Little has been done by the metropolitan community to remedy the problem, and time is now critically short. Only two or three years remain before the conditions I have described here will be experienced, and meanwhile, the trend continues -- hundreds more hospital beds are under active consideration; proposals for unneeded, duplicative specialized services such as additional open-heart surgery units are being put forward; 20 or more computerized axial tomography (CAT) scanners -- at $400 to $500 thousand each -- may be acquired without controls or plan.

To GHI, one thing appears certain: for a number of years, the combined capacities of existing, expanded and new metropolitan area hospitals will far exceed the needs of the projected population. This indicates a crucial need to find other uses for this surplus capacity -- to redirect the excess space, equipment and manpower to levels of care that are less costly and perhaps more appropriate to community needs -- post-acute hospital care, skilled nursing care, ambulatory care, outpatient surgery, rehabilitative care, and the like.

But all that requires planning -- the kind of areawide, metropolitan health care planning which the Washington, D. C. area has not had to date.

In that connection, the Subcommittee has asked me to comment on the current state of health care planning in the District. As my previous remarks have indicated, the District is part of a metropolitan health service area, and it is difficult to discuss the planning for one regional jurisdiction without also discussing the others.

Indeed, this was a basic point in public meetings held in the spring of 1975 by the Metropolitan Washington Council of Governments (COG), to discuss health service area designation under P. L. 93-641. GHI argued hard in these meetings for designation of the entire Washington Standard Metropolitan Statistical Area (SMSA) as a single health service area.

We believed it to be the intent of Congress in the new law to keep SMSA's intact for health planning purposes, and we were supported in that view by such organizations as COG, the Metropolitan Washington Regional Medical Program, the D. C. Hospital Association, the Montgomery County Office of Comprehensive Health Planning, the Public Citizens Health Research Group, and individual hospitals like the George Washington University Hospital and the Washington Hospital Center.

However, in the end, the new law simply tended to formalize the fragmentation of health care planning in the metropolitan area. The governors of Maryland and Virginia sought and received the waivers provided for in the new law which enabled them to keep all the health service areas designated for their states within the boundaries of those states. The District itself, under a special provision of the law, is permitted to maintain a state agency health planning function alone, without being designated as a health service area with its own health systems agency.

The result of all this is that the Washington metropolitan area is emerging with four health planning bodies -- the District's state health planning and development agency, which will very likely be conditionally designated soon; the Montgomery County Health Systems Agency, which is awaiting approval of its application for conditional designation; and the Northern Virginia

Health Systems Agency and the Southern Maryland Health Systems Agency (which includes Prince George's, Charles, Calvert and St. Mary's counties), which have already been conditionally designated.

Despite this fragmentation, there are hopeful signs that a metropolitan health planning mechanism may yet be developed. Efforts to establish such a coordinated health planning arrangement have been undertaken repeatedly in the last ten years, but have always been rebuffed at the last moment by one jurisdiction or another. Now, however, regulations being promulgated under P. L. 93-641 clearly seem to require metropolitan coordination. It is our understanding that the governors of Maryland and Virginia and the District's mayor are consulting on the possibility of an agreement to coordinate their health planning efforts in the Washington SMSA. Health planners representing the District and the three suburban health service areas are meeting together to attempt to hammer out a coordination agreement. Local hospitals and groups of hospitals are displaying a keen interest in coordinated health planning. The Metropolitan Washington Board of Trade recently adopted a report expressing its serious concern with hospital overbuilding in the metropolitan area, and asking COG to study and report on the matter. GHI believes that this interest on the part of an organization of area businessmen represents an important "breakthrough" in gaining public attention to the importance of coordinated health care planning.

Meanwhile, however, proposals are being developed for more and more hospital beds, specialized services, and enormously expensive medical equipment items. The states of Maryland and Virginia have certificate of need laws which provide for a formal, public health planning process, and these laws are under modification to meet the criteria set by the regulations of P. L. 93-641. However, while the District is in the process of drafting such a law for itself, it presently does not have a certificate of need process similar to those of its neighboring states. Certificate of need is issued by the director of the D. C. Department of Human Resources,

who may consult with a committee composed of providers and consumer volunteers and known as the Health Planning Advisory Committee (HPAC).

As far as GHI has been able to ascertain, the District has neither a formal, detailed plan for the development of health care services and facilities in the city, nor effective criteria against which proposals for such services and facilities can be evaluated. To evaluate hospital proposals, the District has utilized a formula provided under the old Hill-Burton Plan. This formula divides total patient days (regardless of patient residence) into D. C. population only, despite the fact that more than 2,000 beds in the District are now occupied by patients from the suburbs. The Hill-Burton calculation, then, results in what we think is a misleading utilization rate for D. C. residents, in that the District population is effectively credited with creating more patient days than actually is the case. For example, according to the 1974 Hill-Burton Plan, the use rate in the District is 1,720.5 patient days per 1,000 D. C. residents. However, if suburban patient days in District hospitals are subtracted from the D. C. patient days, the use rate drops to 1,118.1 per 1,000 D. C. residents.

But even when the misleading Hill-Burton calculation is employed, it shows an excess of 560 acute care hospital beds in the District of Columbia. And proposals for 450 more hospital beds have been presented to the Department of Human Resources.

That, very briefly, is GHI's evaluation of the status of health care planning in the Washington metropolitan area.

Finally, Mr. Chairman, the Subcommittee has requested my comments on the extent to which I believe that the private sector has the capability and capacity to provide the services now provided by the Government of the District of Columbia.

Mr. Chairman, GHI believes that the capability and capacity of private hospitals in the District is enormous, in terms not only of the number of health services available, but the quality of those services. And as I indicated earlier in this statement, hospital construction in the Washington suburbs will make much greater amounts of this capacity available to District residents in the very near future -- if it can be captured in time. If that unused capacity is permitted by inaction to dissipate or disappear, it may be lost forever.

GHI believes that it is crucial that the District demonstrate clearly its understanding that the private hospitals in the D. C. are essential to meet the health care needs of District residents, and its willingness to work with private hospitals and physicians to identify the health care needs of the people of the city, and to design the methods and determine the means of meeting those needs. A vital question for the private hospitals and physicians will be whether they will be able to recover the full cost of caring for District patients. They have not always been able to do so in the past, and it will be up to the District and the federal government to assure them that their efforts to help the District plan its health care future will not be rewarded with institutional and personal financial deficits.

As I have said, there is little time for action. In my opinion, we cannot wait for state health planning agencies and local health systems agencies to be in full operation, with well-defined and approved long-range and annual implementation plans. The planning should have begun years ago, and starting now is almost too late.

A number of knowledgeable persons have recommended that the District divest itself of the health care facilities the District presently operates -- D. C. General Hospital, two other hospital facilities, and 23 neighborhood health centers -- in favor of arrangements made with private sector hospitals and facilities. I think that such an action

would be premature. Much remains to be defined about the actual health care needs of city residents, and the effectiveness of existing services -- public and private -- in meeting those needs. For example, the services of hospital outpatient departments and emergency rooms, neighborhood health centers, and other ambulatory care facilities need to be described, inventoried, and defined by facility, by patient, by physician and by diagnosis. Similar review needs to be undertaken of long-term care services, including skilled nursing care, intermediate care, post-acute hospital care, and the like. We must know what is being done before we decide what should be done.

I believe a reasonable course of action for the District could be as follows:

1. The District should accelerate its efforts to develop an effective certificate of need law and to establish its state health planning and development agency and state health coordinating council under P. L. 93-641.

2. The D. C. Department of Human Resources should convene representatives of private hospitals in the District, either by hospital or through the D. C. Hospital Association, to open discussions on studying the existing and projected capacities and capabilities of those facilities, and the existing and projected health care requirements of D. C. residents.

3. An independent survey of District-operated facilities should be undertaken by the General Accounting Office and/or the Congressional Research Service to inventory and evaluate the current operations and cost-effectiveness of these public facilities in terms of the health care needs of District residents.

4. The District should intensify its role in establishing an effective metropolitan-wide mechanism for the coordination of health care planning, through agreements at both state and local levels.

Mr. Chairman, those are my comments. Time has not permitted me and my staff to develop a more detailed overview of metropolitan health services resources and needs than I have presented here, but I have included for the record with this statement a number of exhibits which support my observations, and I hope they will be useful. I will do my best to furnish to the Subcommittee any additional information it requests, and meanwhile I will be very pleased to try to respond to any questions or comments you may have.

Thank you.

ESTIMATES OF THE POPULATION OF STATES: JULY 1, 1974 AND 1975

[Population as of April 1, 1970, and estimates of population (civilian and total) as of July 1, 1974 and July 1, 1975, for each state]

Region, division, and State	Resident population					Civilian population				
	July 1, 1975[1] (revised)	July 1, 1974	April 1, 1970[2] (revised)	Change, 1970 to 1975		July 1, 1975 (revised)	July 1, 1974	April 1, 1970[2]	Change, 1970 to 1975	
				Number	Percent				Number	Percent
United States	213,121	211,391	203,303	9,817	4.8	211,445	209,676	200,133	10,313	5.1
REGIONS:										
Northeast	49,041	49,173	49,041	401	0.8	49,356	49,203	48,917	440	1.0
North Central	57,404	57,348	56,590	1,814	1.5	57,360	57,292	56,240	1,120	2.0
South	69,113	68,348	62,795	6,318	9.6	67,204	66,241	61,731	5,473	8.9
West	37,563	37,522	34,876	2,684	7.7	37,333	36,711	34,159	3,174	9.3
NORTHEAST:										
New England	12,199	12,156	11,847	351	3.0	12,150	12,098	11,750	400	3.4
Middle Atlantic	37,043	37,017	37,193	50	0.1	37,183	37,104	37,167	92	0.2
NORTH CENTRAL:										
East North Central	40,972	40,902	40,266	713	1.8	40,901	40,821	40,165	736	1.8
West North Central	16,430	16,437	16,324	362	2.2	16,401	16,366	16,217	247	2.4
SOUTH:										
South Atlantic	33,711	33,494	30,674	3,038	9.9	33,161	32,681	29,956	3,205	10.7
East South Central	13,543	13,432	12,974	536	4.7	13,446	13,341	12,674	762	6.0
West South Central	20,855	20,584	19,325	1,530	7.9	20,627	20,299	19,081	1,546	8.1
WEST:										
Mountain	9,644	9,440	8,590	1,054	14.3	9,527	9,374	8,167	1,361	16.7
Pacific	28,734	27,921	25,549	1,680	6.3	27,806	27,287	25,992	1,813	7.0
NEW ENGLAND:										
Maine	1,056	1,049	994	66	6.6	1,049	1,045	982	67	6.8
New Hampshire	814	808	738	80	10.8	813	804	734	80	10.9
Vermont	471	468	445	26	5.9	471	469	445	26	5.9
Massachusetts	5,820	5,799	5,689	131	2.4	5,814	5,791	5,689	125	2.2
Rhode Island	927	932	950	-23	-2.4	923	931	913	8	0.9
Connecticut	3,090	3,088	3,032	63	2.1	3,081	3,072	3,014	64	2.1
MIDDLE ATLANTIC:										
New York	18,126	18,101	18,240	-121	-0.7	18,094	18,074	18,210	-116	-0.6
New Jersey	7,314	7,223	7,171	143	2.0	7,298	7,211	7,133	177	2.5
Pennsylvania	11,627	11,693	11,802	24	0.2	11,416	11,479	11,748	31	0.3
EAST NORTH CENTRAL:										
Ohio	10,759	10,745	10,657	102	1.0	10,744	10,731	10,638	106	1.0
Indiana	5,311	5,303	5,194	116	2.2	5,307	5,302	5,184	124	2.4
Illinois	11,113	11,086	11,113	73	0.7	11,107	11,121	11,057	50	0.5
Michigan	9,157	9,117	8,882	215	2.1	9,143	9,103	8,867	276	3.1
Wisconsin	4,607	4,566	4,419	189	4.3	4,605	4,564	4,415	189	4.3
WEST NORTH CENTRAL:										
Minnesota	3,909	3,894	3,806	120	3.1	3,903	3,892	3,801	122	3.2
Iowa	2,870	2,857	2,825	45	1.6	2,869	2,861	2,825	43	1.5
Missouri	4,763	4,773	4,678	85	1.8	4,734	4,744	4,651	84	1.8
North Dakota	630	626	618	12	2.0	622	623	606	16	2.7
South Dakota	683	681	668	15	2.2	677	675	661	16	2.5
Nebraska	1,549	1,541	1,543	61	4.1	1,535	1,529	1,473	61	4.2
Kansas	2,283	2,264	2,249	18	0.8	2,249	2,237	2,212	38	1.7
SOUTH ATLANTIC:										
Delaware	579	577	548	31	5.7	574	572	542	32	5.9
Maryland	4,098	4,089	3,921	174	4.4	4,051	4,034	3,850	200	5.2
District of Columbia	716	721	757	-40	-5.4	708	713	746	-37	-5.0
Virginia	4,967	4,910	4,651	315	6.8	4,914	4,743	4,604	309	6.7
West Virginia	1,803	1,781	1,744	59	3.4	1,802	1,784	1,741	58	3.4
North Carolina	5,451	5,375	5,084	367	7.2	5,395	5,276	4,990	369	7.4
South Carolina	2,816	2,775	2,591	227	8.8	2,748	2,704	2,513	235	9.4
Georgia	4,936	4,877	4,588	328	7.4	4,877	4,829	4,497	380	8.5
Florida	8,217	8,049	6,791	1,365	20.0	8,982	8,004	6,645	1,340	23.4
EAST SOUTH CENTRAL:										
Kentucky	3,396	3,354	3,221	175	5.4	3,381	3,337	3,173	188	6.0
Tennessee	4,149	4,145	3,926	262	6.7	4,148	4,127	3,900	266	6.8
Alabama	3,814	3,773	3,444	370	4.9	3,550	3,550	3,410	180	3.3
Mississippi	2,368	2,334	2,217	139	5.8	2,323	2,311	2,196	127	5.8
WEST SOUTH CENTRAL:										
Arkansas	2,116	2,068	1,923	193	10.0	2,108	2,068	1,915	192	10.0
Louisiana	3,791	3,743	3,642	146	4.1	3,753	3,730	3,600	153	4.2
Oklahoma	2,717	2,691	2,559	152	6.0	2,684	2,653	2,522	163	6.5
Texas	12,227	12,081	11,199	1,027	9.2	12,063	11,828	11,045	1,059	9.6
MOUNTAIN:										
Montana	745	737	694	53	7.7	742	731	689	53	7.7
Idaho	820	796	713	107	14.9	814	790	708	106	14.9
Wyoming	374	362	332	42	12.5	370	358	329	41	12.5
Colorado	2,504	2,415	2,210	294	14.7	2,488	2,408	2,159	329	15.2
New Mexico	1,117	1,119	1,017	100	11.7	1,111	1,104	1,000	111	13.1
Arizona	2,324	2,160	1,775	448	20.3	2,197	2,133	1,747	450	23.8
Utah	1,306	1,179	1,059	147	13.6	1,302	1,174	1,056	146	13.9
Nevada	592	574	489	103	21.1	584	566	479	104	21.8
PACIFIC:										
Washington	3,544	3,494	3,413	131	3.8	3,491	3,444	3,342	149	4.5
Oregon	2,388	2,355	2,092	197	9.4	2,386	2,353	2,088	198	9.5
California	21,185	20,476	19,071	1,214	6.1	20,996	20,379	19,577	1,319	6.7
Alaska	352	341	303	49	16.3	326	315	270	56	20.8
Hawaii	866	854	770	96	12.3	808	797	715	91	12.8

[1] The resident population estimates for July 1, 1974 and July 1, 1975 differ slightly from that published in Series P-25 No. 608 because of updated military statistics. The civilian estimates are consistent with that report.

[2] Includes officially recognized changes to census counts through September 1975. The "official" 1970 census counts used in apportionment are shown in 1970 Census of the Population, Volume I, Characteristics of the Population, Part A, Number of Inhabitants, p. VIII.

Table 1. ESTIMATES OF THE POPULATION OF MARYLAND COUNTIES: JULY 1, 1973 AND JULY 1, 1974

(State estimates are shown to the nearest thousand, county estimates to the nearest hundred)

County	July 1, 1974 (provisional)	July 1, 1973	April 1, 1970 (census) [1]	Change, 1970 to 1974		Components of change, 1970 to 1974			
				Number	Percent	Births	Deaths	Net migration	
								Number	Percent
Maryland	4,094,000	4,071,000	3,922,399	171,000	4.3	256,000	139,000	54,000	1.4
Allegany	83,600	83,700	81,614	-800	-0.6	1,900	1,300	-1,100	-1.3
Anne Arundel	337,100	327,900	298,035	39,000	13.1	20,400	8,300	26,900	9.0
Baltimore	632,500	630,600	620,409	12,100	2.0	33,600	20,400	-1,000	-0.2
Calvert	21,900	23,700	20,682	1,200	20.3	1,800	900	3,300	16.1
Caroline	20,800	20,600	19,761	1,000	5.1	1,200	1,100	900	4.6
Carroll	79,500	76,600	69,866	10,500	15.2	1,100	2,600	8,600	12.5
Cecil	56,300	55,100	53,291	3,000	5.7	4,100	1,800	700	1.4
Charles	58,200	56,200	47,678	11,600	24.2	3,100	1,400	8,800	18.4
Dorchester	29,200	29,500	29,305	-200	-0.7	1,700	1,700	-200	-0.6
Frederick	94,300	91,900	84,927	9,400	11.0	5,800	3,100	6,900	8.1
Garrett	23,200	23,100	21,176	1,700	7.9	1,600	900	1,000	4.9
Harford	134,200	130,000	115,378	18,800	16.3	8,800	3,000	13,000	11.3
Howard	93,000	85,200	62,394	30,600	49.1	4,500	1,700	27,800	44.5
Kent	16,800	16,700	16,146	600	3.8	900	800	500	3.2
Montgomery	560,300	554,100	522,809	37,500	7.2	30,100	13,500	20,900	4.0
Prince Georges	679,200	688,800	661,719	17,100	2.6	50,100	14,300	-18,700	-2.8
Queen Annes	19,600	19,300	18,322	1,200	6.6	1,000	900	1,100	6.2
St. Marys	51,200	49,200	47,388	3,800	8.0	4,500	1,300	600	1.2
Somerset	19,200	18,900	18,821	400	2.0	1,100	1,200	300	2.3
Talbot	25,200	24,900	23,683	1,500	6.3	1,200	1,300	1,600	6.6
Washington	106,400	106,200	103,829	2,600	2.5	6,500	4,200	300	0.3
Wicomico	57,900	57,100	54,236	3,700	6.7	3,500	2,600	2,803	5.1
Worcester	26,100	25,900	24,312	1,700	6.8	1,500	1,300	1,500	6.1
INDEPENDENT CITY									
Baltimore	864,100	877,800	905,787	-41,700	-4.6	57,900	46,600	-53,000	-5.9

[1] Total does not agree with the sum of the counties due to corrections made to the county populations after release of the official State counts.

[2] Births and deaths are based on reported vital statistics from April 1, 1970 to December 31, 1973, with extrapolations to June 30, 1974. Net migration is the difference between net change and natural increase.

Table 1. ESTIMATES OF THE POPULATION OF VIRGINIA COUNTIES: JULY 1, 1973 AND JULY 1, 1974

(State estimates are shown to the nearest thousand, county estimates to the nearest hundred)

County	July 1, 1974 (provisional)	July 1, 1973	April 1, 1970 census	Change, 1970 to 1974		Components of change, 1970 to 1974			
				Number	Percent	Births	Deaths	Net migration	
								Number	Percent
Virginia	4,908,000	4,844,000	4,648,494	259,000	5.6	330,000	171,000	98,000	2.1
Accomack	29,700	29,600	29,004	700	2.3	1,700	1,800	700	2.6
Albemarle	44,800	42,500	37,780	7,100	18.9	2,300	1,300	6,000	16.0
Alleghany	12,800	12,800	12,461	(Z)	-0.4	500	500	-500	-3.7
Amelia	8,000	8,000	7,562	400	5.7	200	300	300	3.6
Amherst	27,000	27,200	26,072	900	3.6	1,000	900	300	1.1
Appomattox	10,500	10,300	9,384	700	7.4	700	400	500	5.2
Arlington	152,200	162,000	174,284	-21,000	-12.1	10,100	5,200	-26,000	-14.9
Augusta	49,000	47,800	41,220	4,800	10.9	2,700	1,700	3,900	8.8
Bath	4,900	5,300	5,192	-300	-4.7	500	300	-500	-7.2
Bedford	29,100	28,200	26,728	2,400	8.9	1,800	1,100	1,700	6.3
Bland	5,300	5,400	5,423	-100	-1.7	300	300	-100	-2.2
Botetourt	20,100	19,400	18,193	1,900	10.6	1,100	800	1,600	8.8
Brunswick	15,800	16,000	16,172	-300	-2.1	1,100	800	-600	-3.9
Buchanan	33,600	33,600	33,071	1,600	4.8	3,400	1,100	-300	-1.0
Buckingham	10,900	10,700	10,597	300	2.9	700	500	100	0.7
Campbell	50,800	48,100	43,319	7,100	16.3	3,500	1,500	5,100	11.7
Caroline	15,300	14,800	13,935	1,400	9.9	1,000	700	1,100	7.7
Carroll	23,100	23,400	23,092	300	1.4	1,400	1,000	-100	-0.6
Charles City	6,300	6,600	6,158	400	5.9	400	200	200	2.7
Charlotte	12,100	12,300	12,366	-300	-2.3	800	600	-500	-3.9
Chesterfield	97,700	90,500	77,045	20,600	26.7	5,800	2,000	16,800	21.8
Clarke	8,700	8,500	8,102	600	6.8	500	400	500	6.2
Craig	3,700	3,700	3,524	100	4.1	200	200	100	3.3
Culpeper	19,800	19,400	18,218	1,600	8.8	1,300	900	1,200	6.6
Cumberland	6,900	6,700	6,179	800	12.3	500	300	600	9.6
Dickenson	17,600	17,600	16,077	1,500	9.2	1,200	600	900	5.4
Dinwiddie	21,400	21,900	23,046	-3,600	-14.4	1,400	700	-4,300	-17.3
Essex	7,900	7,400	7,098	800	10.6	300	400	600	8.9
Fairfax	516,400	500,700	455,022	61,400	13.5	28,500	8,200	40,000	8.8
Fauquier	28,100	27,900	26,375	1,800	6.7	1,900	1,200	1,000	3.9
Floyd	10,000	9,900	9,775	200	2.5	500	500	200	2.4
Fluvanna	8,300	8,400	7,621	700	9.5	500	300	500	7.1
Franklin	29,900	29,700	28,162	1,700	6.1	1,900	1,100	900	3.3
Frederick	27,100	26,300	28,893	-1,700	-6.0	1,500	900	-2,700	-9.4
Giles	16,300	16,300	16,741	-300	-2.9	1,200	800	-900	-5.1
Gloucester	16,700	16,000	14,059	2,700	18.9	1,000	600	2,300	16.7
Goochland	10,200	10,200	10,068	100	1.2	700	400	-200	-1.7
Grayson	15,400	15,900	15,438	(Z)	-0.3	900	800	-200	-1.4
Greene	5,800	5,700	5,348	500	9.9	400	200	400	7.3
Greensville	9,500	9,600	9,604	-100	-1.3	800	400	-500	-5.4
Halifax	29,600	29,800	30,076	-500	-1.7	2,100	1,400	-1,200	-4.0
Hanover	45,500	43,700	37,479	8,000	21.4	2,400	1,400	7,000	18.8
Henrico	166,200	164,000	154,364	11,900	7.7	10,100	5,100	6,900	4.4
Henry	54,500	53,600	50,901	3,600	7.1	3,700	1,500	1,400	2.7
Highland	2,500	2,500	2,529	(Z)	0.6	100	100	100	2.0
Isle of Wight	19,300	19,300	18,265	1,000	5.6	1,100	800	400	2.3
James City	18,300	18,000	17,853	1,400	8.1	1,300	500	600	3.3
King and Queen	5,600	5,600	5,491	100	2.3	300	300	100	1.4
King George	9,000	8,600	8,039	1,000	11.9	600	300	700	8.1
King William	7,900	7,700	7,497	400	5.7	500	300	300	3.8

See footnotes at end of table.

Hospital Construction

District of Columbia

Hospital	Existing	Certified	Pending	Total
Children's	236	---	---	236
Columbia	154	---	---	154
D. C. General	777	---	---	777
Doctors	322[1]	38[1]	---	322
GWUH	529	---	---	529
Georgetown	521	---	---	521
Greater Southeast	418	---	---	418
Hadley Memorial	81	64[1]	---	145
Howard University	495	---	---	495
~ rtheast Community	---	---	250[2]	---
Providence	387	---	---	387
Capital Hill	250	---	---	250
Sibley Memorial	360	---	---	360
Washington Hosp. Ctr.	880	---	---	880
G. H. A.	---	---	200	---
	5410	102	450	5474

[1]Doctors present certification was reduced by 64 beds in 1976 by D.H.R. to certify Hadley. Doctor's is currently licensed for 322 beds but only operates 284. The Certification for replacement will only be for 322 beds. Replacement beds will equal current licensed beds.

[2]Recommended for certificate of need by DC HPAC.

HOSPITAL CONSTRUCTION
NORTHERN VIRGINIA

Alexandria	Licensed	Approved	Total
Alexandria	410	-	410
Circle Terrace	120	-	120
Jefferson Memorial	119	-	119
Arlington			
Arlington	349	-	349
Northern Va. Doctors	267	-	267
National Orthopaedic	139	-	139
Fairfax			
Centreville	-	120[1]	120
Commonwealth Doctors	160	-	160
Fairfax	656	-	656
Mt. Vernon	-	193[1]	193
Loudon			
Loudon Memorial	107	-	107
Prince William			
Prince William	152	97[2]	152
Potomac	137	-	137
TOTALS	2616	410	2929

[1]Exempt from State Certificate of Need.

[2]Northern Virginia CHP has recommended approval of 97 beds at Prince William Hospital contingent upon Centreville Hospital withdrawing 120 beds

Note: The bed situation in Northern Virginia is a complex issue. There are several hospitals which are operating at less than licensed capacity. There are two pending hospitals which are exempt from the state certificate of need law. Finally, there are several recommendations from Northern Virginia CHP to adjust the bed distribution in the community.

Hospital Construction
Suburban Maryland

	Existing	Certified[1]	Totals
Montgomery County			
Holy Cross	338	112	450
Montgomery General	236	-	236
Psychiatric Institute	-	75	75
Shady Grove Medical Center	-	224	224
Suburban	350	115	465
Washington Adventist	365	-	365
Gaithersburg Community	-	212	212
	1289	738	2027
Prince George's County			
Bowie Health Center	-	176	176
Clinton Community	33	-	33
Greater Laurel	-	236	236
Leland Memorial	76	-	76
Parkway	-	250	250
Prince George's Doctors	222	-	222
Prince George's General	555	-	555
Southern Maryland	-	300	300
	886	962	1848
Total Suburban	2175	1700	3875

[1]All beds indicated have received certificates of conformance and are planned to open prior to 1980.

Distribution of Non-Federal Physicians in Direct Patient Care for Selected Specialties by Jurisdiction: 1974

	% of all physicians in a specialty practicing in each jurisdiction							
Jurisdiction	Primary Care [1]	OB-GYN	PED.	PSYCH.	General Surgery	Surg. Spec.	Other Spec.	TOTAL [2]
D. C.	35.7%	34.9%	25.1%	43.6%	39.7%	33.2%	37.7%	36.5%
Maryland	39.9	39.5	46.8	42.3	34.3	38.2	39.2	40.1
Virginia	24.3	25.6	28.0	14.1	25.8	28.6	23.2	23.3
Totals	99.9%	100.0%	99.9%	100.0%	99.8%	100.0%	100.0%	99.9%

[1] Includes family practice, general practice and internal medicine

[2] Total for physicians in direct patient care

Source: Computer tape from AMA - geocoded by COG

Physicians in Direct Patient Care by Primary Type of Employment and Jurisdictions: March 1974

	Type of Employment						
Jurisdiction	Solo Practice	Practice	Partnership	Hospital	Other	No Classif.	Total
D. C.	722 (18.3%)	145 (3.7%)	185 (4.7%)	137 (3.5%)	201 (5.1%)	49 (1.2%)	1439 (36.
Maryland	724 (18.4%)	135 (3.4%)	257 (6.5%)	140 (3.6%)	158 (4.0%)	133 (3.4%)	1582 (40.
Virginia	466 (11.8%)	115 (2.9%)	174 (4.4%)	50 (1.3%)	111 (2.8%)	43 (1.1%)	924 (23.
Totals	1912 (48.5%)	395 (10.0%)	616 (15.6%)	327 (8.3%)	470 (11.9%)	225 (5.7%)	3945 (100

Source: Computer tape from AMA geocoded by COG - includes data on all known physicians - M.D.'s

Emergency Room Visits by Patient Residence (Top Ten)

Hospital	D.C.	(%)	Mont. Co.	(%)	PG	(%)	Virginia	(%)	Other	Total
D. C. General	1,673	98.6	3	.2	6	.4	7	.4	7	1,696
Pr. George's	71	4.2	13	.8	1,405	92.8	--	--	25	1,514
Greater SE	869	63.9	4	.3	456	33.6	9	.7	21	1,359
Fairfax	10	.9	11	.9	9	.8	1,092	92.9	54	1,176
Suburban	49	5.4	733	80.4	41	4.5	54	5.9	35	912
Providence	687	83.4	15	1.8	115	14.0	---	--	7	824
Holy Cross	26	3.4	559	73.7	141	18.6	1	--	32	759
Wash. Hosp. Ctr.	603	88.0	18	2.6	37	5.4	22	3.2	5	685
Freedmen's	647	97.4	12	1.8	2	.3	2	.3	1	664
Children's	618	93.2	11	1.7	28	4.2	1	.2	5	663
Totals	5,253		1,379		2,240		1,188		192	10,252

Emergency Room Visits by Patient Residence (Ten Hospitals Surveyed)

	D.C. Residents		Va. Residents		Md. Residents		Other	
D. C. Hospitals (6)	5,097	(97.0%)	41	(3.5%)	707	(19.5%)	46	(24.0%)
Va. Hospitals (1)	10	(0.2%)	1,092	(91.9%)	20	(0.6%)	54	(28.1%)
Md. Hospitals (3)	146	(2.8%)	55	(4.6%)	1,892	(79.9%)	92	(47.9%)
Totals	5,253		1,188		3,619		192	

Source: An Analysis of Emergency Room Utilization in Metropolitan Washington, D. C. Institute for Health Care Research

April 23, 1976

Mr. Louis J. Segadelli
Executive Director
Group Health Association
2121 Pennsylvania Avenue, N.W.
Washington, D. C. 20037

Dear Lou:

We read with interest and some concern the April 16 Washingtnn Post article by Victor Cohn, concerning the possibility that Group Health Association may build a hospital in the District of Columbia by 1980.

I recognize that the article quoted Edwin Deagle as having stated the possibility that GHA might purchase, or make some other arrangement for beds in an existing hospital, including the planned-for new Doctors Hospital. As we view it, this plan would be much preferable to the development of new hospital beds in a city that already has far too many.

Without going into great detail in this letter, I must still point out that our staff studies indicate quite clearly that as matters stand, the Washington metropolitan area will have an excess of 1,700 hospital beds by the end of 1980 — beds that will cost at least $220 million to build and $70 million a year to maintain. Except for the Anacostia area, hospital bed occupancy in the D. C. currently averages 80% or even less, and the impact of hospital construction in suburban Maryland — where bed capacity will be doubled from a present 1,800 beds to over 3,600 beds by 1980 — has only begun to be felt.

A grim future thus may lie in store for existing D. C. hospitals. Some may have to close, of course, and this will not only eliminate their inpatient capacity, but also their vital emergency and outpatient services to the communities they serve. Some may seek to convert to some alternative types of services, but this is a costly process compounded by the uncertainties of patient demand or need for such services.

Meanwhile, the situation is further complicated by other factors: the D. C. government's plans to develop a certificate of need law to conform with the requirements of the National Health Planning and Resources Development Act (P. L. 93-641); the role, status and operations of a D. C. state health planning agency under 93-641, and the coordination of that agency with health systems agencies elsewhere in the metropolitan area; the pending applications in the Department of Human Resources for a 250-bed hospital in Northeast, a 75-bed expansion in Southeast, and a total of nearly 300 skilled nursing beds, also in the Anacostia area; the status of the planned new Doctors Hospital, which we understand will be 75-100 beds larger than the existing facility; and finally, the gradually declining population of the D. C.

Under these circumstances, I think that GHI has no alternative but to oppose the issuance of certificate of need for any additional beds in the District of Columbia, unless it can be clearly demonstrated that because of maldistribution of facilities, some portion of the city is currently underserved.

We fully appreciate the desire of GHA to develop and maintain maximum control over the hospital beds to be utilized by GHA members, but we urge you to accomplish this objective by lease or purchase arrangements, rather than by compounding the present problem of excess hospital beds in the D. C.

My staff and I would welcome an opportunity to discuss the issue of "overbedding" in the Washington area with you and other GHA representatives, should you wish to do so.

Sincerely yours,

D. S. Farver
President

cc: Joseph P. Yeldell

Blue Cross®

Group Hospitalization, Inc.
550 12th Street, S.W.
Washington, D.C. 20024
202/484-4500
Chartered by the Congress of the United States

June 18, 1976

Mr. Joseph P. Yeldell
Director of Human Resources
Government of the District of Columbia
Department of Human Resources
Washington, D. C. 20001

Dear Mr. Yeldell:

We read with interest the June 15 Washington Post account of your issuance of certificates of need for expansions of facilities at Greater Southeast Community Hospital and Hadley Memorial Hospital, as well as continuation of the certificate for a new facility for Doctors Hospital.

GHI previously has supported the need for additional acute care hospital beds and emergency and outpatient services in the Southeast area, and the shortage of long-term care beds in the Washington metropolitan area is well known. We welcome your reduction of the Doctors Hospital certification from 385 to 321 beds, since this appears to us to effectively "erase" the notion that another hospital should be developed in Northwest, as was threatened about five years ago when the Department of Human Resources certified a proposal for the Mokam Gardens area (subsequently for a Wisconsin and Van Ness site).

However, since proposals to develop the Northeast Community General Hospital and a 184-bed Group Health Association hospital remain before you, GHI is most interested in the criteria that your health planning staff and the Health Planning Advisory Committe used to review the certified applicants and will use for the Northeast and GHA proposals.

It had been our understanding that no criteria -- including Hill-Burton -- were available for use by D. C. health planners by early 1975, and it would be helpful to us at this point to learn whether and what types of guidelines for health planning are now in use in the D. C.

As I'm sure you know, GHI is seriously concerned about the unnecessary duplication of hospital beds and other health care services which is now taking place in the Washington metropolitan area. Based on our review of existing and approved bed construction proposals throughout the region, the Washington area will have an excess of at least 1,700 beds by 1980 -- unneeded beds that will cost a minimum of $20 million to build and about $70 million annually to maintain. The support of unnecessary beds may represent 15-20% of the $450 average hospital cost per patient day that we expect to see by the end of 1980.

Some suburban hospitals and health planners charge that this situation exists because in past years the D. C. permitted hospital construction which was unneeded in view of the rapid expansion of suburban services. The D. C. may respond with equal logic that the suburbs in recent years have permitted hospital construction which wastefully "replaces" existing D. C. facilities. Whatever the argument, and we suspect that there is logic on both sides of the issue, the situation now demands the maximum possible

degree of cooperation, coordination and consultation between the D. C. and all surrounding Virginia and Maryland jurisdictions. The planned doubling of bed complements in suburban Maryland alone in the next three years will drive down the occupancy rates of some D. C. hospitals to the point that some ultimately may have to close entirely, depriving the D. C. communities they serve not only of inpatient beds, but of the range of emergency and outpatient services that are so vitally needed by the people who live near the hospitals. GHI believes that the longer effective, metropolitan-wide health planning coordination is delayed, the more critical this situation will become.

The proposed Northeast Community General Hospital is a case in point. On the surface, at least, there appears to be a need for health care services and facilities in Northeast D. C. But the dimensions of that need can't be determined without an evaluation of the impact which planned new hospitals and services in neighboring Prince George's County will have on the area the proposed Northeast facility intends to serve. That service area, indeed, includes part of Prince George's. For that reason, it is essential that the D. C. coordinate its plans for the development of health facilities and services in Northeast with Prince George's County and the Southern Maryland Health Systems Agency. We suggest, too, that you request from the Council of Governments' Health Information System (HIS) patient origin data on where Northeast patients currently are obtaining hospital care.

Concerning the proposed Group Health Association hospital, you may recall that we previously sent you a copy of our April 23, 1976 letter to Louis J. Segadelli, executive director of GHA, expressing our concerns about the proposal and urging GHA to lease or purchase bed complements in existing hospitals, rather than contribute to overbedding in the city. We explained to Mr. Segadelli that GHI has no alternative under present circumstances than to ppppsethe development of any additional acute care hospital beds in the D. C., unless it can be clearly demonstrated that because of maldistribution of facilities, some portion of the city is currently underserved. While the bed need in Anacostia hasn't been precisely defined, we feel that a need does exist there which the Hadley certification addresses.

We're aware of your health planning staff's recent participation in regional discussions on a variety of planning issues, and it is our hope that in the coming months, the D. C. Government will accelerate its efforts in that regard. Through close and continuing consultations with health care planners and providers in surrounding jurisdictions, the D. C. can minimize the unfavorable effects of suburban health services development on the economical and efficient delivery of health services in the D. C., and at the same time assure D. C. citizens of continuing high quality, accessible health care.

Please contact me if we can ever provide you with information or assistance of any kind in your health planning efforts. Meanwhile, we will look forward to reviewing any information you can send us on D. C. health planning criteria.

Sincerely,

D. S. Farver
President

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HUMAN RESOURCES
WASHINGTON, D. C. 20004

REPLY TO:
1350 E STREET, N. W.
WASHINGTON, D. C. 20004

JUL 19 1976

Mr. D.S. Farver
President
Group Hospitalization, Inc.
550 - 12th Street, S.W.
Washington, D.C. 20024

Dear Mr. Farver:

Thank you for your letter of comment of June 18, 1976 to me on recent actions in awarding Certificates of Need to Hadley Memorial Hospital for 60 acute beds and Greater Southeast Community Hospital for 186 long-term care beds. As you pointed out the 60 acute beds awarded are badly needed in the Southeast Area of the City as are the emergency and outpatient services also included in the Hadley Certificate of Need. I was pleased that by reducing the size of the projected Doctors Hospital replacement facility in the Northwest Area by 64 beds we were able to reallocate those beds to where they are most needed.

You also referred to the proposals of Northeast Community General Hospital (NCGH) and Group Health Association (GHA) now pending before the Department. As you know, I have advised Dr. Francis Smith sponsor of the NCGH that no action is being taken by the Department on his Certificate of Need request due to insufficient information. In the case of the GHA request, project review procedures are now being undertaken. The validity of that application will be determined when the process is completed.

The Department's review criteria for Certificate of Need remains as it has been (those contained in the State Health Facilities (Hill-Burton) Plan). The provisions of this Plan were extended administratively (see the D.C. Register of June 25, 1976) for an indefinite period or until superseded by the health planning criteria and State Plan mechanisms

required by P.L. 93-641. As you know the Department has been designated by the Mayor as the single state agency to administer for the District the Health Planning Resources Development Act (P.L. 93-641). We are currently engaged in preparing an application to be submitted to the Department of Health, Education and Welfare for conditional designation as a Section 1536 State Agency under P.L. 93-641.

The offer of GHI to make available its assistance in health planning efforts is appreciated and we look forward to participation with it and other planning groups as the new State Agency structure is developed and the provisions of P.L. 93-641 are implemented by the District.

Sincerely,

Joseph P. Yeldell

Joseph P. Yeldell
Director

Blue Cross. Group Hospitalization, Inc.
550 12th Street, S.W.
Washington, D.C. 20024
202/484-4500

July 30, 1976

Mr. Joseph P. Yeldell
Director
Department of Human Resources
1350 E Street, N.W.
Washington, D. C. 20004

Dear Mr. Yeldell:

Thank you for your letter of July 19. As you know, GHI is concerned and actively involved in many health planning issues in the metropolitan area. We are looking forward to working with you and the staff of the new State Agency on planning efforts in the District of Columbia.

As we have said in previous correspondence, we recognize that there is a need for emergency services, outpatient services and acute care beds in the Southeast area of the city. The Radley Hospital expansion addresses itself to a part of this need, but in our view, the most cost effective methods of meeting the remainder of the need are yet to be defined.

"Redistribution" of acute care hospital beds in the District to meet the needs of all residents is a concept we strongly support. However, we feel that this cannot be accomplished only through reallocation of planned beds through the certification process. Steps must be taken to promote the most effective possible coordination and optimal utilization of existing beds in the District. As the State Health Facilities Plan of the District clearly indicated in 1974, there clearly is no overall need for any new acute care hospital beds in the city.

On the contrary, the D. C. Hill-Burton Plan for 1974 shows an excess of 560 acute beds, even though approved hospital construction in the suburban areas is not accounted for the D. C. bed need calculation. The Hill-Burton Plan formula divides total patient days (regardless of patient residence) into D. C. population only. This calculation results in what we believe is a misleading utilization rate for D. C. residents, in that D. C. population is effectively credited with creating more patient days than actually is the case. For example, according to the 1974 Hill-Burton Plan, the use rate in the D. C. is 1,720.5 patient days per 1,000 D. C. residents. However, if suburban patient days in D. C. hospitals are subtracted from the total D. C. patient days, the use rate drops to 1,118.1 per 1,000 D. C. residents. (See Attachment I.)

Based on the above, we feel the Hill-Burton Plan as a criteria for bed need determination is unrealistic, because it fails to recognize suburban construction but at the same time includes suburban patient days in D. C. facilities.

As you know, recent population statistics indicate that not only is the District population declining, but some suburban populations are declining as well. The rapid suburban growth we saw in the 1960's seems to have slowed dramatically and in some areas, the population trend is actually

downward. We believe that this tendency toward stabilization of populations means that it will be difficult to achieve reasonable occupancy rates in the new hospital beds in the suburbs, much less maintain effective utilization of existing District beds. (See Attachment II.) As I'm sure you're aware, we're greatly concerned about the problem of excess hospital beds in the metropolitan area. "Overbedding" not only increases health care costs, but can also deplete already scarce health manpower resources and have an unfavorable effect on the overall quality of care in the metropolitan community.

Members of our staff are currently providing technical assistance to the Task Force on Baltimore/Washington Corridor Hospital Bed Needs. This Task Force was established by Maryland health planners to determine the extent and implications of overbedding of acute hospital beds in the Corridor. The work of the Task Force thus far has clearly demonstrated two facts: (1) there is a surplus of beds in the Baltimore/Washington Corridor; and (2) the present and projected metropolitan population will not be able to generate sufficient utilization to use both suburban and District beds effectively. The Task Force is now attempting to identify some approaches which will reduce the number of hospital beds now proposed for development in the suburbs.

I've raised these issues in this letter only to illustrate the very real dangers which have arisen because of the historical lack of effective, coordinated, metropolitan-wide health planning in the Washington area. It's our belief that the viability of the health care facilities and services of the District of Columbia are seriously threatened by hospital expansion in the suburbs, primarily because the high volume of suburban residents now treated in District facilities will very likely be drastically reduced in the next two or three years.

I hope that you and I and our staffs may have an opportunity to meet in the near future to discuss future courses of action which might help improve the effectiveness and economy of health care services throughout the metropolitan area.

Sincerely yours,

D. S. Farver
President

ATTACHMENT I

IMPACT OF SUBURBAN UTILIZATION
ON THE NEED FOR D. C. ACUTE CARE BEDS

I. 1974 Projection of Bed Needs Excluding Suburban Patients:

Population		Patient	Use	Average	Bed
1973	1980	Days	Rate	Daily Census	Need
737,000	721,000	824,041	1,118.1	2,208	2,610

II. Potential Bed Excess:

A. 1974 total beds existing in D. C.	5,183
B. Bed need according to above	2,610
C. "Vulnerable" beds	2,573

III. Suburban Bed Use in D. C. Hospitals (1974):

	Patient Days	Need
A. Montgomery County	198,023	639
B. Prince George's County	322,395	1,040
C. Northern Virginia	121,688	392
TOTAL	642,106	2,071

ATTACHMENT II

SUBURBAN HOSPITAL BED INVENTORY (1976)

	Existing	Certified
A. Prince George's County	886	962
B. Montgomery County	1,560	663
C. Northern Virginia	2,635	328
TOTAL	5,081	1,953

Note: Since 1974 Prince George's Doctors Hospital (Prince George's County) has opened with 222 beds, Montgomery General Hospital (Montgomery County) has added 75 beds, Alexandria Hospital (Northern Virginia) has added 47 beds, and Arlington Hospital (Northern Virginia) has added 21 beds.

STATEMENT OF J. P. GAMBLE, SENIOR VICE PRESIDENT
GROUP HOSPITALIZATION, INC.

Re: Health Services in the District of Columbia

Before the Committee on Health and Welfare of
the District of Columbia City Council

October 21, 1969

Madame Chairman and Members of the Committee:

I am Joseph P. Gamble, senior vice president of Group Hospitalization, Inc. I have been associated with the organization since 1957, having served as assistant controller, controller, and assistant director prior to being elected to my present office.

Group Hospitalization is the Blue Cross Plan serving the Washington, D. C. metropolitan area. It is a non-profit prepayment plan designed to help subscribers pay the cost of hospital care. We are currently serving more than 1,260,000 participants, and since 1934 we have used approximately half a billion dollars to pay subscriber claims -- about 93% of our total subscription income.

In addition to our service to about one-half of the Washington area population, GHI has a number of other important responsibilities. We serve as administrative agent for Medical Service of D. C., the local Blue Shield Plan which helps over 1,200,000 area residents meet the expense of physician services. We are the Operations Center for the Government-wide Service Benefit Plan for Federal employees which has a world-wide enrollment of 4.6 million Federal employees and dependents and which is underwritten by Blue Cross and Blue Shield Plans throughout the United States. We serve as Part A fiscal intermediary for Medicare for 24 local hospitals -- including the District's Area C, Glenn Dale, and D. C. General facilities -- 13 extended care facilities and 9 home health agencies. As agent for Medical Service of D. C., we also process claims and make disbursements under the Part B supplemental medical insurance portion of Medicare. With Medical Service, we play a key role in the administration of the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). On September 1, we launched the Pro-

gram for Armed Services Separatees (PASS), a program which provides short-term hospital and surgical-medical coverage for men and women who have just been discharged from the Armed Forces. Also, we have actively assisted staff of the D. C. Model Cities Program in an effort to assist in the development of an effective program which would meet the standards of the Department of Housing and Urban Development.

I list these activities simply to illustrate the manner in which GHI has responded to the needs of the community and the nation over the years. We are deeply involved in the health care system in the Washington area. We are a public service institution which shares with you a profound interest in making quality health care available to every citizen of this community.

While Group Hospitalization has not adopted defined corporate policies with respect to situations you are concerned with, I hope that some personal observations will contribute to your deliberations.

Underlying the concerns of this committee, I'm sure, is the belief that good health care is the right of every person who lives in this community. This philosophy has prompted substantial thinking concerning a national health insurance program. While the health care industry in America has enormous strength, there are important gaps. Despite Medicare, Medicaid and local and state welfare programs, a substantial number of citizens still find it difficult to obtain adequate care, and millions more are confused about gaining access to various elements of care. The health care system of this country is a labyrinth through which the patient must grope his way blindly as he strives to get well. The kinks and blind alleys of this system should be eliminated.

For the future development of needed services, careful planning will be required. On a national basis, Blue Cross has thrown its full resources behind the support of comprehensive health planning at the national, state and local levels, in order to help stem the tide of rising medical costs and at the same time help make better health care more readily accessible to all Americans. Here in Washington, Group Hospitalization has long endorsed --

and given financial support to -- the objectives of the Health Facilities Planning Council for Metropolitan Washington, D. C. And as recently as 1966, we sponsored an independent survey of the Washington area's present and future health facilities needs.

In the area of planning, we are currently disturbed over the threatened fragmentation of the planning agency for the metropolitan Washington area. Suburban Maryland and Virginia each apparently are interested in establishing separate planning agencies for those areas. In the District, of course, we have the Health Department and the Health Facilities Planning Council for Metropolitan Washington, D. C. Also intimately interested in health services planning are such organizations as the Metropolitan Washington Council of Governments, the Hospital Council of the National Capital Area, the D. C. Medical Society and other neighboring county medical societies, and others.

Somehow the efforts of all these groups should be coordinated and combined in the interest of better health care for the entire metropolitan area. Costly and unnecessary duplication of health services is already a serious enough problem, without compounding it with duplication of planning and divisiveness in the determination of the health care gaps which most need filling.

One thing appears clear -- and that is that the job of providing quality health care to every citizen is a task too big for either the public sector or the private sector alone. A combined effort is required. It appeared at first that a Medicaid program in the District might provide at least part of the answer. There remains however a substantial number of citizens who must look to D. C. Health Department facilities for care. Also the involvement of private physicians and hospitals has been less than dramatic. Medicaid, then, has not substantially reduced the burden on D. C. Health Department facilities. It has, however, resulted in added administrative chores which are new to the Health Department. The task of administration could have been otherwise managed; indeed, Group Hospitalization and Medical Service submitted a detailed proposal to the D. C. Government showing how this could be accomplished. We felt that our existing relation-

ships with local hospitals and physicians and our expertise in the field could have been of material assistance to the program.

In any event, Medicaid has not solved the problem. It has been suggested that more extensive use of group practice programs might. We at Group Hospitalization have had considerable working experience with this type of plan and we know that such arrangements apparently result in lower utilization of costly hospital care. But we are not at all sure that enough professional manpower can be recruited to this form of practice to meet the needs of the people of D. C. And the question of the relative productivity and efficiency of group practice plans has really not been answered conclusively. I believe that it's advisable to remain flexible on the role of group practice, and to continue to work extensively with it.

It appears to me that the notion of a comprehensive health insurance plan for the needy citizens of the District of Columbia would be a move in the proper direction. As you know, most of those who can afford it are covered by a health benefits program with costs often shared by the employer and the employee. There is need for low income citizens to be entitled to the same type of benefits, with some form of financing from tax funds. Once everyone has this kind of coverage, there would be little or no need for a dual health care system -- a government system for poor people and a private system for everyone else -- and more importantly all would have equal access to care.

The problem that is not often recognized, however is that the manpower, facilities and organization simply do not exist to provide such comprehensive services in a short time. Also, since it is likely that a comprehensive program would cost a good deal more than the community's current health expenditures, more thought needs to be given to spending priorities.

At Group Hospitalization, we think the proper place to begin is at the beginning. An inventory of the facilities and personnel already providing health care in the District of Columbia should be made and these resources should be used to maximum advantage. As you view the

spectrum of public and private health care now available in the community, you will discover significant gaps. It would be futile, I think, for the D. C. Health Department to attempt to fill these gaps with its already overburdened facilities and personnel. And it is highly unlikely that the city can outbid its competition for the increased resources needed to fill those gaps. In my opinion much is to be said for the District of Columbia Government terminating its role as a provider of health care services. The city should then move directly to provide the financing mechanism so that needed health care is provided by non-governmental hospitals and physicians.

The scope of services for which the city would provide benefits would require careful study. It would be a temptation to launch a program which stresses preventive and ambulatory care, for example. But it is doubtful that such services are now available in this community in the required supply. Again, we must start at the beginning and walk before we run. The District should start at expenditure and benefit levels not too far different from those now widely in use. The services covered by the Government-wide Service Benefit Plan, under which some 600,000 federal employees and dependents in the metropolitan area are now enrolled, might be a good starting point. But given the plans, given the facilities, given the services, given the level of benefits -- how is it all to be paid for? And how can we be sure that a sufficient number of private hospitals and physicians will be willing to provide services? To begin with, District funds which are available for expenditures for health services should be determined and that will determine to a large degree the appropirate level of benefits.

As far as the participation of area hospitals and physicians is concerned, I believe that this will come quickly with equitable treatment. It is not fair that a provider of service be asked to provide an $80 service for $38. It is not fair to expect a physician to accept less than a reasonable amount for his service. And it is not fair to a disadvantaged

patient to be identified as a person for whom a fair amount will not be paid.

Of course steps must be taken to keep costs at a minimum -- uniform cost accounting, efficient auditing procedures, effective utilization review, perhaps incentive reimbursement methods would help. If we attempt to provide more services than we are prepared to pay for, we will inhibit the provider from rendering quality care.

Finally, a third party prepayment mechanism seems to me to be an extremely effective method of reimbursing providers of care. This would substantially reduce Health Department administrative burdens and keep expenses to a minimum. We would hope, of course, that Group Hospitalization would be called upon if such an arrangement is considered. Meanwhile, we are ready and most willing to lend our experience and our expertise in the field of health benefits to this committee, to the City Council, and to the Mayor and the Health Department in any discussions on better health care for the citizens of the District of Columbia.

Thank you for this opportunity to present my views. I'll be happy to answer any questions you may have in whatever time is permitted.

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Data for Health Planning*
Number 2
March 1, 1976

HEALTH INFORMATION SYSTEM

Trends in Hospital Beds, Utilization, Personnel and Expenses: 1959-1974

INTRODUCTION

This report provides information on trends in the utilization and operating characteristics of acute care hospitals in the metropolitan Washington area from 1959 to 1974. In Part One of this report, information on the utilization and operating characteristics of non-federal hospitals in the region is presented. Part Two of the report provides information on federal hospitals. The information presented in this report has been compiled from the American Hospital Association's Guide to the Health Care Field (1960-1975 editions). The Health Information System has not verified the data.

This series of reports on Data for Health Planning is prepared by the Health Information System (HIS), a data base designed to support health planning in the metropolitan Washington area. The HIS was developed with an initial grant of $490,000 from Group Hospitalization, Inc., the Blue Cross plan serving the metropolitan Washington area. The system continues in operation with support from Group Hospitalization, Inc., the Metropolitan Washington Regional Medical Program, the Medical Service of the District of Columbia and local governments participating in the Metropolitan Washington Council of Governments.

H I G H L I G H T S

NON-FEDERAL HOSPITALS IN THE METROPOLITAN WASHINGTON AREA

Beds

The number of non-federal hospitals in the region has increased over the last 16 years from 22 to 31 facilities. Of the nine new hospitals in the region, six are located in Northern Virginia.

Since 1960, there has been a 47.0 percent increase in the number of beds at area hospitals--from 6,357 in 1960 to 9,341 in 1974.

The majority of the 2,984 beds added between 1960 and 1974 were located in Northern Virginia (1,713 or 57.4 percent of the total new beds).

The District of Columbia's proportion of the total beds in the metropolitan area has declined from 72.3 percent in 1960 to 53.6 percent in 1974. Northern Virginia has increased its share of the beds in the metropolitan area from 11.6 percent in 1960 to 26.2 percent in 1974. Between 1960 and 1974, beds in the Maryland

* Data for Health Planning is a series of periodic reports designed to make information on health resources available to health planners and administrators in the metropolitan Washington area. For additional information, please contact the Health Information System at 223-6800, ext. 345.

suburbs increased from 16.1 percent to 20.1 percent of the total beds in the region.

The greatest increase in admissions between 1960 and 1974 occurred in Northern Virginia hospitals (64,418 or a 208.0 percent increase). Montgomery County hospitals had a 123.0 percent (30,467) increase in admissions, Prince George's County hospitals had a 62.8 percent (9,862) increase, and the District of Columbia hospitals had a 21.9 percent (32,735) increase in admissions.

The average percent occupancy at metropolitan area hospitals in 1974 was 79.4. District of Columbia hospitals had an average percent occupancy of 78.0 in 1974. In Maryland, during 1974, hospitals in Montgomery County and Prince George's County had occupancy rates of 86.1 and 85.5 percent, respectively. Northern Virginia hospitals had an average percent occupancy of 77.0 in 1974.

Births and Bassinets

Since 1960, there has been a 17.1 percent decrease in the number of births at metropolitan area hospitals--from 45,657 in 1960 to 37,866 in 1974.

Between 1960 and 1974, the District of Columbia experienced a 39.4 percent (-12,388) decrease in births, Montgomery County had an increase of 24.3 percent (1,140), Prince George's County had a 5.4 percent (-173) decrease, and Northern Virginia had an increase of 56.7 percent (3,630).

Since 1960, there has been a decrease of four bassinets in metropolitan area hospitals--from 873 in 1960 to 869 in 1974.

Personnel and Expenses

Since 1960, the number of hospital personnel in the metropolitan area has increased by 127.9 percent--from 11,929 in 1960 to 27,189 in 1974.

Payroll expenses in metropolitan area hospitals have increased by $168,279,000 between 1960 and 1974.

Total hospital expenses in metropolitan area hospitals in 1974 were more than six times that for 1960.

FEDERAL HOSPITALS IN THE METROPOLITAN WASHINGTON AREA

Beds

Between 1960 and 1974, there was a 10.2 percent decrease in beds at the six federal hospitals in the region--from 3,206 to 2,877 beds.

A comparison of the data on federal hospitals for 1960 and 1974 shows a 19.2 percent (9,797) increase in admissions--from 51,006 to 60,803.

Percent occupancy at federal hospitals decreased 8.2 percent between 1960 and 1974--from 84.3 to 76.1.

Births and Bassinets

Births in federal hospitals between 1960 and 1974 declined by 45.2 percent--from 7,482 in 1960 to 4,098 in 1974.

There was an increase of 1.8 percent in the number of bassinets in federal hospitals between 1960 and 1974--from 158 to 161 bassinets.

Personnel

Since 1960, the number of personnel employed in federal hospitals has increased by 75.1 percent--from 5,016 to 8,785 employees.

PART ONE

Non-Federal Hospitals in the Metropolitan Washington Area

Beds and Hospitals (Tables 1-2)

In Table 1, the number of hospital beds reported to the American Hospital Association by non-federal hospitals in the region from 1959 to 1974 is presented. In 1974, the metropolitan Washington area had 31 non-federal hospitals. The number of non-federal hospitals serving the metropolitan area has increased over the last 16 years from 22 to 31 facilities. Between 1959 and 1967, the number of hospitals increased from 22 to 30 hospitals, increasing the number of beds by 1,611 or 26.4 percent. One additional facility, Potomac Hospital, was opened in 1973. Of the nine new hospitals, six are located in Northern Virginia, increasing the total number of beds from 635 in 1959 to 2,357 in 1973. One new facility each opened in the District of Columbia, Montgomery County, and Prince George's County.

Of the 9,341 total beds in the metropolitan Washington area in 1974, 53.6 percent (5,011) were located in the District of Columbia, 13.1 percent (1,221) were in Montgomery County, 7.0 percent (658) were in Prince George's County, and 26.2 percent (2,451) were in Northern Virginia. In 1960, 72.3 percent (4,597) of the total beds were located in the District of Columbia, 10.0 percent (636) were in Montgomery County, 6.1 percent (386) were in Prince George's County, and 11.6 percent (738) were in Northern Virginia.

Table 2 provides information on the percent change in the number of beds for three five-year intervals between 1960 and 1974. Since 1960, there has been a 47.0 percent increase in the number of beds at area hospitals -- from 6,357 in 1960 to 9,341 in 1974. The majority of the 2,984 beds added between 1960 and 1974 in the region were located in Northern Virginia (1,713 beds or 57.4 percent of the total new beds), 19.6 percent or 585 new beds were added in Montomgery County, 272 beds or 9.1 percent were added in Prince George's County, and the District of Columbia gained 414 new beds or 13.9 percent of the new beds constructed during this time period.

The District of Columbia, between 1960 and 1974, shows the smallest overall increase in beds (9.0 percent), while Northern Virginia, reflective of the greatest increase in new facilities, shows the largest increase in beds (232.1 percent) for the same time period. In Montgomery County, the number of beds increased by 92.0 percent, while in Prince George's County there has been a 70.5 percent increase between 1960 and 1974.

Based on the 1960 population of the metropolitan Washington area, there were 3.1 beds per 1,000 persons in the region.* In 1974, there were 3.2 beds per 1,000 persons, indicating that hospital construction has essentially kept pace with population growth. In the District of Columbia in 1960, there were 6.0 beds per 1,000 persons, and by 1974 there were 6.9 beds per 1,000 persons. Montgomery County had 1.9 beds per 1,000 persons in 1960 and, in 1974, the County had 2.2 beds per 1,000 persons. In Prince George's County, there were 1.1 beds per 1,000 population in 1960, and this became 1.0 beds per 1,000 population by 1974. Northern Virginia, in 1960, had 1.2 beds per 1,000 population and by 1974, had increased its beds per 1,000 population to 2.5.

Symbol Key to Tables

\- = No Data Available

* = Hospital Not Open

** = Estimated from the Monthly Hospital Utilization Report, Hospital Council of the National Capital Area.

† = Not Applicable

†† = Closed Ob Service

* The source of the 1960 population figures is the U.S. Bureau of the Census' Decennial Census of the Population. The 1974 population figures are estimates from the U.S. Bureau of the Census, Series P-25.

TABLE 1

METROPOLITAN WASHINGTON COUNCIL OF GOVERNMENTS
HEALTH INFORMATION SYSTEM
AMERICAN HOSPITAL ASSOCIATION GUIDE ISSUE DATA: 1960-1975

NUMBER OF BEDS

HOSPITAL NAME	1959	1960	1961	1962	1963	1964	1965	1966	1967	1968	1969	1970	1971	1972	1973	1974
CHILD HOPS NHC	200	200	222	215	216	216	216	216	228	236	236	220	226	226	226	213
COL.HOSP FR WOMEN	118	118	125	154	154	154	152	152	152	152	153	153	153	154	154	154
DC GENERAL HOSP	1118	1121	1121	1121	1121	1299	1121	936	741	957	980	983	951	926	800	730
DOCTORS HOPSITAL	307	307	307	307	307	307	307	323	323	323	323	322	322	284	284	284
GREATER SE COMM	*	*	*	*	*	*	*	252	338	406	410	410	418	418	418	418
HOWARD UNIV HOSP	382	382	382	392	437	437	514	439	439	447	449	449	428	417	423	423
GEORGETOWN U HOSP	353	380	380	388	395	397	392	397	397	397	397	394	405	407	396	359
GEO WASH UNI HOSP	417	425	427	428	430	430	427	427	449	455	528	522	529	529	540	535
HADLEY MEM HOSP	67	68	66	68	67	65	85	85	83	82	77	77	81	81	80	80
PROVIDENCE HOSP	350	350	350	367	367	367	367	365	365	367	367	387	390	387	377	362
ROGERS MEM HOSP	152	220	250	250	250	250	250	250	250	250	250	250	250	250	218	218
SIBLEY MEM HOSP	248	248	340	311	339	335	335	335	335	335	346	355	355	357	360	360
WASH HOSP CENTER	778	778	787	787	813	808	802	806	817	829	829	845	824	880	824	875
DC TOTAL	4490	4597	4757	4788	4896	5065	4968	4983	4917	5236	5345	5367	5332	5316	5100	5011
HOLY CROSS HOSP	*	*	*	*	224	232	260	260	260	288	340	340	340	344	344	344
MONTGOMERY GEN	73	74	77	77	77	77	77	77	55	54	54	54	158	161	161	161
SUBURBAN HOSPITAL	198	300	280	280	280	280	245	245	296	350	350	350	350	350	350	350
WASH ADVENTIST	266	262	282	282	282	282	282	287	287	297	302	302	302	302	313	366
MTG TOTAL	537	636	639	639	863	871	864	869	898	989	1046	1046	1150	1157	1168	1221
CLINTON COMMUNITY	*	-	-	36	36	36	36	36**	33	33	33	33	33	33	33	33
E LELAND MEM HOSP	51	51	51	45	45	62	73	73	73	73	76	76	76	76	76	76
P.G. GENERAL HOSP	390	335	385	385	381	381	393	361	361	361	494	494	494	494	515	549
PG TOTAL	441	386	436	466	462	479	502	470	467	467	603	603	603	603	624	658
ARLINGTON HOSP	250	250	250	250	246	250	250	247	247	250	250	266	266	268	261	325
NAT ORTHO-RENAB	78	78	100	100	100	110	110	110	110	110	132	126	128	128	141	141
NO VA DOCTORS	*	68	70	71	71	100	140	140	140	140	183	267	267	267	267	267
ALEXANDRIA HOSP	190	190	190	258	304	304	313	323	323	330	330	330	330	337	337	344
CIRCLE TERRACE	67	67	68	68	68	68	-	67	67	105	127	127	127	127	123	124
JEFFERSON MEM HOS	*	*	*	*	*	*	-	-	92	120	119	119	119	119	119	119
CMNWLTH DOCTORS	*	*	*	*	*	*	*	*	-	80	80	80	80	131	131	131
FAIRFAX HOPSITAL	*	*	248	266	266	282	282	282	308	308	308	494	530	584	614	616
LOUDOUN MEM HOSP	50	85	85	85	85	85	85	85	85	85	85	85	85	85	85	107
POTOMAC HOSPITAL	*	*	*	*	*	*	*	*	*	*	*	*	*	*	125	125
PR WILLIAM HOSP	*	*	*	*	*	60	60	60	60	60	60	60	125	154	154	152
N VA TOTAL	635	738	1011	1098	1140	1259	1240	1314	1432	1588	1674	1954	2057	2200	2357	2451
SMSA TOTAL	6103	6157	6843	6991	7361	7674	7574	7636	7714	8280	8668	8970	9142	9276	9249	9341

TABLE 2

HEALTH INFORMATION SYSTEM
NUMBER OF BEDS AND PERCENT CHANGE IN BEDS

JURISDICTION	HOSP. NAME	1960	1964	% CH 60-64	1965	1969	% CH 65-69	1970	1974	% CH 70-74	% CH 60-74
DC	CHILD HOSP NMC	200	216	8.0	216	236	9.3	220	213	3.1-	6.5
	COL HOSP FU WOMEN	118	154	30.5	152	153	.7	153	154	.7	30.5
	DC GENERAL HOSP	1121	1299	15.9	1121	980	12.5-	983	730	25.6-	34.8-
	DOCTORS HOSPITAL	307	307	.0	307	323	5.2	322	284	11.7-	7.4-
	GREATER SE COMM	*	*		*	410	.0	410	418	2.0	.0
	HOWARD UNIV HOSP	382	437	14.4	514	449	12.5-	449	423	5.7-	10.7
	GEORGETOWN U HOSP	380	397	4.5	392	397	1.3	394	359	8.8-	5.4-
	GEO WASH UNI HOSP	425	430	1.2	427	528	23.7	522	535	2.5	25.9
	HADLEY MEM HOSP	68	65	4.3-	85	77	9.3-	77	80	3.9	17.6
	PROVIDENCE HOSP	350	367	4.9	367	367	.0	387	362	6.4-	3.4
	ROGERS MEM HOSP	220	250	13.6	250	250	.0	250	218	12.7-	.8-
	SIBLEY MEM HOSP	248	335	35.1	335	346	3.3	355	360	1.4	45.2
	WASH HOSP CENTER	778	808	3.9	802	829	3.4	845	875	3.6	12.5
TOTAL		4597	5065	10.2	4968	5345	7.6	5367	5011	6.5-	9.0
MTG	HOLY CROSS HOSP	*	232	.0	260	340	30.8	340	344	1.2	.0
	MONTGOMERY GEN	74	77	4.1	77	54	29.8-	54	161	198.1	117.6
	SUBURBAN HOSPITAL	300	280	6.6-	245	350	42.9	350	350	.0	16.7
	WASH ADVENTIST	262	282	7.6	282	302	7.1	302	366	21.2	39.7
TOTAL		636	871	36.9	864	1046	21.1	1046	1221	16.7	92.0
PG	CLINTON COMMUNITY	-	36	.0	36*	33	8.2-	33	33	.0	.0
	LELAND MEM HOSP	51	62	21.6	73	76	4.1	76	76	.0	49.0
	P G GENERAL HOSP	335	381	13.7	393	494	25.7	494	549	11.1	63.9
TOTAL		386	479	24.1	502	603	20.1	603	658	9.1	70.5
NO.VA	ARLINGTON HOSP	250	250	.0	250	250	.0	266	325	22.2	30.0
	NAT ORTHO-REHAB	78	110	41.0	110	132	20.0	126	141	11.9	80.8
	NO VA DOCTORS	68	100	47.1	140	183	30.7	267	267	.0	[illegible]
	ALEXANDRIA HOSP	190	304	60.0	313	330	5.4	330	344	4.2	81.1
	CIRCLE TERRACE	67	68	1.5	-	127	.0	127	124	2.3-	85.1
	JEFFERSON MEM HOS	*	*		-	119	.0	119	119	.0	.0
	CMNWLTH DOCTORS	*	*		*	80	.0	80	131	63.8	.0
	FAIRFAX HOSPITAL	*	282	.0	282	308	9.2	494	616	24.7	.0
	LOUDOUN MEM HOSP	85	85	.0	85	85	.0	85	107	25.9	25.9
	POTOMAC HOSPITAL	*	*		*	*		*	125	.0	.0
	PR WILLIAM HOSP	*	60	.0	60	60	.0	60	152	153.3	.0
TOTAL		738	1259	70.6	1240	1674	35.0	1954	2451	25.4	232.1
TOTAL		[illegible]	7674	20.7	7574	8668	14.4	8970	9341	4.1	47.0

SOURCE: AMERICAN HOSP.ASSOC.,'GUIDE TO THE HEALTH CARE FIELD',1960-75

Utilization (Tables 3-6)

In Table 3, the number of admissions to non-federal hospitals in the region from 1959 to 1974 is displayed. In 1974, there were 358,580 admissions to non-federal hospitals in the metropolitan area. Of the total admissions to non-federal hospitals in the area during 1974, 50.9 percent (182,407) were in District of Columbia hospitals, 15.4 percent (55,233) were in Montgomery County hospitals, 7.1 percent (25,555) were in Prince George's County hospitals, and 26.6 percent (95,385) were in Northern Virginia hospitals. In 1960, the District of Columbia accounted for 67.7 percent (149,672) of the total admissions in the region, while Montgomery County had 11.2 percent (24,766), Prince George's County had 7.1 percent (15,693), and Northern Virginia had 14.0 percent (30,967).

Table 4 reflects the percent change in number of admissions to metropolitan area hospitals for three five-year intervals between 1960 and 1974. During this period, the number of admissions to non-federal hospitals increased by 137,482 or 62.2 percent -- from 221,098 in 1960 to 358,580 in 1974. Between 1960 and 1974, the population of the metropolitan area also increased -- from 2,064,090 in 1960 to 2,956,300 in 1974 or 43.2 percent.* Since 1960, District of Columbia hospitals had a 21.9 percent (32,735) increase in admissions, Montgomery County hospitals had a 123.0 percent (30,467) increase, Prince George's County had a 62.8 percent (9,862) increase, and Northern Virginia had a 208.0 percent (64,418) increase in admissions.

On Table 5, the average daily census, or the average number of inpatients in each hospital per day is displayed. Generally, Northern Virginia and Montgomery County show steady increases for each year of data between 1959 and 1974, while the District of Columbia and Prince George's County show variations among the years.

A comparison of the average daily census figures for 1960 and 1974 reveals the Montgomery and Prince George's Counties 1974 levels were twice that of 1960, increases of 130.9 and 119.4 percent, respectively. In Northern Virginia, there was a three-fold increase from 1960 to 1974. During this same period, the District of Columbia experienced the smallest increase, 8.4 percent. In the metropolitan area, there was a 50.2 percent increase between 1960 and 1974 in the average daily census in non-federal hospitals.

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*The source of the 1960 population is the U.S. Bureau of the Census' Decennial Census of the Population. The 1974 population is an estimate from the U.S. Bureau of the Census, Series P-25.

Table 6 displays the percent occupancies for each hospital from 1966 to 1974. The American Hospital Association did not collect percent occupancy prior to 1966. In 1974, the average percent occupancy for hospitals in the metropolitan area was 79.4 -- a decline of .7 percent since 1966. In the District of Columbia, hospitals had a 78.0 percent occupancy rate in 1974. Since 1966, Montgomery County hsopitals have shown increasing occupancy rates -- from 76.7 percent in 1966 to 86.1 percent in 1974. In Prince George's County, the occupancy rates have fluctuated over the years, going from 92.8 percent in 1970 to 85.5 percent in 1974. The occupancy rate in Northern Virginia hospitals has declined since 1970, when it was 85.9 percent, to 77.0 percent in 1974.

TABLE

METROPOLITAN WASHINGTON COUNCIL OF GOVERNMENTS
HEALTH INFORMATION SYSTEM
AMERICAN HOSPITAL ASSOCIATION GUIDE ISSUE DATA: 1960-1975

NUMBER OF ADMISSIONS

HOSPITAL NAME	1959	1960	1961	1962	1963	1964	1965	1966	1967	1968	1969	1970	1971	1972	1973	1974
CHILD HOPS NHC	12098	11430	12527	12746	12398	12395	13168	13141	12768	12488	12130**	11803	11851	10767	10879**	10652
COL.HOSP FR WOMEN	7425	7172	7798	7884	9243	9124	9739	9739	9712	9600	9942	10253	12325	12676	13232	13925
DC GENERAL HOSP	24178	23868	23831	23715	22045	22854	22462	20723	17823	17250	17964	18675	18026	17414	15979	14910
DOCTORS HOPSITAL	11556	11566	11939	12462	10488	10135	10210	9705	11117	11126	10118	10120	10379	8894**	8940	8809
GREATER SE COMM	*	*	*	*	*	*	*	2530	11773	15005	17012	18135	18738	18875	19065	18356
HOWARD UNIV HOSP	10758	10890	11430	11019	11801	12387	11639	11687	11075	10127	10382	11073	11376	10735	10600	10985
GEORGETOWN U HOSP	12465	12789	12899	12682	12312	12492	12304	12044	12736	13048	13325	13623	14244	14634	14666	13704
GEO WASH UNI HOSP	16210	15952	16720	15077	16092	16357	15859	14965	15748	15617	16580	17301	17425	16716	19426	20042
HADLEY MEM HOSP	2669	2826	2916	2733	2760	3094	3532	3986	3506	3242	1985	5398	3493	3616	3768	3605
PROVIDENCE HOSP	16798	16564	17247	17469	17770	18098	17922	17103	15784	14631	14881	14673	15359	14738	14362	14011
ROGERS MEM HOSP	5066	6108	6842	7687	8015	7897	7919	7568	6675	6634	6398	7357	7588	7771	8168	7978
SIBLEY MEM HOSP	10190	-	8814	10971	11264	11742	11742	12161	11675	11559	11593	12235**	12060	12842	13545	13184
WASH HOSP CENTER	29977	30507	30961	31445	31079	31373	35360	30261	30074	29517	29713	31339	32547	32187	31718	32246
DC TOTAL	159390	149672	163924	165890	165267	167948	171856	165613	170466	169844	172023	181985	185411	181865	184348	182407
HOLY CROSS HOSP	*	*	*	*	-	11276	13254	14099	14403	15039	16751	18603	18790	19058	19131	19433
MONTGOMERY GEN	3523	3429	3138	3047	3014	2981	2884	2566	2442	2387	2219	2454	3495	5823	6973	7278
SUBURBAN HOSPITAL	9228	10434	11817	12789	13028	12756	12572	12233	12037	14209	15613	16331	16976	17193	16849	16074
WASH ADVENTIST	10531	10903	11310	12037	11977	10932	10862	10822	10361	10357	10433	10876	11046	11249	11552	12448
MTG TOTAL	23284	24766	26265	27873	28019	37945	39572	39720	39243	41992	45016	48264	50307	53323	54505	55233
CLINTON COMMUNITY	*	-	-	-	1943	1618	-	1448	1945**	1466	1741	1993	2108**	1981	1818**	1725
E LELAND MEM HOSP	2110	2118	2107	2128	2408	2386	2861	3326	3170	3143	3276	3238	3512	3389	3320	3375
P.G. GENERAL HOSP	12698	13575	14856	16084	17796	17820	17773	17249	15818	15755	17052	23588	24429	20168	20721	20455
PG TOTAL	14808	15693	16963	18212	22147	21824	20634	22023	20933	20364	22069	28819	30049	25538	25859	25555
ARLINGTON HOSP	13112	12479	11274	10622	10570	10573	10467	9649	9560	9166	9197	9349	9233	9094	8806	10028
NAT ORTHO-RENAB	1713	1751	2067	2347	2411	2300	2296	2460	2394	2516	2736	2777	3040	3130	3411	3518
NO VA DOCTORS	*	-	3751	3537	3612	4571	5390	6279	6254	6124	6488	8159	8923	9316	9117	8629
ALEXANDRIA HOSP	11037	10881	10753	12348	13858	14757	15128	14415	14816	14002	14090	14154	14470	14383	13712	13875
CIRCLE TERRACE	3106	2981	2962	2856	3039	2912	-	2678	2538	4138	4936	5058	5300	5243	4867	4887
JEFFERSON MEM HOS	*	*	*	*	*	*	-	-	4164	4620	4981	5065	5216	5092	4991	4819
CMNWLTH DOCTORS	*	*	*	*	*	*	*	*	-	3198	3852	3816	3771	4716	5272	5873
FAIRFAX HOPSITAL	*	*	4899	10617	12604	13726	14215	14302	14545	15149	15143	19146	22091	25537	27174	27419
LOUDOUN MEM HOSP	2870	2875	3270	3010	3019	3149	2957	2935	2683	2967	3119	3221	3315	3387	3501	3682
POTOMAC HOSPITAL	*	*	*	*	*	*	*	*	*	*	*	*	*	*	3414	5110
PR WILLIAM HOSP	*	*	*	*	*	1533	3098	3112	3294	3672	4070	4509	5258	6792	7168	7545
N VA TOTAL	31838	30967	38976	45337	49113	53521	53551	55830	60248	65552	68612	75248	80617	86690	91433	95385
SMSA TOTAL	229320	221098	246128	257312	264546	281238	285613	283186	290890	297752	307720	334316	346384	347416	356145	358580

TABLE 4

HEALTH INFO[illegible]TION SYSTEM
NUMBER OF ADMISSIONS AND PERCENT CHANGE IN ADMISSIONS

JURISDICTION	HOSP. NAME	1960	1964	% CH 60-64	1965	1969	% CH 65-69	1970	1974	% CH 70-74	% CH 60-74
DC	CHILD HOSP NMC	11430	12395	8.4	13168	12130**	7.8-	11803	10652	9.7-	6.7-
	COL HOSP FL WOMEN	7172	9124	27.2	9739	9942	2.1	10253	13925	35.8	94.2
	DC GENERAL HOSP	23848	22854	4.1-	22462	17964	19.9-	18675	14910	20.1-	37.4-
	DOCTORS HOSPITAL	11566	10135	12.3-	10210	10118	.8-	10170	8809	12.9-	23.7-
	GREATER SE COMM	*	*		*	17012	.0	18135	18356	1.2	.0
	HOWARD UNIV HOSP	10898	12387	13.7	11639	10382	10.7-	11073	10985	.7-	.9
	GEORGETOWN U HOSP	12789	12492	2.2-	12304	13325	8.3	13673	13704	.6	7.2
	GEO WASH U I HOSP	15952	16357	2.5	15859	16580	4.5	17301	20042	15.8	25.6
	HADLEY MEM HOSP	2826	3094	9.5	3532	1985	43.7-	5398	3605	33.1-	27.6
	PROVIDENCE HOSP	16564	18098	9.3	17922	14481	16.9-	14673	14011	4.4-	15.3-
	ROGERS MEM HOSP	6108	7897	29.3	7919	6398	19.1-	7357	7978	8.4	30.6
	SIBLEY MEM HOSP	-	11742	.0	11742	11593	1.2-	12235**	13184	7.8	.0
	WASH HOSP CENTER	30587	31373	2.6	35360	29713	15.9-	31339	32246	2.9	5.7
TOTAL		149672	167968	12.2	171856	172023	.1	181985	182407	.2	21.9
MTG	HOLY CROSS HOSP	*	11278	.0	13254	16751	26.4	18603	19433	4.5	.0
	MONTGOMERY GEN	3429	2981	13.0-	2884	2219	23.0-	2454	7278	196.6	112.2
	SUBURBAN HOSPITAL	10434	12756	22.3	12572	15413	24.2	16331	16074	1.5-	54.1
	WASH ADVENTIST	10993	10932	.3	10867	10433	3.8-	10876	12448	14.5	14.2
TOTAL		24856	37945	53.2	39572	45816	13.8	48264	55233	14.4	123.0
PG	CLINTON COMMUNITY	-	1618	.0	-	1741	.0	1993	1725	13.3-	.0
	LEILAND MEM HOSP	2118	2386	12.7	2861	3276	14.5	3238	3375	4.2	59.3
	P G GENERAL HOSP	13575	17820	31.3	17773	17052	4.0-	23588	20455	13.2-	50.7
TOTAL		15693	21824	39.1	20634	22069	7.0	28819	25555	11.2-	62.8
NO.VA	ARLINGTON HOSP	12479	10573	15.2-	10467	9197	12.0-	9349	10028	7.3	19.5-
	NAT ORTHO-OPHAR	1751	2300	31.4	2296	2736	19.2	2777	3518	26.7	100.9
	NO VA DOCTORS	-	4571	.0	5390	6488	20.4	8159	8629	5.8	.0
	ALEXANDRIA HOSP	10881	14757	35.6	15128	14090	6.8-	14154	13875	1.9-	27.5
	CIRCLE TERRACE	2981	2912	2.2-	-	4936	.0	5058	4887	3.3-	63.9
	JEFFERSON MEM HOS	*	*		-	4981	.0	5065	4819	4.8-	.0
	CMNWLTH DOCTORS	*	*		*	3452	.0	3810	5873	54.1	.0
	FAIRFAX HOSPITAL	*	13726	.0	14215	15143	6.5	19146	27419	43.2	.0
	LOUDOUN MEM HOSP	2875	3144	9.5	2957	3119	5.5	3221	3682	14.3	28.1
	POTOMAC HOSPITAL	*	*		*	*		*	5110	.0	.0
	PR WILLIAM HOSP	*	1533	.0	3098	4070	31.4	4509	7545	67.3	.0
TOTAL		30467	53521	72.8	53551	68612	28.1	75248	95385	26.8	208.0
TOTALS		221098	281238	27.2	285613	307720	7.7	334316	358580	7.3	62.2

SOURCE: AMERICAN HOSP.ASSOC.,"GUIDE TO THE HEALTH CARE FIELD",1960-75

TABLE 5

METROPOLITAN WASHINGTON COUNCIL OF GOVERNMENTS
HEALTH INFORMATION SYSTEM
AMERICAN HOSPITAL ASSOCIATION GUIDE ISSUE DATA: 1960-1975

AVERAGE DAILY CENSUS

HOSPITAL NAME	1959	1960	1961	1962	1963	1964	1965	1966	1967	1968	1969	1970	1971	1972	1973	1974
CHILD HOPS NMC	149	130	146	162	160	153	170	164	158	161	156**	154	148	141	145**	145
COL.HOSP FR WOMEN	107	90	97	98	112	111	121	121	119	115	119	115	116	114	120	113
DC GENERAL HOSP	891	919	904	886	882	903	923	859	645	589	621	602	557	561	556	536
DOCTORS HOPSITAL	259	259	270	273	270	266	272	267	284	270	272	265	254	237**	208	189
GREATER SE COMM	*	*	*	*	*	*	*	105	231	313	359	375	387	401	399	373
HOWARD U.IV HOSP	327	322	336	338	342	375	361	354	397	355	353	349	349	329	304	305
GEORGETOWN U HOSP	273	296	313	300	295	311	305	304	318	322	321	317	320	317	317	295
GEO WASH UNI HOSP	358	362	378	374	373	376	378	377	383	391	419	436	426	424	433	516
HADLEY MEM HOSP	42	51	54	53	52	53	60	73	72	70	60	72	68	68	70	66
PROVIDENCE HOSP	300	298	316	314	326	330	325	317	310	311	347	315	322	313	312	304
ROGERS MEM HOSP	126	165	184	201	-	213	214	212	205	208	206	196	186	188	179	170
SIBLEY MEM HOSP	155	154	176	236	243	273	272	255	275	276	278	287	278	289	295	281
WASH HOSP CENTER	614	635	673	665	677	666	682	661	669	676	693	689	695	682	682	698
DC TOTAL	3596	3681	3847	3900	3732	4030	4083	4069	4066	4057	4204	4172	4106	4064	4020	3991
HOLY CROSS HOSP	*	*	*	*	-	184	203	226	228	235	279	307	306	309	313	315
MONTGOMERY GEN	45	46	45	45	45	44	44	42	43	42	43	42	59	106	124	130
SUBURBAN HOSPITAL	162	165	201	210	210	214	212	202	204	261	269	291	288	296	299	297
WASH ADVENTIST	204	235	225	240	242	243	241	238	238	244	253	257	259	259	266	288
MTG TOTAL	411	446	471	495	497	685	700	708	713	782	844	897	912	970	1002	1030
CLINTON COMMUNITY	*	-	-	-	27	22	-	32	26**	26	25	31	29**	27	28**	27
E LELAND MEM HOSP	38	38	39	38	41	43	56	64	64	65	70	70	70	68	68	68
P.G. GENERAL HOSP	233	250	289	323	344	344	350	347	312	309	342	457	434	427	529	537
PG TOTAL	271	288	328	361	412	409	406	443	402	400	437	558	533	522	625	632
ARLINGTON HOSP	228	236	223	218	221	219	225	219	218	217	220	218	213	204	203	229
NAT ORTHO-REHAB	64	71	81	81	90	87	83	83	79	86	99	98	109	106	112	109
NO VA DOCTORS	*	-	65	62	66	78	96	116	122	121	136	180	196	197	199	191
ALEXANDRIA HOSP	166	168	167	194	228	246	254	250	272	264	266	267	278	268	261	250
CIRCLE TERRACE	59	60	62	58	58	58	-	57	55	85	102	105	108	107	101	96
JEFFERSON MEM HOS	*	*	*	*	*	*	-	-	80	90	99	100	97	94	94	93
CMNWLTH DOCTORS	*	*	*	*	*	*	*	*	-	61	70	72	71	86	92	99
FAIRFAX HOPSITAL	*	*	126	194	231	277	257	263	283	281	287	365	425	485	508	506
LOUDOUN MEM HOSP	53	52	62	59	60	61	60	61	60	68	67	71	72	66	72	72
POTOMAC HOSPITAL	*	*	*	*	*	*	*	*	*	*	*	*	*	*	65	80
PR WILLIAM HOSP	*	*	*	*	*	54	44	40	49	58	64	69	83	114	125	133
N VA TOTAL	570	587	786	866	954	1080	1019	1089	1218	1331	1410	1545	1652	1727	1832	1858
SMSA TOTAL	4848	5002	5432	5622	5595	6204	6208	6309	6399	6570	6895	7172	7203	7283	7479	7511

TABLE 6

METROPOLITAN WASHINGTON COUNCIL OF GOVERNMENTS
HEALTH INFORMATION SYSTEM
AMERICAN HOSPITAL ASSOCIATION GUIDE ISSUE DATA: 1960-1975

PERCENT OCCUPANCY

HOSPITAL NAME	1966	1967	1968	1969	1970	1971	1972	1973	1974
CHILD HOPS NMC	75.9	72.1	68.8	66.3**	70.0	65.5	62.4	64.4**	68.1
COL.HOSP FR WOMEN	79.6	78.3	76.0	78.1	75.2	75.8	74.0	77.9	73.4
DC GENERAL HOSP	83.3	81.2	87.3	64.0	61.6	57.7	59.9	65.3	70.5
DOCTORS HOPSITAL	86.7	87.9	83.6	84.1	82.3	78.9	77.6**	73.2	66.5
GREATER SE COMM	41.7	78.3	80.5	87.3	91.5	94.2	95.9	95.5	89.2
HOWARD UNIV HOSP	80.6	90.4	80.7	78.5	77.7	79.5	78.9	73.1	72.1
GEORGETOWN U HOSP	76.6	80.1	81.1	81.0	80.5	81.0	77.9	80.1	77.6
GEO WASH UNI HOSP	88.3	89.5	85.9	88.5	82.6	80.7	80.2	80.2	95.7
HADLEY MEM HOSP	85.9	86.7	85.4	73.6	93.5	86.1	84.0	87.5	82.5
PROVIDENCE HOSP	86.8	84.9	84.7	94.7	84.2	82.6	80.7	82.1	82.2
ROGERS MEM HOSP	84.8	82.0	83.2	82.2	78.4	74.4	75.2	74.3	78.0
SIBLEY MEM HOSP	76.1	82.1	82.4	83.2	82.5	78.3	81.0	81.9	78.1
WASH HOSP CENTER	82.0	82.5	82.1	83.6	82.4	83.5	80.4	78.1	80.0
DC TOTAL	79.1	82.8	81.7	80.4	80.2	78.3	77.5	78.3	78.0
HOLY CROSS HOSP	86.9	87.7	89.7	90.5	90.3	90.0	90.6	91.0	91.6
MONTGOMERY GEN	54.5	78.2	77.8	80.0	77.8	62.8	66.7	77.0	80.7
SUBURBAN HOSPITAL	82.4	80.6	81.8	76.9	83.1	82.3	84.6	85.4	84.9
WASH ADVENTIST	82.9	82.9	82.7	85.2	85.1	85.8	85.8	86.9	87.0
MTG TOTAL	76.7	82.4	83.0	83.2	84.1	80.2	81.9	85.1	86.1
CLINTON COMMUNITY	88.9	77.4**	78.8	76.5	93.9	89.0**	81.8	84.1**	81.8
E LELAND MEM HOSP	87.7	87.7	89.0	93.6	92.1	92.1	89.5	89.5	89.5
P.G. GENERAL HOSP	89.4	86.4	85.6	78.9	92.5	87.9	86.4	86.9	85.1
PG TOTAL	88.7	83.8	84.5	83.0	92.8	89.7	85.9	86.8	85.5
ARLINGTON HOSP	88.7	88.3	87.5	88.2	85.5	80.1	76.1	77.5	76.1
NAT ORTHO-RENAB	75.5	71.8	78.2	77.5	75.4	85.8	82.9	85.5	77.3
NO VA DOCTORS	82.9	87.1	86.4	92.4	75.3	73.4	73.8	75.4	71.5
ALEXANDRIA HOSP	78.1	84.2	80.0	80.7	80.9	84.2	81.0	77.4	75.3
CIRCLE TERRACE	85.1	82.1	101.2	86.8	82.7	85.0	84.3	80.8	78.0
JEFFERSON MEM HOS	-	87.0	88.2	83.2	84.0	81.5	79.0	79.0	78.2
CMNWLTH DOCTORS	*	-	76.3	87.9	90.0	88.8	72.9	70.2	75.6
FAIRFAX HOPSITAL	93.3	94.0	91.2	93.0	86.5	83.5	84.8	83.8	82.1
LOUDOUN MEM HOSP	71.8	70.6	80.0	78.5	83.5	84.7	77.6	84.7	81.8
POTOMAC HOSPITAL	*	*	*	*	*	*	*	62.5	64.0
PR WILLIAM HOSP	66.7	81.7	96.7	107.4	115.0	90.2	75.5	81.2	87.5
N VA TOTAL	80.3	83.0	86.6	87.6	85.9	83.7	78.8	78.0	77.0
SMSA TOTAL	80.1	82.9	83.8	83.3	83.9	81.5	79.4	79.9	79.4

Births and Bassinets (Tables 7-10)

Data on the number of births in non-federal hospitals from 1959 to 1974 are included on Table 7. Of the 31 hospitals included on Table 7, seven had no obstetric service and during the 16 year span four additional hospitals closed their obstetric services. These closings occurred between 1963 and 1969 at Doctors Hospital, Hadley Memorial Hospital, Clinton Community Hospital, and Eugene Leland Memorial Hospital. Of the 37,866 births in the metropolitan area hospitals during 1974, 50.2 percent (19,005) were in District of Columbia hospitals, 15.4 percent (5,839) were in Montgomery County hospitals, 7.9 percent (2,992) were in Prince George's County hospitals, and 26.5 percent (10,030) were in Northern Virginia hospitals. In 1960, 31,393 or 68.8 percent of the total area births were in District of Columbia hospitals, 4,699 or 10.3 percent were in Montgomery County hospitals, 3,165 or 6.9 percent were in Prince George's County hospitals, and 6,400 or 14.0 percent were in Northern Virginia hospitals.

Table 8 illustrates the percent change in births for three five-year intervals from 1960 to 1974. Since 1960, there has been a 17.1 percent decrease in the number of births at metropolitan area hospitals -- from 45,657 in 1960 to 37,866 in 1974. Over this period, the District of Columbia experienced a decrease of 39.4 percent (-12,388), Montgomery County had an increase of 24.3 percent (1,140), Prince George's County had a 5.4 percent (-173) decrease, and Northern Virginia had an increase of 56.7 percent (3,630). The number of hospitals experiencing decreased numbers of births rose from eight at the end of 1964 to 16 at the end of 1969. The same number of hospitals, 16, experienced a decrease by the end of 1974.

Table 9 presents the number of bassinets available in each hospital from 1959 to 1974. In 1974, the District of Columbia had 52.0 percent (452) of the region's bassinets, Montgomery County had 13.5 percent (117), Prince George's County had 8.3 percent (72) and Northern Virginia had 26.2 percent (228). Of the 873 bassinets in metropolitan area hospitals in 1960, 609 or 69.8 percent were located in District of Columbia hospitals, 92 or 10.5 percent were in Montgomery County hospitals, 64 or 7.3 percent were in Prince George's County hospitals, and 108 or 12.3 percent were in Northern Virginia hospitals.

In Table 10, the percent change in the number of bassinets available at each hospital in five-year intervals from 1960 to 1974 is displayed. Since 1960, there has been a decrease of four bassinets in metropolitan area hospitals -- from 873 in 1960 to 869 in 1974. Between 1960 and 1974, bassinets in the District of Columbia decreased by 25.7 percent (-157), Montgomery County had an increase of 27.2 percent (25), Prince George's County had an increase of 12.5 percent (8), and Northern Virginia had an increase of 111.1 percent (120).

METROPOLITAN WASHINGTON COUNCIL OF GOVERNMENTS
HEALTH INFORMATION SYSTEM

TABLE 7

AMERICAN HOSPITAL ASSOCIATION GUIDE ISSUE DATA: 1960-1975

NUMBER OF BIRTHS

HOSPITAL NAME	1959	1960	1961	1962	1963	1964	1965	1966	1967	1968	1969	1970	1971	1972	1973	1974
CHILD HOPS NNC †																
COL.HOSP FR WOMEN	4298	3961	4218	4075	5020	5095	4844	4834	4781	4714	4405	4349	4588	4298	3985	3820
DC GENERAL HOSP	6373	6519	6715	6392	5908	6080	5948	5553	5367	4781	4786	5094	4574	3639	2588	2207
DOCTORS HOPSITAL	1492	1492	1498	1161	##	##	##	##	##	##	##	##	##	##	##	##
GREATER SE COMM	*	*	*	*	*	*	*	72	1785	2006	2070	2538	2522	2606	2545	1816
HOWARD UNIV HOSP	3016	3005	3379	3199	3570	3538	3020	2920	2636	2008	1940	2012	1878	1529	1316	1152
GEORGETOWN U HOSP	3158	2944	2988	2881	2637	2616	2461	2247	2291	2290	2197	2175	2289	2095	1932	1868
GEO WASH UNI HOSP	3646	3538	4054	3866	3830	3982	3582	3204	3093	2812	2911	2917	2752	2241	2231	2115
HADLEY MEM HOSP	341	358	393	376	373	405	460	505	419	232	##	##	##	1	##	##
PROVIDENCE HOSP	4104	4130	4487	4508	4557	4686	4546	3981	3666	2848	2643	2548	2480	2060	1872	1474
ROGERS MEM HOSP †																
SIBLEY MEM HOSP	1860	1543	1064	1476	1604	1902	1833	1587	1525	1598	1661	1852	1658	1544	1480	1568
WASH HOSP CENTER	3882	3903	4120	4146	4038	3749	3662	3587	3348	3343	3488	3514	3464	3269	3142	2985
DC TOTAL	32170	31393	32916	32080	31537	32053	30356	28490	28911	26632	26101	26999	26205	23282	21091	19005
HOLY CROSS HOSP	*	*	*	*	-	2307	2877	3113	3312	3461	3687	3877	3897	3291	3219	3378
MONTGOMERY GEN	-	973	964	800	812	756	716	632	535	470	371	401	367	398	466	434
SUBURBAN HOSPITAL	1702	1607	1779	1877	1860	1639	1424	1295	1239	1310	1611	1623	1644	1351	1275	1324
WASH ADVENTIST	1988	2119	2131	2311	2103	1669	1534	1396	1238	1102	1146	1109	1040	835	721	703
MTG TOTAL	3690	4699	4874	4988	4775	6371	6551	6436	6324	6343	6815	7010	6948	5975	5681	5839
CLINTON COMMUNITY	*	-	-	-	127	126	-	54	##	##	##	##	##	##	##	##
E LELAND MEM HOSP	320	317	277	238	295	287	283	273	253	##	##	##	##	##	##	##
P.G. GENERAL HOSP	2986	2848	3130	3325	3807	3918	4258	4182	4106	3996	4088	4041	4078	3832	3229	2992
PG TOTAL	3306	3165	3407	3563	4229	4331	4541	4509	4359	3996	4088	4041	4078	3832	3229	2992
ARLINGTON HOSP	2752	2529	2310	1910	1773	1748	1488	1314	1336	1217	1143	1268	1338	1164	1044	1070
NAT ORTHO-RENAB †																
NO VA DOCTORS †	*	-														
ALEXANDRIA HOSP	3426	3311	3356	3374	3652	3901	3767	3709	3662	3362	3370	3389	3432	2860	2658	2599
CIRCLE TERRACE †																
JEFFERSON MEM HOS †	*	*	*	*	*	*	-									
CMNWLTH DOCTORS †	*	*	*	*	*	*	*	*	-							
FAIRFAX HOPSITAL	*	*	1025	2206	2490	3219	3233	3528	3945	4222	4886	4843	4741	4473	4427	4315
LOUDOUN MEM HOSP	579	560	631	549	618	602	588	504	533	533	508	552	563	495	465	452
POTOMAC HOSPITAL	*	*	*	*	*	*	*	*	*	*	*	*	*	*	240	511
PR WILLIAM HOSP	*	*	*	*	*	305	806	829	810	927	896	1058	1215	1173	1151	1083
N VA TOTAL	6757	6400	7322	8039	8533	9775	9882	9884	10286	10261	10803	11110	11289	10165	9985	10030
SMSA TOTAL	45923	45657	48519	48670	49074	52530	51330	49319	49880	47232	47807	49160	48520	43154	39986	37866

TABLE 8

HEALTH INFORMATION SYSTEM
NUMBER OF BIRTHS AND PERCENT CHANGE IN BIRTHS

JURISDICTION	HOSP. NAME	1960	1964	% CH 60-64	1965	1969	% CH 65-69	1970	1974	% CH 70-74	% CH 60-74
DC	CHILD HOSP NMC †										
	COL HOSP FP WOMEN	3961	5095	28.6	4844	4405	9.0-	4349	3820	12.1-	3.5-
	DC GENERAL HOSP	6519	6080	6.6-	5948	4786	19.4-	5094	2207	56.6-	66.0-
	DOCTORS HOSPITAL	1492	#	99.9-	#	#		#	#		99.9-
	GREATER SE COMM	*	*		*	2070	.0	2538	1816	28.3-	.0
	HOWARD UNIV HOSP	3005	3538	17.7	3020	1940	35.7-	2012	1152	42.6-	61.6-
	GEORGETOWN U HOSP	2944	2616	11.0-	2461	2197	10.6-	2175	1868	14.0-	36.4-
	GEO WASH UNI HOSP	3538	3982	12.5	3582	2911	18.6-	2917	2115	27.4-	40.1-
	HADLEY MEM HOSP	358	405	13.1	460	#	99.9-	#	#		99.9-
	PROVIDENCE HOSP	4130	4686	13.5	4546	2643	41.8-	2548	1474	42.1-	64.2-
	ROGERS MEM HOSP †										
	SIBLEY MEM HOSP	1543	1902	23.3	1833	1661	9.3-	1852	1568	15.2-	1.6
	WASH HOSP CENTER	3903	3749	3.8-	3662	3488	4.7-	3514	2985	15.0-	23.4-
TOTAL		31393	32053	2.1	30356	26101	13.9-	26999	19005	29.5-	39.4-
MTG	HOLY CROSS HOSP	*	2307	.0	2877	3687	28.2	3277	3378	12.8-	.0
	MONTGOMERY GEN	973	756	22.2-	716	371	48.1-	401	434	8.2	55.3-
	SUBURBAN HOSPITAL	1607	1639	2.0	1424	1411	13.1	1623	1324	18.3-	17.5-
	WASH ADVENTIST	2119	1669	21.1-	1534	1146	25.2-	1109	703	36.5-	66.7-
TOTAL		4699	6371	35.6	6551	6815	4.0	7010	5839	16.6-	24.3
PG	CLINTON COMMUNITY	-	126	.0	-	#		#	#		
	LELAND MEM HOSP	317	287	9.4-	283	#	99.9-	#	#		99.9-
	P G GENERAL HOSP	2848	3918	37.6	4258	4088	3.9-	4041	2992	25.9-	5.1
TOTAL		3165	4331	36.8	4541	4088	9.9-	4041	2992	25.9-	5.4-
NO.VA	ARLINGTON HOSP	2529	1748	30.8-	1488	1143	23.1-	1268	1070	15.5-	57.6-
	NAT ORTHO-REHAB †										
	NO VA DOCTORS †	-									
	ALEXANDRIA HOSP	3311	3901	17.8	3767	3370	10.4-	3389	2599	23.2-	21.4-
	CIRCLE TERRACE †										
	JEFFERSON MEM HOS †	*	*								
	CMNWLTH DOCTORS †	*	*		*						
	FAIRFAX HOSPITAL	*	3219	.0	3233	4886	51.1	4843	4315[1]	10.9-	.0
	LOUDOUN MEM HOSP	560	602	7.5	588	508	13.5-	552	452	18.0-	19.2-
	POTOMAC HOSPITAL	*	*		*	*		*	511	.0	.0
	PR WILLIAM HOSP	*	305	.0	806	896	11.2	1058	1083	2.4	.0
TOTAL		6400	9775	52.7	9882	10803	9.3	11110	10030	9.7-	56.7
TOTALS		45657	52530	15.1	51330	47807	6.8-	49160	37866	23.0-	17.1-

SOURCE: AMERICAN HOSP.ASSOC.,'GUIDE TO THE HEALTH CARE FIELD',1960-75

[1]This is a revised figure for 1974 reported to the Health Information System by Fairfax Hospital.

TABLE 9

METROPOLITAN WASHINGTON COUNCIL OF GOVERNMENTS
HEALTH INFORMATION SYSTEM
AMERICAN HOSPITAL ASSOCIATION GUIDE ISSUE DATA: 1960-1975

NUMBER OF BASSINETS

HOSPITAL NAME	1959	1960	1961	1962	1963	1964	1965	1966	1967	1968	1969	1970	1971	1972	1973	1974
CHILD HOPS NMC †																
COL.HOSP FR WOMEN	78	68	88	128	90	90	92	92	92	92	83	83	83	83	83	83
DC GENERAL HOSP	129	129	129	129	129	129	129	129	129	129	129	129	129	126	81	54
DOCTORS HOPSITAL	44	44	44	44	#	#	#	#	#	#	#	#	#	#	#	#
GREATER SE COMM	*	*	*	*	*	*	*	30	56	56	30	56	56	56	56	56
HOWARD UNIV HOSP	50	50	50	50	50	50	75	75	75	50	63	63	34	47	47	47
GEORGETOWN U HOSP	60	60	60	60	60	60	60	60	60	60	50	50	50	50	50	50
GEO WASH UNI HOSP	63	63	71	71	73	73	60	58	51	51	53	56	51	47	56	56
HADLEY MEM HOSP	8	8	8	10	12	10	8	8	8	8	#	#	#	#	#	#
PROVIDENCE HOSP	58	58	58	58	58	58	58	58	58	58	46	46	46	32	32	26
ROGERS MEM HOSP †																
SIBLEY MEM HOSP	40	40	40	38	38	38	34	34	34	34	30	35	32	24	24	24
WASH HOSP CENTER	89	89	89	85	85	85	85	85	65	80	85	85	85	85	56	56
DC TOTAL	619	609	637	673	595	593	601	629	628	618	569	603	566	550	485	452
HOLY CROSS HOSP	*	*	*	*	-	50	46	50	50	50	50	50	50	46	46	46
MONTGOMERY GEN	20	17	20	13	13	13	14	13	13	13	13	13	12	18	18	18
SUBURBAN HOSPITAL	33	40	36	34	34	34	21	34	34	34	35	34	34	34	34	35
WASH ADVENTIST	35	35	33	33	44	44	44	41	30	35	35	30	30	30	18	18
MTG TOTAL	88	92	89	80	91	141	125	138	127	132	133	127	126	128	116	117
CLINTON COMMUNITY	*	-	-	-	9	10	-	9	#	#	#	#	#	#	#	#
E LELAND MEM HOSP	10	10	10	5	5	6	11	11	11	#	#	#	#	#	#	#
P.G. GENERAL HOSP	54	54	54	54	54	54	72	72	72	72	72	72	64	72	72	72
PG TOTAL	64	64	64	59	68	70	83	92	83	72	72	72	64	72	72	72
ARLINGTON HOSP	32	32	32	32	32	32	32	32	32	32	32	32	32	32	32	30
NAT ORTHO-RENAB †																
NO VA DOCTORS †	*	-														
ALEXANDRIA HOSP	56	56	56	66	66	66	66	66	66	66	66	66	66	58	58	58
CIRCLE TERRACE †																
JEFFERSON MEM HOS †	*	*	*	*	*	*	-									
CMNWLTH DOCTORS †	*	*	*	*	*	*	*	*	-							
FAIRFAX HOPSITAL	*	*	40	70	60	60	60	60	60	60	60	60	60	60	85	85
LOUDOUN MEM HOSP	15	20	20	20	20	20	20	20	20	20	20	20	20	20	20	19
POTOMAC HOSPITAL	*	*	*	*	*	*	*	*	*	*	*	*	*	*	20	20
PR WILLIAM HOSP	*	*	*	*	*	20	16	20	16	16	16	16	16	16	16	16
N VA TOTAL	103	108	148	188	178	198	194	198	194	194	194	194	194	186	231	228
SMSA TOTAL	874	873	938	1000	932	1002	1003	1057	1032	1016	968	996	950	936	904	869

TABLE 10

HEALTH INFORMATION SYSTEM
NUMBER OF BASSINETS AND PERCENT CHANGE IN BASSINETS

JURISDICTION	HOSP. NAME	1960	1964	% CH 60-64	1965	1969	% CH 65-69	1970	1974	% CH 70-74	% CH 60-74
DC	CHILD HOSP NMC †										
	COL HOSP FR WOMEN	68	90	32.4	92	83	9.7-	83	83	.0	22.1
	DC GENERAL HOSP	129	129	.0	129	129	.0	129	54	58.0-	58.0-
	DOCTORS HOSPITAL	44	#	99.9-	#	#		#	#		99.9-
	GREATER SE COMM	*	*		*	30	.0	56	56	.0	.0
	HOWARD UNIV HOSP	50	50	.0	75	63	15.9-	63	47	25.3-	5.9-
	GEORGETOWN U HOSP	60	60	.0	60	50	16.6-	50	50	.0	16.6-
	GEO WASH UNI HOSP	63	73	15.9	60	53	11.6-	56	56	.0	11.0-
	HADLEY MEM HOSP	8	10	25.0	8	#	99.9-	#	#		99.9-
	PROVIDENCE HOSP	58	58	.0	58	46	20.6-	46	26	43.4-	55.1-
	ROGERS MEM HOSP †										
	SIBLEY MEM HOSP	40	38	4.9-	34	30	11.7-	35	24	31.3-	39.9-
	WASH HOSP CENTER	89	85	4.4-	85	85	.0	85	56	34.0-	37.0-
TOTAL		609	593	2.5-	601	569	5.2-	603	452	24.9-	25.7-
MTG	HOLY CROSS HOSP	*	50	.0	46	50	8.7	50	46	7.9-	.0
	MONTGOMERY GEN	17	13	23.4-	14	13	7.0-	13	18	38.5	5.9
	SUBURBAN HOSPITAL	40	34	14.9-	21	35	66.7	34	35	2.9	12.4-
	WASH ADVENTIST	35	44	25.7	44	35	20.4-	30	18	39.9-	48.5-
TOTAL		92	141	53.3	125	133	6.4	127	117	7.8-	27.2
PG	CLINTON COMMUNITY	-	10	.0	-	#		#	#		.0
	LELAND MEM HOSP	10	6	39.9-	11	#	99.9-	#	#		99.9-
	P G GENERAL HOSP	54	54	.0	72	72	.0	72	72	.0	33.3
TOTAL		64	70	9.4	83	72	13.2-	72	72	.0	12.5
NO.VA	ARLINGTON HOSP	32	32	.0	32	32	.0	32	30	6.2-	6.2-
	NAT ORTHO-REHAB †										
	NO VA DOCTORS †	-									
	ALEXANDRIA HOSP	56	66	17.9	66	66	.0	66	58	12.0-	3.6
	CIRCLE TERRACE †										
	JEFFERSON MEM HOS †	*	*								
	CMNWLTH DOCTORS †	*	*		-						
	FAIRFAX HOSPITAL	*	60	.0	60	60	.0	60	85	41.7	.0
	LOUDOUN MEM HOSP	20	20	.0	20	20	.0	20	19	4.9-	4.9-
	POTOMAC HOSPITAL	*	*		*	*		*	20	.0	.0
	PR WILLIAM HOSP	*	20	.0	16	16	.0	16	16	.0	.0
TOTAL		108	198	83.3	194	194	.0	194	228	17.5	111.1
TOTALS		873	1002	14.8	1003	968	3.4-	996	869	12.7-	.4-

SOURCE: AMERICAN HOSP.ASSOC.,'GUIDE TO THE HEALTH CARE FIELD',1960-75

Personnel and Expenses (Tables 11-14)

In Tables 11 and 12, data on the number of employees in metropolitan area hospitals are presented. Since 1960, the number of hospital personnel in the metropolitan area has increased by 127.9 percent. Of the 27,189 hospital employees in 1974 in the metropolitan area, 56.0 percent were located in the District of Columbia, 13.0 percent were in Montgomery County, 7.1 percent were in Prince George's County, and 23.9 percent were in Northern Virginia. All the jurisdictional totals for 1974 represent substantial increases over those recorded for 1960. The jurisdiction having the greatest increase is Northern Virginia, which quadrupled its number of hospital personnel. The Montgomery County level in 1974 was three times that found during 1960. Prince George's County more than doubled the number of personnel. The District of Columbia experienced the smallest increase (75.3 percent) in the metropolitan area.

Payroll expenses, as presented in Table 13, indicate an increase of $168,279,000 between 1960 and 1974. The 1974 level of payroll expenses was five times that of 1960. As can be seen in Table 14, total expenses in metropolitan area hospitals for 1974 were more than six times that for 1960.

TABLE 11

METROPOLITAN WASHINGTON COUNCIL OF GOVERNMENTS
HEALTH INFORMATION SYSTEM
AMERICAN HOSPITAL ASSOCIATION GUIDE ISSUE DATA: 1960-1975

NUMBER OF PERSONNEL

HOSPITAL NAME	1959	1960	1961	1962	1963	1964	1965	1966	1967	1968	1969	1970	1971	1972	1973	1974
CHILD HOPS NMC	467	461	582	690	644	658	708	770	848	992	-	1126	1174	879	-	979
COL.HOSP FR WOMEN	274	290	304	347	345	356	403	411	405	415	407	465	468	468	452	453
DC GENERAL HOSP	1635	1702	1702	1688	1754	1764	1813	1940	1713	1780	1797	2043	1906	1696	1712	1711
DOCTORS HOPSITAL	474	462	488	482	521	554	540	563	591	740	696	265	370	-	495	526
GREATER SE COMM	*	*	*	*	*	*	*	481	690	1000	1049	1185	1173	1089	1303	1263
HOWARD UNIV HOSP	698	662	667	782	840	811	802	924	845	999	1084	1196	1085	1055	1180	1398
GEORGETOWN U HOSP	830	853	1012	1046	1019	985	998	1127	1202	1771	1332	1122	1441	1162	1378	1258
GEO WASH UNI HOSP	943	995	1035	1040	1071	1092	1257	1348	1335	1020	1427	1605	1655	1579	1741	2289
HADLEY MEM HOSP	147	143	158	144	196	198	191	202	209	197	261	211	241	254	259	283
PROVIDENCE HOSP	650	693	620	694	702	753	750	887	910	853	915	968	1072	1017	974	994
ROGERS MEM HOSP	244	308	330	370	444	449	411	430	434	402	520	561	558	524	564	598
SIBLEY MEM HOSP	419	398	488	585	474	617	468	498	488	573	690	923	742	746	844	866
WASH HOSP CENTER	1788	1768	1812	1819	1833	2150	1889	1920	2152	2208	2189	2203	2277	2370	2159	2596
DC TOTAL	8569	8675	9198	9687	9843	10387	10230	11501	11822	12950	12367	13873	14162	12839	13061	15214
HOLY CROSS HOSP	*	*	*	*	-	448	555	527	596	665	682	797	825	832	1076	1132
MONTGOMERY GEN	82	80	93	90	99	98	96	96	92	128	128	118	359	378	421	445
SUBURBAN HOSPITAL	365	369	486	460	476	498	457	597	641	651	917	742	742	769	754	884
WASH ADVENTIST	567	619	650	718	696	698	690	709	814	787	881	916	831	481	952	1078
MTG TOTAL	1014	1068	1229	1268	1271	1742	1798	1929	2143	2231	2608	2573	2757	2460	3203	3539
CLINTON COMMUNITY	*	-	-	-	54	51	-	75	84	89	93	76	-	99	-	84
E LELAND MEM HOSP	63	84	78	86	89	105	158	195	240	230	261	230	223	235	238	241
P.G. GENERAL HOSP	648	639	743	1028	904	894	916	991	989	1031	1483	1309	1361	1471	1461	1613
PG TOTAL	711	723	821	1114	1047	1050	1074	1261	1313	1350	1837	1615	1584	1805	1699	1938
ARLINGTON HOSP	559	522	542	571	556	539	-	576	544	577	701	769	775	851	733	914
NAT ORTHO-RENAB	141	230	258	253	249	293	303	301	310	288	370	320	347	348	374	341
NO VA DOCTORS	*	-	128	128	125	167	223	241	249	256	327	420	457	479	517	562
ALEXANDRIA HOSP	462	481	522	618	631	683	714	854	838	890	1241	938	994	1117	879	960
CIRCLE TERRACE	104	108	112	113	117	117	-	108	109	159	198	198	180	200	218	246
JEFFERSON MEM HOS	*	*	*	*	*	*	-	-	193	190	189	205	219	217	232	249
CMNWLTH DOCTORS	*	*	*	*	*	*	*	*	-	144	237	194	124	252	304	345
FAIRFAX HOPSITAL	*	*	500	578	636	640	671	725	793	850	1211	1669	1473	2009	1890	1784
LOUDOUN MEM HOSP	109	122	140	128	119	127	133	142	144	153	159	165	186	197	215	298
POTOMAC HOSPITAL	*	*	*	*	*	*	*	*	*	*	*	*	*	*	237	346
PR WILLIAM HOSP	*	*	*	*	*	105	108	132	144	172	197	217	347	381	390	453
N VA TOTAL	1375	1463	2202	2389	2433	2671	2152	3079	3324	3679	4830	5095	5102	6051	5989	6498
SMSA TOTAL	11669	11929	13450	14458	14594	15850	15254	17770	18602	20210	21642	23156	23605	23455	23952	27189

TABLE 12

HEALTH INFORMATION SYSTEM

Number of Personnel and Percent Change in Personnel: 1960 - 1974

JURISDICTION	HOSP. NAME	1960	1964	% CH 60-64	1965	1969	% CH 65-69	1970	1974	% CH 70-74	% CH 60-74
DC	CHILD HOSP NMC	461	658	42.7	708	-	.0	1126	979	13.0-	112.3
	COL HOSP FR WOMEN	290	356	22.7	403	407	.9	465	453	2.5-	56.2
	DC GENERAL HOSP	1702	1764	3.6	1813	1797	.8-	2043	1711	16.2-	.5
	DOCTORS HOSPITAL	462	554	19.9	540	696	28.8	265	526	98.4	13.8
	GREATER SE COMM	*	*		*	1049	.0	1185	1263	6.5	.0
	HOWARD UNIV HOSP	662	811	22.5	802	1084	35.1	1196	1398	16.8	111.1
	GEORGETOWN U HOSP	853	985	15.4	998	1332	33.4	1122	1258	12.1	47.4
	GEO WASH UNI HOSP	995	1092	9.7	1257	1427	13.5	1605	2289	42.6	130.0
	HADLEY MEM HOSP	143	198	38.4	191	261	36.6	211	283	34.1	97.9
	PROVIDENCE HOSP	693	753	8.6	750	915	22.0	968	994	2.6	43.4
	ROGERS MEM HOSP	308	449	45.7	411	520	26.5	561	598	6.5	94.1
	SIBLEY MEM HOSP	398	617	55.0	468	690	47.4	923	866	6.1-	117.5
	WASH HOSP CENTER	1708	2150	25.8	1889	2189	15.8	2203	2596	17.8	51.9
TOTAL		8675	10387	19.7	10230	12367	20.8	13873	15214	9.6	75.3
MTG	HOLY CROSS HOSP	-	448	.0	555	682	22.8	797	1132	42.0	.0
	MONTGOMERY GEN	80	98	22.5	96	128	33.3	118	445	277.1	456.3
	SUBURBAN HOSPITAL	369	498	34.9	457	917	100.6	742	884	19.1	139.5
	WASH ADVENTIST	619	698	12.7	690	881	27.6	916	1078	17.6	74.1
TOTAL		1068	1742	63.1	1798	2608	45.0	2573	3539	37.5	231.4
PG	CLINTON COMMUNITY	-	51	.0	-	93	.0	76	84	10.5	.0
	LELAND MEM HOSP	84	105	25.0	158	261	65.1	230	241	4.7	186.9
	P G GENERAL HOSP	639	894	39.9	916	1483	61.8	1309	1613	23.2	152.4
TOTAL		723	1050	45.2	1074	1837	71.0	1615	1938	20.0	168.0
NO.VA	ARLINGTON HOSP	522	539	3.2	-	701	.0	769	914	18.8	75.0
	NAT ORTHO-REHAB	230	293	27.3	303	370	22.1	320	341	6.5	48.2
	NO VA DOCTORS	-	167	.0	223	327	46.6	420	562	33.8	.0
	ALEXANDRIA HOSP	481	683	41.9	714	1241	73.8	938	960	2.3	99.5
	CIRCLE TERRACE	108	117	8.3	-	198	.0	198	246	24.2	127.7
	JEFFERSON MEM HOS	*	*		-	189	.0	205	249	21.4	.0
	CMNWLTH DOCTORS	*	*		*	237	.0	194	345	77.8	.0
	FAIRFAX HOSPITAL	*	640	.0	671	1211	80.4	1669	1784	6.8	.0
	LOUDOUN MEM HOSP	122	127	4.0	133	159	19.5	165	298	80.6	144.2
	POTOMAC HOSPITAL	*	*		*	*		*	346	.0	.0
	PR WILLIAM HOSP	*	105	.0	108	197	82.4	217	453	108.7	.0
TOTAL		1463	2671	82.5	2152	4830	124.4	5095	6498	27.5	344.2
TOTALS		11929	15850	32.8	15254	21642	41.8	23156	27189	17.4	127.9

SOURCE: AMERICAN HOSP.ASSOC.,'GUIDE TO THE HEALTH CARE FIELD',1960-75

TABLE 13

METROPOLITAN WASHINGTON COUNCIL OF GOVERNMENTS
HEALTH INFORMATION SYSTEM
AMERICAN HOSPITAL ASSOCIATION GUIDE ISSUE DATA: 1960-1975

PAYROLL EXPENSES (IN THOUSANDS)

HOSPITAL NAME	1959	1960	1961	1962	1963	1964	1965	1966	1967	1968	1969	1970	1971	1972	1973	1974
CHILD HOPS NHC	1630	1572	1757	2060	2479	2654	3103	3509	4191	4938	-	7056	7838	8025	-	9405
COL.HOSP FR WOMEN	746	798	931	1055	1255	1488	1680	1796	1937	2265	2440	2740	3486	3782	3803	4259
DC GENERAL HOSP	7116	7970	8801	9087	10006	11815	-	13054	12148	12954	11714	13684	15827	18076	-	19895
DOCTORS HOPSITAL	1396	1255	1534	1633	2332	2547	2701	2602	3241	3319	-	2358	2528	-	3622	-
GREATER SE COMM	*	*	*	*	*	*	*	977	-	4834	5996	7694	9039	9460	10694	11753
HOWARD UNIV HOSP	3700	3824	4500	4643	5137	5642	5759	6237	6286	6641	8416	10241	12696	14485	15363	17958
GEORGETOWN U HOSP	3188	3465	3614	3776	3812	4567	5064	5358	5289	7203	7772	9070	10673	11968	12818	13081
GEO WASH UNI HOSP	3290	3357	3616	3906	4145	4473	4449	5459	3620	6678	7882	9415	11274	11041	-	-
HADLEY MEM HOSP	409	480	536	578	747	813	825	945	1033	1237	946	1228	1995	2094	2321	2383
PROVIDENCE HOSP	-	-	-	-	-	-	3108	3154	3960	4714	5152	6239	7498	7938	8007	8188
ROGERS MEM HOSP	-	-	-	-	-	-	-	-	-	-	2609	3221	3684	3992	4175	4464
SIBLEY MEM HOSP	1046	1181	1308	1522	1802	2017	2100	2240	2539	3021	4606	4542	-	-	-	-
WASH HOSP CENTER	6320	6663	7116	7620	8493	9493	10327	10894	11989	12447	13946	16215	17498	20062	19708	22122
DC TOTAL	28841	30565	33713	35880	40208	45509	39116	56225	56233	70251	71479	93703	104036	111523	80511	113508
HOLY CROSS HOSP	*	*	*	*	-	2389	2893	3384	3374	3937	4622	5427	6971	7435	8673	10378
MONTGOMERY GEN	302	271	277	386	400	401	433	550	619	594	700	802	1937	2859	3381	3881
SUBURBAN HOSPITAL	930	1141	1302	1648	1867	2053	2146	2313	2883	3427	3829	4470	4983	5385	5870	6438
WASH ADVENTIST	1779	1859	2101	2423	2772	2875	3048	3284	3824	4794	5317	6254	6988	8061	8822	9142
MTG TOTAL	3011	3271	3680	4457	5039	7718	8520	9531	10700	12752	14468	16953	20879	23740	26746	29839
CLINTON COMMUNITY	*	-	-	-	197	267	-	315	-	338	517	-	-	421	-	507
E LELAND MEM HOSP	201	221	254	265	288	362	515	692	949	1069	1209	1400	1778	1979	1935	2110
P.G. GENERAL HOSP	1620	1894	2144	2605	3014	3318	3711	4243	4485	5127	5970	7603	9077	5761	9859	12343
PG TOTAL	1821	2115	2398	2870	3499	3947	4226	5250	5434	6534	7696	9003	10855	8161	11794	14960
ARLINGTON HOSP	1961	1882	1984	2046	2062	2258	2502	2612	3078	3833	4348	4837	5901	6361	6766	8654
NAT ORTHO-RENAB	243	567	700	766	777	887	953	915	896	1352	1730	1836	2375	2587	2842	2971
NO VA DOCTORS	*	-	274	455	477	613	825	1069	1285	1481	1769	2496	3052	3405	4337	3669
ALEXANDRIA HOSP	1378	1422	1655	2340	2327	3091	3089	3367	4160	4679	5138	5842	6720	7246	7069	7785
CIRCLE TERRACE	224	249	354	336	552	373	-	402	455	582	1681	1583	1365	1622	1815	-
JEFFERSON MEM HOS	*	*	*	*	*	*	-	-	816	861	1160	1386	1483	1605	1704	1876
CMNWLTH DOCTORS	*	*	*	*	*	*	*	*	-	925	1210	1421	1600	2209	2508	2840
FAIRFAX HOPSITAL	*	*	966	1867	1982	2614	2960	3362	4023	5098	6672	9283	11344	13301	15088	14944
LOUDOUN MEM HOSP	279	314	316	374	344	406	438	442	529	645	734	879	979	1176	1431	1640
POTOMAC HOSPITAL	*	*	*	*	*	*	*	*	*	*	*	*	*	*	2679	2551
PR WILLIAM HOSP	*	*	*	*	*	168	476	538	546	716	705	1194	1790	2467	2832	3427
N VA TOTAL	4085	4434	6249	8184	8521	10410	11243	12707	15788	20172	25147	30757	36609	41979	49071	50357
SMSA TOTAL	37758	40385	46040	51391	57267	67584	63105	83713	88155	109709	118790	150416	172379	185403	168122	208664

TABLE 14

METROPOLITAN WASHINGTON COUNCIL OF GOVERNMENTS
HEALTH INFORMATION SYSTEM
AMERICAN HOSPITAL ASSOCIATION GUIDE ISSUE DATA: 1960-1975

TOTAL EXPENSES (IN THOUSANDS)

HOSPITAL NAME	1959	1960	1961	1962	1963	1964	1965	1966	1967	1968	1969	1970	1971	1972	1973	1974
CHILD HOPS NMC	2397	2417	2622	3043	3573	3942	4450	5055	6169	7350	-	11416	12580	12903	-	14282
COL.HOSP FR WOMEN	1132	1231	1482	1613	1961	2248	2795	2781	3085	3473	4059	4387	5989	6568	7041	7773
DC GENERAL HOSP	10051	10984	11963	12215	12952	-	-	16294	16499	18661	21246	24373	30439	26137	-	34926
DOCTORS HOPSITAL	2306	2288	2419	2568	3958	3925	4207	4535	5305	5607	7737	8988	9765	-	8271	-
GREATER SE COMM	*	*	*	*	*	*	*	1667	6776	9546	11930	15292	18026	20560	21348	23542
HOWARD UNIV HOSP	4583	4761	5377	5517	6190	6687	6954	7643	9724	10460	13443	15799	19065	22171	23532	26294
GEORGETOWN U HOSP	4190	5102	5127	5415	6070	-	7468	8137	9176	11445	13383	15363	18342	20702	22200	23663
GEO WASH UNI HOSP	5302	5454	5629	6097	6488	7013	7691	8801	10595	12122	14033	17757	19511	18787	20647	24981
HADLEY MEM HOSP	764	835	886	897	1132	1220	1252	1594	1756	2398	1617	2416	3005	3425	3922	4160
PROVIDENCE HOSP	-	-	-	-	-	-	5448	5504	7040	7655	8820	11053	13782	14516	15649	15664
ROGERS MEM HOSP	-	-	-	-	-	-	-	-	-	-	4517	5571	6323	6863	7232	7768
SIBLEY MEM HOSP	1700	1972	2065	2944	3958	4283	4699	4992	5504	5914	8922	9238	10479	12226	13890	15384
WASH HOSP CENTER	10087	10412	11125	11879	13352	14472	16008	16735	18871	20090	25709	29212	32514	37646	40196	44092
DC TOTAL	42512	45456	48695	52188	59634	43790	60972	83738	100700	114721	135416	170865	199820	202504	183928	242529
HOLY CROSS HOSP	*	*	*	*	-	4144	4899	5491	5709	6415	7748	9444	11448	12266	14906	18502
MONTGOMERY GEN	505	490	507	588	635	693	731	773	863	1010	1231	1459	4195	6069	6881	7762
SUBURBAN HOSPITAL	1793	1929	2275	3029	2941	3241	3358	3607	4267	6313	7037	8094	9044	10588	10859	11600
WASH ADVENTIST	3220	3507	3556	3847	4311	4515	4884	5136	6065	7311	8022	9585	11166	12365	13943	17805
MTG TOTAL	5518	5926	6338	7464	7887	12593	13872	15007	16904	21049	24038	28582	35853	41288	46589	55669
CLINTON COMMUNITY	*	-	-	-	366	505	-	355	-	790	904	-	-	1190	-	1360
E LELAND MEM HOSP	389	419	474	509	557	-	924	1239	1545	1875	2114	2291	2688	2947	3244	3488
P.G. GENERAL HOSP	2505	2962	3488	4141	4555	5150	5734	6503	7382	8025	9675	12834	15966	18618	22000	23479
PG TOTAL	2894	3381	3962	4650	5478	5655	6658	8097	8927	10690	12693	15125	18654	22755	25244	28327
ARLINGTON HOSP	2983	3314	3782	3462	3635	4111	4521	5061	5601	6775	7538	8474	10219	10822	11745	15575
NAT ORTHO-RENAB	448	902	1105	1258	1287	1449	1533	1525	1534	1984	2476	2987	4025	4281	4804	5117
NO VA DOCTORS	*	-	568	738	771	966	1297	1635	1940	2128	2737	4003	5246	5774	7368	8108
ALEXANDRIA HOSP	2406	2198	2489	3548	3839	4529	4907	5321	6317	7960	8868	9949	11568	12544	12655	14500
CIRCLE TERRACE	414	449	568	621	860	681	-	773	774	1022	2173	2639	3016	3404	3985	-
JEFFERSON MEM HOS	*	*	*	*	*	*	-	-	1701	1929	2338	3163	3478	3811	4131	4492
CMNWLTH DOCTORS	*	*	*	*	*	*	*	*	-	1493	2225	2560	2949	3700	5068	5627
FAIRFAX HOPSITAL	*	*	1697	2432	3402	5279	5919	6105	7950	7723	10525	14039	17461	23814	24839	25002
LOUDOUN MEM HOSP	468	494	614	645	578	657	705	800	899	1097	1258	1384	1718	2033	2520	3141
POTOMAC HOSPITAL	*	*	*	*	*	*	*	*	*	*	*	*	*	*	5202	5840
PR WILLIAM HOSP	*	*	*	*	*	248	722	772	1227	1287	1322	2292	3430	4638	5767	6673
N VA TOTAL	6719	7357	10423	12704	14372	17920	19604	21992	27943	33398	41460	51490	63110	74821	88084	94075
SMSA TOTAL	57643	62120	69418	77006	87371	79958	101106	128834	154474	179858	213607	266062	317437	341368	343845	420600

PART TWO

Federal Hospitals in the Metropolitan Washington Area

Beds and Hospitals (Tables 15-16)

In Table 15, the number of beds in metropolitan area federal hospitals from 1959 to 1974 is displayed. As can be seen on Table 15, the number of federal hospitals in the metropolitan Washington area has remained unchanged during the 16 years of data included in this report. There were two hospitals in the District of Columbia, two hospitals in Northern Virginia, and one hospital each in Montgomery County and Prince George's County.

In 1974, of the 2,877 total federal hospital beds in the metropolitan area, 55.9 percent (1608) were found in the District of Columbia, 25.3 percent (729) were in Montgomery County, 9.9 percent (285) were in the Prince George's County, and 8.9 percent (255) were located in Northern Virginia. In 1960, there were 3,206 beds of which 49.4 percent (1585) were in the District of Columbia, 28.9 percent (925) were in Montgomery County, 7.8 percent (250) were in Prince George's County, and 13.9 percent (446) were in Northern Virginia.

Between 1960 and 1974, there was a 10.2 percent decrease in the number of beds -- from 3,206 to 2,877 beds. The District of Columbia had a 1.4 percent increase (23), Montgomery County had a 21.1 percent decrease (-196), Prince George's Conunty had a 14.0 percent increase (35) and Northern Virginia had a decrease of 42.8 percent (-191) in the number of beds in federal hospitals.

TABLE 15

METROPOLITAN WASHINGTON COUNCIL OF GOVERNMENTS
HEALTH INFORMATION SYSTEM
AMERICAN HOSPITAL ASSOCIATION GUIDE ISSUE DATA: 1960-1975

NUMBER OF BEDS

HOSPITAL NAME	1959	1960	1961	1962	1963	1964	1965	1966	1967	1968	1969	1970	1971	1972	1973	1974
VET ADMIN HOSP	335	335	335	335	335	335	560	707	702	702	694	694	694	708	708	708
WATER REED HOSP	1244	1250	1468	1465	1465	1493	1485	1635	1659	1553	1553	1541	1190	1130	870	900
DC TOTAL	1579	1585	1803	1800	1800	1828	2045	2342	2361	2255	2247	2235	1884	1838	1578	1608
NAVAL MEDICAL CEN	946	925	900	850	825	650	650	725	900	1050	1050	750	750	662	695	729
MTG TOTAL	946	925	900	850	825	650	650	725	900	1050	1050	750	750	662	695	729
ANDREWS USAF BASE	250	250	250	250	250	250	250	250	350	350	350	350	350	350	350	285
PG TOTAL	250	250	250	250	250	250	250	250	350	350	350	350	350	350	350	285
US DEWITT ARMY	336	321	225	240	219	225	230	240	240	300	300	300	210	190	190	180
NAVAL HOSP (PW)	125	125	83	100	130	130	130	169	169	169	169	169	110	110	75	75
N VA TOTAL	461	446	308	340	349	355	360	409	409	469	469	469	320	300	265	255
SMSA TOTAL	3236	3206	3261	3240	3224	3083	3305	3726	4020	4124	4116	3804	3304	3150	2888	2877

TABLE 16

HEALTH INFORMATION SYSTEM

NUMBER OF HOSPITAL BEDS AND PERCENT CHANGE IN HOSPITAL BEDS

JURISDICTION	HOSP. NAME	1960	1964	% CH 60-64	1965	1969	% CH 65-69	1970	1974	% CH 70-74	% CH 60-74
DC	VET ADMIN HOSP	335	335	.0	560	694	23.9	694	708	2.0	111.3
DC	WALTER REED HOSP	1250	1493	19.4	1485	1553	4.5	1541	900	41.5-	28.0-
JURIS TOTAL		1585	1828	15.3	2045	2247	9.8	2235	1608	28.0-	1.4
MTG	NAVAL MEDICAL CEN	925	650	29.7-	650	1050	61.5	750	729	2.8-	21.1-
JURIS TOTAL		925	650	29.7-	650	1050	61.5	750	729	2.8-	21.1-
PG	ANDREWS USAF BASE	250	250	.0	250	350	40.0	350	285	18.5-	14.0
JURIS TOTAL		250	250	.0	250	350	40.0	350	285	18.5-	14.0
NO.VA	US DEWITT ARMY	321	225	29.9-	230	300	30.4	300	180	40.0-	43.9-
NO.VA	NAVAL HOSP (PW)	125	130	4.0	130	169	30.0	169	75	55.6-	40.0-
JURIS TOTAL		446	355	20.4-	360	469	30.2	469	255	45.6-	42.8-
FINAL TOTALS		3206	3083	3.8-	3305	4116	24.5	3804	2877	24.3-	10.2-

SOURCE: AMERIAN HOSP.ASSOC.. 'GUIDE TO THE HEALTH CARE FIELD', 1960-75

Utilization (Tables 17-20)

Table 17 displays the number of admissions to federal hospitals between 1959 and 1974 and Table 18 presents the percent change in the number of admissions at each facility for three five-year intervals. Northern Virginia was the only jurisdiction in which a decrease in admissions occurred between 1960 and 1974. While the admissions to Northern Virginia facilities decreased by 15.5 percent, the District of Columbia, Montgomery County, and Prince George's County increased by 50.3 percent, 3.3 percent, and 25.7 percent, respectively.

A comparison of the data for the region for 1960 and 1974 reveals a 19.2 percent (9,797) increase in admissions to federal hospitals -- from 51,006 to 60,803 admissions. The greatest number of admissions in 1974 occurred in the District of Columbia which had 46.9 percent (28,527) of the total admissions. Montgomery County had 22.5 percent (13,682), Prince George's County had 13.6 percent (8,266) and Northern Virginia had 17.0 percent (10,328) of the total admissions. In 1960, the District of Columbia had 37.2 percent (18,969), Montgomery County had 25.9 percent (13,236), Prince George's County had 12.9 percent (6,572) and Northern Virginia had 24.0 percent (12,229) of the total admissions to federal hospitals.

Table 19 illustrates the average daily census for each facility from 1959 through 1974. For the metropolitan Washington area there has been a 19.9 percent decrease in the average daily census between 1959 and 1974. All the jurisdictions experienced a decrease, ranging from 38.3 percent in Northern Virginia to 15.2 percent in the District of Columbia. Montgomery County and Prince George's County had decreases of 23.6 percent and 18.2 percent, respectively.

The percent occupancies for each federal hospital are presented on Table 20. With the exception of Northern Virginia, which shows an increase between 1966 and 1974, all the jurisdictions experienced decreases in percent occupancy at federal hospitals. The greatest decrease occurred in Prince George's County where the percent occupancy at Andrew's Air Force Base Hospital went from 96.8 in 1966 to 66.1 in 1974. In the metropolitan Washington area, percent occupancy at federal hospitals decreased 8.2 percent between 1966 and 1974.

TABLE 17

METROPOLITAN WASHINGTON COUNCIL OF GOVERNMENTS
HEALTH INFORMATION SYSTEM
AMERICAN HOSPITAL ASSOCIATION GUIDE ISSUE DATA: 1960-1975

NUMBER OF ADMISSIONS

HOSPITAL NAME	1959	1960	1961	1962	1963	1964	1965	1966	1967	1968	1969	1970	1971	1972	1973	1974
VET ADMIN HOSP	4210	4482	4685	4821	5205	5563	5374	6404	7099	6915	9624	7019	7801	8959	11530	12540
WATER REED HOSP	14604	14487	13357	15178	15788	15731	15592	16250	16898	17666	-	16626	16076	15335	14975	15987
DC TOTAL	18814	18969	18042	19999	20993	21294	20966	22654	23997	24581	9624	23645	23877	24294	26505	28527
NAVAL MEDICAL CEN	12828	13236	12641	13097	12098	11389	11411	11740	12868	13863	13450	13203	13115	12689	12426	13682
MTG TOTAL	12828	13236	12641	13097	12098	11389	11411	11740	12868	13863	13450	13203	13115	12689	12426	13682
ANDREWS USAF BASE	5907	6572	7072	7706	7709	7412	7435	7742	8251	8367	8586	8396	8097	9045	7789	8266
PG TOTAL	5907	6572	7072	7706	7709	7412	7435	7742	8251	8367	8586	8396	8097	9045	7789	8266
US DEWITT ARMY	9489	8738	9488	10309	9960	9494	9269	9246	10686	10747	-	9505	9164	8773	8276	7346
NAVAL HOSP (PW)	3260	3491	3153	3052	2960	2996	2714	2591	2685	2712	2909	2746	2985	3245	3383	2982
N VA TOTAL	12749	12229	12641	13361	12920	12490	11983	11837	13371	13459	2909	12251	12149	12018	11659	10328
SMSA TOTAL	50298	51006	50396	54163	53720	52585	51795	53973	58487	60270	34569	57495	57238	58046	58379	60803

TABLE 18

HEALTH INFORMATION SYSTEM

NUMBER OF ADMISSIONS AND PERCENT CHANGE IN ADMISSIONS

JURISDICTION	HOSP. NAME	1960	1964	% CH 60-64	1965	1969	% CH 65-69	1970	1974	% CH 70-74	% CH 60-74
DC	VET ADMIN HOSP	4482	5563	24.1	5374	9624	79.0	7019	12540	78.6	179.7
DC	WALTER REED HOSP	14487	15731	8.5	15592	-	.0	16626	15987	3.8-	10.3
JURIS TOTAL		18969	21294	12.2	20966	9624	54.0-	23645	28527	20.6	50.3
MTG	NAVAL MEDICAL CEN	13236	11389	13.9-	11411	13450	17.8	13203	13682	3.6	3.3
JURIS TOTAL		13236	11389	13.9-	11411	13450	17.8	13203	13682	3.6	3.3
PG	ANDREWS USAF BASE	6572	7412	12.7	7435	8586	15.4	8396	8266	1.5-	25.7
JURIS TOTAL		6572	7412	12.7	7435	8586	15.4	8396	8266	1.5-	25.7
NO.VA	US DEWITT ARMY	8738	9494	8.6	9269	-	.0	9505	7346	22.7-	15.9-
NO.VA	NAVAL HOSP (PW)	3491	2996	14.1-	2714	2909	7.1	2746	2982	8.5	14.5-
JURIS TOTAL		12229	12490	2.1	11983	2909	75.7-	12251	10328	15.6-	15.5-
FINAL TOTALS		51006	52585	3.0	51795	34569	33.2-	57495	60803	5.7	19.2

SOURCE: AMERIAN HOSP.ASSOC.,'GUIDE TO THE HEALTH CARE FIELD',1960-75

TABLE 19

METROPOLITAN WASHINGTON COUNCIL OF GOVERNMENTS
HEALTH INFORMATION SYSTEM
AMERICAN HOSPITAL ASSOCIATION GUIDE ISSUE DATA: 1960-1975

AVERAGE DAILY CENSUS

HOSPITAL NAME	1959	1960	1961	1962	1963	1964	1965	1966	1967	1968	1969	1970	1971	1972	1973	1974
VET ADMIN HOSP	306	297	297	307	299	308	316	592	654	641	616	595	614	612	627	625
WATER REED HOSP	1302	1070	1011	1103	1122	1101	1130	1746	1288	1343	-	1139	1032	779	713	738
DC TOTAL	1608	1367	1308	1406	1421	1409	1446	2338	1942	1984	616	1734	1646	1391	1340	1363
NAVAL MEDICAL CEN	690	745	641	700	665	564	595	606	714	800	783	806	537	524	494	527
MTG TOTAL	690	745	641	700	665	564	595	606	714	800	783	806	537	524	494	527
ANDREWS USAF BASE	274	225	224	223	299	241	252	242	243	309	322	292	284	262	218	224
PG TOTAL	274	225	224	223	299	241	252	242	243	309	322	292	284	262	218	224
US DEWITT ARMY	208	183	180	187	177	167	176	186	201	209	-	198	173	144	141	123
NAVAL HOSP (PW)	87	89	81	69	76	95	79	84	95	99	105	82	70	64	70	59
N VA TOTAL	295	272	261	256	253	262	255	270	296	308	105	280	243	208	211	182
SMSA TOTAL	2867	2609	2434	2585	2638	2476	2548	3456	3195	3401	1826	3112	2710	2385	2263	2296

TABLE 20

METROPOLITAN WASHINGTON COUNCIL OF GOVERNMENTS
HEALTH INFORMATION SYSTEM
AMERICAN HOSPITAL ASSOCIATION GUIDE ISSUE DATA: 1960-1975

PERCENT OCCUPANCY

HOSPITAL NAME	1966	1967	1968	1969	1970	1971	1972	1973	1974
VET ADMIN HOSP	83.7	93.2	91.3	88.3	85.7	88.5	87.8	88.6	88.3
WATER REED HOSP	112.0	78.2	83.6	-	72.9	85.7	66.3	69.8	84.2
DC TOTAL	97.9	85.7	87.5	88.3	79.3	87.1	77.1	79.2	86.3
NAVAL MEDICAL CEN	85.8	92.8	86.5	74.6	89.6	71.6	69.9	74.3	74.6
MTG TOTAL	85.8	92.8	86.5	74.6	89.6	71.6	69.9	74.3	74.6
ANDREWS USAF BASE	96.8	88.4	88.3	92.0	83.4	81.1	74.9	62.3	66.1
PG TOTAL	96.8	88.4	88.3	92.0	83.4	81.1	74.9	62.3	66.1
US DEWITT ARMY	77.5	83.8	73.3	-	66.0	82.4	70.2	74.2	64.7
NAVAL HOSP (PW)	49.7	56.2	58.6	62.1	48.5	63.6	58.2	67.3	78.7
N VA TOTAL	63.6	70.0	66.0	62.1	57.3	73.0	64.2	70.8	71.7
SMSA TOTAL	84.3	82.1	80.3	79.3	74.4	78.8	71.2	72.8	76.1

Births and Bassinets (Tables 21-24)

Data describing the number of births in federal hospitals between 1959 and 1974 appear on Table 21, and data indicating the percent changes in births for three five-year intervals appear on Table 22. Of the six hospitals, only the Veterans Administration Hospital has no obstetric service.

Births in federal hospitals between 1960 and 1974 declined by 45.2 percent, from 7,482 in 1960 to 4,098 in 1974. All of the hospitals experienced a decreased number of births during this time span with a range of decreases from 27.6 percent (Andrews Air Force Base, Prince George's County) to 59.9 percent (Naval Medical Center, Montgomery County). The District of Columbia had a decrease of 36.1 percent, and Northern Virginia had a decrease of 47.1 percent in births between 1960 and 1974.

The number of bassinets available in federal hospitals from 1959 to 1974 and their percent changes for three five-year intervals appear on Tables 23 and 24. In the metropolitan Washington area, there was an increase of 1.8 percent in the number of bassinets in federal hospitals between 1960 and 1974 -- from 158 to 161 bassinets.

TABLE 21

METROPOLITAN WASHINGTON COUNCIL OF GOVERNMENTS
HEALTH INFORMATION SYSTEM
AMERICAN HOSPITAL ASSOCIATION GUIDE ISSUE DATA: 1960-1975

NUMBER OF BIRTHS

HOSPITAL NAME	1959	1960	1961	1962	1963	1964	1965	1966	1967	1968	1969	1970	1971	1972	1973	1974
VET ADMIN HOSP +																
WATER REED HOSP	1207	1116	1035	1102	1117	1144	1074	974	1104	1122	-	1176	1005	702	714	713
DC TOTAL	1207	1116	1035	1102	1117	1144	1074	974	1104	1122	-	1176	1005	702	714	713
NAVAL MEDICAL CEN	1677	1906	1732	1635	1531	1509	1489	1367	1381	1398	1583	1593	1512	1252	1050	764
MTG TOTAL	1677	1906	1732	1635	1531	1509	1489	1367	1381	1398	1583	1593	1512	1252	1050	764
ANDREWS USAF BASE	1037	1346	1412	1478	1497	1514	1562	1388	1456	1492	1469	1605	1316	1125	1095	974
PG TOTAL	1037	1346	1412	1478	1497	1514	1562	1388	1456	1492	1469	1605	1316	1125	1095	974
US DEWITT ARMY	1906	2133	2129	2134	2201	2143	1963	1715	1744	1778	-	1947	1566	1171	1102	1023
NAVAL HOSP (PW)	908	981	946	911	976	871	697	720	691	693	754	650	672	640	656	624
N VA TOTAL	2814	3114	3075	3045	3177	3014	2660	2435	2435	2471	754	2597	2238	1811	1758	1647
SMSA TOTAL	6735	7482	7254	7260	7322	7181	6785	6164	6376	6483	3806	6971	6071	4890	4617	4098

TABLE 22

HEALTH INFORMATION SYSTEM

NUMBER OF BIRTHS AND PERCENT CHANGE IN BIRTHS

JURISDICTION	HOSP. NAME	1960	1964	% CH 60-64	1965	1969	% CH 65-69	1970	1974	% CH 70-74	% CH 60-74
DC	VET ADMIN HOSP +										
DC	WALTER REED HOSP	1116	1144	2.5	1074	-	.0	1176	713	39.3-	36.1-
JURIS TOTAL		1116	1144	2.5	1074	-	.0	1176	713	39.3-	36.1-
MTG	NAVAL MEDICAL CEN	1906	1509	20.8-	1489	1583	6.3	1593	764	52.0-	59.9-
JURIS TOTAL		1906	1509	20.8-	1489	1583	6.3	1593	764	52.0-	59.9-
PG	ANDREWS USAF BASE	1346	1514	12.4	1562	1469	5.9-	1605	974	39.3-	27.6-
JURIS TOTAL		1346	1514	12.4	1562	1469	5.9-	1605	974	39.3-	27.6-
NO.VA	US DEWITT ARMY	2133	2143	.4	1963	-	.0	1947	1023	47.4-	52.0-
NO.VA	NAVAL HOSP (PW)	981	871	11.2-	697	754	8.1	650	624	4.0-	36.3-
JURIS TOTAL		3114	3014	3.2-	2660	754	71.6-	2597	1647	36.5-	47.1-
FINAL TOTALS		7482	7181	4.0-	6785	3806	43.9-	6971	4098	41.2-	45.2-

SOURCE: AMERICAN HOSP.ASSOC.,"GUIDE TO THE HEALTH CARE FIELD",1960-75

TABLE 23

METROPOLITAN WASHINGTON COUNCIL OF GOVERNMENTS
HEALTH INFORMATION SYSTEM
AMERICAN HOSPITAL ASSOCIATION GUIDE ISSUE DATA: 1960-1975

NUMBER OF BASSINETS

HOSPITAL NAME	1959	1960	1961	1962	1963	1964	1965	1966	1967	1968	1969	1970	1971	1972	1973	1974
VET ADMIN HOSP +																
WATER REED HOSP	28	24	24	28	28	28	36	36	27	27	-	24	27	27	19	19
DC TOTAL	28	24	24	28	28	28	36	36	27	27	-	24	27	27	19	19
NAVAL MEDICAL CEN	57	50	50	50	40	42	50	50	50	50	50	50	40	40	40	40
MTG TOTAL	57	50	50	50	40	42	50	50	50	50	50	50	40	40	40	40
ANDREWS USAF BASE	19	19	19	19	35	35	35	35	35	35	35	35	35	35	35	35
PG TOTAL	19	19	19	19	35	35	35	35	35	35	35	35	35	35	35	35
US DEWITT ARMY	47	47	47	47	49	49	49	49	49	49	-	49	49	49	49	49
NAVAL HOSP (PW)	18	18	11	18	18	18	18	16	22	19	19	22	22	18	15	18
N VA TOTAL	65	65	58	65	67	67	67	65	71	68	19	71	71	67	64	67
SMSA TOTAL	169	158	151	162	170	172	188	186	183	180	104	180	173	169	158	161

TABLE 24

HEALTH INFORMATION SYSTEM

NUMBER OF BASSINETS AND PERCENT CHANGE IN BASSINETS

JURISDICTION	HOSP. NAME	1960	1964	% CH 60-64	1965	1969	% CH 65-69	1970	1974	% CH 70-74	% CH 60-74
DC	VET ADMIN HOSP +										
DC	WALTER REED HOSP	24	28	16.6	36	-	.0	24	19	20.8-	20.8-
JURIS TOTAL		24	28	16.6	36	-	.0	24	19	20.8-	20.8-
MTG	NAVAL MEDICAL CEN	50	42	16.0-	50	50	.0	50	40	20.0-	20.0-
JURIS TOTAL		50	42	16.0-	50	50	.0	50	40	20.0-	20.0-
PG	ANDREWS USAF BASE	19	35	84.2	35	35	.0	35	35	.0	84.2
JURIS TOTAL		19	35	84.2	35	35	.0	35	35	.0	84.2
NO.VA	US DEWITT ARMY	47	49	4.2	49	-	.0	49	49	.0	4.2
NO.VA	NAVAL HOSP (PW)	18	18	.0	18	19	5.5	22	18	18.1-	.0
JURIS TOTAL		65	67	3.0	67	19	71.6-	71	67	5.6-	3.0
FINAL TOTALS		158	172	8.8	188	104	44.6-	180	161	10.5-	1.8

SOURCE: AMERIAN HOSP.ASSOC.."GUIDE TO THE HEALTH CARE FIELD".1960-75

Personnel (Tables 25-26)

Since 1960, the number of personnel employed in federal hospitals has increased by 75.1 percent -- from 5,016 to 8,785 employees. The greatest increase (106.6 percent) is noted for Montgomery County, while Northern Virginia experienced the smallest increase (33.7 percent). The District of Columbia and Prince George's County increased by 78.8 percent and 71.0 percent, respectively.

NOTE: Data on payroll expenses and total expenses for federal hospitals has been excluded because it was incomplete.

TABLE 25

METROPOLITAN WASHINGTON COUNCIL OF GOVERNMENTS
HEALTH INFORMATION SYSTEM
AMERICAN HOSPITAL ASSOCIATION GUIDE ISSUE DATA: 1960-1975

NUMBER OF PERSONNEL

HOSPITAL NAME	1959	1960	1961	1962	1963	1964	1965	1966	1967	1968	1969	1970	1971	1972	1973	1974
VET ADMIN HOSP	603	527	563	680	598	918	1077	1372	1469	1359	1377	1150	1560	1584	1598	1401
WATER REED HOSP	1816	2233	2100	2074	1930	1921	1925	2419	2236	2243	-	2578	2662	2412	2227	3535
DC TOTAL	2419	2760	2663	2754	2528	2839	3002	3791	3705	3602	1377	3728	4222	3996	3825	4936
NAVAL MEDICAL CEN	809	973	969	947	1048	910	942	956	1111	650	1401	1223	1402	1329	2003	2011
MTG TOTAL	809	973	969	947	1048	910	942	956	1111	650	1401	1223	1402	1329	2003	2011
ANDREWS USAF BASE	346	328	828	807	670	368	377	357	463	458	451	373	429	486	511	561
PG TOTAL	346	328	828	807	670	368	377	357	463	458	451	373	429	486	511	561
US DEWITT ARMY	584	718	574	620	580	533	607	743	864	845	-	720	884	557	655	935
NAVAL HOSP (PW)	223	237	245	237	255	221	214	247	264	252	241	254	245	262	385	342
N VA TOTAL	807	955	819	857	835	754	821	990	1128	1097	241	974	1129	819	1040	1277
SMSA TOTAL	4381	5016	5279	5365	5081	4871	5142	6094	6407	5807	3470	6298	7182	6630	7379	8785

TABLE 26

HEALTH INFORMATION SYSTEM

NUMBER OF PERSONNEL AND PERCENT CHANGE IN PERSONNEL

JURISDICTION	HOSP. NAME	1960	1964	% CH 60-64	1965	1969	% CH 65-69	1970	1974	% CH 70-74	% CH 60-74
DC	VET ADMIN HOSP	527	918	74.1	1077	1377	27.8	1150	1401	21.8	165.8
DC	WALTER REED HOSP	2233	1921	13.9-	1925	-	.0	2578	3535	37.1	58.3
JURIS TOTAL		2760	2839	2.8	3002	1377	54.1-	3728	4936	32.4	78.8
MTG	NAVAL MEDICAL CEN	973	910	6.4-	942	1401	48.7	1223	2011	64.4	106.6
JURIS TOTAL		973	910	6.4-	942	1401	48.7	1223	2011	64.4	106.6
PG	ANDREWS USAF BASE	328	368	12.1	377	451	19.6	373	561	50.4	71.0
JURIS TOTAL		328	368	12.1	377	451	19.6	373	561	50.4	71.0
NO.VA	US DEWITT ARMY	718	533	25.7-	607	-	.0	720	935	29.8	30.2
NO.VA	NAVAL HOSP (PW)	237	221	6.7-	214	241	12.6	254	342	34.6	44.3
JURIS TOTAL		955	754	21.0-	821	241	70.6-	974	1277	31.1	33.7
FINAL TOTALS		5016	4871	2.8-	5142	3470	32.5-	6298	8785	39.4	75.1

SOURCE: AMERIAN HOSP.ASSOC.,'GUIDE TO THE HEALTH CARE FIELD',1960-75

TECHNICAL NOTES

DEFINITION OF TERMS

Admissions	The number of patients accepted for inpatient service during the 12 months of the report period. This number excludes newborns.
Bassinets	The number of bassinets set up and staffed for use in the nursery at the close of the reporting period (September 30)
Beds	The number of beds, cribs, and pediatric bassinets regularly available (set up and staffed for use) for inpatients as of the close of the reporting period (September 30). The number of beds includes only operating beds and not constructed bed capacity. This number excludes bassinets for newborn infants.
Births	The number of infants born in the hospital and accepted for service in a newborn infant bassinet during the 12 months of the report period. This number excludes stillbirths.
Average Daily Census	The average number of patients receiving care each day during the 12 months of the report period. This number does not include newborns.
Payroll Expense	The payroll expenses include all salaries and wages paid to full-time and part-time personnel during the 12 months of the report period. Salaries and wages paid to medical and dental interns and residents, and other trainees (e.g., medical technology trainees, x-ray therapy trainees, administrative residents) are excluded.
Percent Occupancy	The ratio of average daily census to average number of beds maintained during the 12 months of the reporting period.
Personnel	The number of persons on the payroll at the end of the reporting period (September 30). This number includes full-time equivalents of part-time personnel but excludes medical and dental interns and residents and other trainees. Full-time personnel are those whose regularly schedules work week is 35 hours or more. Part-time personnel are those whose work week is less than 35 hours. Full-time equivalents are calculated on the basis that two part-time persons equal one full-time person.
Reporting Period	The 12 month period beginning October 1 and ending September 30 of the following year. The year of the data indicated on the tables in this report corresponds to the end year of the reporting period. For example, for the year 1974 the data was collected during the period October 1, 1973 through September 30, 1974.
Total Expense	The total expense includes payroll expense and non-payroll expense for the 12 months of the report period. Non-payroll expenses include employee benefits, professional fees, depreciation expense, interest expense and all other expenses (e.g., supplies, purchased services).

SOURCE: American Hospital Association Guide to the Health Care Field 1975.

YEAR OF ESTABLISHMENT FOR NON-FEDERAL AND FEDERAL ACUTE CARE HOSPITALS IN THE METROPOLITAN WASHINGTON AREA 1/

NON-FEDERAL HOSPITALS

HOSPITAL NAME	YEAR ESTABLISHED
DISTRICT OF COLUMBIA	
Children's Hospital National Medical Center	1870
Columbia Hospital for Women	1866
District of Columbia General Hospital	1843
Doctors Hospital	1940
George Washington University Hospital	1848
Georgetown University Hospital	1898
Greater Southeast Community Hospital (formerly Morris Cafritz Memorial Hospital)	1966 (April) 2/
Hadley Memorial Hospital	1952
Howard University Hospital (formerly Freedman's Hospital)	1861
Providence Hospital	1861
Rogers Memorial Hospital (formerly Eastern Dispensary and Casualty Hospital)	1888
Sibley Memorial Hospital	1895
Washington Hospital Center	1958
MARYLAND	
Montgomery County	
Holy Cross Hospital of Silver Spring	1963 (January) 2/
Montgomery County General Hospital	1918
Suburban Hospital	1943
Washington Adventist Hospital (formerly Washington Sanitarium & Hospital)	1907

Prince George's County	
Clinton Community Hospital (formerly Southern Maryland General Hospital)	1959
Eugene Leland Memorial Hospital	1942
Prince George's General Hospital and Medical Center	1944
NORTHERN VIRGINIA	
Alexandria City	
Alexandria Hospital	1872
Circle Terrace Hospital	1940
Jefferson Memorial Hospital	1965 (March) 2/
Arlington County	
Arlington Hospital	1943
National Orthopedic and Rehabilitation Hospital	1947
Northern Virginia Doctors Hospital	1960 (August) 2/
Fairfax County	
Commonwealth Doctors Hospital	1967 (July) 2/
Fairfax Hospital	1961 (February) 2/
Loudoun County	
Loudoun Memorial Hospital	1917
Prince William County	
Prince William Hospital	1964 (June) 2/
Potomac Hospital Corporation	1972 (November) 2/

FEDERAL HOSPITALS

HOSPITAL NAME	YEAR ESTABLISHED
DISTRICT OF COLUMBIA	
Veterans Administration Hospital	1920
Walter Reed General Hospital	1909
MARYLAND	
Montgomery County	
Naval Medical Center	1942
Prince George's County	
Andrews USAF Base (Malcolm Grow U.S. Air Force Medical Ctr.)	1958
NORTHERN VIRGINIA	
Fairfax County	
U.S. Dewitt Army Hospital	1917
Prince William County	
Naval Hospital	1941

SOURCES: 1/ American Hospital Association's Guide to the Health Care Field 1965

2/ Health Information System survey of hospitals

REPORT OF THE
HUMAN DEVELOPMENT BUREAU
TO THE
EXECUTIVE COMMITTEE OF THE
BOARD OF DIRECTORS OF THE
METROPOLITAN WASHINGTON BOARD OF TRADE
JUNE 7, 1976

QUESTION: Does the District of Columbia Metropolitan Area need to construct facilities for additional acute hospital beds considering all economic and use data?

The Chairman and the Staff Director of the Human Development Bureau of the Board have studied with interest and care the material on the above question supplied to the Board of Trade by Group Hospitalization, Inc., including the statement and attachments thereto listed as Exhibits 1.00 through 13.02, all as shown on a list of Exhibits following page 13 of the statement by Barry P. Wilson, Vice President, Public Affairs of Group Hospitalization, Inc., at meetings held by the Metropolitan Washington Council of Governments on March 18, 24 and 25, 1975 and the data filed therewith; the "Brief - Public Law 93-641 (National Health Planning and Resource Development Act of 1974)" -- particularly the section dealing with the District of Columbia; an article appearing on March 22, 1976 in the Washington Post headlined "Hospital Cost Here Passes $200.00 a Day" together with a table headed "Typical Rates In Area" (hospital rates); the letter to Joseph B. Danzansky, President of the Metropolitan Washington Board of Trade, dated March 25 and signed by D. S. Farver, President of Group Hospitalization Inc.; the letter to Louis J. Segadelli, Executive Director, Group Health Association, dated April 23, 1976 and signed also by D. S. Farver, President of Group Hospitalization, Inc., with a "blind" copy to Charles Diehl of George Washington University and Joseph Danzansky of the Board of Trade; and, finally, an undated memorandum entitled "Does the District of Columbia Need Additional Acute Hospital

Beds" (including article from the Washington Star dated 3/11/76 headlined "Will D.C. Doctors Flee to Suburbs?"

From the mass of data supplied either in the body of the material cited above or in the Exhibits attached thereto, it is obvious that what constitutes an

> "adequate supply of acute care beds for the Washington D. C. Standard Metropolitan Statistical Area (S.M.S.A.) cannot be definitively answered..." [Exhibit 11.01, page 1, Hospital Bed Need Calculation, Summary Sheet attached to Statement of Barry P. Wilson at meetings held by Metropolitan Washington C.O.G., March 18, 24 and 25, 1975].

The aforesaid Summary Sheet continues to state:

> "Meanwhile, a number of important questions remain unanswered -- questions which GHI [Group Hospitalization, Inc.] staff feels can only be answered at the metropolitan regional level. For example, the population patterns of the entire S.M.S.A. must be examined carefully. GHI staff has been unable to identify any projections for the District of Columbia as a whole or for sub-area within the District..." [Hospital Bed Need Calculations, Summary Sheet, Exhibit 11.01, page 1, supra]

If persons who have not only expertise of long standing in this area, but also an economic stake in the outcome of the decision-making process are unable to

> "identify any projections for the District of Columbia as a whole or for sub-areas within the District..."

it is obvious that the Chairman of the Human Development Bureau of the Board of Trade and its Staff Director do not have the expertise and qualifications to come to appropriate decisions as to whether planned and approved increases in hospital bed capacity are viable from the standpoint of either economics or sociology.

It appears to us, admittedly untrained and inexpert in either statistical methodology or the intricacies of health

care delivery, that planned expansion of facilities in counties surrounding the area of the geographic boundaries of Washington, D. C., may not be justified totally in view of existing facilities and those under construction within the geographic area of the District of Columbia itself. Indeed, if the planned expansion of facilities within the Standard Metropolitan Statistical Area of the District of Columbia -- plus those already operating and under construction within the geographic area of Washington, D. C., itself -- are actually built, it is claimed by Group Hospitalization, Inc. that there may be an excess of 1,700 acute care beds, in less than four years, by 1980. According to the Vice President, Public Affairs, Group Hospitalization, Inc., this represents ONE HUNDRED AND NINETEEN MILLION DOLLARS ($119,000,000) in excess construction costs. [Our emphasis]

Assuming, without knowing, that this estimate of the Vice President, Public Affairs, Group Hospitalization, Inc., is not exaggerated, continuing the expanded construction of health care facilities within the Washington, D. C., Metropolitan Area should be reviewed carefully by persons competent in this field, which we certainly do not claim to be. We say this with full recognition that all governmental entities within the S.M.S.A. of Washington, D. C. wish to create in their various limited geographic and governmental subdivisions health and hospital care facilities geographically contiguous to their residents. But the economies of scale must be considered and continuing expansion of health care facilities in each governmental subdivision within the S.M.S.A. -- or even within only some of the larger subdivisions -- without proper regard to economically sound standards of utilization may result in economic chaos and upheaval.

Recommendations

We recommend therefore that:

1. The Council of Governments create immediately a Special Study Group with a member from each of the entities comprising the Council of Governments to study this entire problem of health care and Planning and Resource Development within the S.M.S.A. of Washington, D. C.; and that

2. This Special Study Group make a recommendation within the shortest period of time feasible of the total needs for construction of health care facilities within the S.M.S.A. of the District of Columbia, taking into consideration the costs of construction and equipping of new health care facilities and the impact of such new facilities on existing facilities.

Respectfully submitted,

HUMAN DEVELOPMENT BUREAU

By_____
Raymond R. Dickey, Chairman

CURRENT OCCUPANCY RATE IN DISTRICT OF COLUMBIA HOSPITALS

Senator CHILES. Thank you for your statement.

What is the current occupancy rate in the hospitals in the District of Columbia?

Mr. WILSON. Approximately 80 percent as of March 31, this year.

Senator CHILES. What would you expect that average rate to be in 1980?

Mr. WILSON. That is very difficult to state precisely, because it depends on migrations of suburban patients to District of Columbia hospitals, and we can't evaluate precisely what will take place in that area.

We will assume this: If approximately 2,000 beds in the District are used today by suburban patients, approximately 75 percent of those patients in the future could be expected to utilize and use suburban hospital beds. That is approximately 1,500 beds that are affected in the District, which would become excess to the needs of the District.

If that takes place, we will see occupancy rates averaging close to 60 percent in the District.

Senator CHILES. What occupancy rate is required by hospitals in order to remain in a healthy financial condition?

Mr. WILSON. If the Hill-Burton plan is correct, it states 85 to 90 percent is a desirable occupancy to allow for seasonal fluctuations and to provide for disaster and other emergencies.

Senator CHILES. If that is true, what kind of situation are you going to have if you have a 60-percent occupancy rate?

Mr. WILSON. The hospital's only options in those kinds of situations is to reduce services, to consider closing entirely, or raise its charges to the patients who do occupy or represent 60-percent occupancy.

Those charges would be unfeasible, in my opinion. So the hospital's real option is to take a look at reducing services or consider closing altogether.

Senator CHILES. Would it be correct that hospitals would be forced to close down, based on the current projections?

Mr. WILSON. Mr. Chairman, that is one feasible course for a hospital. I say feasible. That is one possible course.

CONVERSION OF EXISTING HOSPITALS

I think it would be a far more desirable course of action for the hospital to analyze its situation today in terms of the new hospital construction in the suburbs, and take steps to plan conversion of its existing plan to either using long-term care, ambulatory care, and outpatient services of various kinds, rather than close altogether.

Senator CHILES. You are talking about the possibility of District of Columbia General changing now, and going to long-term care?

Mr. WILSON. That would be one possibility available to District of Columbia General, or to private hospitals in the District, which find that the need for acute hospital care is no longer as great as it was.

Senator CHILES. We talked about District of Columbia General. The same things that are true there are going to happen to occupancy rates in the private hospitals in the District, is that correct?

Mr. WILSON. I don't think there is any doubt about that, sir.

Senator CHILES. They are also going to be forced to either raise the rates, which will become economically impossible to the patients because they won't be matching rates in the suburban districts in which you could have an outflow of patients from the District, which is the reverse of before; or they will have to change the type of care or close down?

Mr. WILSON. Yes, sir.

Senator CHILES. How many private hospitals are there in the District that you think are going to suffer this kind of effect? Some of them generate their own patients, such as Georgetown.

Mr. WILSON. There are 14 private hospitals in the District. The hospitals that will be most affected will be those hospitals that today have the highest proportion of suburban patients, and we will assume that the hospital construction in the suburbs will alleviate the need of suburban residents to come to the District for hospital care except for highly specialized services such as those available at the regional centers.

DISTRICT OF COLUMBIA MEDICAL CHARITIES PROGRAM

Senator CHILES. The District of Columbia medical charities program pays private hospitals to provide services to the poor, and it is currently limited by law to $76 a day. What is, in your opinion, the effect of the $76 per day limitation?

Mr. WILSON. In view of the fact the average day is $207, and $76 is only a little over a third of that, that certainly would not encourage private hospitals to provide care to residents. To the extent it does not receive costs from one group of patients, it must raise its charges to other patients. I think that is unfair. I think in terms of the community, all taxpayers have a responsibility to pay for the care of the needy, not just sick people.

Senator CHILES. Hasn't it always been true that virtually every hospital has taken in, or has been required to take in, some charity patients, that the nonindigent patients have always carried part of that load in their hospital bills?

Mr. WILSON. Yes, sir; that has always been true to some extent. But today, in view of the wide variety of programs in health coverage available to people, this is less and less necessary. We fill most of the gaps in terms of health care coverage, and this is just one remaining gap that needs to be filled as well.

Senator CHILES. Shouldn't every hospital be required to do some charity work regardless of whether it is a private or public hospital?

Mr. WILSON. Yes, sir, I think that is so. I believe that is the law with regard to those hospitals that have received Federal contributions which have been made toward hospital construction. Historically, the hospitals that receive that kind of aid from taxpayers have a responsibility to provide charity care.

NATIONAL HEALTH CARE COSTS

Senator CHILES. Can you give the subcommittee the total amount spent on health care in the Nation now and 10 years ago, and what this large increase has done to the mortality rate or morbidity rate in the Nation?

If you don't have those figures, we would like you to furnish them.

Mr. WILSON. Yes, sir, I do have them. In 1965, the total national bill for health care was $38.9 billion. In 1975, the total bill was $118.5 billion. That is an increase of $79.6 billion. It is very difficult to measure any particular effect on the health status of Americans as a result of that $79 billion expenditure over a period of 10 years.

As a matter of fact, although we have increased the national health expenditure 10 times over the last 25 years, we have increased the life expectancy of the average American adult male by only a little over 1 year in that period of time.

It has been said by some that we could increase our national health care expenditures to double what they are now, to nearly $250 billion, without being able statistically to determine any particular result of that expenditure for health care. The fact is that our expectation of health care has become unreasonable, and we have tended to look at health care as the solution to all of the health problems that we see in this country.

As a matter of fact, such items as environmental conditions, economic and educational status, public health education, a variety of factors of that kind seem to have a lot more to do with how healthy people were than health care does.

That is not to say that we need somehow to scrap our health care establishment. On the contrary, we have to maintain it to be made well when we are ill. But we must come to realize, I think, Mr. Chairman, our resources are finite. We do not have enough resources as a nation to do all of these things, and we must begin to address ourselves to factors other than health care which have more to do with our health status than health care does.

Senator CHILES. Thank you very much, Mr. Wilson.

COMMUNITY MEDICINE COMMITTEE, DISTRICT OF COLUMBIA MEDICAL SOCIETY

STATEMENT OF ARTHUR H. HOYTE, M.D., CHAIRMAN, COMMUNITY MEDICINE COMMITTEE, DISTRICT OF COLUMBIA MEDICAL SOCIETY

PREPARED STATEMENT

Senator CHILES. The subcommittee will now hear from Dr. Hoyte, the chairman of the community medicine committee of the District of Columbia Medical Society.

Dr. HOYTE. Thank you, Mr. Chairman. I would first like to offer my prepared statement for inclusion in the record at this point, after which I will summarize my remarks and answer any questions you may have.

Senator CHILES. It is so ordered.

[The statement follows:]

Mr. Chairman and Distinguished Committee Members:

My name is Arthur H. Hoyte. I come before you as a citizen/physician who has concentrated his energies and time on health related issues within the District of Columbia. I am a Board Certified Obstetrician-Gynecologist employed full time at the Georgetown School of Medicine where I hold the appointments of Assistant Professor in the Departments of Community Medicine and OB-Gyn.

My interest in the health status of disadvantaged populations and in organized health care delivery systems is reflected in my professional work experience which started in 1968 with the Kaiser Permanent Health Plan. In 1970, I joined the Office of Economic Opportunity as a health officer. One of my primary responsibilities while at O.E.O. was to evaluate O.E.O. funded Neighborhood Health Centers. In 1971 I joined the faculty of the Georgetown University School of Medicine. In addition to other duties I served as a senior planner of the Washington, D.C. component of the Georgetown University sponsored Health Maintenance Organization. Subsequent to that experience, I served as a member of the planning team of the East of the River Health Plan.

Over the past two years I have devoted the majority of my efforts to cultivating the educational potential of disadvantaged youths with the thought that a sound education leads to job opportunities. A job in turn offers the individual options for an improved environment and better nutrition and thus enhanced health.

Today, I was requested to focus my testimony on the extent to which adequate primary health care services are available in the District of Columbia and the extent to which these services are available in each of the regions of the city. For the most insightful information on this subject I would like to refer the Committee to four documents.

The first is the Report of the Mayor's Task on Public Health Goals which was published in 1970 (hereafter referred to as the 1970 Mayor's Task Force Report). The second is a Report to Congress: A Study of Programs for Health Service in Outpatient Health Centers in the District of Columbia (hereafter referred to as the G.A.O. report). This second report was submitted to Congress by the Comptroller General of

the United States in July 1973. The third document, the Report of the Task Force to Prepare a Comprehensive Action Plan for an Outpatient Health Delivery System in the District of Columbia (hereafter referred to as the 1975-1976 Task Force Report). This latter report was prepared in 1975-1976, in response to questions and criticisms generated by the 1973 Comptroller General's Report.

The fourth is a 1976 computer printout from the Council of Government of the Washington Metropolitan Area (C.O.G.) listing most if not all ambulatory health services in the Washington Metropolitan Area. This document offers the following information:

1) common name used by the provider facility
2) sponsoring organization or agency
3) address and telephone numbers of the provider and sponsor
4) types of services offered by each provider facility
5) hours of operation
6) number of non-acute visits
7) number of emergency or acute visits
8) the reporting period

The 1970 Report of the Mayor's Task Force on Public Health Goals was very critical of the status of the health delivery system of the District of Columbia.

The Report characterized the District of Columbia as being "health poor, nearly health bankrupt." It also stated that the services were poorly distributed and fragmented.

Three years later a study team from the General Accounting Office reaffirmed that ambulatory care services in the District of Columbia were fragmented, poorly distributed and in addition poorly utilized.

Today if one reads the Washington Post or discusses health services in the District of Columbia with patient/consumers and/or with health professionals, one is likely to encounter characterizations of ambulatory care services in the District in such terms as poorly organized, poorly managed, fragmented, unstable, inadequate etc.

It is obvious that the negativism that was conspicuous in the 1970 Mayor's Task Force Report has persisted. Why is this true? Who should shoulder the blame? What can be done?

The remainder of my testimony concentrates on trying to answer these questions.

The 1970 Mayor's Task Force Report was generated at the height of the activism of the 60's which focused on human needs and followed the Civil Rights movement. At that time public clinics were overcrowded, impersonal, and offered limited (non-comprehensive) services. The District Medicaid program was still in its infancy and certain areas of the city were devoid of health services.

Exhibit I is a map of the District of Columbia. It demonstrates the District of Columbia's four health areas* and also pinpoints the location of existing hospitals in the District. Please note that on the exhibit almost all hospital beds, hospital outpatient departments, as well as hospital emergency rooms are located west of the Anacostia River. In addition, the hospitals which are east of the Anacostia River are located near to the District-Maryland state line and thereby are utilized extensively by Maryland residents. The distribution of hospital beds, hospital outpatient departments and emergency rooms within the District of Columbia is essentially unchanged today.

Exhibit II identifies the location of non-hospital public and private outpatient services in 1970. This particular exhibit is misleading, for although the dots and x's represent facilities providing services, there is no indication of the type or extent of services offered by each facility. Inspite of this fact, I felt it appropriate to include this exhibit to underscore the dearth of outpatient services which were being provided east of the Anacostia River in 1970. The private services that were provided in this area at the time were primarily those provided by two "free" clinics.

The open circles on Exhibit II designate public and private comprehensive ambulatory care facilities that were established since 1970.

*In 1970 the city was divided into four health service areas designated by A,B,C and D. It was subsequently subdivided into nine service areas and the "letter" designation was replaced by a numerical designative.

Exhibits III, IV and V further underscore the fact that there were few, if any emergency, mental health, retardation or rehabilitative services available to the residents east of the Anacostia River in 1970.

Exhibit VI summarizes the areas within the District which were essentially devoid of public or private health facilities at that time.

Exhibit VII makes reference to the fact that the Northeast and Southeast sections of the city were serviced by only 10% of the District of Columbia's private practicing physicians,although these same geographic areas contained 51% of the total population. It should be pointed out that the data listed on Exhibit VII was collected crudely. Every fourth private physician's office listed in the Yellow Pages of the District of Columbia phone book was designated on a map. It's clear that data collected in such a manner fails to identify the days or time that the physician was available. It is well known that many physicians have offices in the District, particularly in the underserved areas,that are open only a few hours a day and only a few days each week.

In addition to being highly critical of the available facility and manpower resources, the 1970 report presented disturbing morbidity and mortality data as depicted in Exhibit VIII.

This exhibit suggested that the District had morbidity and mortality rates which were among the worst in the country.

Finally, exhibit IX lists the main recommendations made by the Mayor's Task Force. Please make note of recommendations' numbers 2,3,6,10,14,16,17, for they do not differ greatly in intent from recommendations made in the 1975-1976 Task Force Report.

What was done? Following the Report of the Mayor's Task Force, the D.C. Government responded by developing a Master Plan which I am told called for the placement of 30 comprehensive neighborhood health clinics throughout the District and the effecting of a vertical, continuous primary care and referral system. Implementation of that plan was started with the establishment of five new comprehensive neighborhood health clinics. The efforts to effect the Master Plan, soon fizzled because of multiple factors, the most significant being the lack of finances.

By 1973, as the General Accounting Office found, although increased services and facilities had been established east of the Anacostia River, ambulatory care facilities and services were still poorly distributed and poorly utilized. Exhibit X indicates where the comprehensive health care facilities were located at the time of the G.A.O. report. (Note that numbers rather than letters are now used to denote service areas).

Exhibit XI depicts the utilization pattern of each comprehensive facility in 1973.**

It should be noted, that a review of 1972 Vital Statistics Data reflecting morbidity and mortality suggested that there was not a significant improvement in the overall morbidity and mortality in the District of Columbia since the 1970 Mayor Task Force Report. (see Exhibit XII). I would be very happy to give my views on this point if the Committee so desires.

In response to the criticisms made by the G.A.O. report, the Department of Human Resources prepared the Report of the Task Force to Prepare a Comprehensive Action Plan for an Outpatient Health Delivery System in the District of Columbia.

This Report acknowledges that organized ambulatory care facilities are poorly distributed and that many such facilities are poorly utilized. The Report directly or indirectly points to inadequate and non-continuous financing of health care services, duplication and overlap between federally funded and District of Columbia funded programs, and unsatisfactory data collection and revenue collection practices. These deficiencies are among the many reasons for the poor distribution and utilization of comprehensive health facilities in the District.

The 1975-1976 Task Force assigned to prepare a comprehenisve action plan for an outpatient health delivery system in the District of Columbia,

**Note that the A.M.A, and A.D.A. data used by the G.A.O. was based on physicians in office practice. It could be argued that such standards are inappropriate to judge physician usage in public health clinics when one considers that clinic utilization is effected by such things as the filling out of forms, means testing for eligibility, encounters with social workers etc. However, the graphs in Exhibit XI are useful for showing relative utilization of the clinics in the District of Columbia.

appropriately, explicitly and implicitly, pointed out that adequate ambulatory services will not be available to District residents until:

1) the overall health planning capability is strengthened
2) the federal government (DHEW) develops a formal agreement with the District which ascertains that duplicative and overlapping efforts to provide services do not occur
3) the private sector within the District shows greater willingness to accept reasonable costs for support of the public health effort
4) the Congress is willing to assume a fairer share of the District Medicaid costs.
5) services are more appropriately distributed and made more accessible to the economically disadvantaged within the District
6) the District is able to define an equitable sliding scale fee schedule for services rendered and to tighten its fiscal and organizational management practices
7) the District is able to recruit more practitioners to work in the most underserved areas of the city.

It is of note that the 1975-1976 Task Force recommended that the Federal and District government support Health Maintenance Organization (HMO) efforts "in all feasible ways." Enhanced health educational efforts were also strongly recommended. The two areas which in my opinion were not stressed strongly enough related to the physician extenders and licensure. I feel that there should be an increased use of physician extenders and that the practitioner and facility licensure policies of the District should be strengthened.

I concur with many, if not most of the points and recommendations made in the 1975-1976 Task Force report.

In conclusion, as my testimony implied or stated, there is some truth to negative characterizations of the present status of ambulatory health care in the District of Columbia.

Who is to blame? In my opinion no one individual or one group of individuals or one agency is to blame. It is a blame to be shared by many, including the Congress, the Mayor, the Director and staff of the Department of Human Resources, the private physicians, hospitals and

the private medical schools within the District of Columbia and the general citizenry. To my mind, the situation is tragic and the essence of the tragedy is that many skilled and dedicated workers within the Department of Health have not been adequately supported by the Congress or the community. The individuals I speak of (certainly not all or even most within the DHR bureaucracy) have sustained and applied themselves diligently inspite of frequent frustrations and the almost constant demoralizing negativism that permeates the written and visual media. Yes, fiscal and organizational management undoubtedly needs to be improved within DHR, and greater automony of budget and management needs to be extended to division chiefs. But by the same token, allow the District the opportunity to implement long-term ambulatory care plans.

It should be kept in mind that all large metropolitan areas across the country have problems with health care delivery systems. In my opinion, there will be no significant improvement in the adequacy of ambulatory care available to the indigent within the District of Columbia until:

1) adequate financing of ambulatory care is available to the near poor as well as the poor
2) the consumer/patient is convinced that he or she is a primary determiner of health status
3) ambulatory care delivery systems are better distributed
4) the private sector assumes a greater share of the responsibility to deliver quality adequate services to the disadvantaged at reasonable costs.
5) the Congress holds DHR, the private sector and itself accountable to provide the District with a more acceptable health delivery system.

It is my opinion that all the ingredients needed for a Model Urban Ambulatory Care Health Delivery System are avilable to D.C. at reasonable cost. The District offers the Congress a laboratory by which it could assess payment mechanisms, private/public health care partnerships and the impact of ambulatory care services on overall health if:

1) All members of the team in the Congress, DHR and the private sectors, including the media, recognize the benefits of working together and make their criticisms constructive.

2) The Congress were willing to use its leverage to encourage the public and private sector to join in partnership to establish a network of comprehensive ambulatory care centers. These centers would have clear and well defined referral connections and communications with secondary care (specialist) and tertiary care (hospital) providers. On innumerable occassions I have witnessed the leadership of the Department of Health extend itself in search of help from the private sector. Unfortunately, the Public Health Department rarely finds itself in a buyers' market when soliciting services from the private sector in the District of Columbia. The Congress could and should enhance the District's bargaining position.

3) The Congress were willing to hold a Partnership of the Public and the Private Sector accountable at least annually for its expenditures and for the quality of services offered by the partnership.

4) The Congress were willing to assist the District in the funding of a five year Public/Private partnership endeavor.

I close with the submission of a final exhibit which outlines a proposal which I feel has merit.

I again thank you for the opportunity to appear before you.

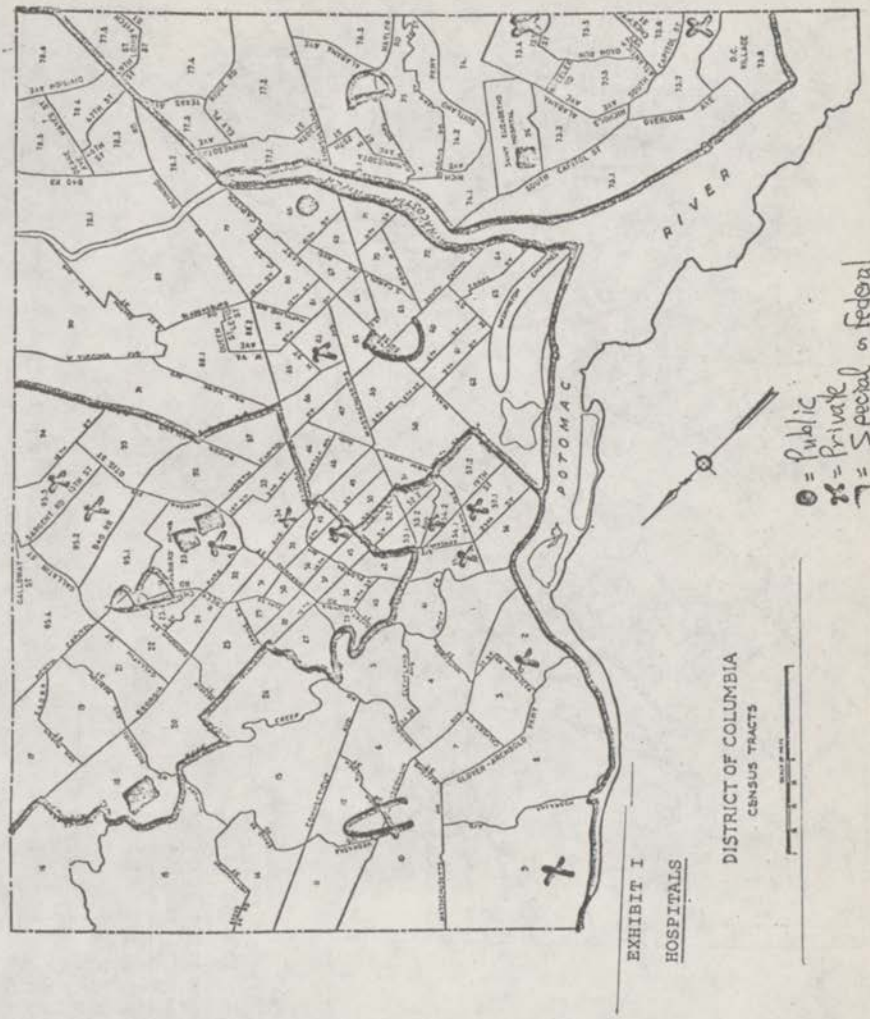


EXHIBIT I

HOSPITALS

DISTRICT OF COLUMBIA
CENSUS TRACTS

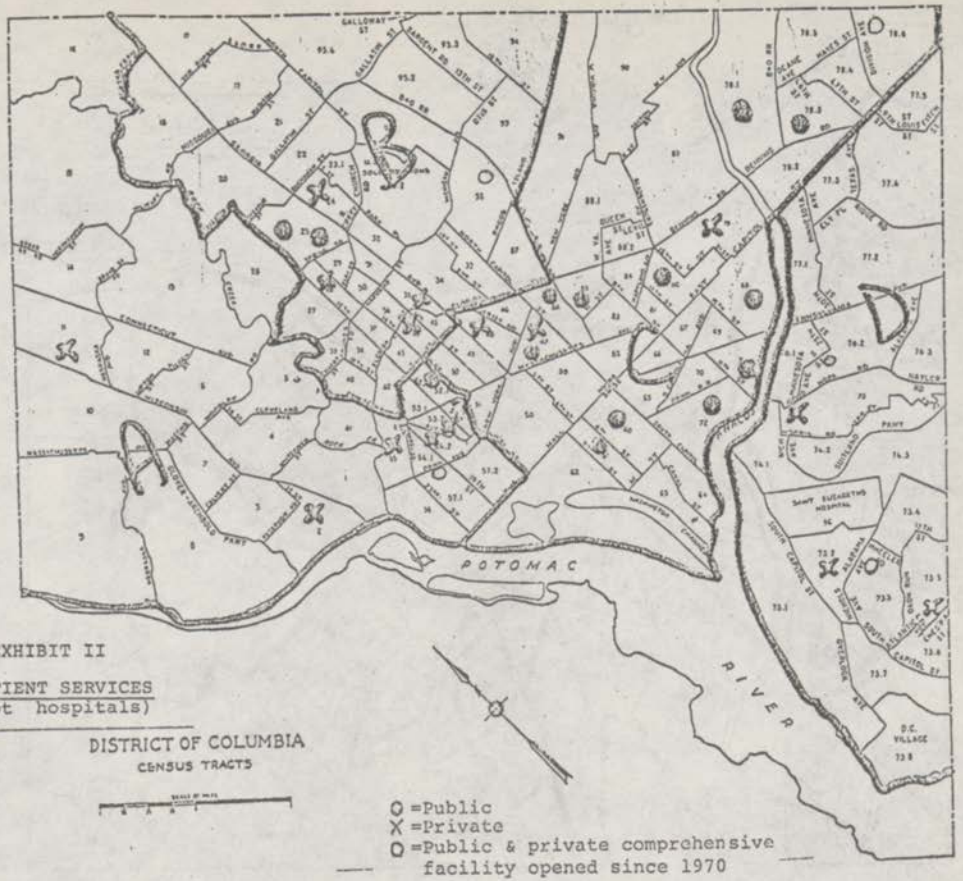


EXHIBIT II

OUTPATIENT SERVICES
(except hospitals)

DISTRICT OF COLUMBIA
CENSUS TRACTS

O =Public
X =Private
O =Public & private comprehensive facility opened since 1970

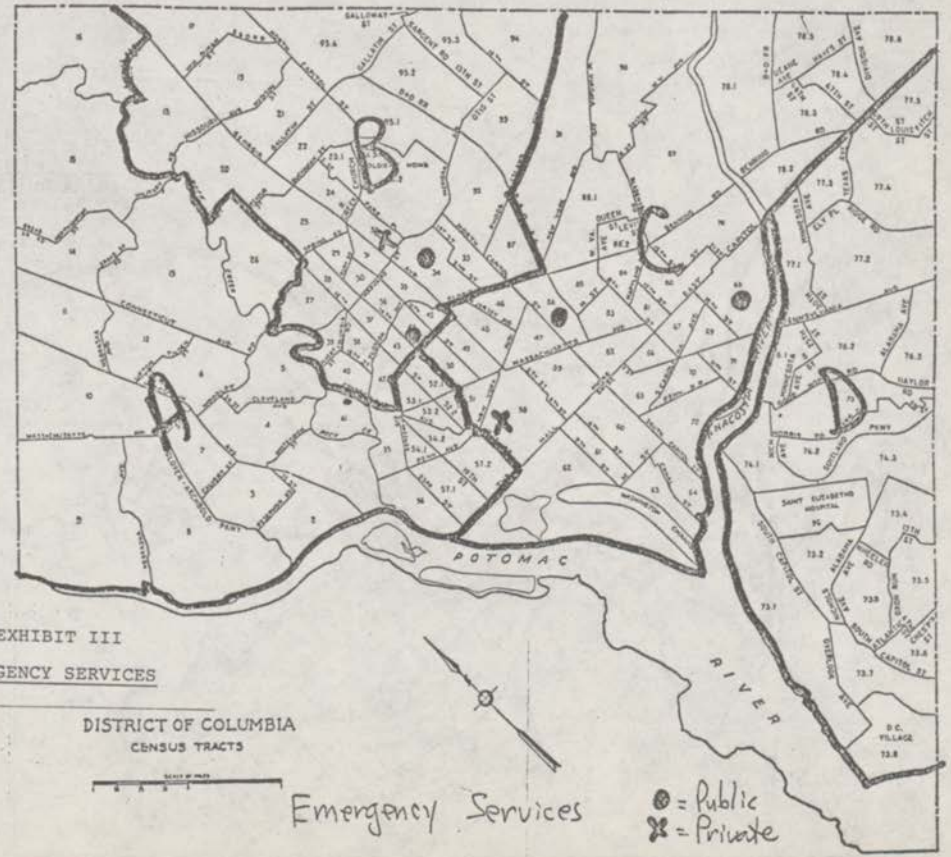


EXHIBIT III

EMERGENCY SERVICES

DISTRICT OF COLUMBIA

CENSUS TRACTS

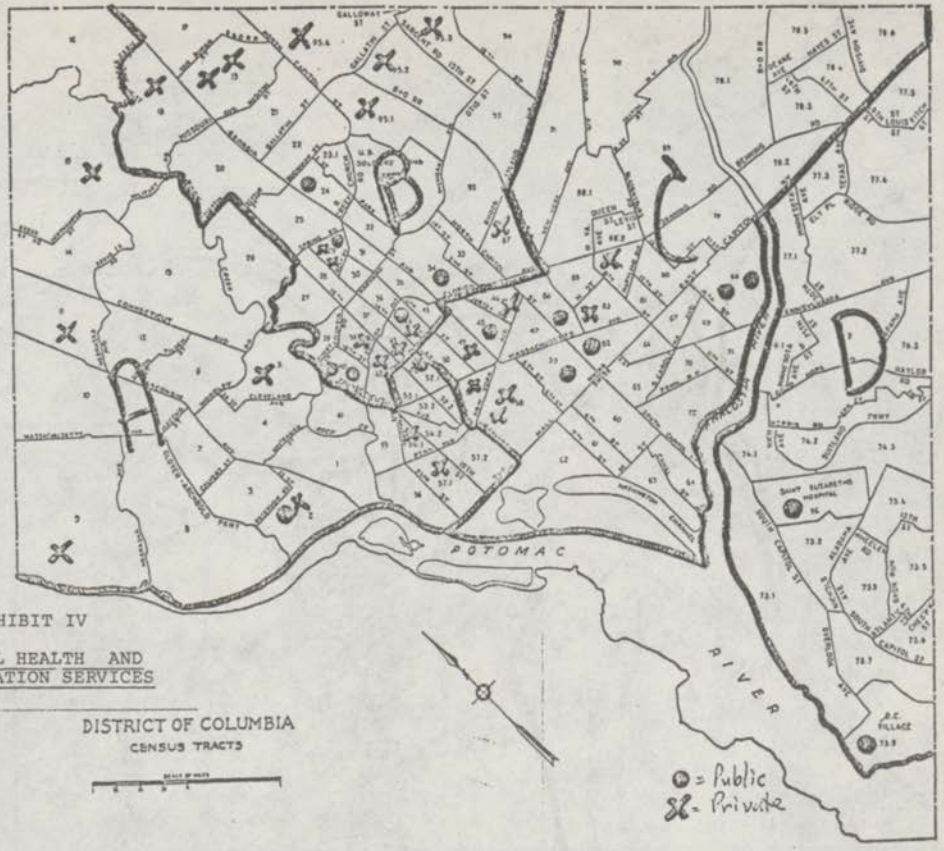


EXHIBIT IV

MENTAL HEALTH AND
RETARDATION SERVICES

DISTRICT OF COLUMBIA
CENSUS TRACTS

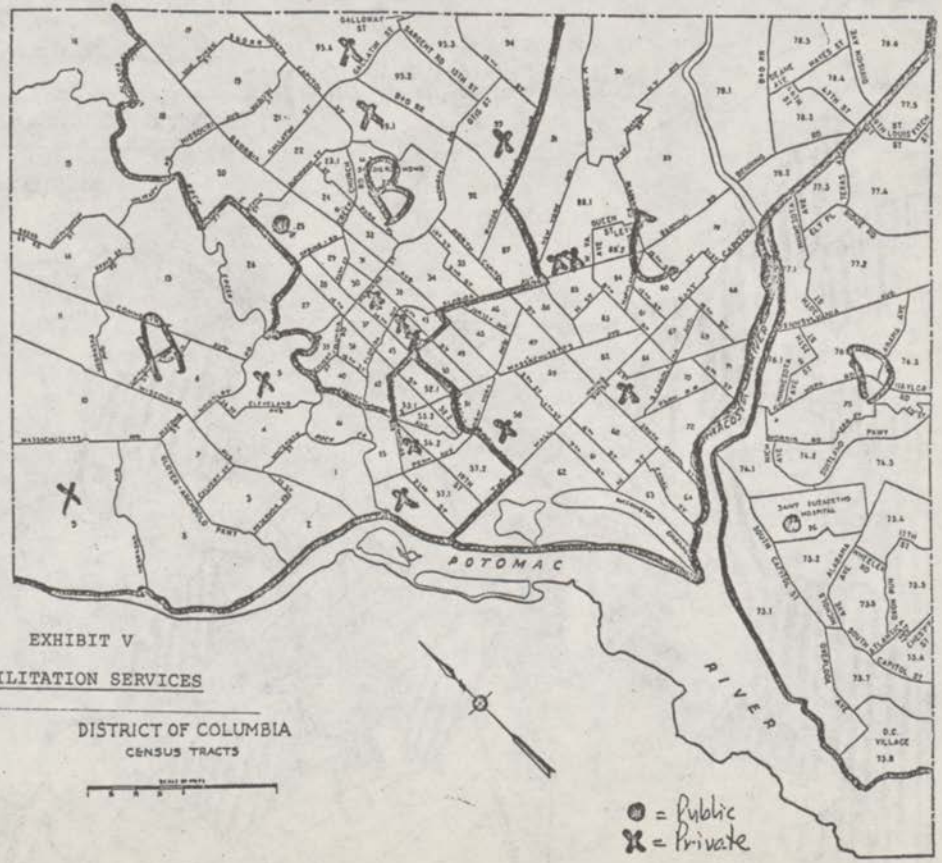


EXHIBIT V

REHABILITATION SERVICES

DISTRICT OF COLUMBIA

CENSUS TRACTS

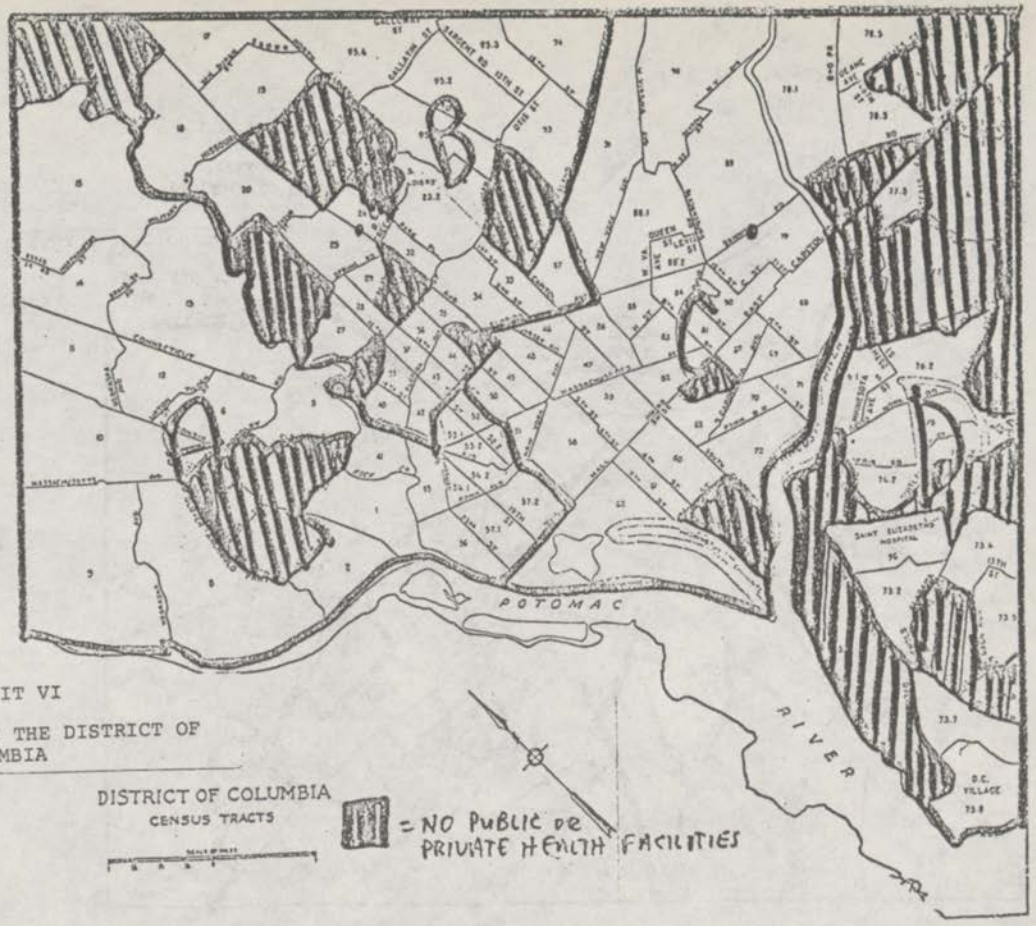


EXHIBIT VI

HEALTH AREAS OF THE DISTRICT OF COLUMBIA

EXHIBIT VII: PHYSICIAN DISTRIBUTION

	% OF D.C. POPULATION	% OF 500 RANDOMLY-SELECTED PHYSICIANS
NORTHWEST	47%	88%
NORTHEAST	26%	6%
SOUTHWEST	2%	2%
SOUTHEAST	25%	4%
AREA A	18%	70%
AREA B	32%	19%
AREA C	32%	7%
AREA D	18%	4%

EXHIBIT VIII: MORBIDITY AND MORTALITY DATA

Table 1

Infant mortality rates per thousand live births for Washington D.C., the United States, the average of the 11 other cities of similar size, D.C. rank among these cities, and D.C. rank among states.

Year	D.C.	Average of other cities	U.S.	D.C. city rank (of 12)	D.C. state rank (of 51)
1960	35.8	27.0	26.0	highest rate	2nd highest rate
1961	35.2	27.4	25.3	highest rate	2nd highest rate
1962	34.9	27.2	25.3	highest rate	2nd highest rate
1963	33.0	26.8	25.2	highest rate	2nd highest rate
1964	34.0	27.0	24.8	highest rate	2nd highest rate
1965	32.0	27.0	24.7	highest rate	3rd highest rate
1966	34.5	26.8	23.7	highest rate	2nd highest rate
1967	30.3	24.6	22.4	2nd highest rate	----------
1960-1967 change					
	- 15.6%*	- 8.9%	- 14.0%		

* a minus sign indicates a decrease in the rate
a plus sign indicates an increase in the rate

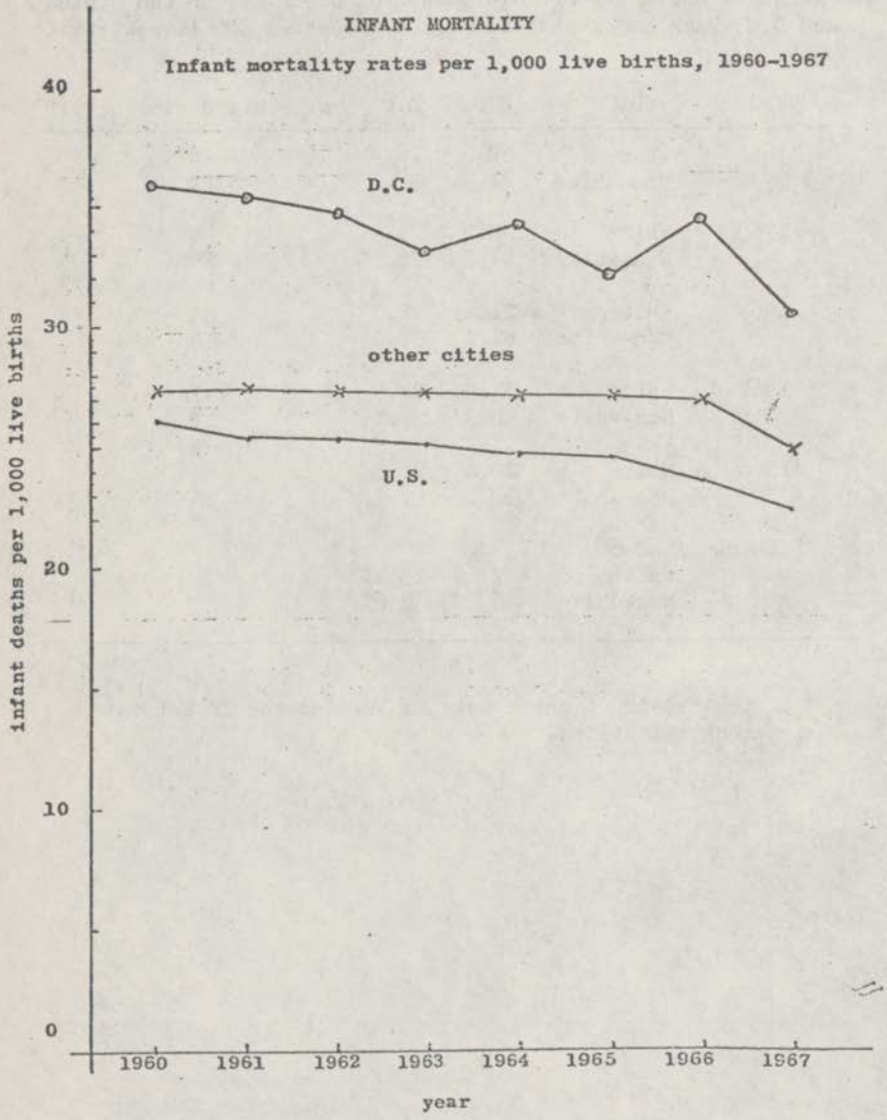
Table 2

Infant mortality by color, Washington, D.C., United States, and D.C. rank among states. Rates are per 1,000 live births.

YEAR	COLOR	U.S.	D.C.	D.C. state rank of 51*
1962	White	22.3	26.4	48
	Non-white	41.4	38.3	21
1963	White	22.2	25.4	44
	Non-white	41.5	36.1	15
1964	White	21.6	22.6	33
	Non-white	41.1	38.0	16
1965	White	21.5	24.5	47
	Non-white	40.3	34.1	17
1966	White	20.6	22.9	44
	Non-white	38.8	37.3	26
% Change 1962-66				
	White	- 7.6%	-13.2%	
	Non-white	- 6.3%	- 2.6%	

* 51 implies the highest rate, 1 implies the lowest rate among all states.

Figure 1


INFANT MORTALITY
Infant mortality rates per 1,000 live births, 1960-1967
40
30
20
10
0
infant deaths per 1,000 live births
D.C.
other cities
U.S.
1960
1961
1962
1963
1964
1965
1966
1967
year

INFANT MORTALITY Figure 2

D.C. infant mortality per 1,000 live births, versus Quintile number (increasing poverty); average of fiscal years 1966 and 1967.

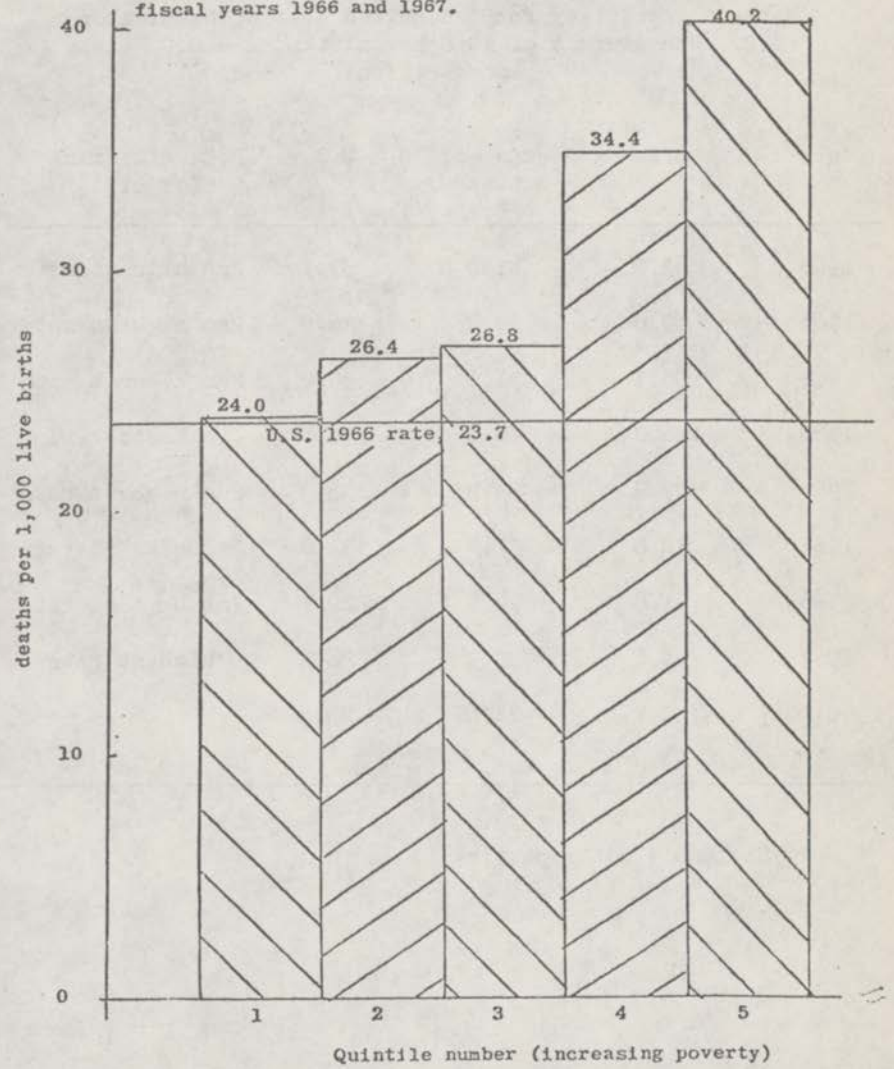


Table 3

Maternal mortality for the United States, Washington, D.C., the average of 10 other cities, and D.C. rank among cities.

Year	D.C.	Average of 10 cities*	U.S.	D.C. city rank (of 11)
1960	82.1	41.0	37.1	2nd highest rate
1961	89.0	50.0	36.9	2nd highest rate
1962	85.5	51.0	35.2	2nd highest rate
1963	106.0	44.0	35.8	highest rate
1964	99.9	33.2	33.3	2nd highest rate
1965	58.8	37.4	31.6	3rd highest rate
1966	91.8	44.5	29.1	2nd highest rate
1967	95.0	30.9	28.3	highest rate
1960-1967	+15.7%	-24.6%	-23.8%	

* St. Louis not reporting

Figure 3

MATERNAL MORTALITY PER 100,000 LIVE BIRTHS FOR
D.C.; OTHER CITIES; AND THE U.S. 1960-1967

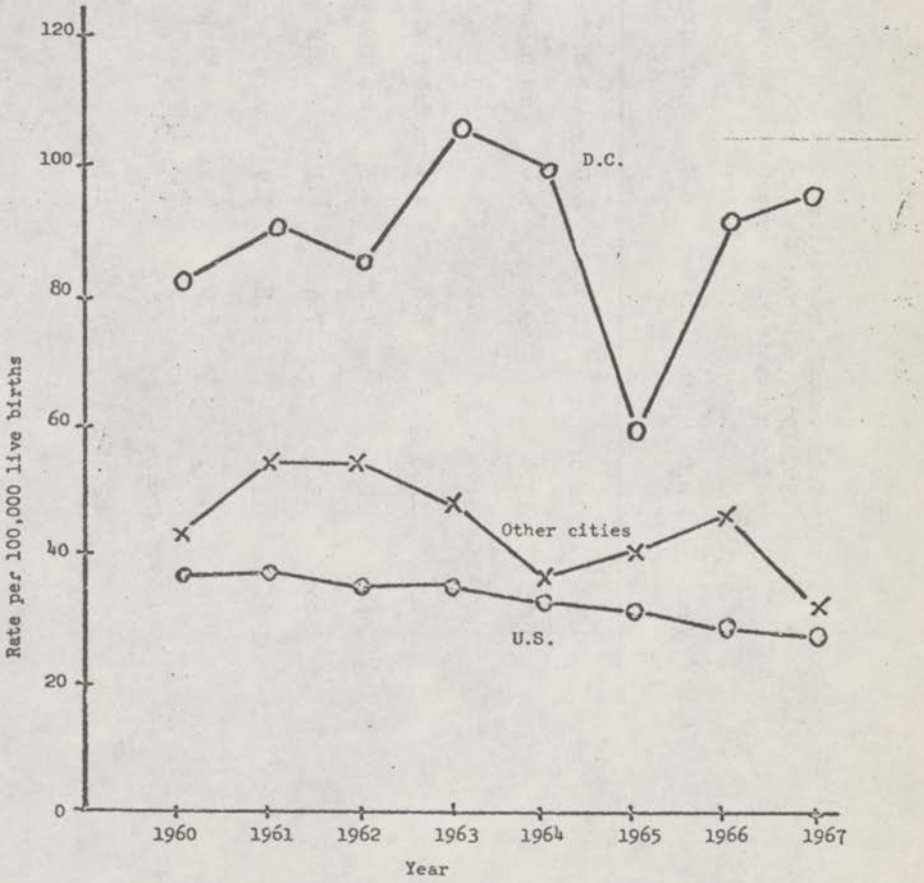


Table 4

Tuberculosis mortality rates per 100,000 population 1960-1967, for the District of Columbia, eleven cities of comparable size (see text), and the United States

Year	D.C.	Other Cities	U.S.	D.C. city rank (of 12)	D.C. state rank (of 51)
1960	13.5	10.5	6.0	4th highest rate	highest rate
1961	13.4	9.4	5.4	3rd highest rate	highest rate
1962	11.9	8.8	5.1	3rd highest rate	highest rate
1963	12.3	8.8	4.9	2nd highest rate	highest rate
1964	12.0	7.7	4.3	3rd highest rate	highest rate
1965	12.7	7.6	4.1	highest	highest rate
1966	11.5	6.8	3.9	tied for highest	highest rate
1967	10.5	6.5	3.5	3rd highest rate	--------
1960-1967 change					
	-22.5%	-38.1%	-41.7%		

Figure 4

TUBERCULOSIS

Tuberculosis mortality rates per 100,000 population, 1960-1967

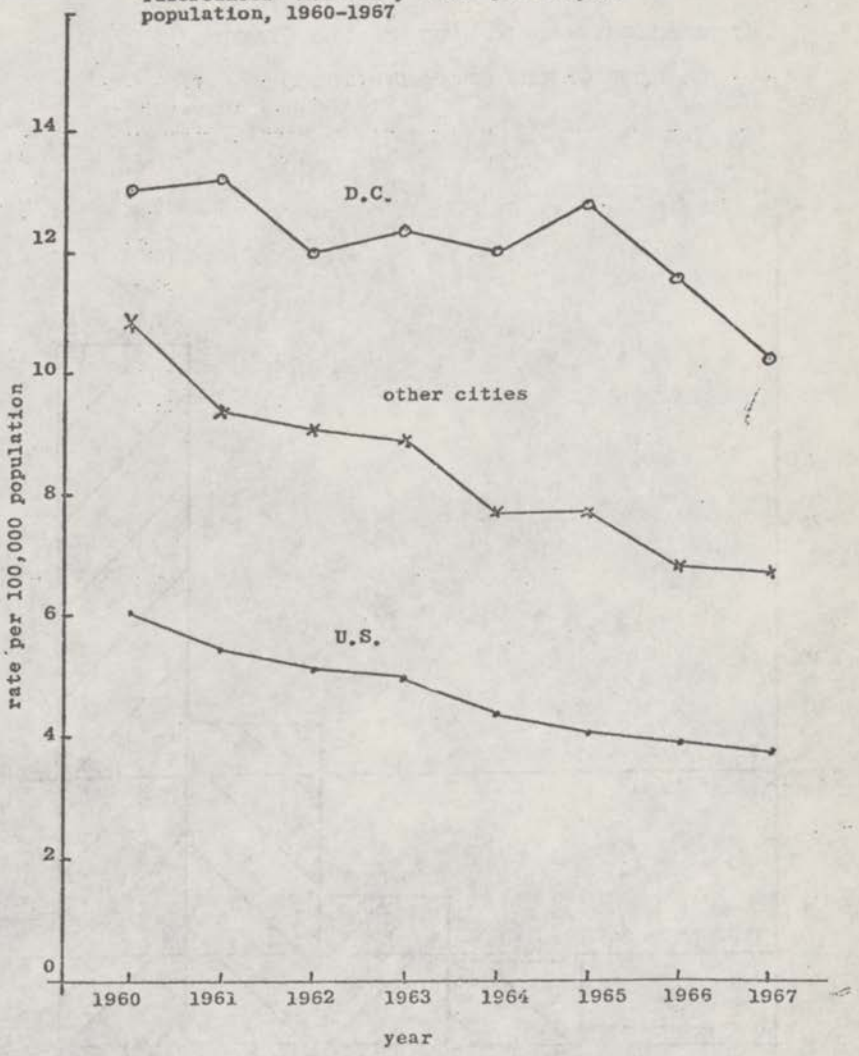


Figure 5

1967 TUBERCULOSIS MORTALITY RATES PER 100,000 PERSONS

VS. INCOME QUINTILE (INCREASING POVERTY)

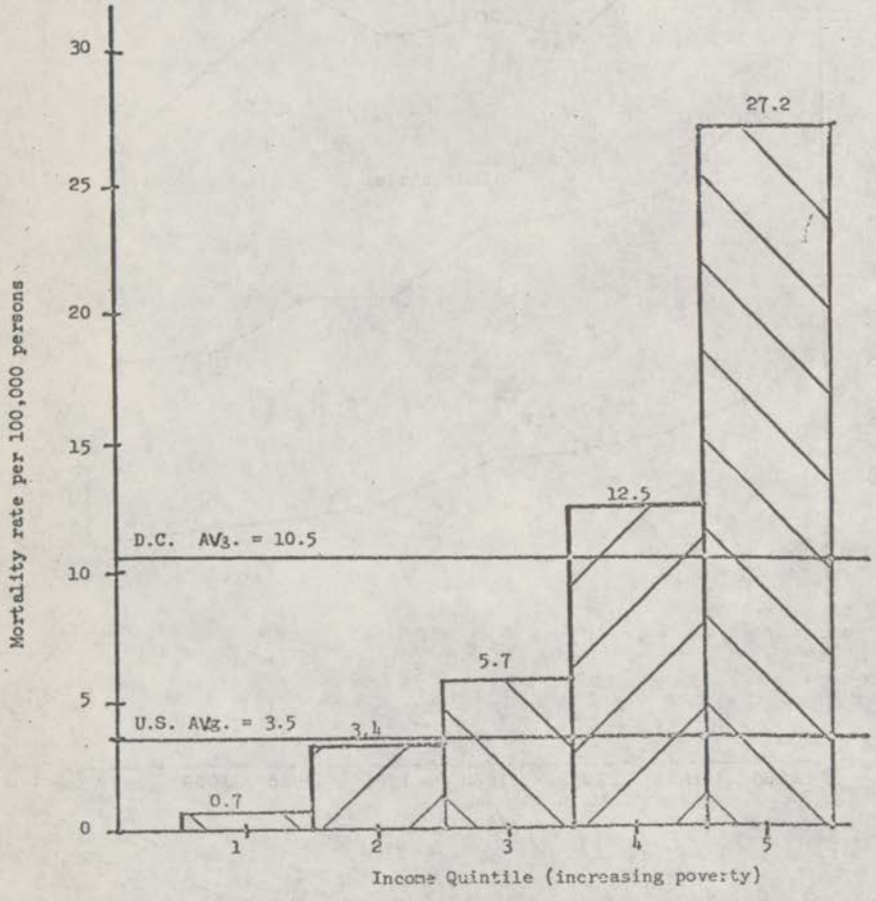


EXHIBIT IX: MAIN RECOMMENDATIONS MADE BY THE MAYOR'S TASK FORCE OF 1970

1) Decentralize operations of the Health Department, so that the administrators of D. C. General, Glendale, the comprehensive community mental health centers, and neighborhood health centers each have complete autonomy for budget, personnel allocation, repairs, management, etc.

2) Negotiate with existing organizations (Group Health, Medical Schools, private medical groups) to provide pre-paid comprehensive health care on a fixed fee basis to panels of consumers in various areas of the city.

3) Create an efficient mechanism for medicare medicaid payments. Such funds should be made available to the operating budgets of facilities giving care (D. C. General, etc.).

4) Call for the immediate establishment of a Washington, D. C. Health Manpower Council to set up programs for health manpower development and specifically institute a manpower training center on the St. Elizabeth site.

5) Speed up the construction of neighborhood health centers (currently part of the TRI-Level system; proposed as the new Ambulatory Health Center). Techniques for flexible designs be made a prime criteria for construction.

6) Reorganization of Health Department statistical analysis to give output data and evaluation of health services as well as the existing health and disease indices.

7) Medical societies and health department jointly sponsor a Home-Care Emergency Service for D. C., with a 15-minute response time by radio dispatched car. Returned medical corpsmen can be trained, and made directly responsible to supervising MD to run this service. Funds should be applied for immediately from Health, Education and Welfare (HEW) and Department of Transportation.

8) Day care centers be opened at all facilities, for staff and patients so that maximum participation of manpower and facilities can be achieved. The new HEW emphasis on child care facilities can lead to potential funding.

9) Contact with U. S. Civil Service Commission to use the force of the large medical insurance plans to institute experimental total insurance programs for full health care (see recommendations of McNerney Task Force on Medicaid and Related Programs November 1969).

10) Creation of a committee of citizens, professionals, and the media to recommend how to increase the level of knowledge about health in all its complexity in the District. We assume that the more knowledge available, the more competent the decisions about health can be.

11) create citywide broad planning authority for health to expand and supercede the current Planning Council (314-A agency).

12) plan for budgetary analysis -- leading to a reallocation of currently available funds and requests for new funding.

13) the establishment of a "watch dog" group to monitor the Health Department.

This Subcommittee would like to see this group constantly pushing for reform and modernization of the Health Department, whether in the area of budget, personnel, buildings, community relations, procedures, or whatever.

The watch dog group should have direct access to the Mayor's office and should establish and maintain a meaningful liaison with Capital Hill.

14) that facilities be placed at convenient and strategic locations designed to serve people within a geographical area. It should be of the comprehensive type - offering the whole array of medical services, serving all age groups.

15) that there be some kind of a central filing system; this system would contain records of families and individual members contact with any health or welfare agency.

16) that a referral and follow-through system be established so that residents will not be shuttled back and forth needlessly.

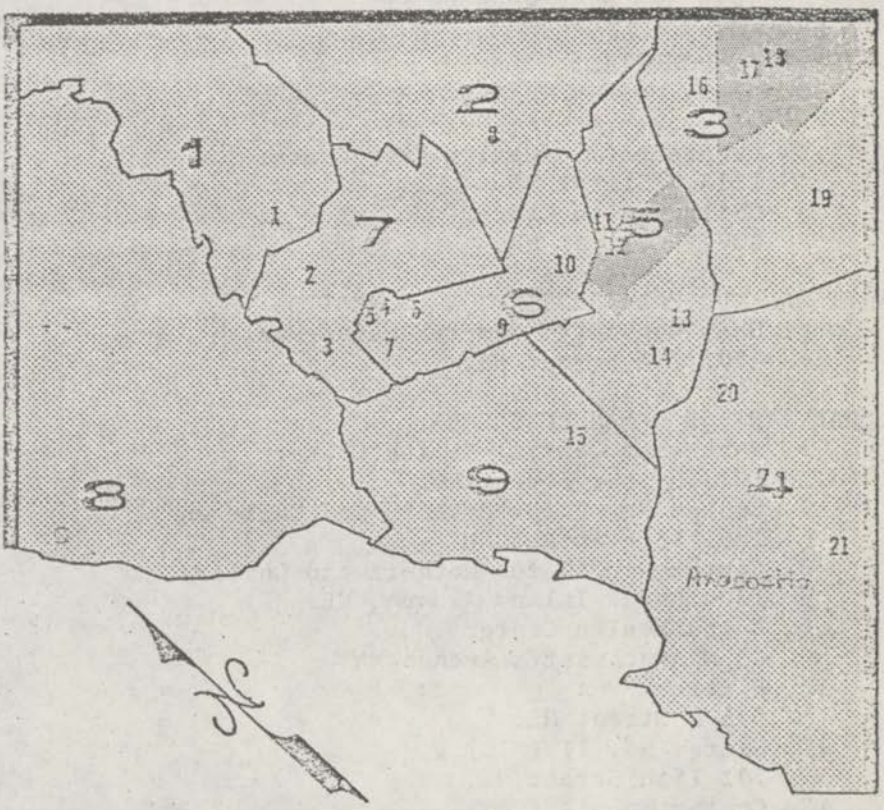
17) that all health and health related agencies, private and public, have better and closer working relationships so that service and programs of different specializations can complement and supplement each other.

18) that transportation be provided for elderly blind, lame and mothers having to take young children to clinics.

19) that appointments for clinics be made over the telephone, instead of persons having to come in.

EXHIBIT X
1973

LOCATION OF OUTPATIENT HEALTH CENTERS IN THE DISTRICT OF COLUMBIA



LARGE NUMBERS REFER TO D.C. SERVICE AREAS
SMALL NUMBERS REFER TO LOCATION OF OUTPATIENT HEALTH CENTERS

OUTPATIENT HEALTH CENTERS

IN THE DISTRICT OF COLUMBIA (note a)

COMMUNITY GROUP HEALTH FOUNDATION, INC.:

2. Community Group Health Foundation Center
   14th and Park Road NW.

CHILDREN'S HOSPITAL:

3. Adams Morgan Health Center
   2320 17th Street NW.
4. Comprehensive Health Care Center
   1116 W Street NW.
5. Child Health Center
   1307 W Street NW.

NATIONAL MEDICAL ASSOCIATION FOUNDATION:

6. Shaw Community Comprehensive Health Center
   1701 7th Street NW.

DEPARTMENT OF HUMAN RESOURCES:

1. Northwest Central Health Center
   1325 Upshur Street NW.
7. Center No. 2 for Mothers and Children
   1801 14th Street NW.
8. Center No. 10 for Mothers and Children
   1300 Rhode Island Avenue, NE.
9. Gales Health Center
   65 Massachusetts Avenue NW.
10. H Street
    635 H Street NE.
11. Center No. 17 (MIC)
    702 15th Street NE.
12. Center No. 17 (C&Y)
    702 15th Street NE. (target area shaded)
13. Potomac Gardens
    1227 G Street SE.
14. Authur Capper
    1011 7th Street SE.
15. Southwest
    850 Delaware Avenue SW.
16. Parkside
    701 Kenilworth Terrace NE.

17. Center No. 18 (MIC)
    4130 Hunt Place NE.
18. Center No. 18 (C&Y)
    4130 Hunt Place NE. (target area shaded)
19. Center No. 16
    330 Ridge Road SE.
20. Anacostia
    Between 13th and 14th on W Street SE.
21. Congress Heights
    8th and Xenia Streets SE.

[a]Numbers are keyed to exhibit map.

1973 GAO-Statement on Utilization of Outpatient Health Centers in the District of Columbia.

UNDERUSE OF OUTPATIENT HEALTH SERVICES

Outpatient health center operators have periodically accumulated statistics on the number of patient visits and the number of available physician hours by medical specialty for each of their health centers, but no one organization has analyzed this information District-wide. As a result, no one organization had data on the use of the individual medical services for all health centers or on whether the use was above or below average compared with published data on the average use of these types of services.

Each center gave us information on the number of patient visits and the number of full-time equivalent physicians by medical specialty for all or a part of the period April 1, 1971, to March 31, 1972. We computed, for each of the medical specialties, the daily average number of patient visits and the number of full-time equivalent physicians available each day for each center and divided the number of patient visits by the number of equivalent physicians to arrive at a daily usage rate. Health center officials agreed with this approach for calculating usage rates.

Our analysis showed wide variances among the centers in the average number of daily patient visits per physician. When comparing American Medical Association (AMA) published data and American Dental Association (ADA) survey data on the average number of patient visits an hour that each physician should be able to handle with health center data, our analysis showed that the use of health center services was generally below average. We used the AMA and ADA data on physicians in an office practice because standards had not been established specifically for outpatient health centers.

Two of the principal factors contributing to the below-average usage rates experienced by several of the centers were (1) the location of many centers in the same general area of the District which centers, in total, provided more health care capability than the residents were actively seeking and (2) an inequitable distribution of physicians by medical specialty among the centers in relationship to the age and sex of the population being served.

Our examination of the use of health services provided in two poverty areas showed that the usage rates for the many Cardozo-Shaw health centers were less than the average rates for such services,and that the rates for the few Anacostia centers were generally higher than those for the Cardozo-Shaw centers.

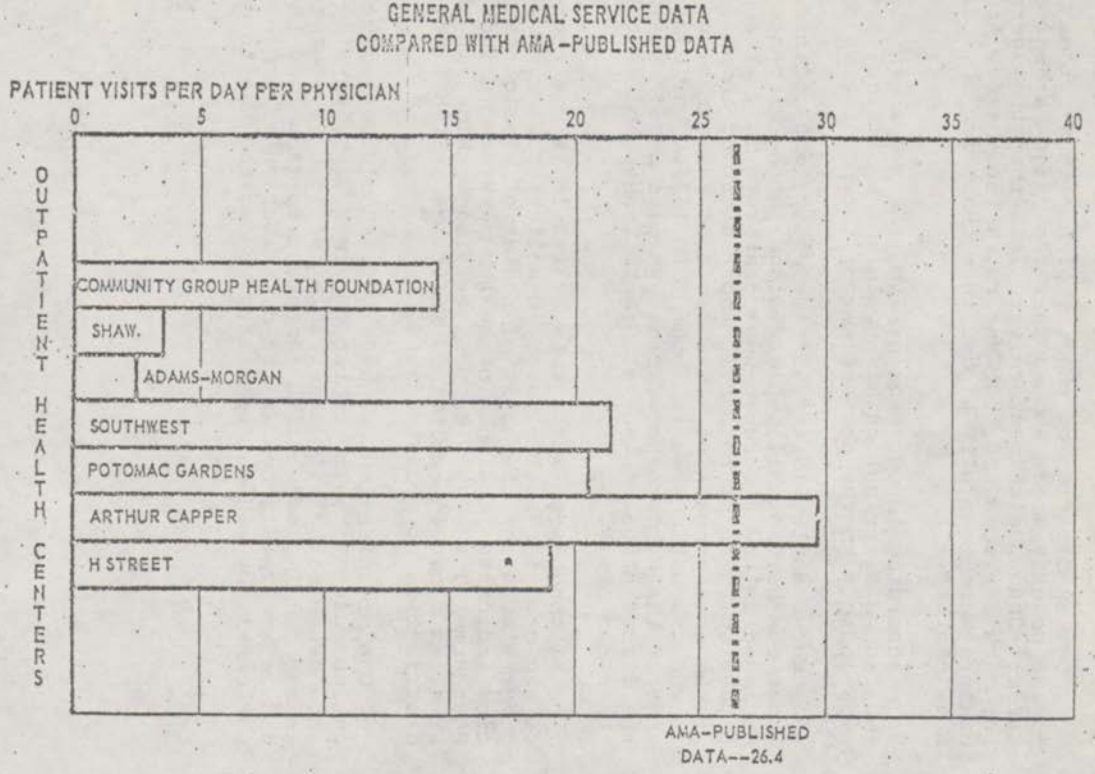
According to our examination, the two areas also had imbalanced distribution of physicians by medical specialty in relationship to the age and sex of the population being served.

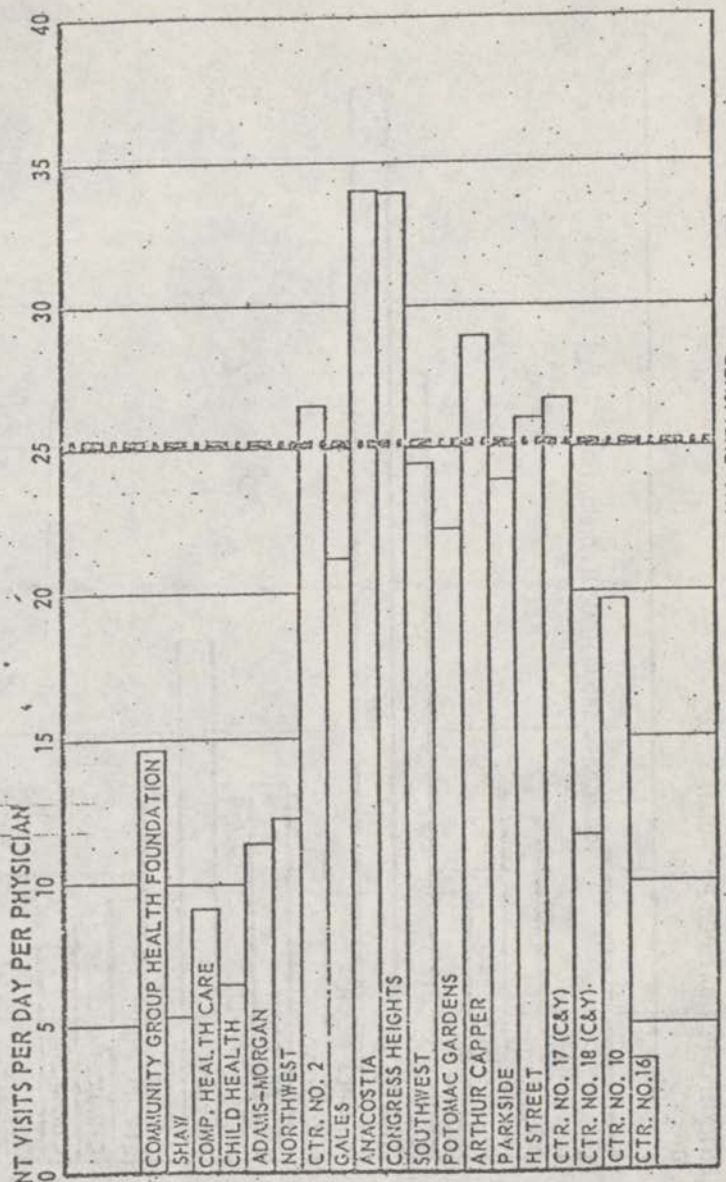
For example, 15.4 full-time equivalent pediatricians, or about one-half of all pediatricians in the 21 centers, were employed in the 8 Cardozo-Shaw centers. This area has about 33,000 children up to age 12 representating about 32 percent of the area population. The ratio of pediatricians to children in the Anacostia area is about 1 to 16,600, or almost 8 times that of the Cardozo-Shaw area. We also noted imbalances in the distribution of general practitioners and dentists between these two areas.

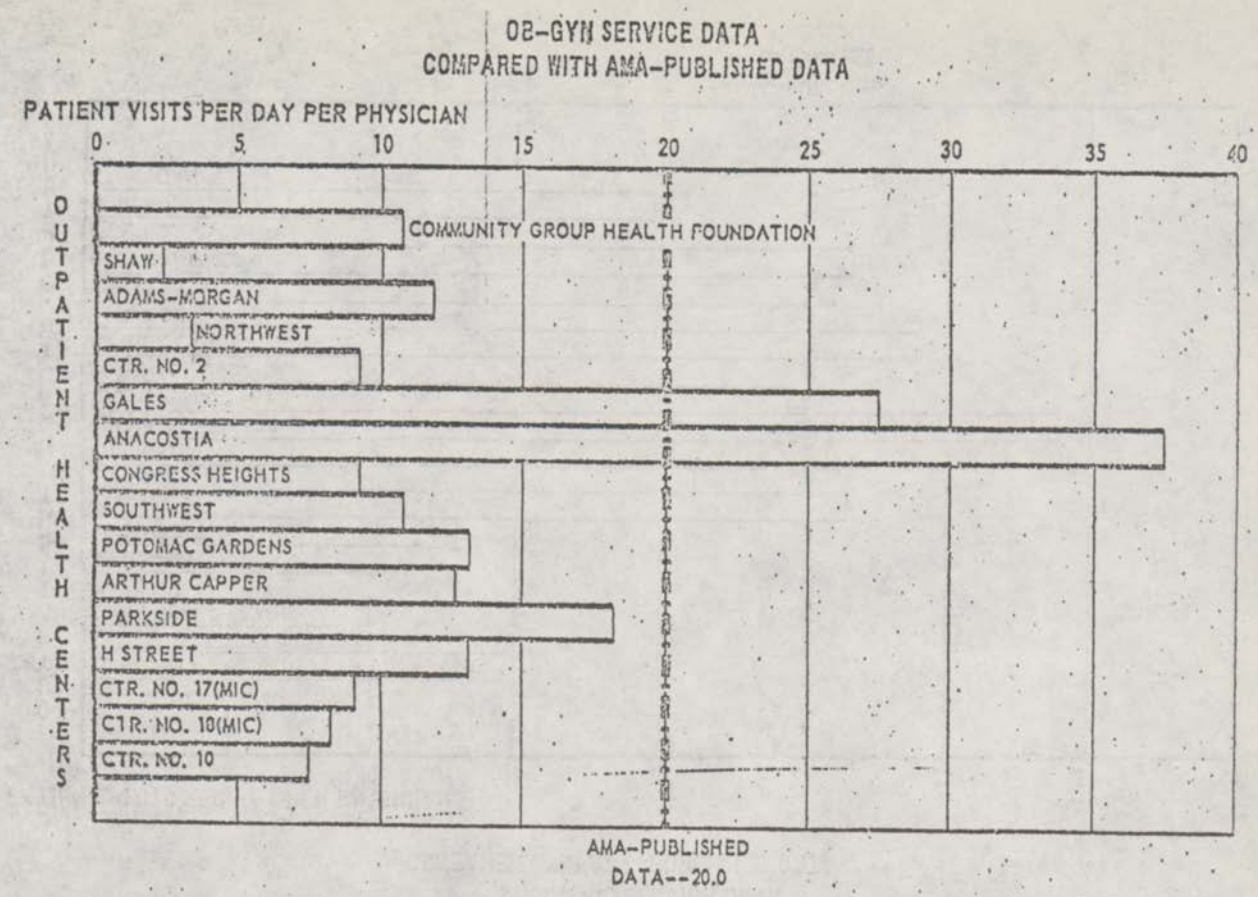
Although population data by itself is not representative of the need for health care, we believe that a comparison of poverty areas on the basis of number of physicians and population indicates imbalance of health services in those areas. Furthermore, the heavier pediatrician workload in the Anacostia area, as shown in exhibit C, indicates an imbalance in the distribution of pediatricians.

One organization, such as DHR, should periodically review patient use of health center services District-wide and compare usage rates with acceptable levels of performance to assess and improve health center performance and to identify and adjust imbalances in the distribution of professional personnel, by medical specialty, among the health centers.

EXHIBIT XI: UTILIZATION PATTERNS OF COMPREHENSIVE FACILITIES (1973)




PEDIATRIC SERVICE DATA
COMPARED WITH AMA-PUBLISHED DATA
PATIENT VISITS PER DAY PER PHYSICIAN
0
5
10
15
20
25
30
35
40
OUTPATIENT HEALTH CENTERS
COMMUNITY GROUP HEALTH FOUNDATION
SHAW
COMP. HEALTH CARE
CHILD HEALTH
ADAMS-MORGAN
NORTHWEST
CTR. NO. 2
GALES
ANACOSTIA
CONGRESS HEIGHTS
SOUTHWEST
POTOMAC GARDENS
ARTHUR CAPPER
PARKSIDE
H STREET
CTR. NO. 17 (C&Y)
CTR. NO. 18 (C&Y)
CTR. NO. 10
CTR. NO. 16
AMA-PUBLISHED DATA--25.6


OB-GYN SERVICE DATA
COMPARED WITH AMA-PUBLISHED DATA
PATIENT VISITS PER DAY PER PHYSICIAN
0
5
10
15
20
25
30
35
40
OUTPATIENT HEALTH CENTERS
COMMUNITY GROUP HEALTH FOUNDATION
SHAW
ADAMS-MORGAN
NORTHWEST
CTR. NO. 2
GALES
ANACOSTIA
CONGRESS HEIGHTS
SOUTHWEST
POTOMAC GARDENS
ARTHUR CAPPER
PARKSIDE
H STREET
CTR. NO. 17(MIC)
CTR. NO. 10(MIC)
CTR. NO. 10
AMA-PUBLISHED
DATA--20.0

DENTAL SERVICE DATA
COMPARED WITH ADA SURVEY DATA

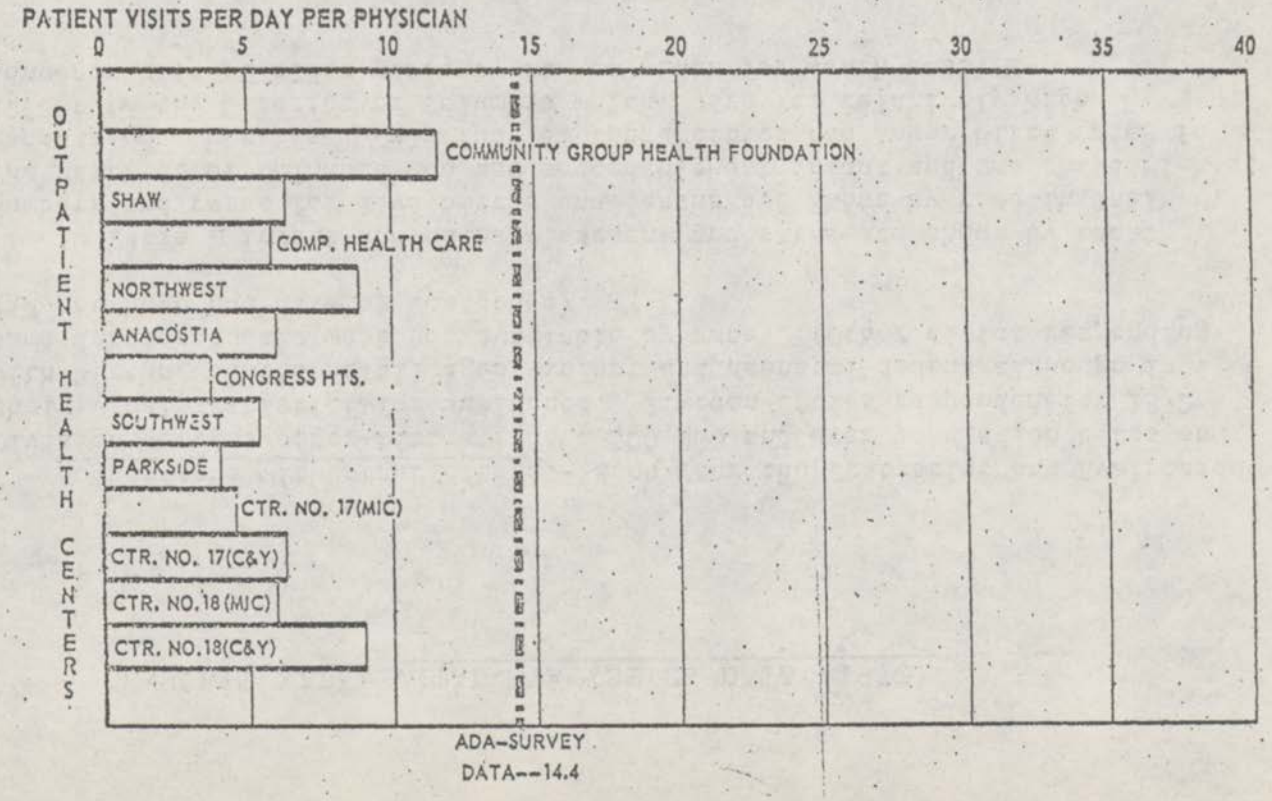


EXHIBIT XII: VITAL STATISTICS DATA (1972)

Comparisons with other cities.--Each year the Statistics and Evaluation Division queries other cities in the 500,000 and over population class on their vital statistics for residents. Sixteen cities responded for 1972 with births, deaths at all ages, infant and neonatal deaths although in some instances data were not available by race. (Other cities responding did not have the data by residence).

In Table L infant and neonatal deaths and rates are shown by race. Numbers and rates for live births and deaths are shown by race in Table M. The District of Columbia had the second highest infant and the third highest neonatal death rates. Only four of these cities had lower birth rates in 1972 than the District of Columbia which, with its relatively high concentration of older persons, ranked ninth for death rate.

Table L.--INFANT DEATHS AND NEONATAL DEATHS BY RACE, BY NUMBER, RATE AND RANK: CITIES OVER 500,000 POPULATION, 1972 (BY PLACE OF RESIDENCE)

City	Infant Deaths[1]									Neonatal Deaths[1]								
	Total			White			Negro			Total			White			Negro		
	Number	Rate	Rank	Number	Rate	Rank	Number	Rate	Rank	Number	Rate	Rank	Number	Rate	Rank	Number	Rate	Rank
Baltimore, Md.	263	19.8	10	65	12.5	14	198	24.6	10	181	13.6	13	50	9.6	13	131	16.3	10
Chicago, Ill.	1,541	25.6	5	530	18.0	3	1,011	33.0	2	1,107	18.4	4	405	13.8	3	702	22.9	3
Cleveland, Ohio	328	26.1	4	140	21.4	1	188	31.2	5	230	18.3	5	100	15.3	2	130	21.6	5
Columbus, Ohio	173	18.1	13	115	16.1	9	58	23.3	11	109	11.4	16	74	10.4	12	35	14.4	13
Dallas, Texas	340	22.0	7	NA	NA	NA	NA	NA	NA	215	13.9	12	NA	NA	NA	NA	NA	NA
Detroit, Mich.	741	27.4	1	178	17.9	4	563	32.9	3	540	20.0	2	126	12.7	8	414	24.2	2
Houston, Texas	517	12.0	17	NA	NA	NA	NA	NA	NA	384	14.8	9	NA	NA	NA	NA	NA	NA
Indianapolis, Ind.	247	18.6	12	174	17.4	7	73	22.5	12	185	14.0	11	134	13.4	5	51	15.7	12
Jacksonville, Fla.	174	17.5	14	111	15.9	10	63	21.3	13	128	12.9	14	81	11.6	9	47	15.9	11
Kansas City, Mo.	170	20.8	9	95	17.4	7	75	27.5	9	124	15.2	8	70	12.8	7	54	19.8	9
Philadelphia, Pa.	595	21.3	8	219	14.5	11	376	29.2	6	432	15.4	7	171	11.3	10	261	20.3	7
Phoenix, Ariz.	180	15.7	15	146	14.3	12	34	28.3	7	133	11.6	15	107	10.5	11	26	21.6	5
Pittsburgh, Pa.	133	23.0	6	66	17.5	6	67	33.1	1	96	16.6	6	52	13.8	3	44	21.8	4
St. Louis, Mo.	267	26.2	3	71	17.7	5	196	31.6	4	213	20.9	1	52	13.0	6	161	26.0	1
San Antonio, Texas	300	19.8	10	NA	NA	NA	NA	NA	NA	218	14.4	10	NA	NA	NA	NA	NA	NA
Seattle, Wash.	81	14.7	16	56	13.5	13	25	18.1	14	53	9.6	17	NA	NA	NA	NA	NA	NA
Washington, D. C.	323	27.2	2	27	19.7	2	296	28.1	8	235	19.8	3	22	16.1	1	213	20.3	7

[1]Rates per 1,000 live births.

Table M.--NUMBER, RATES AND RANK ORDER OF LIVE BIRTHS AND DEATHS BY RACE: CITIES OVER 500,000 POPULATION, 1972
(BY PLACE OF RESIDENCE, RATES PER 1,000 POPULATION)

City	Live Births									Deaths								
	Total			White			Negro			Total			White			Negro		
	Number	Rate	Rank	Number	Rate	Rank	Number	Rate	Rank	Number	Rate	Rank	Number	Rate	Rank	Number	Rate	Rank
Baltimore, Md.	13,265	15.1	14	5,220	11.7	8	8,045	18.5	11	11,081	12.6	3	6,771	15.2	4	4,310	9.9	5
Chicago, Ill.	60,082	17.8	5	29,411	13.4	6	30,671	25.9	2	39,449	11.7	7	28,460	13.0	6	10,989	9.3	9
Cleveland, Ohio	12,564	16.7	10	6,535	14.3	4	6,029	20.6	9	9,001	12.0	6	6,002	13.1	5	2,999	10.2	3
Columbus, Ohio	9,564	17.7	7	7,130	16.3	2	2,434	23.8	6	4,914	9.1	11	3,917	9.0	9	997	9.7	6
Dallas, Texas	15,442	17.5	8	NA	NA	NA	NA	NA	NA	7,367	8.4	14	NA	NA	NA	NA	NA	NA
Detroit, Mich.	27,050	18.7	3	9,945	13.3	7	17,105	24.4	3	18,045	12.4	4	1,426	15.3	3	6,619	9.4	8
Houston, Texas	25,890	19.2	2	NA	NA	NA	NA	NA	NA	9,737	7.2	17	NA	NA	NA	NA	NA	NA
Indianapolis, Ind.	13,259	17.8	5	10,012	NA	NA	3,247	NA	NA	6,561	8.8	13	NA	NA	NA	NA	NA	NA
Jacksonville, Fla.	9,950	18.3	4	6,987	16.5	1	2,963	24.3	5	4,913	9.0	12	3,475	8.2	10	1,438	11.8	1
Kansas City, Mo.	8,181	16.3	12	5,450	14.1	5	2,731	23.6	7	5,418	10.8	10	4,260	11.0	8	1,158	10.0	4
Philadelphia, Pa.	27,965	14.5	15	15,089	NA	NA	12,876	NA	NA	23,886	12.4	4	16,480	NA	NA	7,406	NA	NA
Phoenix, Ariz.	11,430	17.0	9	10,227	16.3	2	1,203	26.6	1	5,155	7.6	16	4,816	7.7	11	339	7.5	11
Pittsburgh, Pa.	5,792	11.4	16	3,770	NA	NA	2,022	NA	NA	6,845	13.5	2	5,584	NA	NA	1,261	NA	NA
St. Louis, Mo.	10,210	16.4	11	4,009	11.0	9	6,201	24.4	3	8,832	14.2	1	6,035	16.5	1	2,797	11.0	2
San Antonio, Texas	15,117	22.0	1	NA	NA	NA	NA	NA	NA	5,609	8.1	15	NA	NA	NA	NA	NA	NA
Seattle, Wash.	5,522	10.7	17	4,144	9.2	10	1,378	21.2	8	6,041	11.7	7	5,529	12.3	7	512	7.9	10
Washington, D.C.	11,886	15.8	13	1,368	7.3	11	10,518	18.6	10	8,313	11.0	9	2,894	15.4	2	5,419	9.8	7

Figure 2 - Live Births and Deaths - District of Columbia Residents, 1940 - 1972

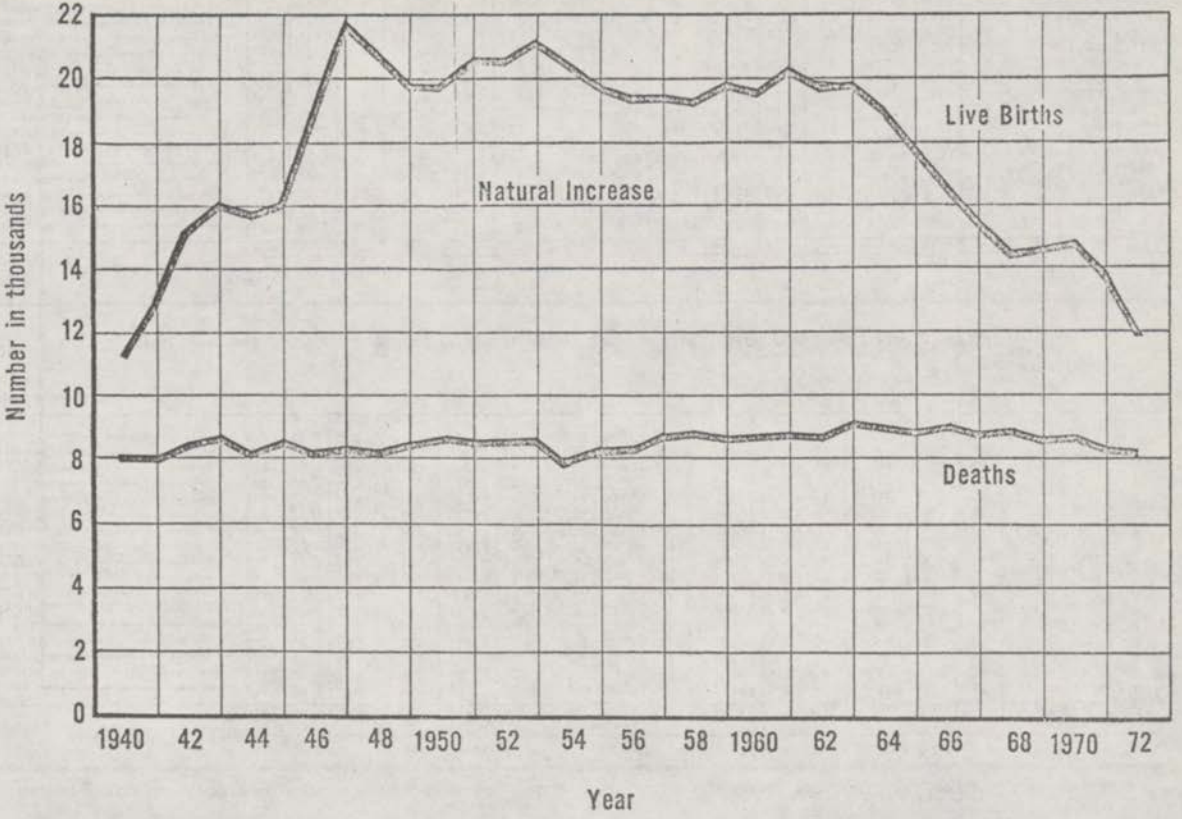


Figure 3, Leading Causes of Death : District of Columbia 1952, 1962, and 1972

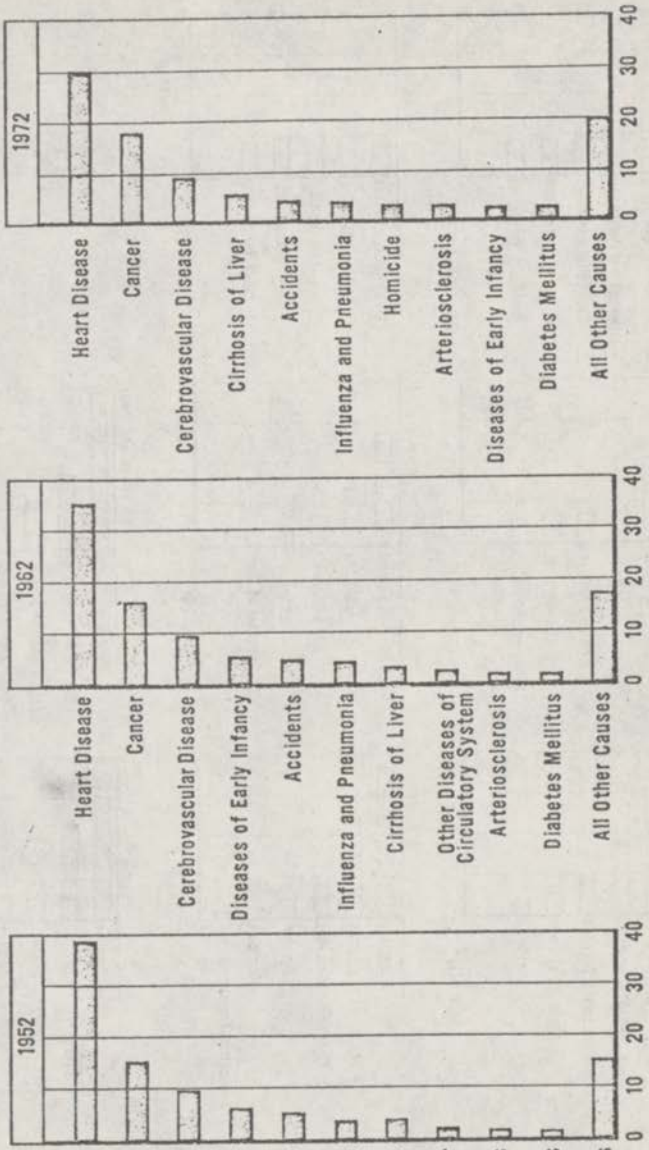
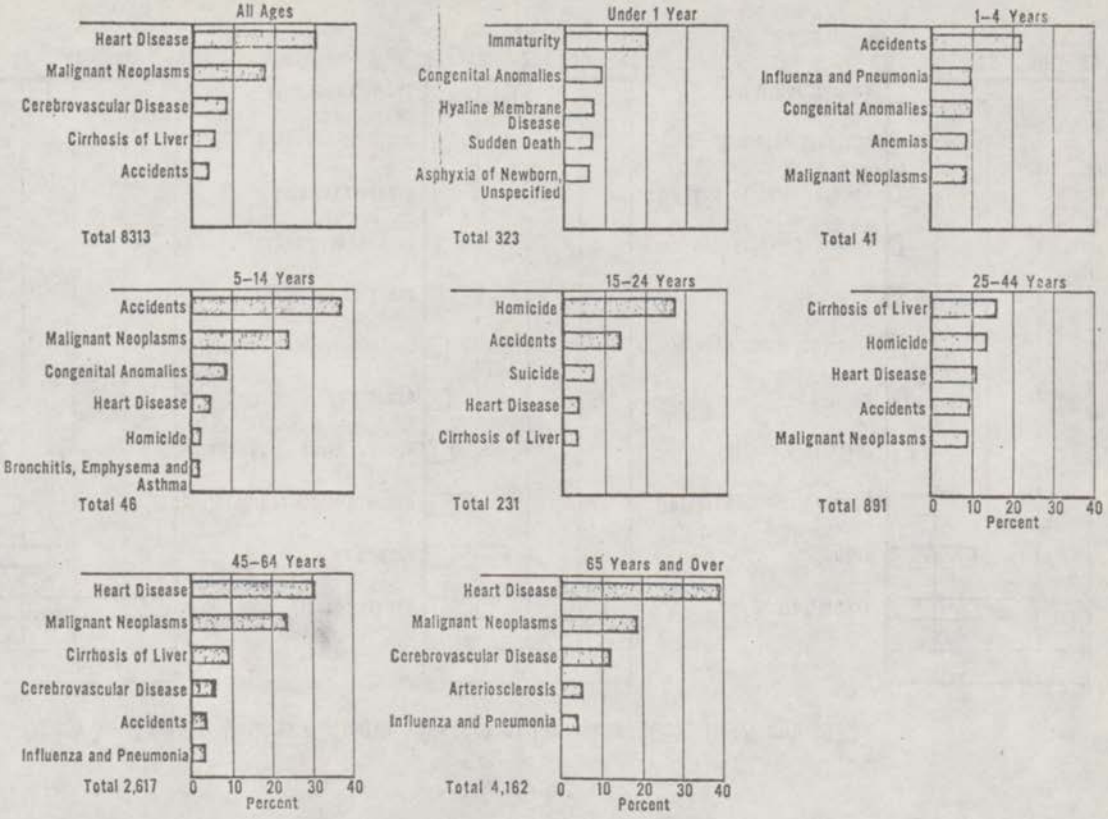


Figure 4 Leading Causes of Death in Selected Age Groups; District of Columbia, 1972



Proposal: To Plan, Develop and Offer Adequate Quality Health Services to the Less Advantaged of the District of Columbia.

Primary Responsible Parties:

1. The Government of the District of Columbia.
2. The Citizens of the District of Columbia.
3. The Medical Schools of the District of Columbia.
4. The Health Maintenance Organizations of the District of Columbia.

Objective Overseer of the Project:

The Congress of the United States (more specifically the House and Senate District Committee's).

Comment: It is imperative that the Congress serve in this role as the "Objective Overseer", for only it has the influence and leverage to encourage purposeful dialogue and reasonable cooperation between the public and private health sectors. Both the District government and certain elements of the private sector of the District of Columbia have significant indebtedness to the tax-payer (Congress) and should be held accountable for using their expertise and resources to enhance the health of the most needy in the community. The proposed role as an "Objective Overseer" would be appropriate and consistent with the District Committee's mandated responsibility to assure fiscal and social integrity of the District of Columbia.

Specific Proposal:

A District of Columbia Health Planning and Development Commission would be appointed by Congress to produce and implement a plan within four years which would reflect a well integrated public health delivery system that is jointly sponsored by the District Government, the three District of Columbia University Medical Centers and other select components of the local private health sector.

All commissioners will be initially received a year probationary appointment. Permanent appointment to the commission will be considered only after the Congress can certify that a probationary commissioner has fulfilled the following:

1. Attended 90% of Commission meetings and training sessions during the preceding year.
2. Passed an examination which assesses the probationary commissioner's knowledge of the demographic specifics, the historical evolution of the D.C. health care system and other appropriate knowledge of health planning and delivery.

This Commission would be expected to analyze the needs for a balanced ambulatory care system (inclusive of acute care, chronic care, extended care and home care). On the basis of this examination, an application for Hill-Burton funds for renovation should be prepared and a special DCGH appropriation to underwrite start-up operational costs of a much expanded, integrated program which the Congress would be asked to support.

Simultaneously, a congressional appropriation to provide "state" funds to match the federal Medicaid contribution would be sought, including an amount sufficient to extend Medicaid to cover the medically indigent not receiving categorical cash benefits.

A final point about ambulatory services: it appears that, in the forseeable future, the Outpatient Department at D.C. General and the primary care clinics of the Department of Human Resources will continue to be an important part of the ambulatory services accessible to the citizens of D.C., regardless of waht happens with Medicaid funding. Consequently, a part of the reorganization should be to expect all ambulatory services providing primary care, in affiliation with an expanded ambulatory service at DCGH, to form an effective network of primary and

secondary ambulatory services for D.C. residents who choose to use these services for their ambulatory care.

This should be done in a manner which will, at the same time, make it easy for primary care privately practicing physicians in D.C. to use DCGH as their community hospital. This is not to propose a massive expansion of ambulatory services to compete with private practice; rather it is recognizing a fact of life that, for the foreseeable future, substantial ambulatory services will be required of city government or any non-profit corporation which contracts to subserve this function. See Attachments I and II.

Some arguments to support the feasibility of the approach:

1. Congress has made its intent clear in both the Senate and House Health Manpower bills that it will utilize its leverage to channel medical students and graduates into medically underserved areas.

   Many of todays students are anxious for primary care experiences and anxious to deliver care to the underserved in an humanistic way, inspite of the posture of many faculty members within medical schools accross the nation who have little interest in primary care or the general health problems of the underserved community.

Student enthusiasm for such an opportunity combined with Congressional interest and fair financial compensation to medical schools for services provided as well as some financial assistance for educational needs would be sufficient incentives to strongly encourage dialogue that would result in a specific program.

2. Congress has also made clear its intent to strengthen the managerial and fiscal practices of the District Government. Improvement in

this area should lessen the medical school's and/or an HMO's apprehension about satisfactory supportive services and efficient and fair payment for services rendered. In addition, improved data and income collection practices would greatly help in financing the demonstration project.

3. Congressional assistance in defining a fairer federal share in the financing of the District's Medicaid program would also help the demonstration finance itself.

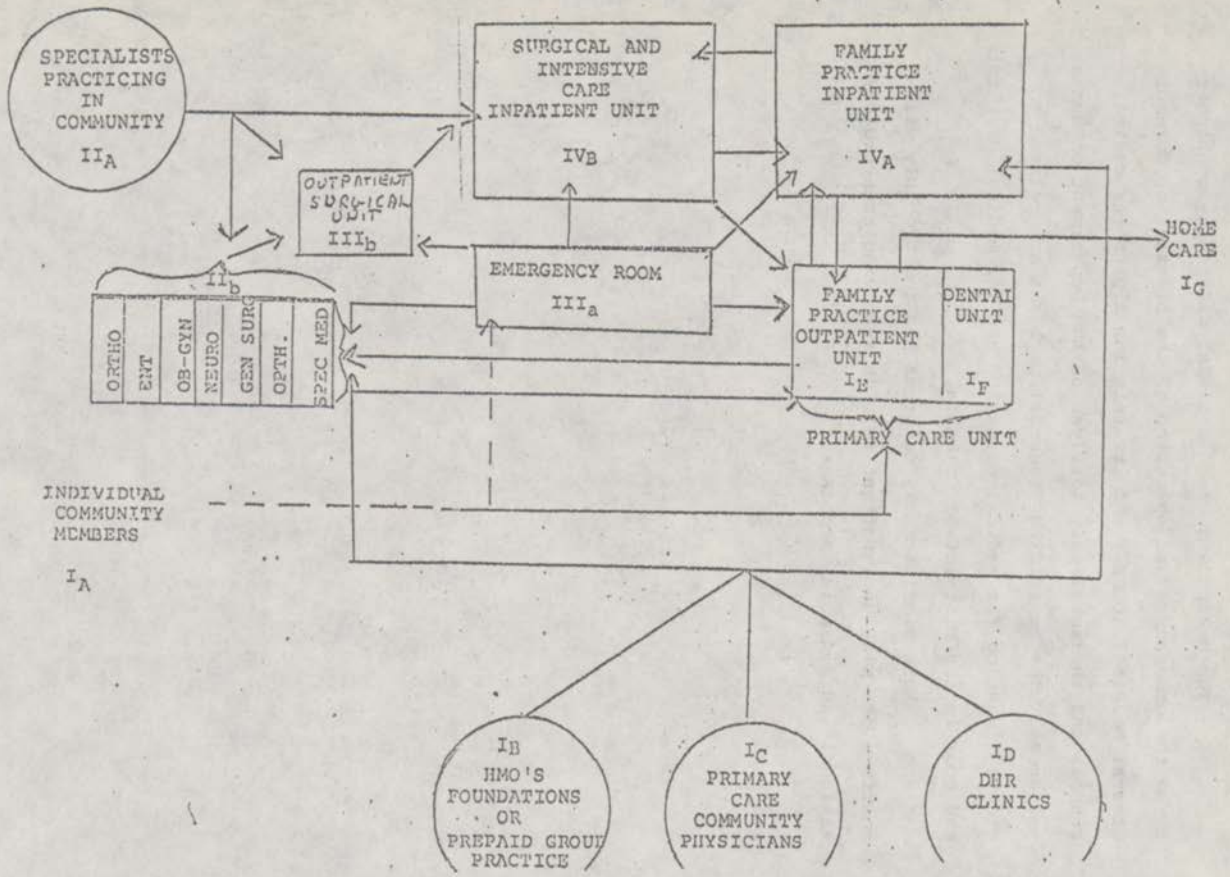
4. Both health sciences education and health services in the Washington Metropolitan Area have significant problems. While these problems are not unique, they are exacerbated by the peculiar relationship among the local political jurisdications and the federal government; the latter serving both as the major employer and the source of very substantial financial support to the local government of the District of Columbia and to health components in the private sector.

Therefore, in seeking a solution to these problems, it seems worthwhile, first of all, to link the problems in medical education with the problems in health services availability and to recognize that there are major organizational and fiscal components ot the problems in both areas. Long range solutions would require an integrated strategy, aimed at improving the organizational structure and the financial underpinning of both medical education and health services; and, perhaps as importantly, relating these developments to overall planning of health services for the Washington Metropolitan Area.

The overriding organizational difficulty continues to be the governance and operation of the District of Columbia General Hospital (DCGH), and its relationship to the medical schools and the ambulatory services of the Department of Human Resources. The overriding financial problems are related to stable financing for medical education and for medical care for the poor in the District of Columbia.

Most significantly Congress has and probably will continue, to play an important role in resolving such organizational and financial problems.

D.C.G.H. - HOSPITAL-CENTERED COMMUNITY HEALTH SYSTEM ATTACHMENT I



ATTACHMENT II

Interested Party	Advantages	Disadvantages
1. Medical Schools	1. May enhance recuirtment for certain types of medical students.	1. Would take effort, commitment, realignment of resources.
	2. Could build on role as change agents to improve federal relations and community relations, and change the schools' image.	2. Would involve a bigger commitment to outpatient services.
	3. Would affort opportunity to train health science students in primary care.	3. Might involve loss of control over some provision of services.
	4. Would allow them to develop a specialty referral capability, and would allow them to utilize specialty personnel to better advantage.	
	5. Expansion of family medicine concept is politically expendient.	
2. Staff at D.C.G.H.	1. Would afford the opportunity to rationalize the outpatient department, assigning patients to the unit where they can receive the most appropriate care.	1. Possible loss of grant.
	2. Would allow better utilization of experts and specialists, including more teaching time and better care for patients.	2. Would necessitate reorganization of staff, and perhaps staff dissatisfaction.
	3. The existence of a DCGH residency program would allow better recruitment program for residents and for allied health professionals.	3. Change, in general, is often threatening to personnel and an education program would be necessary.
3. Department of Human Resources	1. Could offer the community a more responsive service.	1. If funding is short-term, alternate sources of funding would have to be investigated.
	2. Would allow reationalization of the delivery system, by achieving continuity of patient care.	2. Any reorganization is costly, disruptive to personnel, and threatening to the system.
	3. Achieves a commitment of philosophy and money to ambulatory care.	
	4. Would decrease long-term costs by emphasizing prevention and avoiding crisis-oriented medicine.	
	5. Would include the potential of raising general community health standards by the emphasis on education and prevention.	

Interested Party	Advantages	Disadvantages
	6. Proposed model is easily transferable to other outpatient ambulatory units.	
4. Department of Human Resources Clinics	1. Would enhance continuity of patient care.	1. Would include the possibility of a greater work load for staff, and could extend the working day to in-hospital responsibility, with no financial incentive.
	2. Would affort opportunity for continuing education of staff physicians.	
	3. Would enhance recruitment efforts for certain types of physicians, allowing both inpatient and outpatient experiences for full-time doctors.	
5. Private physicians in the community	1. Affords opportunity for general practitioners to gain hospital privleges and to become involved in the program of a teaching hospital.	1. Proposed model might represent a threat to private practices, either through loss of patients to the family practice unit, or through patient dissatisfaction with the DCGH inpatient unit.
	2. Affords opportunity for continuing education.	
	3. Would make consultant services available to participating physicians, through the new system.	
6. Group Practices Now in Developing Stages	1. Would make hospital beds available, thus making comprehensive care possible and the group concept viable.	1. Proposed model might take patients from the enrolled population of group practice.
7. D.C. Community	1. Would provide continuity of care, and would allow identification with the hospital, on the part of the patient.	1. Possible influx of new patients might represent a threat to those already using the hospital, especially those with no other options.
	2. Offers potential for new jobs, upward mobility, career ladders, with the concept of the team approach and increased use of allied health professionals.	2. Allied health professionals might not be readily acceptable to the community.
8. D.C. Medical Society	1. Offers opportunity for recognition and consolidation of continuing education programs for physicians.	1. Concepts may not be acceptable to all groups within the Society.

HEALTH STATUS OF DISADVANTAGED/ORGANIZED HEALTH CARE DELIVERY SYSTEMS

Dr. HOYTE. Mr. Chairman and distinguished committee members, my name is Arthur H. Hoyte. I come before you as a citizen-physician who has concentrated his energies and time on health-related issues within the District of Columbia over the last several years.

I am a board-certified obstetrician-gynecologist, employed full time at the Georgetown School of Medicine, where I hold the appointments of assistant professor in the departments of community medicine and obstetrics-gynecology.

My interest in the health status of disadvantaged populations and in organized health care delivery systems is reflected by my professional work experience, which started in 1968 with the Kaiser Permanent Health Plan.

In 1970, I joined the Office of Economic Opportunity as a health officer. One of my primary responsibilities with OEO was to evaluate OEO-funded neighborhood health centers.

In 1971, I joined the faculty at Georgetown. In addition to other duties, I also served as a senior planner of the Washington, D.C., component of the Georgetown University-sponsored health maintenance organization. Subsequent to that experience, I served as a member of the planning team of the East of the River Health Plan.

Over the past 2 years I have devoted the majority of my efforts to cultivating the educational potential of disadvantaged youths with the thought that a sound education leads to job opportunities. A job, in turn, offers the individual options for an improved environment and better nutrition and, thus, enhanced health.

I could not help but agree almost in totality with the testimony given by Mr. Wilson. There is a differential between medical and health care. Health is a much broader concept, in my mind, as reflected by my last few years' activities. The greater focus on environment, nutrition, and education will do a lot to improve, and more than the health facilities, per se.

PRIMARY HEALTH CARE SERVICES

But today, I was requested to focus my testimony on the extent to which adequate primary health care services are available in the District of Columbia and the extent to which these services are available in each of the regions of the city. For the most insightful information on this subject, I would like to refer the committee to four documents.

The first is the report of the Mayor's Task Force on Public Health Goals, which was published in 1970—hereafter referred to as the 1970 Mayor's Task Force Report.

The second is a report to Congress: A Study of Programs for Health Service in Outpatient Health Centers in the District of Columbia—hereafter referred to as the GAO report.

This second report was submitted to Congress by the Comptroller General of the United States in July 1973.

The third document, the Report of the Task Force To Prepare a Comprehensive Action Plan for an Outpatient Health Delivery System in the District of Columbia—hereafter referred to as the

1975–76 Task Force Report, prepared by the Department of Human Resources. This latter report was prepared in 1975–76, in response to questions and criticisms generated by the 1973 Comptroller General's report.

The fourth is a 1976 computer printout, which I have submitted to the committee. It does list such data as the number of organizations providing health patient care for outpatient visits, as well as hours of operation.

The 1970 Report of the Mayor's Task Force on Public Health Goals was very critical of the status of the health delivery system of the District of Columbia.

The report characterized the District of Columbia as being health poor, nearly health bankrupt. It also stated that the services were poorly distributed and fragmented.

Three years later, a study team from the General Accounting Office reaffirmed that ambulatory care services in the District of Columbia were fragmented, poorly distributed and, in addition, stated poorly utilized.

Today, if one reads the Washington Post or discusses health services in the District of Columbia with patient consumers and/or with health professionals, one is likely to encounter characterizations of ambulatory care services in the District in such terms as poorly organized, poorly managed, fragmented, unstable, inadequate, et cetera.

1970 MAYOR'S TASK FORCE REPORT

It is obvious that the negativism that was conspicuous in the 1970 Mayor's Task Force Report has persisted. Why is this true? Who should shoulder the blame? What can be done?

The remainder of my testimony concentrates on trying to answer these questions.

The 1970 Mayor's Task Force Report was generated at the height of the activism of the sixties, which focused on human needs and followed the civil rights movement. At that time, public clinics were overcrowded, they were impersonal, and offered limited, noncomprehensive services.

The District medicaid program was still in its infancy and certain areas of the city were devoid of health services.

EXHIBITS SUMMARIZED

I have some exhibits and I will try to summarize them. Exhibit I is a map of the District of Columbia. It demonstrates the District of Columbia's four health areas. There were four at that time. There are nine at the present time. If you have time later and go through these exhibits, you will see there were very few, if any, outpatient facilities provided on the east side of the Anacostia River. Both hospitals were located on the Maryland-District line and catered to a great extent to Maryland residents.

At that time, the two outpatient clinics in this area were actually free clinics. The distribution of hospital beds, hospital outpatient departments and emergency rooms within the District of Columbia is essentially unchanged today.

Exhibit II identifies the location of nonhospital public and private outpatient services in 1970. This particular exhibit is misleading, for although the dots and X's represent facilities providing services, there is no indication of the type or extent of services offered by each facility.

In spite of this fact, I felt it appropriate to include this exhibit to underscore the dearth of outpatient services which were being provided east of the Anacostia River in 1970. The private services that were provided in this area at the time were primarily those provided by the two free clinics. The open circles on exhibit II designate public and private comprehensive ambulatory care facilities that were established since 1970.

I also have exhibits III, IV and V, which underscore the facts that I just mentioned.

Exhibit VI summarizes the areas within the District which were essentially devoid of public or private health facilities at that time.

Exhibit VII makes reference to the fact that the Northeast and Southeast sections of the city were serviced by only 10 percent of the District of Columbia's private practicing physicians at that time, although these same geographic areas contained 51 percent of the total population.

But it should be pointed out that the data listed on exhibit VII was collected crudely. Every fourth private physician's office listed in the yellow pages of the District of Columbia phone book was designated on a map. It is clear that data collected in such a manner fails to identify the days or time that the physicians were available. It is well known that many physicians have offices in the District, particularly in the underserved areas, that are open only a few hours a day and only a few days each week.

DISTRICT MORBIDITY AND MORTALITY RATES

In addition to being highly critical of the available health facility and manpower resources, the 1970 report presented disturbing morbidity and mortality data as depicted in exhibit VIII.

This exhibit suggests that the District had morbidity and mortality rates which were among the worst in the country.

Finally, exhibit IX lists the main recommendations made by the Mayor's task force. Please make note of the recommendations, Nos. 2, 3, 6, 10, 14, 16, and 17, for they do not differ greatly in intent from recommendations made in the 1975–76 Task Force Report.

MASTER PLAN IMPLEMENTED

With all that, what was done? Following the report of the Mayor's task force, the District of Columbia government responded by developing a master plan, which I am told called for the placement of approximately 30 comprehensive neighborhood health clinics throughout the District, and the effecting of a vertical, continuous primary care and referral system.

Implementation of that plan was started with the establishment of five new comprehensive neighborhood health clinics. The efforts to effect the master plan soon fizzled because of multiple factors, the most significant being the lack of finances.

By 1973, as the General Accounting Office found, although increased services and facilities had been established east of the Anacostia River, ambulatory care facilities and services were still poorly distributed and poorly utilized.

Exhibit X indicates where the comprehensive health care facilities were located at the time of the GAO report. Note that numbers rather than letters are now used to denote service areas.

The exhibit XI depicts the utilization pattern of each comprehensive facility in 1973. As I mentioned, the GAO report felt the centers of the District were underutilized.

Note that the AMA and ADA data used by the GAO was based on physicians in office practice. It could be argued that such standards are inappropriate to judge physician usage in public health clinics when one considers that clinic utilization is affected by such things as the filling-out of forms, means testing for eligibility, encounters with social workers, and other types of administrative matters that are not physician related.

However, the graphs in exhibit XI are useful for showing relative utilization of the clinics in the District of Columbia at that time.

It should be noted that a review of 1972 vital statistics data reflecting morbidity and mortality suggested that there was not a significant improvement in the overall morbidity and mortality in the District of Columbia since the 1970 Mayor's Task Force Report.

I also include another exhibit, which is No. XII, that Congress can see from this that the rates do not significantly change from 1970. But I would be very happy to give my views on this point if the committee so desires at a later time.

In response to the criticisms made by the GAO report, the Department of Human Resources prepared the "Report of the Task Force To Prepare a Comprehensive Action Plan for an Outpatient Health Delivery System in the District of Columbia."

This report acknowledges that organized ambulatory care facilities are poorly distributed at the present time, and that many such facilities are not well utilized. The report directly or indirectly points to inadequate and noncontinuous financing of health care services, duplication and overlap between federally funded and District of Columbia funded programs, and unsatisfactory data collection and revenue collection practices existing at the present time.

These deficiencies are among the many reasons for the poor distribution and utilization of comprehensive health facilities in the District.

DISTRICT AMBULATORY SERVICES

The 1975–76 task force assigned to prepare a comprehensive action plan for an outpatient health delivery system in the District of Columbia, appropriately, explicitly and implicitly, pointed out that adequate ambulatory services will not be available to District residents until—

First, the overall health planning capability is strengthened.

Second, the Federal Government develops a formal agreement with the District which ascertains that duplicative and overlapping efforts to provide services do not occur.

Third, until the private sector within the District shows greater willingness to accept reasonable costs for support of the public health effort.

Fourth, until the Congress is willing to assume a fairer share of the District medicaid costs.

Fifth, until services are more appropriately distributed and made more accessible to the economically disadvantaged within the District.

Sixth, until the District is able to define an equitable sliding scale fee schedule for services rendered and to tighten its fiscal and organizational management practices.

Seventh, until the District is able to recruit more practitioners to work in the most underserved areas of the city.

It is of note that the 1975–76 task force recommended that the Federal and District Government support health maintenance organization efforts in all feasible ways. I would like to stress that point because in the first testimony it is speaking in terms of excess beds. I think the health maintenance concept was suggesting that one can cut down on hospital utilization in a more organized and rational fashion than the laissez faire approach used at the present time in terms of hospitalization.

Enhanced health educational efforts were also strongly recommended. The two areas, which in my opinion, were not stressed strongly enough related to the physician extenders and licensure. I feel that there should be an increased use of physician extenders and that the practitioner and facility licensure policies of the District should be strengthened.

I concur with many, if not most, of the points and recommendations made in the 1975–76 Task Force Report.

In conclusion, as my testimony implied or stated, there is some truth to negative characterizations of the present status of ambulatory health care in the District of Columbia.

But who is to blame? In my opinion, no one individual, or one group of individuals, or one agency is to blame. It is a blame to be shared by many, including the Congress, including the Mayor, the director and staff of the Department of Human Resources, the private physicians, hospitals, and the private medical schools in the District of Columbia as well as citizens.

TRAGIC SITUATION

To my mind, the situation is tragic and the essence of the tragedy is that many skilled and dedicated workers within the Department of Health have not been adequately supported by the Congress or the community.

The individuals I speak of—certainly not all or even most within the DHR bureaucracy—have sustained and applied themselves diligently in spite of frequent frustrations, and the almost constant demoralizing negativism that permeates the written and visual media.

Yes, fiscal and organizational management undoubtedly needs to be improved within DHR, and greater autonomy of budget and management needs to be extended to division chiefs. But, by the same token, the Congress needs to allow the District the opportunity to implement long-term ambulatory care plans.

INGREDIENTS OF SUCCESSFUL HEALTH CARE DELIVERY SYSTEM

It should be kept in mind that all large metropolitan areas across the country have problems with their health care delivery systems. In my opinion, there will be no significant improvement in the adequacy of ambulatory care available to indigent residents within the District of Columbia until:

First, adequate financing of ambulatory care is available to the near poor as well as the poor. Medical care for patients and others.

Second, until the consumer patient is convinced that he or she is a primary determiner of health status.

Third, until ambulatory care delivery systems are better distributed.

Fourth, until the private sector assumes a greater share of the responsibility to deliver quality adequate services to the disadvantaged at reasonable costs.

Fifth, until the Congress holds DHR, the private sector and itself accountable to provide the District with a more acceptable health delivery system.

SUCCESSFUL JOINT EFFORT POSSIBLE

It is my opinion that all ingredients needed for a model urban ambulatory care health delivery system are available to the District of Columbia at reasonable cost. The District offers the Congress a laboratory by which it could assess payment mechanisms, private-public health care partnerships and the impact of ambulatory care services on overall health if:

First, all members of the team, and that includes the Congress, DHR and the private sectors, including the media, recognize the benefits of working together and make their criticisms constructive.

Second, if the Congress were willing to use its leverage to encourage the public and private sector to join in partnership to establish a network of comprehensive ambulatory care centers. These centers would have clear and well-defined referral connections and communications with secondary care—specialist—and tertiary care—hospital—providers.

On innumerable occasions I have witnessed the leadership of the Department of Human Resources extend itself in search of help from the private sector. Unfortunately, the Public Health Department rarely finds itself in a buyer's market when soliciting services from the private sector in the District of Columbia. The Congress could and should enhance the District's bargaining position.

Third, if the Congress were willing to hold a partnership of the public and the private sector accountable, at least annually, for its expenditures and for the quality of services offered by the partnership, this would help greatly, also.

Fourth, if the Congress were willing to assist the District in the funding of a 5-year public-private partnership endeavor.

I close with the submission of a final exhibit, which is basically the draft of a proposal which I feel has merit.

I again thank you for the opportunity to appear before you.

Senator CHILES. Thank you, Doctor, for your statement.

In your opinion, how well does the current location of neighborhood health centers help correct the distribution problem?

NEED FOR BETTER DISTRIBUTION FACILITIES

Dr. HOYTE. In my opinion, the current location does not help correct that distribution problem. If one views the location of the facilities and finds a majority are in the Northwest, and central city area, east of the Anacostia River where there is still a large part of the population, there are basically three health centers, two operated by Human Resources and one by a private organization.

There is a need to better distribute facilities available to the District.

Senator CHILES. What alternatives are there in the city-run hospitals and neighborhood health centers to assure that primary health care is available to District citizens?

Dr. HOYTE. As I mentioned before, I do not think the District is in a position to set up an effective system of its own.

The private sector has an obligation to assist the District in trying to effect a sound system. At the same time, we have a peculiar situation in the District, in that many work for either the District or Federal Government, having very comprehensive health insurance plans. As a result, it is relatively easy in the District for a private practitioner to make a very adequate income.

And because of that factor, and because the District is limited in terms of what it can offer practitioners of care—it is about one-third—and also because of the fact that the sites where the District government tends to have its facilities, they are not among the most appealing areas.

In my testimony I suggested just by the Congress being interested in seeing private and public partnership, that the private sector owes the Federal Government a great deal. And it seems to me it is appropriate to try to effect that partnership because it is only that way, and I feel only that way, that you will have an alternative that is satisfactory.

NEGATIVE REPUTATION OF CITY HEALTH CLINICS

Senator CHILES. What reputation do the city health clinics have in the medical profession?

Dr. HOYTE. As I mentioned before, it is relatively negative. But I think it is relatively unfair in the sense that the media, both the radio and the video media, basically focus on the negatives, and that permeates the feeling and thinking throughout the city.

Again, there are some problems with the District government in terms of its accounting, in terms of its management, but I think those problems are trying to be addressed.

Senator CHILES. I know you have included a table in your testimony, but in your opinion, are the people in the District any sicker or healthier than the people around the country?

Dr. HOYTE. It depends on what data you are looking at. If you are looking at infant mortality rates or sclerosis of the liver, I would say sicker.

I believe there was a report brought out by HEW, saying that from that data you can't make a conclusion they are sicker or healthier. But if you look at the resources in the District in terms of private physicians, in terms of hospital beds, one would think they should be healthier.

I go back to the comments made by the preceding witness, in order to get good health care you have to go beyond medical services.

Senator CHILES. Thank you, Dr. Hoyte, for your fine presentation.

MUNICIPAL RESEARCH BUREAU

STATEMENT OF PHILIP M. DEARBORN, EXECUTIVE DIRECTOR, DISTRICT OF COLUMBIA MUNICIPAL RESEARCH BUREAU

ACCOMPANIED BY DEBORAH RODOCK

PREPARED STATEMENT

Senator CHILES. The subcommittee will now hear from Mr. Dearborn, Executive Director of the Municipal Research Bureau.

I would appreciate it if you would summarize and keep it within 10 minutes, as it gives me time to ask questions.

Mr. DEARBORN. Thank you, Senator.

My associate, Deborah Rodock, is also present.

I would like to present my prepared statement for inclusion in the record at this point.

[The statement follows:]

Senator Chiles and members of the District of Columbia Appropriations Subcommittee, thank you for inviting the D. C. Municipal Research Bureau to testify on the District's health care delivery system. Because of the scope of this topic, we have chosen to narrow our discussion to the role of D. C. General Hospital in the City's health system.

In our June, 1975 report on the District of Columbia General Hospital, the Bureau found that, no clear purposes or goals have been established by the City for the Hospital, and that changing patterns of utilization raise substantial questions about the future of the Hospital. For example, admissions declined 26.2% between fiscal years 1971-1975, and elderly inpatient stays increased from 39.4% of the medical/surgical days in 1974 to 51.7% in 1975; the average length of stay for the elderly was 46.8 days. At December hearings before the City Council Committee on Human Resources and Aging, the Bureau raised the question, is there a need for a City operated acute inpatient care facility, and if so, who will be its primary users? We still feel that this question needs to be answered.

During a period when inpatient acute care use of the Hospital has declined, the City's expenditure for operating the facility has increased from $34.3 million in fiscal 1974 to $38.5 million in 1975, and to over $40 million in 1976. This substantial investment of District funds is likely to increase, if the quality of care is improved and maintained. Therefore, the City must determine the most cost effective and efficient manner for delivering acute hospital care services. Stated in terms of zero base budgeting, this means defining the reasons D. C. General exists, and then determining whether those reasons justify spending $40 million to support the facility, or whether there are other less costly alternatives.

Today, we will discuss four issues, which the Bureau has identified as needing further study before final answers can be made about the future of the Hospital. Although there are certainly other issues that may need consideration, it appears that these four go to the heart of the problem.

First, would there be an inadequate number of acute care beds available in the District of Columbia, without the use of D. C. General Hospital?

During calendar year 1975, the Hospital Council of the National Capitol Area reported a total of 4,931 beds in District hospitals, of which 700 were at D. C. General. When departmental occupancy levels are considered, D. C. General on the

average had 558 beds filled in fiscal 1975, with an estimated 100 of these beds occupied by chronically ill persons. Without D. C. General's beds in fiscal 1975, the private hospitals' occupancy (exclusive of long term and newborn)would have increased from 72.5% to 86%. Thus the private facilities may presently have the capacity to absorb D. C. General's patients.

Between 1970 and 1974, 727 new inpatient acute care beds were opened in suburban jurisdictions. This hospital construction may drain off suburban patients from District acute care facilities. In 1969, the most recent year for which information is available, the Health Facilities Planning Council found that 46.2% of all patients in District hospitals were Maryland and Northern Virginia residents. More current data on patient origin and place of hospitalization is being gathered by the Council of Governments Health Information System.

In addition, the Professional Standards Review Organization, which is currently evaluating the medical necessity of Medicaid and Medicare inpatient stays, has estimated that 500 patients are in acute care facilities only because the more appropriate level of skilled nursing or intermediate care is not available. If these patients are moved to an appropriate level of care, then there will be a more rapid turnover of acute care beds, which has the effect of increasing vacant bed capacity.

Both the increase in suburban bed capacity and the likely removal of chronic care patients from acute care hospitals will have a significant impact on whether there is a continued need for D. C. General Hospital, and whether the inpatient capacity of private hospitals would be sufficient over the long term to absorb those acutely ill patients who are currently treated by D. C. General Hospital.

While we question the need for D. C. General's inpatient acute care beds, it must be noted that the Hospital is performing a vital service through its emergency and outpatient departments. In fiscal year 1974, there were 105,622 registrants for emergency care and 189,848 outpatient visits. Based on these figures the Bureau's Hospital report suggested that emergency room and outpatient care be continued because there appears to be substantial demand for these services.

Second, <u>is D. C. General providing quality care at a lower cost than private hospitals</u>?

Because D. C. General's rates are inclusive of all medical services, while private hospitals have separate billings for most doctors' fees, physicians salaries must be deducted from the cost of operations at D. C. General in order to make cost comparisons with private hospitals. When this is done, the average actual per diem cost at D. C. General Hospital in 1975 was $149 (see Table I), compared with the $146, weighted fiscal 1975 average per diem cost reimbursement, that was received by private District hospitals from the Medicaid program. While it appears from this actual cost comparison that D. C. General is only slightly more expensive than private hospitals, this is a comparison of average costs and does not consider the quality of care that is rendered.

On September 11, 1975, Judge Barrington Parker ruled that "the treatment and care of patients and the facilities at D. C. General fall well below any acceptable level of quality and efficiency...." A staffing analysis, submitted to Judge Parker by the Department of Human Resources on July 1, 1976, details the positions that will be filled during fiscal 1977 "to provide a comparable level of services as (is) found in other District hospitals." These inpatient staffing costs will add $2 million to the Hospital's budget (see Table I). If D. C. General had been staffed to provide quality care in fiscal 1975, the daily cost would have increased to $160, or $11 per day higher than the average for all hospitals.

However, because this average includes some limited service hospitals, it may be more appropriate to compare costs of D. C. General with only the comprehensive teaching hospitals in the District. On the basis of the 1975 average Medicaid reimbursement, the other three teaching hospitals experienced the following costs per day:

George Washington	$144
Howard	178
Georgetown	182

Therefore, even when the cost of quality inpatient care at D. C. General Hospital is compared with the costs at other teaching hospitals, it appears that there may be little or no difference in average daily costs.

Third, is D. C. General Hospital needed to support training and educational programs?

D. C. General Hospital provides a clinical experience for 206 medical students in training from Howard and Georgetown Medical Schools. Whether this use of D. C.

General provides justification for continuing the Hospital, or whether suitable alternatives for clinical experience could be provided in the community, needs to be explored.

Fourth, do private hospitals refuse to admit City residents?

Assuming there is sufficient private bed capacity in the City to accommodate all those people needing hospitalization, then refusal to admit, if it does occur, may be due to racial or economic discrimination. To the extent that racial discrimination occurs, the problem should be promptly addressed by the City and Federal governments.

If Medicaid and Medicare patients, whose hospital care costs are fully reimbursed, are readily admitted to private hospitals, then it would appear that discrimination in admittance is probably economically based. One form of economic discrimination may result from the way in which the District operates its indigent health care program (D. C. Medical Charities). Hospitals which treat these patients receive the statutory rate of $76 per inpatient day--an amount equal to about half of the costs incurred. Presumably private hospitals try to minimize the number of Medical Charities patients they admit and instead transfer a substantial number of these patients, as well as other persons with no source of pay, to D. C. General. In fiscal 1974, approximately 14% of all D. C. General's inpatient admissions were transferred from private hospitals. Thus D. C. General's occupancy is increased by what appears to be an unwillingness of private hospitals to treate some patients. However, despite this significant number of transfers, private hospitals that received Hill Burton monies reported to HEW in June, 1975 that they had rendered $3.5 million of free care.

If the City reimbursed the private hospitals for the full cost of treating indigent patients, then the economic basis for refusing to care for these patients would be removed. Paying the full cost would be justified only if such costs were equal to or less than those for similar care at D. C. General.

Conclusion

The discussion of these four issues is not intended to provide answers about D. C. General Hospital's future, but it should highlight the need for better planning for the facility. While the Hospital will undoubtedly continue to provide acute care over the short term, there are genuine questions that need to be answered about its

appropriate role over the long term in the City's health care system. Consideration should again be given to the Nelsen Commission's recommendation that the District government "not directly provide health services, either inpatient or ambulatory, where feasible alternatives exist which are consistent with economy, efficiency and improved services."

Table I
Average Per Diem Costs at D.C. General Hospital
(A Comparison of Actual Care Costs with Quality Care Costs)
Fiscal 1975

	$30,591,182	Inpatient Cost
Less	2,809,721	Inpatient Medical Officers' Salaries
	$27,781,461	Actual Inpatient Costs

Actual Inpatient Costs	÷	Inpatient Days	=	Per Diem Cost of Operations
$277,781,461	÷	186,632	=	$149

	$27,781,461	Actual Inpatient Costs
Add	2,033,578	Staffing Costs for Quality Level Care
	$29,815,039	Quality Inpatient Care Costs

Quality Inpatient Care Costs		Inpatient Days		Per Diem Cost of Operations
$29,815,039	÷	186,632	=	$160

Sources: Mayor Washington's submission to City Council on proposed user fees at D. C. General for fiscal year 1976, based on fiscal 1975 actual operating expenses.

Group Hospitalization, Inc., "Medicare Cost Audit Report FY-75."

Robert Johnson, Executive Director, D. C. General Hospital, "Staffing Analysis" submitted to U.S. District Court for CA 275-71.

ASSISTANCE TO DISTRICT OF COLUMBIA GOVERNMENT PROCESSES

I would like to preface by saying that the Municipal Research Bureau is a nonprivate membership corporation operating in the District of Columbia to assist government processes in the District.

In our June 1975 report on the District of Columbia General Hospital, the Bureau found that no clear purposes or goals have been established by the city for the hospital, and that changing patterns of utilization raise substantial questions about the future of the hospital.

For example, admissions declined 26.2 percent between fiscal years 1971–75, and elderly inpatient stays increased from 39.4 percent of the medical-surgical days in 1974 to 51.7 percent in 1975. The average length of stay for the elderly was 46.8 days.

At the December hearings before the City Council Committee on Human Resources and Aging, the Bureau raised the question of whether there is a need for a city-operated acute inpatient care facility, and, if so, who will be its primary users? We still feel that this question needs to be answered.

During a period when inpatient acute care use of the hospital has declined, the city's expenditure for operating the facility has increased from $34.3 million in fiscal 1974 to $38.5 million in 1975, and to over $40 million in 1976.

This substantial investment of District funds is likely to increase, especially if the quality of care is improved and maintained. Therefore, the city should determine the most cost effective and efficient manner for delivering acute hospital care services. Stated in terms of zero base budgeting, we think this means defining the reasons District of Columbia General exists, and then determining whether those reasons justify spending $40 million to support the facility, and whether there are other less costly alternatives the District might use for health care services.

Today, we will discuss four issues, which the Bureau has identified as needing further study before final answers can be made about the future of the hospital, while it appears these four go to the heart of the problem.

ACUTE CARE BEDS AVAILABLE

First, would there be an inadequate number of acute care beds available in the District of Columbia, without the use of District of Columbia General Hospital? I think Mr. Wilson covered most of this quite adequately. Without District of Columbia General's beds in fiscal 1975, the private hospitals' occupancy would have increased from 72.5 percent to about 86 percent.

While we question the need for District of Columbia General's inpatient acute care beds—factors we think relate to the suburban development previously discussed—it must be noted that the hospital is performing a vital service through its emergency and outpatient departments.

In fiscal year 1974, there were 105,622 registrants for emergency care and 189,848 outpatient visits. Based on these figures, the Bureau's hospital report suggested that emergency room and outpatient care must be continued because there appears to be substantial demand for these services in this geographical area of the city.

AVERAGE PER DIEM COST AT DISTRICT OF COLUMBIA GENERAL

Second, is District of Columbia General providing quality care at a lower cost than private hospitals? In order to do a comparison, it is necessary to do adjusting because District of Columbia General includes doctors' fees while private hospitals generally have separate billings.

When this is done, the average actual per diem cost at District of Columbia General Hospital in 1975 was $149, compared with the $146, weighted fiscal 1975 average per diem cost reimbursement that was received by private District hospitals from the medicaid program.

While it appears from this actual cost comparison that District of Columbia General is only slightly more expensive than private hospitals, this is a comparison of average costs and does not consider the quality of care that is rendered.

We know on September 11, 1975, Judge Barrington Parker ruled that "the treatment and care of patients and the facilities at District of Columbia General fall well below any acceptable level of quality and efficiency." A staffing analysis, submitted to Judge Parker by the Department of Human Resources on July 1, 1976, details the positions that will be filled during fiscal 1977; in the District's words, "to provide a comparable level of services as found in other District hospitals."

These inpatient staffing costs will add $2 million to the hospital's budget. If District of Columbia General had been staffed to provide quality care in fiscal 1975, we estimate the daily cost would have increased to $160, or $11 per day higher than the average for all hospitals.

However, because this average includes some limited service hospitals, it may be more appropriate to compare costs of District of Columbia General with only the comprehensive teaching hospitals in the District. On the basis of the 1975 average medicaid reimbursement, the other three teaching hospitals experienced the following costs per day: George Washington, $144; Howard, $178; Georgetown, $182.

Therefore, even when the cost of quality inpatient care at District of Columbia General Hospital is compared with the costs at other teaching hospitals, it appears that there may be little or no difference in average daily costs.

TRAINING AND EDUCATIONAL PROGRAMS

The third issue to consider is whether District of Columbia General Hospital is needed to support training and educational programs. District of Columbia General Hospital provides a clinical experience for 206 medical students in training from Howard and Georgetown Medical Schools. Whether this use of District of Columbia General provides justification for continuing the hospital in its present form, or whether suitable alternatives for clinical experience could be provided in the community, needs to be explored.

PRIVATE HOSPITALS' SERVICE TO RESIDENTS

Fourth, do private hospitals refuse to admit city residents? If you assume there is sufficient private bed capacity in the city to accom-

modate all those people needing hospitalization, then refusal to admit, if it does exist, may be due to racial or economic discrimination. To the extent there is racial discrimination, the problem should be promptly addressed by the city and Federal Governments. And I don't think it should be a subject for our considerations.

If medicaid and medicare patients, whose hospital care costs are fully reimbursed, are readily admitted to private hospitals, then it would appear that discrimination in admittance is probably economically based, since many of them are poor and black that are receiving medicare and medicaid, and we think that could be used as a test to determine the nature of discrimination if it does exist..

One form of economic discrimination may result from the way in which the District operates its indigent health care program. Hospitals which treat these patients receive the statutory rate of $76 per inpatient day.

I think it should be noted in reference to your earlier point, the hospitals do provide $3½ million worth of free care.

Presumably, private hospitals try to minimize the number of medical charities patients they admit and, instead, transfer a substantial number of these patients, as well as other persons with no source of pay, to District of Columbia General.

TRANSFERS TO DISTRICT OF COLUMBIA GENERAL

In fiscal 1974, we know 14 percent of all District of Columbia General's inpatient admissions were transferred from private hospitals. Thus, it appears District of Columbia General's occupancy is increased by what appears to be an unwillingness of private hospitals to treat some patients. However, despite this significant number of transfers, private hospitals that received Hill-Burton moneys reported to HEW in June 1975 that they had rendered $3.5 million of free care.

If the city reimbursed the private hospitals for the full cost of treating indigent patients, then the economic basis for refusing to care for these patients would be removed. It would make sense for the District to pay the full cost only if the costs equal the lower cost for similar care at District of Columbia General.

The discussion of these four issues is not intended to provide answers about District of Columbia General Hospital's future, but it should highlight the need for better planning for the facility. The hospital will undoubtedly continue to treat acute care over the short term. There are genuine questions that need to be answered about its appropriate role over the long term in the city's health care system.

Consideration should again be given to the Nelsen Commission's recommendation that the District government not directly provide health services, either inpatient or ambulatory, where feasible alternatives exist which are consistent with economy, efficiency and improved services.

Senator CHILES. In summary, are you questioning the need for the city to operate its own acute care hospital?

Mr. DEARBORN. Senator, we think there are substantial questions that need a clearer understanding before a decision can be made. Either there is a continuing need, or there isn't.

ALTERNATIVE USES FOR DISTRICT OF COLUMBIA GENERAL

Senator CHILES. What alternative uses exist for District of Columbia General Hospital's facility if you are not going to use it for acute care?

Mr. DEARBORN. It appears, Senator, there is a need in the District for skilled and intermediate nursing care, treatment of the chronically ill. We are currently doing research on this, as are a number of other organizations, and the extent of this need and the extent to which District of Columbia General could fill it is uncertain. But based on evidence to date, it looks like there is a major shortage of this type of care.

Senator CHILES. If District of Columbia General was to continue as an acute care facility, who specifically should it serve?

Mr. DEARBORN. Senator, we don't know the answer to that. We think that would require a careful analysis of the patients, showing an analysis of the neighborhood locations from which they come, their economic status and eligibility for third-party payment.

Senator CHILES. Should it just be limited to the indigent?

Mr. DEARBORN. Certainly one alternative would be to open the hospital up to nonindigent patients and operate it as a community hospital.

SUBSIDY—$17.7 MILLION

Senator CHILES. A recent report put out by the Municipal Research Bureau, indicated District of Columbia General could account for less than 50 percent of operating expenses in fiscal year 1974, and the city had to provide a $17.7 million subsidy to District of Columbia General over its share of indigent programs at District of Columbia General.

Does that $17.7 subsidy in fiscal 1974 indicate or suggest District of Columbia General gave $17.7 million for free services to individuals who were not indigent?

Mr. DEARBORN. We have tried in preparation for this hearing to identify the reasons for that. The reasons should be apparent from the accounting system in the hospital. And I believe you are going to hear from the Andersen Co., in connection with their report as to why that does not reveal particularly what is accountable for that.

We think there are three primary causes, however. One is medicaid not being claimed. For instance, in 1974 the Department of Human Resources identified 3 percent of the patient load as being medicaid eligible, yet reimbursements from that program represent only 24 percent of the inpatient days, a gap of 15 percent between what was medicaid eligible, and what was actually regarded as having been reimbursed.

Second, with regard to medicare, the hospital reported 80,700 days of care rendered to elderly persons. I think that clearly accounts for a substantial additional amount. We don't know why. It may be their medicare ran out, and in many cases should have been labeled potential medicaid patients.

The third is the cost of operating the emergency room from which they recovered only $1.1 million in revenues.

Those three reasons account for all but a couple of million of the $17.7 million.

Senator CHILES. Thank you very much for your testimony.

ARTHUR ANDERSEN & CO.

STATEMENT OF CHARLES A. BOWSHER, ARTHUR ANDERSEN & CO.

ACCOMPANIED BY FRED LAWRENCE AND PAT GALVANI

PREPARED STATEMENT

Senator CHILES. Next, we will hear from Mr. Charles Bowsher, of Arthur Andersen & Co. We will insert your prepared statement in the record at this point.

[The statement follows:]

Mr. Chairman and members of the Subcommittee, I appreciate this opportunity to appear before you. As requested in your letter of July 29, 1976, my statement will focus on material regarding the health care billing and collection policies and procedures presented in our firm's recent report on Accounting and Financial Management Practices of the District of Columbia. Also, in accord with your request, I will provide the Subcommittee with a description of the major elements that should be included in a billing and collections system.

As we stated in our report we found that: "Health care billing and collection policies are not well defined. Systems and procedures are fragmented and outmoded, and the collection effort is undisciplined and understaffed. Some health care charges, particularly those of neighborhood health clinics, are not properly recorded on patient records to enable billing and collection. Considering that not all patients are billed under the present ineffective practices and procedures, it is impossible to determine the amount of understatement of third party reimbursements from Medicare, Medicaid and various medical insurance programs.

We understand that it is the Department of Human Resource's policy to provide health care services to all in need regardless of the ability to pay. It appears that confusion exists, both internally and on the part of the public, as to the meaning of this policy. Apparently, it is sometimes construed to mean that all health services are free, especially in the outpatient and emergency room service areas.

For example, we found that there are many outpatient and emergency room private pay charges which have not been entered into the automated patient billing system. We were informed that few emergency room or outpatient private pay bills have been prepared for D.C. General Hospital during the past two and one half years. Similar charges for neighborhood health clinics are not billed and in some cases are not even recorded by the neighborhood clinic for possible billing. Because many charges are unrecorded, it is impossible to ensure collection for services from patients or from third-party insurers.

For accounts that have been billed, there are inadequate procedures to assure collection. As stated in our report: "The computerized hospital billing system contains in excess of $100 million of delinquent accounts receivable. These accounts, primarily for inpatients at D.C. General and Glendale Hospitals, represent health care services which were billed, but never collected by the Department of Human Resources. ...Collection efforts are minimal despite the fact that DHR estimates that $10 to $20 million of these accounts could be collected."

Our review did not include a determination of the collectible portion of these outstanding receivables. The estimate included in the report resulted from discussions with DHR personnel. We understand that they had performed account analyses in prior periods to develop this estimate.

The important point is that there are inadequate policies and procedures to assure proper control over health care billings and collections.

An effective billing and collections system is predicated on a clear definition of policies as to services to be billed, methods by which billings will be determined and conditions under which billings will be waived, reduced or written off. The systems developed under these policies must then be oriented

toward assuring that patient account resolution begins at the earliest point possible in the process. There are about six functions involved in this process which must be well coordinated to assure effective patient account resolution. These are preadmission, admission, financial counseling, billing, cashiering and collection. These functions are applicable to hospital inpatients as well as emergency room or clinic patients. The organization and personnel assigned to these functions may differ between facilities, but the objectives of the functions should be the same.

The preadmission function can contribute to overall patient accounting effectiveness by gathering and verifying data on all but emergency admitted patients prior to the time that the patient arrives for health services. Key elements for effective patient accounting controls performed in this function are:

1. Contacting patients to obtain all appropriate personal and financial information to prepare the registration form.

2. Verifying financial information (especially insurance coverage) and estimating the hospital bill as a basis for determining the patients portion of the bill.

3. Reviewing hospital records to identify any prior amounts due from the patient.

4. Recontacting the patient to review financial arrangements and requesting any required preadmission deposit.

The admission function begins when a patient enters a facility for health care services. Key elements for effective patient accounting controls performed in this function are:

1. Completing any missing personal or financial information for preadmitted patients.

2. For all patients who were not preadmitted, performing the information gathering and verification steps described in the preadmission function.

3. Completing all forms, obtaining proper signatures for consent for surgery, insurance assignment of benefits, guarantee of account, release of medical information, or others as required.

4. Referring patients to Cashiers or Financial Counseling for receipt of deposits or resolution of financial arrangements.

5. Insuring that the patient is transported to the appropriate location and that registration forms are properly distributed.

6. Recording all information necessary to maintain an accurate census.

The financial counseling function has as an objective the final determination of how a patient's account will be resolved by the time the patient is discharged. Patients will be referred to financial counseling by admissions personnel or the financial counselor may initiate contact with the patient or

guarantor. Key elements for effective patient accounting controls performed in this function are:

1. Reviewing all new admissions and consulting with the patient or guarantor as to financial requirements that are not covered by deposits or insurance benefits.

2. Assisting patients in applying for Medicaid or other financial assistance programs.

3. Establishing payment arrangements for amounts due from the patient or guarantor.

4. Identifying and properly classifying accounts for which partial or full amounts will be waived or reduced for charity or free care services.

The billing function should focus on timely preparation of accurate bills for services rendered. Key elements for effective patient accounting controls performed in this function are:

1. Monitoring and follow-up on outstanding insurance coverage verification requests and final diagnosis forms.

2. Assuring that charges for all services performed are recorded in the patient's account.

3. Preparing final bills for patients and third party payors, documenting the billing information in the patient account file and in third party billing logs.

4. Investigating insurance billing rejections and follow-up on a timely basis.

5. Answering inquiries concerning the billing of accounts.

The cashiering function is responsible for cash receipts processing and proper posting of receipts to patient accounts. Key elements for effective patient accounting controls performed in this function are:

1. Maintaining the in-house patient account file and explaining and collecting any outstanding patient balances at time of discharge.

2. Collecting time-of-service payments from outpatients, emergency room and clinic patients.

3. Preparing bank deposits and reconciling cash receipts to cash deposits.

4. Preparing the appropriate posting transactions to credit individual patient's accounts for patient payments, third party receipts, and contractual adjustments.

Collection is the final function in the process of patient account resolution. This function is charged with the responsibility of determining that all billings to patients or third parties are paid in accordance with the financial arrangements made with the patient or guarantor. Key elements for effective patient accounting controls performed in this function are:

1. Follow-up with patients after discharge by periodic statements, letters and/or telephone contact to assure payments due from patients or guarantors are made in accordance with financial arrangements.

2. Follow-up with insurance companies or other third party payors on billings outstanding after normal payment periods.

3. Coordinating and monitoring accounts placed with collection agencies for more intensive collection effort.

4. Completing final disposition of all accounts on a timely basis.

Each of these elements must be present in a patient accounting system to ensure that all services are billed and that all billings are accounted for by full payment or by an accurate determination that unpaid amounts are in fact uncollectible. The current policies and practices in the Department of Human Resources do not address completely the key elements I have described. This has resulted in the revenue and collections problems described in our report.

Thank you very much Mr. Chairman. I will be pleased to answer any questions you may have.

HEALTH CARE BILLING AND COLLECTION POLICIES AND PROCEDURES

Senator CHILES. Mr. Bowsher, would you please summarize your statement for the subcommittee.

Mr. BOWSHER. Mr. Chairman, I would like to point out that I am accompanied here today by two of my associates, Fred Lawrence on my right, and Mr. Pat Galvani on my left.

Mr. Chairman, I appreciate this opportunity to appear before you. As requested in your letter of July 29, 1976, my statement will focus on material regarding the health care billing and collection policies and procedures presented in our firm's recent report on accounting and financial management practices of the District of Columbia.

Also, in accord with your request, I will provide the subcommittee with a description of the major elements that should be included in a billing and collections system.

As we stated in our report, we found that Health care billing and collection policies are not well defined. Systems and procedures are fragmented and outmoded, and the collection effort is undisciplined and understaffed.

ABSENCE OF THIRD-PARTY BILLINGS

Some hospital care charges, particularly those of neighborhood health clinics, are not properly recorded on patient records to enable billing and collection. Considering that not all patients are billed under the present ineffective practices and procedures, it is impossible to determine the amount of understatement of third-party reimbursements from medicare, medicaid and various medical insurance programs.

Senator CHILES. What you are saying is that the city is losing revenue because it is not making third-party billings that they properly could make; is that correct?

Mr. BOWSHER. Yes.

Senator CHILES. There is no way you could tell what the extent of that is?

Mr. BOWSHER. That is correct.

Senator CHILES. On the basis of the records they now keep?

Mr. BOWSHER. Yes.

We understand that it is the Department of Human Resources policy to provide health care services to all in need regardless of the ability to pay. However, it appears that confusion exists, both internally and on the part of the public, as to the meaning of this policy. Apparently, it is sometimes construed to mean that all health services are free, especially in the outpatient and emergency room areas.

For example, we found that there are many outpatient and emergency room private pay charges which have not been entered into the automated patient billing system. We were informed that few emergency room or outpatient private-pay bills have been prepared for the District of Columbia General Hospital during the past 2½ years.

Similar charges for neighborhood health clinics are not billed and in some cases are not even recorded by the neighborhood clinic for possible billing. Because many charges are unrecorded, it is impossible to insure collection for services from patients or from third-party insurers.

For accounts that have been billed, there are inadequate procedures to assure the collection. As stated in our report: "The computerized hospital billing system contains in excess of $100 million of delinquent accounts receivable. These accounts, primarily for inpatients at District of Columbia General and Glendale Hospitals, represent health care services which were billed, but never collected by the Department of Human Resources. Collection efforts are minimal despite the fact that DHR estimates that $10 to $20 million of these accounts could be collected."

On this point, there is $100 million of charges that have actually been billed. This isn't all of the other charges where somebody got some free service that perhaps they would have paid for at one of the clinics or something. This is the charges that actually were billed.

Senator CHILES. A bill was rendered and not collected?

Mr. BOWSHER. That is correct.

LAX COLLECTION PROCEDURES

Senator CHILES. And the Department itself has estimated that some $10 million to $20 million of those accounts could be collected but nothing has been done to collect them?

Mr. BOWSHER. Very little effort, that is right.

Our review did not include a determination of the collectible portion of these outstanding receivables. The estimate included in the report resulted from discussions with DHR personnel. We understand that they had performed account analyses in prior periods to develop this estimate.

The important point is that there are inadequate policies and procedures to assure proper control over health care billings and collections.

An effective billing and collections system is predicated on a clear definition of policies as to services to be billed, methods by which billings will be determined and conditions under which billings will be waived, reduced or written off.

The systems developed under these policies must then be oriented toward assuring that patient account resolution begins at the earliest point possible in the process. There are about six functions involved in this process which must be well coordinated to assure effective patient account resolution.

These are preadmission, admission, financial counseling, billing, cashiering, and collection. These functions are applicable to hospital inpatients as well as emergency room or clinic patients. The organization and personnel assigned to these functions may differ between facilities, but the objectives of the functions should be about the same.

In my statement I have a description of each of those functions, and if time is short, I would be happy to put it in the record.

Senator CHILES. If you just put that in the record, I think that would be OK.

Mr. BOWSHER. Fine.

That pretty much concludes our statement.

Senator CHILES. Based on your analysis of the city's current billing system, you believe additional funds could be raised from all sources,

including medicaid, medicare, and third-party insurance and individual pay?

Mr. BOWSHER. That is correct.

Senator CHILES. But you can't make any estimate of what that would be?

Mr. BOWSHER. No.

NEW COLLECTION SYSTEM

Senator CHILES. What approximate amount of time do you estimate would be required for the city to establish a proper billing and collection system?

Mr. BOWSHER. I will answer that in two parts. I think you could have initial efforts which would improve the controls around the system that exists today. I think that effort might take about 6 months, and I think you could get quite a few improvements and realize some savings from that effort.

To put in a new system, one to do the complete job, I think that would take a year to 2 years.

Senator CHILES. So you could make substantial improvement within 6 months. What would be the cost of doing that? Do you have any estimate what you are talking about, costwise?

Mr. BOWSHER. Not too definitive, Mr. Chairman, because on the system you would have to do the preliminary system, kind of like having an architect design a system first, and then you would have a pretty good estimate of what the cost would be to install that system. But it would run several thousand dollars. My associate, Fred Lawrence, can shed light on that.

Mr. LAWRENCE. Senator, one of the things we have found in health care institutions in the past, when you undertake improvement in patient accounts, particularly with the lack of discipline or lack of procedures that have existed in the past in the DHR functions regarding patient care, the cost is sizable, in the six digits.

But the other thing we found is that the recovery of that cost through increased revenue, improved cash flow, normally pays out in a very short time period. Sometimes in as little as 12 months; certainly within a couple of years.

Senator CHILES. So you are saying it is going to be over $100,000?

Mr. LAWRENCE. I would anticipate, based on my experience in working with similar sized institutions here in the District and around the country, it could well exceed six digits; yes.

Senator CHILES. Would this be part of the work that would be done in the plan that you have submitted?

Mr. BOWSHER. It was contemplated, Senator Chiles.

Senator CHILES. We are referring to the Authorization Committee plan included in the legislation, which is not the law yet, but has passed in both Houses?

Mr. BOWSHER. It is included in that overall plan that you have referred to.

Senator CHILES. It wouldn't take full implementation of this plan to go out and collect this $10 million to $20 million existing on the books?

Mr. BOWSHER. No.

Senator CHILES. What would it take to try?

Mr. LAWRENCE. There are a couple of ways to attack that. One of the resources that are not directly available to the people in the District organization, some health care and, I might add, institutions in the educational area with extensive outstanding, old receivables, have made use of collection agencies to assist them for a percentage of the cash collected.

The cost is hard to define. I would think this, however: Whether you are able to organize an effort within the District, or whether you are able to organize something utilizing outside resources, you should be looking at collection costs in excess of 15 percent, but perhaps under 30 to 35 percent, of the cash that is ultimately realized out of the receivables.

Senator CHILES. Thank you very much for your statement and your testimony.

Mr. BOWSHER. Thank you, Mr. Chairman.

GENERAL ACCOUNTING OFFICE

STATEMENT OF VICTOR L. LOWE, DIRECTOR, GENERAL GOVERNMENT DIVISION, GENERAL ACCOUNTING OFFICE

ACCOMPANIED BY FRANK MEDICO, ASSISTANT DIRECTOR, GENERAL GOVERNMENT DIVISION, GENERAL ACCOUNTING OFFICE

PREPARED STATEMENT

Senator CHILES. We will now hear from Mr. Lowe, of the General Accounting Office.

Mr. Lowe, we will insert your prepared statement in the record at this point. Will you introduce your associates and summarize your statement.

[The statement follows:]

Mr. Chairman and Members of the Subcommittee:

We are here at your request to testify concerning the District's billing and collection policy for health care services provided District residents. You requested an estimate of the additional revenue that would be raised in fiscal year 1977 if the city implemented its own billing policy as discussed in the fiscal year 1977 hearing record. In providing an estimate, you requested that we use the data provided by the District to the Subcommittee for the fiscal years 1976 and 1977 hearing record and the District's fiscal year 1977 budget document.

In February 1972 we wrote to the Director, Department of Human Resources, on the results of our study at the Department's neighborhood health centers. The study showed that the centers were providing free health care to all patients, regardless of the patient's income or financial status. We suggested that in view of the limited financial resources available to the District to provide health care, it was essential to assure that those who could afford to pay for health services should pay. We suggested that the District reevaluate its policy for providing free health care to all patients at its neighborhood health centers.

Since issuing our report we have followed up with the Director concerning the status of the Department's efforts to bill for health services, but we have not performed any recent audit work on this particular subject. As you indicated in your letter, in spite of GAO's recommendations and your Subcommittee's urgings, four years after GAO's report the city has still not implemented a billing system for health care services.

Just a few days ago, on July 29, 1976, the Director, Department of Human Resources, forwarded a proposed bill to the Mayor's Special Assistant for Legislation. The health services to be provided free, without regard for the recipient's ability to pay, are set forth in the proposed bill. As of August 6, 1976, the proposal had not been forwarded to the

City Council for consideration. It is interesting to note that this proposed bill does not even mention billing patients who are able to pay; it does not establish guidelines for determining which patients should be billed; and, it does not give any guidelines for establishing charges for services. In other words, the proposed bill falls far short of establishing a billing policy.

Although there is considerable data in the fiscal years 1976 and 1977 hearing records and the Department of Human Resources fiscal year 1977 budget justification document concerning the operations of the District's health facilities, sufficient information is not available to permit us to make a dependable estimate of the amount of additional revenue the District could realize in 1977 by properly billing for health services.

Development of such an estimate would be rather straightforward if the needed information were available and reliable. Unfortunately, the needed information is not available:

1. There is no basis to identify the number of patients who should pay.

2. There is no basis to estimate the types and frequency of the services to be provided to patients who should pay.

3. There is no basis to estimate what effect the assessment of fees would have on the number of patients. Some, perhaps many, would go elsewhere for treatment if they had to pay.

Given these uncertainties, we are unable to provide you with a reliable estimate of the additional revenues that would accrue to the District as a result of implementing a billing system for health services. We are of the opinion that the revenue effect of a billing system will be unknown until such time as it has been implemented by the District and experience has been gained in its operation.

In June 1976, Arthur Andersen & Co., in its report on accounting and financial management practices of the District Government, stated with respect to the Department of Human Resources:

> "In summary, health care billing practices of DHR suffer from a lack of well-defined policies, fragmented and outmoded systems and procedures, and understaffed collection efforts. With continuation of these practices, it is impossible to determine whether DHR is maximizing its health care reimbursements from Medicare, Medicaid, various insurance programs and private parties. The Department is in critical need of a well-controlled, coordinated patient accounting and billing system to serve all of its health care agencies. Such a system will not be effective, however, until DHR clearly defines those services to be billed, the method by which the billing will be determined and the conditions under which billings will be waived or reduced."

Mr. Chairman, we fully understand the usefulness to your Subcommittee of a reliable estimate of potential revenues that could be derived by institution of a valid billing policy and system for health services. We have tried; unfortunately, we do not believe that a reliable estimate can be prepared from data maintained by the District Government.

Fully recognizing the unreliability of the data base, there appears to be a way of developing a range of estimates based on a set of assumptions.

The District estimates that in fiscal year 1977 that it will collect from third parties (Medicare, Medicaid, and insurance companies) a total of $17,900,000. It seems to us that it would be reasonable to expect that a vigorous screening of patients would result in increased revenue for the District. If a 10-percent increase is obtained this would amount to $1,790,000. A 20-percent increase, which is not entirely unreasonable considering the lack of a collection system in the District, would bring in a total of $3,580,000.

The hearing record on the District's budget for fiscal year 1977 (page 496) indicates that a total of 552,000 nonpublic interest visits to its facilities will be made. If it is assumed that one-third of these visits will be made by patients in a position to pay <u>something</u> on their bills, a substantial amount of revenues could be raised. If each such patient (184,000) were charged $10, that would amount to $1,840,000. If a 25-percent collection rate was made, the District would receive $460,000 in additional revenue. If a vigorous collec-

tion effort was made at the time the service was rendered, the collection rate for such minimal fees might even reach 50 percent or $920,000 a year.

If a vigorous effort is made to collect from those patients in a position to pay at the time service is rendered, it would be reasonable to expect that some of these patients would elect to seek private care, resulting in a decrease in the cost of the program. For each percentage point reduction in service load for such patients a savings of approximately $700,000 could, theoretically, be realized, offset by whatever the collections would be from this group.

We share your concern that the District Government has allowed the health services billing problem to remain uncorrected for so long a time. Hopefully, your Subcommittee's attention to this problem will stimulate the District to take corrective action.

If the Subcommittee is able to get the District to take action on a proper billing system, we will be glad to review it in operation and report back to you.

Mr. Chairman, this concludes my prepared statement.

POSSIBLE SAVINGS/REVENUES

	Lower estimate	Upper estimate
Increased collections from third parties:		
10 percent increase	$1,790,000	----------
20 percent increase	----------	$3,580,000
Increased collections from those who can pay:		
184,000 patients x $10 x .25	460,000	----------
184,000 patients x $10 x .50	----------	920,000
Savings due to decreased patient load:		
1 percent decrease	700,000	----------
5 percent decrease	----------	3,500,000
Total	$2,950.00	$8,000,000

BILLING AND COLLECTION POLICY FOR HEALTH CARE SERVICES

Senator CHILES. Mr. Lowe, please proceed.

Mr. LOWE. Mr. Chairman, we are here at your request to testify concerning the District's billing and collection policy for health care services provided District residents.

I have with me Mr. Frank Medico, who is our assistant director in charge of all the work we do at the District of Columbia government.

I was pleased to hear prior witnesses refer to one of our 1973 reports on health care systems. I would like to preface my statement by pointing out that we have a staff of 18 to 20 men at the District government on a continual basis. Frequently, it sounds as if we are being critical of the District. I think the top officials at the District realize we are taking a constructive approach, and are trying to find the problems, find what causes the problems, and offer constructive solutions.

You requested an estimate of the additional revenue that would be raised in fiscal year 1977 if the city implemented its own billing policy as discussed in the fiscal year 1977 hearing record.

In providing an estimate, you requested that we use the data provided by the District to the subcommittee for the fiscal years 1976 and 1977 hearing record and the District's fiscal year 1977 budget document.

NO RESTRICTION ON FREE HEALTH CARE

In February 1972, we wrote to the Director of the Department of Human Resources, on the results of our study at the Department's neighborhood health centers. The study showed that the centers were providing free health care to all patients, regardless of income or financial status.

We suggested that in view of the limited financial resources available to the District to provide health care, it was essential to assure that those who could afford to pay for health services should pay. We suggested that the District reevaluate its policy for providing free health care to all patients at its neighborhood health centers.

Since issuing our report, we have followed up with the director concerning the status of the Department's efforts to bill for health services, but we have not performed any recent audit work on this particular subject. As you indicated in your letter, in spite of GAO's recommendations and your subcommittee's urgings, 4 years after GAO's report, the city has still not implemented a billing system for health care services.

Just a few days ago, on July 29, 1976, the Director, Department of Human Resources, forwarded a proposed bill to the Mayor's Special Assistant for Legislation. The health services to be provided free without regard for the recipient's ability to pay are set forth in the proposed bill.

As of August 6, 1976, the proposal had not been forwarded to the City Council for consideration. It is interesting to note that this proposed bill does not even mention billing patients who are able to pay; it does not establish guidelines for determining which patients should be billed, and it does not give any guidelines for establishing

charges for services. In other words, the proposed bill falls far short of establishing a billing policy.

INFORMATION UNAVAILABLE FOR ESTIMATE

Although there is considerable data in the fiscal years 1976 and 1977 hearing records, and the Department of Human Resources fiscal year 1977 budget justification document concerning the operations of the District's health facilities, sufficient information is not available to permit us to make a dependable estimate of the amount of additional revenue the District could realize in 1977 by properly billing for health services.

Development of such an estimate would be rather straightforward if the needed information were available and reliable. Unfortunately, the needed information is not available. There is no basis to identify the number of patients who should pay. There is no basis to estimate the types and frequency of the services to be provided to patients who should pay. There is no basis to estimate what effect the assessment of fees would have on the number of patients. Some—perhaps many—would go elsewhere for treatment if they had to pay.

In June 1976, Arthur Andersen & Co., in its report on accounting and financial management practices of the District government, stated with respect to the Department of Human Resources—I think this was pretty well alluded to just a minute ago by a representative of that firm:

> In summary, health care billing practices of DHR suffer from a lack of well-defined policies, fragmented and outmoded systems and procedures, and understaffed collection efforts. With continuation of these practices, it is impossible to determine whether DHR is maximizing its health care reimbursements from medicare, medicaid, various insurance programs and private parties.
>
> The Department is in critical need of a well-controlled, coordinated patient accounting and billing system to serve all of its health care agencies. Such a system will not be effective, however, until DHR clearly defines those services to be billed; the method by which the billing will be determined and the conditions under which billings will be waived or reduced.

Mr. Chairman, we fully understand the usefulness to your subcommittee of a reliable estimate of potential revenues that could be derived by institution of a valid billing policy and system for health services. We have tried. Unfortunately, we do not believe that a reliable estimate can be prepared from data maintained by the District government.

Fully recognizing the unreliability of the data base, there appears to be a way of developing a range of estimates based on a set of assumptions.

At least one of the assumptions we used has been borne out by two of the previous witnesses this morning: Mr. Phil Dearborn, who referred to the lack of billing for medicare and medicaid which was available; and the representatives from Arthur Andersen.

SCREENING OF PATIENTS

The District estimates that in fiscal year 1977, that it will collect from third-parties—medicare, medicaid, and insurance companies—a total of $17,900,000. It seems to us that it would be reasonable to expect that a vigorous screening of patients would result in increased revenue for the District, as previously testified to.

If a 10-percent increase is obtained, that would amount to $1,790,000. A 20-percent increase, which is not entirely unreasonable considering the lack of a collection system in the District, would bring in a total of $3,580,000.

The hearing record on the District's budget for fiscal year 1977, page 496, indicates that a total of 552,000 non-public-interest visits to its facilities will be made. If it is assumed that one-third of these visits will be made by patients in a position to pay something on their bills, a substantial amount of revenues could be raised.

If each such patient were charged $10, that would amount to $1,840,000. If a 25-percent collection rate was made, the District would receive $460,000 in additional revenue. If a vigorous collection effort was made at the time the service was rendered, the collection rate for such minimal fees might even reach 50 percent, or $920,000 a year.

If a vigorous effort is made to collect from those patients in a position to pay at the time service is rendered, it would be reasonable to expect that some of these patients would elect to seek private care, resulting in a decrease in the cost of the program.

For each percentage point reduction in service load for such patients, a saving of approximately $700,000 could, theoretically be realized, offset by whatever the collections would be from this group of patients.

We share your concern that the District government has allowed the health services billing problem to remain uncorrected for so long a time. Hopefully, your subcommittee's attention to this problem will stimulate the District to take corrective action.

If the subcommittee is able to get the District to take action on a proper billing system, we will be glad to review it in operation and report back to you.

Mr. Chairman, that concludes my prepared statement, and we will try to answer any questions you may have for us.

Senator CHILES. Based on the data and other information given to the subcommittee, what is GAO's estimate of the amount of additional revenue the city could raise if a proper system were implemented?

Mr. LOWE. Based on the three factors I have outlined, the lower and upper estimate range from $3 to $8 million.

Senator CHILES. So between $3 and $8 million, with the assumptions you have made, could be collected?

Mr. LOWE. Yes; I think reasonable people might argue with the numbers here, but I think the theory is sound. Numbers may be higher or lower.

Senator CHILES. Thank you very much, Mr. Lowe.

I am going to vote, and when I come back we will hear from Mayor Washington.

Mr. LOWE. Thank you.

[A brief recess was taken.]

DISTRICT OF COLUMBIA

OFFICE OF THE MAYOR

STATEMENT OF WALTER E. WASHINGTON, MAYOR, THE DISTRICT OF COLUMBIA

ACCOMPANIED BY:

ROBERT JOHNSON, ADMINISTRATOR, DISTRICT OF COLUMBIA GENERAL HOSPITAL
WILLIAM WASHINGTON, M.D., ADMINISTRATOR OF COMMUNITY HEALTH AND HOSPITAL ADMINISTRATION
JULIAN DUGAS, CITY ADMINISTRATOR
COMER S. COPPIE, SPECIAL ASSISTANT TO MAYOR FOR BUDGET AND MANAGEMENT SYSTEMS

DISTRICT OF COLUMBIA HEALTH CARE PROBLEMS

Senator CHILES. It is the committee's pleasure now to hear from Mayor Washington on our health care problems.

Mayor WASHINGTON. Mr. Chairman, I have a brief statement. This statement is responsive basically to your letter to me.

Senator CHILES. All right, sir.

Mayor WASHINGTON. There are some other aspects of the total problem we may be treating.

STATEMENT OF MAYOR WASHINGTON

I am pleased to appear today to express my support for the committee's efforts in general, and more specifically my support of the general philosophy that has been used in looking at the city's budget under your chairmanship.

In an earlier appearance before your committee, Mr. Chairman, I stated my view that the mission approach to budget review provides a sound framework and a greater opportunity for us to address and focus directly on critical issues and emerging trends. Of course, what emerging trends I refer to, more specifically, is zero-based budgeting, which we have worked on in this area you are hearing today. I want you to know that I am prepared to go as far as we can, within the constraints of timing, in the budget to arrive at this approach.

I also expressed my hope that the precedent you have set will be extended and continued as the city moves forward in the home rule period.

As I pointed out, I support the zero-base review of the city's health care delivery system and other program areas which you, no doubt, will look into in the future. Such reviews provide a forum through which our programs can be better understood and allow us the opportunity to work cooperatively in reviewing the important policy and funding considerations which support our service delivery systems.

Over the years the city has moved responsibly to meet the challenge of providing adequate resources and facilities for the health care needs of a changing city population. The health and health care available to a community is truly one of the vital signs of the general well-being of that community.

Even though we are faced with ever-increasing numbers of our citizens who are unable to pay for health care, we have pursued and continue to pursue a policy which requires appropriate payment for these services from every citizen who is able to pay. At the same time, we will not deny services to citizens simply because they lack adequate resources. We think that would not be in the public interest.

In response to our own concern and that of others regarding the determination of those health services that are in the public interest, and the cost to the city of providing health care, we are continually looking for ways to keep the definition of "public interest" services current and to insure proper reimbursement for services that are deemed non-public-interest services. In that regard, we have drafted legislation which will soon be forwarded to the Council. This legislation will:

Modernize the District of Columbia's policy on health services versus current treatment models and recent financing mechanisms for health services;

Provide for a better understanding of those health services regarded as public interest. I think, in terms of understanding, the area of public interest is one of the problems which, obviously, you are addressing today, Mr. Chairman;

Enable the Department of Human Resources to maximize its financial resources for health care to citizens;

Insure an administrative mechanism whereby the determination of health services in the public interest shall be kept current; and

Provide a means of alerting citizens to ways in which they can obtain health protection, thus, avoid financial hardship to themselves, their families, and the community.

A copy of this draft legislation has been provided to the committee.

The submission of this legislation to the Council has not been done in the time frame originally projected—as I inquired—because of the considerable amount of research required in the drafting.

However, now that this phase has been completed, your committee, the City Council, and the general public will have an opportunity to review, analyze and provide substantive comments on our proposals.

Mr. Yeldell, the Director of the Department of Human Resources, is here. He will be happy to answer any questions you may have regarding our current health care policies or services.

PLACEMENT OF THE LEGISLATION OFFICE

Mr. Chairman, I am aware this is a brief statement and we will probably pursue it with appropriate questions. I purposely kept this brief. I would like to, if I may, digress on one other matter before your committee as you move toward markup. That is the matter of our Legislative Office, which in the 1976 budget was placed by your committee in the office of the Corporation Counsel, instead

of being permitted to continue to function as an independent entity in the Executive Office of the Mayor.

In your report you indicated your committee will review the adequacy of this organizational arrangement in fiscal year 1977, to assure the Mayor has an effective coordinating capability. As you know, Mr. Chairman, I wrote to you, as well as Chairman Natcher on July 20, expressing my strong support for an independent status for the Legislation Office.

I also requested at that time that you transfer the legislation function to the Office of the Mayor. While this action will not completely satisfy the total requirement, it will provide a better working relationship than the current placement.

Mrs. Rogers is here, but I would say to you, Mr. Chairman, in the interest of time, as I have analyzed the functioning of this Office without getting into details, it is essential that through the entire legislative process that is maintained directly in relation to my operations.

This Office not only monitors the Council legislation from its inception in committee, but through the Committee of the Whole, through the first and second readings and thereafter, during the period that the legislation is awaiting my signature, which involves rather substantial staff coordination in order to furnish me with the appropriate background for acting on legislative matters. Moreover, the Office has a rather substantial function in servicing the congressional committees such as the budget committees; the two District Committees, as well as individual Congressmen who from time to time make inquiries.

It would be virtually impossible, in my belief, that this work could be assigned and function as effectively as it is if it were not placed directly in my office and directly under my day-to-day supervision, which is what the situation is today.

Mr. Chairman, I would not say much more about that, but I hope you find it possible to accommodate the Mayor in this instance in permitting this office to continue to function under my specific direction.

Senator CHILES. Mr. Mayor, on this subject—before we get back to health care—I believe the discussion that took place in the conference committee, and the discussion in the markup on the Senate side, indicated an objection to setting up a separate office for legislative counsel. It is our feeling that every time you set up a separate office you have to add all the emoluments and overhead items that add to the unnecessary cost of the government.

It was placed in the Corporation Counsel because there was an existing department. And I don't think there would be any objection—there certainly wouldn't be on my part—to placing it in the Office of the Mayor.

Mayor WASHINGTON. Yes, Mr. Chairman, I appreciate that.

Senator CHILES. I don't think our discussion really focused on exactly were it should ago. We were looking for a place to house it rather than creating another office with all the emoluments we thought would go with that new office.

Mayor WASHINGTON. I think it would better function as an integral part of my operations, which have to be in direct relationship to the Congress in legislative matters.

Senator CHILES. Thank you for your statement.

DEPARTMENT OF HUMAN RESOURCES

STATEMENT OF JOSEPH P. YELDELL, DIRECTOR, DEPARTMENT OF HUMAN RESOURCES

ACCOMPANIED BY SHEPARD COHEN, COMPTROLLER

PREPARED STATEMENT

Senator CHILES. I know Mr. Yeldell has a statement, too.

Mr. Yeldell, I wonder if you could summarize your statement so I could ask you both questions on it.

Mr. YELDELL. I would be happy to, Mr. Chairman.

Senator CHILES. Your statement in full will be included in the record.

[The statement follows:]

MR. CHAIRMAN:

WASHINGTON, D. C. HAS A POPULATION OF APPROXIMATELY 730,000. THIS POPULATION IS COMPOSED OF VARIOUS ECONOMIC STRATA. THE RANGE IS FROM THE UPPER AND MIDDLE CLASS INDIVIDUAL, MANY OF WHOM ARE DIPLOMATS AND REPRESENTATIVES OF GOVERNMENTS, REPRESENTATIVES OF THE PEOPLE (SENATORS, CONGRESSMEN AND APPROPRIATE STAFF), AND OTHER HIGH-LEVEL GOVERNMENTAL WORKERS, TO THE INDIGENT, POVERTY-STRICKEN RESIDENT WITH POOR HOUSING, POOR SANITATION, POOR NUTRITION, AND IN MANY INSTANCES, POOR HEALTH CARE. BETWEEN THESE TWO EXTREMES LIE A GREAT BODY OF PERSONS SOME OF WHOM ARE MODERATELY ABLE TO CARE FOR THEIR SOCIAL AND HEALTH CARE NEEDS.

THE TRADITIONAL METHOD OF PROVIDING HEALTH CARE HAS GENERALLY BEEN THAT THE PRIVATE HEALTH SECTOR PROVIDES FOR PAYING (AND THIRD-PARTY PAY) CONSUMERS AND A SUBSTANTIALLY LARGE BODY OF PEOPLE ARE PROVIDED IN PUBLIC FACILITIES, PAID FOR BY THE CITY GOVERNMENT FROM CONGRESSIONAL APPROPRIATIONS AND FEDERAL REVENUE SOURCES.

THE THRUST OF THE FEDERAL GOVERNMENT IN THE HEALTH CARE AREA IN RECENT TIMES HAS BEEN TO RECOGNIZE QUALITY HEALTH CARE AS A RIGHT OF ALL RATHER THAN THE PRIVILEGE OF A FEW. LEGISLATION RECENTLY PASSED, CURRENTLY BEING CONSIDERED AND

PENDING, ATTEMPTS TO RESOLVE SOME OF THE BASIC ISSUES RAISED BY THIS CONCERN.

THE LEVEL OF HEALTH IN THIS AREA SHOULD NOT BE DETERMINED BY THE HIGHEST LEVEL OR LOWEST LEVEL AVAILABLE, BUT RATHER BY WHAT IS AVAILABLE TO THE ENTIRE POPULATION ON AN AVERAGE BASIS. THIS IS TO SAY THAT A SINGLE STANDARD OF HEALTH CARE SHOULD BE AVAILABLE TO ALL AND THAT THE HIGHEST QUALITY HEALTH CARE IS THAT RENDERED TO ALL PERSONS WITHOUT DISCRIMINATION, ECONOMIC OR OTHERWISE.

THERE ARE LOCATED IN THE CITY OF WASHINGTON, THREE EXCELLENT MEDICAL SCHOOLS AND TWO EXCELLENT DENTAL SCHOOLS. AN INCREASING PARTICIPATION IN THE PROVISION OF HEALTH CARE SERVICES AS WELL AS THEIR MORE TRADITIONAL ROLE OF TRAINING AND RESEARCH MUST BE REALIZED.

THE MEDICAL SOCIETIES ARE ALSO INCREASINGLY INTERESTED IN THE MATTER OF PROVISION OF HEALTH CARE AND REPRESENT A SUBSTANTIALLY SIGNIFICANT POTENTIAL FOR IMPROVING OUR OVERALL CAPABILITY.

FINALLY, BUT OF THE UTMOST IMPORTANCE, IS THE PRESSURE, MOST DESERVED, FROM THE RECIPIENT CONSUMER POPULATION. PEOPLE IN THE DISTRICT OF COLUMBIA, PRIMARILY THE BASIC CONSUMER, ARE BECOMING MORE INVOLVED IN ATTEMPTING TO OBTAIN

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HIGH-QUALITY SERVICES OF ALL KINDS. THIS CONCERN AND INVOLVEMENT EXTENDS SUBSTANTIALLY OR MOST SIGNIFICANTLY INTO THE PROVISION OF HEALTH CARE SERVICES FIELD.

THE DEPARTMENT OF HUMAN RESOURCES' CONTINUUM OF HEALTH CARE PLAN CAN BE ALIGNED TO FORM THE BASIC CONCEPT FOR DELIVERY OF HIGH-QUALITY HEALTH SERVICE. IN INTERPRETING THIS SYSTEM, ONE SHOULD KEEP IN MIND THAT THIS SYSTEM DOES NOT EXCLUDE THE PRIVATE HEALTH SECTOR, RATHER THE PRIVATE HEALTH SECTOR CAN BE AND IS INCLUDED IN EACH AND EVERY STEP. IT IS RATHER A PARTNERSHIP WHEREBY PRIVATE PROVIDERS AND PUBLIC PROVIDERS WORK COOPERATIVELY TO PROVIDE SERVICES IN A HUMANE AND DIGNIFIED FASHION WITHOUT ECONOMIC OR OTHER DISCRIMINATION AND WITH THE UTMOST OF CONCERN FOR THE HEALTH AND RELATED WELFARE OF THE CLIENTS.

HOME CARE SERVICES

THESE SERVICES ARE THOSE TO BE RENDERED IN THE PATIENTS' HOME. OBVIOUSLY, A DETERMINATION MUST BE MADE AS TO WHETHER THIS IS THE BEST FACILITY FOR CARING FOR THE INDIVIDUAL. A MEDICALLY SOUND DECISION SHOULD BE MADE BY THE PHYSICIAN INVOLVED (IF THE PHYSICIAN IS THE FIRST PERSON TO SEE THE PATIENT).

OTHERS BEING INVOLVED IN THE PROVISION OF SERVICES IN A HOME SETTING COULD BE MEDICAL STUDENTS, INTERNS, RESIDENT PHYSICIANS, PRIVATE PHYSICIANS, MENTAL HEALTH WORKERS, SOCIAL WORKERS, NURSING PERSONNEL, COMMUNITY HEALTH WORKERS, NUTRITIONISTS, ETC. THE ADVANTAGES OF PROVIDING SERVICES AT PATIENT'S HOMES WOULD BE THOSE ASSOCIATED WITH MAINTAINING AND INTEGRATED FAMILY, ASSURING AN ILL MOTHER THAT HER 3 or 4 CHILDREN WOULD HAVE SOME MONITORING IF SHE IS MINIMALLY ILL OR THAT CARE WOULD BE AVAILABLE IF SHE IS THE HEAD OF HOUSEHOLD AND NEEDS TO GO INTO A HOSPITAL, ETC. IT IS ALSO USEFUL TO GIVE PERSONS COMING INTO THE HOME, PHYSICIANS, NURSES, WORKERS, ETC., OBJECTIVE VIEWS AND EVALUATION OF WHAT EFFECT THE PATIENT'S HOME SITUATION HAS UPON THE ILLNESS AND VICE VERSA. IN THIS FASHION, BOTH HEALTH WORKERS AND PATIENT MAY COME TO UNDERSTAND EACH OTHERS PROBLEMS AND CAN HOPEFULLY WORK PRODUCTIVELY TO IMPROVE THESE RELATIONSHIPS. FOR THE MEDICAL STUDENT, THIS VIEWING DISEASE CONDITIONS WITHIN THE HOME MAY HELP TO DEVELOP AN AWARENESS OF HOME SITUATIONS AND THEIR EFFECT ON THE PRODUCTION AND COMMUNICABILITY OF DISEASE AS WELL AS NOTING THE EFFECTS OF THE PRESENCE OR LACK OF SATISFACTORY NUTRITION, SANITATION, HOUSING, ETC.

THE NEIGHBORHOOD HEALTH CENTER

THIS FACILITY WOULD BE THE NEXT LEVEL IN THE SYSTEM. THE ADVANTAGES ARE THAT THE PATIENT IS STILL CLOSE TO HIS OWN NEIGHBORHOOD WHICH REDUCES THE TRANSPORTATION COMPONENT AND ALLOWS THE PATIENT TO RETURN TO HIS HOME ON THE DAY THE SERVICE IS SOUGHT AND RENDERED. THIS RESULTS IN THE SHORTEST PERIOD OF TIME AWAY FROM HOME, AND THE SERVICE CAN BE RENDERED AT A SUBSTANTIALLY LOWER COST THAN THAT OCCASIONED BY TREATMENT IN A HOSPITAL BASED FACILITY. HERE AGAIN, MEDICAL STUDENTS, INTERNS, RESIDENT PHYSICIANS, MENTAL HEALTH WORKERS, NUTRITIONISTS, SOCIAL WORKERS, ETC., CAN BE BASED AND UTILIZED TO TREAT AND COUNSEL THE PERSON TO RETURN TO THE HOME FROM THE NEIGHBORHOOD HEALTH CENTER AND ALSO TO FOLLOW THE PATIENT INTO HOSPITAL CARE FACILITIES IF THAT IS NECESSARY. A PHYSICIAN DIAGNOSING A CASE IN THE NEIGHBORHOOD HEALTH CENTER, FOR EXAMPLE A SURGEON, MIGHT FOLLOW THE PATIENT INTO THE ACUTE HOSPITAL, PERFORM THE SURGERY AND PROVIDE APPROPRIATE POST-SURGICAL FOLLOWUP CARE IN THE NEIGHBORHOOD HEALTH CENTER, THEREBY MAINTAINING CONTINUITY OF CARE.

IF THE NEIGHBORHOOD HEALTH CENTER IS EQUIPPED WITH BASIC LABORATORY CAPABILITY, INCLUDING X-RAY

EQUIPMENT AND CAN PERFORM TESTS AND THERAPIES FOR LEASS THAN THAT PERFORMED IN AN ACUTE HOSPITAL, THE COST WILL ALSO REMAIN LOW, AND THE NEED TO ADMIT PATIENTS FOR LONG PERIODS TO HOSPITALS FOR DIAGNOSTIC PROCEDURE CAN BE MINIMIZED. THE NEXT STEP THEN LEADS TO -

THE ACUTE GENERAL HOSPITAL

IF NUMBERS 1 AND 2 ABOVE ARE UTILIZED APPROPRIATELY, THE ACUTE HOSPITAL CAN BE MORE EFFECTIVELY LIMITED TO THE CASES WHERE HOSPITAL TYPE HEALTH CARE MUST BE RENDERED. OPERATIONS, SERIOUS AND CRITICAL ILLNESSES, AND SUCH LIKE CONDITIONS WOULD BE THE PRIMARY CONDITIONS ADMITTED FOR HOSPITALIZATION. WITH THE BACKUP IN THE NEIGHBORHOOD HEALTH CENTER, THE HOSPITAL STAYS MAY BE REDUCED CONSIDERABLY, REDUCING THE COST PER PATIENT. THE AVERAGE INPATIENT DAYS PER PATIENT MAY ALSO BE REDUCED. OBVIOUSLY, THE VARIOUS DISCIPLINES MENTIONED ABOVE SHOULD BE AVAILABLE IN THIS FACILITY AS WELL AS IN THE HOME CARE SECTION AND THE NEIGHBORHOOD HEALTH CENTER. ADDITIONAL DISCIPLINES OCCASIONED BY THE PECULIAR NATURE OF A HOSPITAL SHOULD BE AVAILABLE AND THOUGHT AND CONSIDERATION SHOULD BE GIVEN TO NOT DUPLICATING SUBSTANTIALLY EXPENSIVE KINDS OF TREATMENT CAPABILITY IN SEVERAL DIFFERENT HOSPITALS.

AS FOR EXAMPLE, CAPABILITY FOR OPEN-HEART SURGERY NEED NOT PARTICULARLY BE AVAILABLE IN EVERY HOSPITAL WITHIN THE DISTRICT OF COLUMBIA. COOPERATIVE AGREEMENTS BETWEEN HOSPITALS WOULD ALLOW FOR THE TRANSPORTATION AND TREATING OF PATIENTS IN SPECIAL HOSPITALS WHICH HAVE THESE CAPABILITIES. THIS WOULD TEND TO REDUCE THE COST OF EQUIPMENT OF PROVIDING INVOLVED BUT PERHAPS INFREQUENT TYPES OF CARE SO THAT THE RESOURCES SAVED MAY BE USED IN OTHER WAYS.

OUR IN-TRAINING PERSONNEL, FOLLOWING THIS SCHEME, HAVE AN OPPORTUNITY TO VIEW THE PATIENT IN THE VARIOUS SETTINGS MENTIONED.

THE CHRONIC DISEASE AND REHABILITATIVE FACILITY

THOSE PATIENTS WHO HAVE FOLLOWED THE ABOVE EVER-INCREASING LEVELS OF HEALTH CARE AND WHO REQUIRE CONTINUING TREATMENT BELOW THAT OF AN ACUTE GENERAL HOSPITAL, BUT SUBSTANTIALLY ABOVE THAT AVAILABLE IN A NEIGHBORHOOD HEALTH CENTER AND WHICH CANNOT BE PROVIDED AT HOME MIGHT BE PLACED IN A LONG-TERM CARE FACILITY. AGAIN, THE SEVERAL DISCIPLINES MUST BE AVAILABLE TO CARRY OUT THEIR SPECIAL CAPABILITIES. HERE, THERE SHOULD BE A GREATER CAPABILITY FOR PHYSICAL MEDICINE AND REHABILITATION ACTIVITIES SINCE THESE MEASURES OFTEN REQUIRE LONG-TERM APPLICATION. (CERTAIN SMALLER CAPABILITY IN THIS AREA IS ALOS NECESSARY IN THE ACUTE CARE

FACILITY. HOWEVER, WHEN IT BECOMES EVIDENT THAT A PATIENT WILL REQUIRE A PROLONGED PERIOD OF TREATMENT, TRANSFER TO A CHRONIC OR LONG-TERM CARE FACILITY WILL BE INDICATED.) OBVIOUSLY, MEDICAL SCHOOLS FOR TRAINING PURPOSES SHOULD BE INVOLVED HERE. THE POPULATION OF THIS CITY AS WELL AS THE UNITED STATES IN GENERAL CONTAINS MORE SENIOR CITIZENS AND MORE PEOPLE ARE SURVIVING LONGER, SO THAT LONG-TERM CARE CONDITIONS AND DISEASES MAY FORM AN INCREASINGLY SIGNIFICANT PART OF A PHYSICIANS PRACTICE.

THE EXTENDED AND LONG-TERM CARE

FOLLOWING THE ABOVE AND FOR THOSE PERSONS WHO ARE SUBSTANTIALLY ADVANCED IN AGE AND WHO ARE NOT NECESSARILY BED CONFINED WITH ILLNESS, BUT WHO DO NOT HAVE A FAMILY AND/OR THE CAPABILITY OF LIVING ALONE, CERTAIN LONG-TERM FACILITIES ARE NECESSARY. WITHIN THESE FACILITIES MAY BE A PORTION DIRECTED MORE TOWARD THE MEDICAL OR DISPENSARY MODEL AND ALSO A PORTION WHICH REPRESENTS PRIMARY LIVING QUARTERS. NEVERTHELESS, IN EACH OF THESE AREAS, CERTAIN HEALTH CARE CAPABILITIES MUST BE AVAILABLE. FOR EXAMPLE, A RESIDENT MAY SUDDENLY REQUIRE AN OPERATION DUE TO APPENDICITIS OR SOME OTHER KIND OF ILLNESS. HEALTH CAPABILITIES MUST BE MAINTAINED

WITHIN THIS FACILITY REQUIRING JUDGEMENT ON THE PART OF HEALTH WORKERS.

WHEN TAKEN AS A UNIFIED SYSTEM, IT IS MY EARNEST BELIEF, IF COMMITMENT IS MADE BY GOVERNMENT HEALTH WORKERS AND THE HEALTH COMMUNITY, THAT SUCH A SYSTEM WILL PROVIDE HIGH QUALITY HEALTH SERVICE TO ALL OF THE CITIZENS OF THE DISTRICT OF COLUMBIA.

THE INCREASES IN THE COST OF HEALTH CARE IS NOT PREDICATED EXCLUSIVELY UPON THE ACCESSIBILITY OF HEALTH SERVICES, BUT THE NEED FOR HEALTH SERVICES. THE PUBLIC HEALTH SYSTEM IN THE DISTRICT IS GEARED TOWARD PEOPLE WHO NEED HEALTH SERVICES AND WHO ARE USUALLY UNAWARE OF THEIR HEALTH STATUS. THIS APPROACH IS NOT ONLY HUMANE; IT IS COST BENEFICIAL. BY IDENTIFYING DISEASES IN THEIR EARLIEST FORM WE ARE ABLE TO AVOID MORE COSTLY TREATMENT IN LATER YEARS AFTER THE DEBILITATION HAS PROGRESSED. THE CHHA EMPHASIZES FAMILY CARE. PRIMARY CONTACT WITH COMMUNICABLE DISEASES OBVIOUSLY SHOULD BE INVESTIGATED AND TREATED AS EARLY AS POSSIBLE.

OUR CONCERN FOR MAXIMUM HEALTH CARE ESPECIALLY RESULTS IN POSITIVE COST/BENEFIT ANALYSIS WHEN CONSIDERED IN LIGHT OF THE TOTAL HUMAN RESOURCES SYSTEM. ILLNESSES IF LEFT UNTREATED WILL RESULT IN LOSS OF INCOME, UNEMPLOYMENT, BIRTH DEFECTS AND

ULTIMATELY UNTIMELY DEATH. THE BYPRODUCTS OFTEN BECOME COSTS TO THE OTHER SEGMENTS OF THE DEPARTMENT. PERSONS AFFECTED MAY BECOME WELFARE RECIPIENTS; REQUIRE INSTITUTIONALIZATION; AND THEIR CHILDREN MAY BECOME MEMBERS OF SINGLE PARENT HOUSEHOLDS AND THEREBY ELIGIBLE FOR PUBLIC ASSISTANCE.

THE ADVANTAGES OF AN APPROPRIATE HEALTH SYSTEM FAR EXCEEDS THE COST WHEN VIEWED IN ITS TOTALITY.

REFERENCES THAT IDENTIFY D.C. AS "NUMBER ONE IN THE NATION WITH REGARD TO PHYSICIAN TO POPULATION RATIOS" AND PROJECTIONS "THAT THE METROPOLITAN AREA WILL HAVE A SURPLUS OF 1,700 SHORT-TERM BEDS BY 1980" ARE GROSSLY MISLEADING. THERE IS NO EVIDENCE THAT PROPER CONSIDERATION WAS GIVEN TO THE UNIQUENESS OF THE DISTRICT. FOR EXAMPLE, THERE ARE THREE INTERNATIONALLY PROMINENT MEDICAL COLLEGES IN WASHINGTON, D.C. (HOWARD, GEORGETOWN AND GEORGE WASHINGTON UNIVERSITIES). HOW MUCH CONSIDERATION WAS GIVEN TO THEIR SUBSTANTIAL FACULTIES; DID THE STUDY DIFFERENTIATE BETWEEN PHYSICIANS WHO ARE SPECIALISTS VIS-A-VIS THOSE ADMINISTERING PRIMARY CARE (WHICH IS DHR'S HEALTH CONCERN) AND DID IT ELIMINATE THE GOVERNMENT PHYSICIANS WHO DO NOT ENGAGE IN TREATMENT OF D.C. RESIDENTS INCLUDING MILITARY HOSPITALS IN THE DISTRICT? IT WOULD BE

GROSSLY UNFAIR TO DERIVE ANY INFERENCE FROM THE AMA PUBLICATION WITHOUT THESE SAFEGUARDS.

THE MATTER OF EMPTY BEDS PER SE MUST BE LOOKED AT IN PERSPECTIVE. DCGH IS UNDER A COURT ORDER TO REDUCE ITS NUMBER OF PATIENTS OR INCREASE ITS STAFF. THIS OBVIOUSLY IS CONTRARY TO AREA WIDE PATIENT CENSUS DATA, BUT AGAIN POINTS OUT THE WEAKNESS OF STATISTICAL INFERENCE WHICH CAN SKEW. WE COULD ASK WHY THIS PHENOMENON AND SPECULATE; HOWEVER, OUR EXPERIENCE DOCUMENTS THAT MANY ARE ACTUALLY REFERRED FROM SOME OF THE UNDER-UTILIZED INSTITUTIONS. NEVERTHELESS, THE DEPARTMENT WOULD WELCOME RELIEF BY THE PRIVATE SECTOR BUT UNTIL THIS COOPERATION IS EVIDENT, D.C. GENERAL IS OBLIGATED TO MAINTAIN HOSPITALIZATION CAPABILITY FOR THE INDIGENT AND MEDICALLY INDIGENT PERSON.

THE QUESTION OF WHETHER THERE IS A NEED FOR THE CITY TO PROVIDE HEALTH CARE SERVICES CONTINUALLY COMES BEFORE US. IT SEEMS TO US THAT THE VERY ISSUE IS BASED ON WHAT IS FELT TO BE AN ERRONEOUS ASSUMPTION, THAT THE PRIVATE SECTOR, BEING UNDERUTILIZED, WOULD WELCOME AN OPPORTUNITY TO EXPAND ITS CLIENTELE, INCLUDING THE UNDERPRIVILEDGED, AND DO SO AT A REDUCED COST. THIS IS CONSIDERED CORRO-BORATED BY AMA DATA ON AVERAGE NATIONAL COSTS WHICH AGAIN MIXES RATES ATTRIBUTAL TO RURAL

LIVING THAT SHOULD NOT BE EVALUATED STRICTLY ON THE BASIS OF AVERAGE COST NATIONWIDE.

PREVIOUS CONTRACTS WITH THE PRIVATE SECTOR FOR PROVIDING MEDICAL SERVICES HAVE BEEN TERMINATED BECAUSE OF THE HIGH COST OF SERVICES. HOWEVER, THE CONTRACT PRICE WAS ADEQUATE FOR INTERNAL OPERATION. ADDITIONALLY, THE PRIVATE SECTOR HAS BEEN MOST VOCAL IN ATTEMPTING TO SECURE AN INCREASE IN THE MEDICAID REIMBURSEMENT RATE FOR PROVIDING HEALTH SERVICE. THEIR CALIM IS THE NEED FOR THE DISTRICT "TO PAY REASONABLE COST" WHICH EXCEEDS THE PER CAPITA INVESTMENT AT PUBLIC INSTITUTIONS.

AS STATED ABOVE, DHR ENCOURAGES MORE INVOLVEMENT BY T.. PRIVATE SECTOR, BUT TO ASSUME THAT OVERALL IT WILL "BE MORE COST EFFECTIVE" IS INCONCLUSIVE AT THIS TIME. SIMILARLY, THE FINDINGS OF ADEQUACY OF THE LEVEL OF HEALTH OF RESIDENTS OF THE DISTRICT AS REPORTED BY THE NATIONAL CENTER FOR HEALTH SERVICES MUST BE FOOTNOTED. THE DISTRICT OF COLUMBIA IS THE NATION'S CAPITAL. ITS POPULATION INCLUDES DIPLOMATS, CONGRESSMEN AND THEIR STAFF, LOBBYISTS AND THE LIKE ALL WHO HAVE APPROPRIATE HEALTH CARE AND LOWER THE OVERALL RATE OF D.C. ILLNESSES. BUT THEY ARE NOT CLIENTS OF THE DEPARTMENT. TO BE MEANINGFUL, WASHINGTON'S INNERCITY MUST BE CATALOGED. BY THAT WE REFER TO SOUTHEAST AND FAR NORTHEAST WASHINGTON WHERE THE BULK OF THE PUBLIC

HEALTH ACTIVITY IS PROVIDED. WE THINK THAT SUFFICIENT EVIDENCE OF SIGNIFICANT ILLNESS WOULD BE FOUND TO JUSTIFY THE COMMITMENT OF RESOURCES.

AS A MATTER OF FACT, THE HEALTH RESOURCES FOR DHR CLIENTELE IN THE DISTRICT ARE INADEQUATE. THE PUBLIC SECTOR HAS SEVERE SHORTAGES IN NURSING, EPIDEMIOLOGICAL AND ALLIED HEALTH SERVICE PERSONNEL SUCH AS OCCUPATIONAL HEALTH SPECIALISTS, OCCUPATIONAL AND PHYSICAL THERAPISTS, VOCATIONAL AND ACCIDENT PREVENTION SPECIALISTS, ETC. ADDITIONALLY, THE CITY'S SUPPLY OF DOCTORS IS SERIOUSLY BELOW QUALITY STANDARDS.

AS THE DEPARTMENT'S REPONSE TO SENATE QUERIES IN APRIL 1976 INDICATES, THE DEFINITION OF SERVICES PROVIDED IN THE PUBLIC INTEREST IS NO SIMPLE MATTER. WE REVIEWED SEVEN PAGES OF GOVERNING AND INVOLVED FEDERAL AND DISTRICT STATUTES. THEY RANGE FROM STATUTES GOVERNING PAYMENT OF D.C. INDIGENT PERSONS HOSPITALIZED OUTSIDE THE DISTRICT OF COLUMBIA THROUGH REGULATIONS THAT STATE THAT FEDERAL FUNDS "MAY NOT SUPPLANT D.C. APPROPRIATED FUNDS. THIS SITUATION PROBABLY JUSTIFIES THE ENTRY IN THE D.C. CODE, TITLE VIII, CHAPTER H, WHICH ESTABLISHES THAT "THE COMMISSIONERS HAVE DETERMINED THAT THE CLINICS OF THE DISTRICT OF COLUMBIA DEPARTMENT OF PUBLIC HEALTH, EXCEPT THOSE INDICATED HEREIN, BE OPERATED IN THE PUBLIC INTEREST

WITHOUT CHARGE FOR CLINICAL SERVICES, UNLESS VOLUNTARY PAYMENTS ARE MADE; THAT FOR ALL PATIENTS RECEIVING CARE IN THE OUTPATIENT CLINICS AT THE DISTRICT OF COLUMBIA GENERAL HOSPITAL AND, AFTER THE FIRST VISIT IN THE PRENATAL AND DENTAL (EXCLUDING SCHOOL CHILDREN) CLINICS OF THE DEPARTMENT OF PUBLICH HEALTH..."

THE DEPARTMENT OF HUMAN RESOURCES HAS SCREENED MUCH MATERIAL TO IDENTIFY EIGHT SPECIFICALLY CODIFIED HEALTH SERVICES THAT ARE DEEMED TO BE IN THE PUBLIC INTEREST; VENEREAL DISEASE, TUBERCULOSIS, PRENATAL CARE, FAMILY PLANNING, IMMUNIZATION, LEAD POISONING, DIABETES AND HYPERTENSION. THIS LIST IS NOT ALL INCLUSIVE. INDEED, THE CITY COUNCIL MUST LEGISLATE WHAT, IF ANY, ADDITIONAL HEALTH SERVICES MUST BE VIEWED AS "IN THE PUBLIC INTEREST." IT MUST ALSO SUPERSEDE THE ALREADY ESTABLISHED REGULATIONS PROHIBITING CHARGES FOR SERVICES PROVIDED AT THE NEIGHBORHOOD CLINICS AND OUTPATIENT CLINICS OF D. C. GENERAL HOSPITAL AS REFERENCED ABOVE.

TWO YEARS LEAD TIME WOULD BE EXTREMELY OPTIMISTIC. PLACED IN THE PROPER PERSPECTIVE, IT WOULD BE NECESSARY TO ENVISION THE TIME REQUIREMENT TO PREPARE FOR THE COMMUNITY RESPONSE TO CHARGES FOR PREVIOUSLY FREE SERVICE; TRAINING OF

MEDICAL STAFF TO BE GUIDED BY THE PROFIT MARGIN; COMPETITION BETWEEN THE PUBLIC AND PRIVATE SECTOR; SECURITY OF FACILITIES LOCATED IN LOW-RENT AND HIGH-RISK NEIGHBORHOODS; COMPUTERIZATION OF CHARGES, PAYMENT, ETC. AND MANAGEMENT AND CONTROL POLICIES AND PROCEDURES. THE SENATE SEEMED TO GIVE RECOGNITION TO THIS SIGNIFICANT PROBLEM ASSOCIATED WITH BILLING, ETC BY TENTATIVELY EARMARKING $1.5 MILLION IN ADDITIONAL F.Y. 1977 RESOURCES FOR ADDRESSING JUST THIS MATTER. AS A LONG-RANGE PROPOSAL, THIS LATTER PROPOSITION IS WORTH CONSIDERATION. OF COURSE, THIS WILL ALSO REQUIRE THE RESOLUTION OF THE "PUBLIC INTEREST ISSUE" DISCUSSED ABOVE.

FINALLY, MR. CHAIRMAN, I HAVE GREAT APPRECIATION FOR YOUR CONCERN THAT THE CITY MAXIMIZE ITS RESOURCES BY PROPERLY BILLING AND COLLECTING FOR THOSE SERVICES FOR WHICH PAYMENT SHOULD BE MADE. THERE IS NO QUESTION THAT IMPROVEMENTS IN OUR SYSTEM ARE POSSIBLE AND CHARGES ARE UNDERWAY. BY OCTOBER1, OUR COMPUTER SYSTEM WILL BE IN PLACE AND A NEW AUTOMATED BILLING SYSTEM WILL BE IMPLEMENTED. THIS SYSTEM, ACCOMPANIED BY ADDITIONAL PERSONNEL WILL SMOOTH OUT THE PROCESS OF BILLING AND COLLECTING FOR MEDICAID, MEDICARE, AND THIRD PARTY INSURACE CLINENTS IN OUR INSTITUTIONS AND AT

OUR NEIGHBORHOOD HEALTH CENTERS. UPON COMPLETION OF CITY COUNCIL ACTION DEFINING "PUBLIC INTEREST SERVICES, WE WILL ALSO IMPLEMENT PROPER BILLINGS AND COLLECTIONS FOR PERSONAL PAY CLIENTS AT THE NEIGHBORHOOD HEALTH CENTERS.

YOU CAN BE ASSURED, MR. CHAIRMAN, THAT WE WILL EXERT EVERY EFFORT TO APPROPRIATELY EXAMINE EACH AND EVERY PERSON TREATED AS TO PAY ABILITY AND EXERT MAXIMUM EFFORT TO COLLECT FOR SUCH SERVICES. I WOULD REMIND YOU, HOWEVER, THAT IN OUR JUDGEMENT WE ARE PRESENTLY COLLECTING WITHIN $2 TO $3 MILLION OF THE MAXIMUM POTENTIAL COLLECTIBLE. I KNOW THAT GAO AND OTHERS FEEL THAT A GREAT MANY MORE DOLLARS CAN BE COLLECTED BY GREATER EFFORTS IN COLLECTING FOR PERSONAL PAY PATIENTS. WHAT IS NOT UNDERSTOOD ABOUT THIS CATEGORY OF PERSONAL PAY PATIENTS IS THAT THESE PEOPLE BY AND LARGE REALLY HAD NO CAPABILITY TO PAY. FEW QUALIFIED AND ESTABLISHED PAYERS REQUEST MEDICAL ASSISTANCE AT THE NEIGHBORHOOD HEALTH CENTERS AND/OR D. C. GENERAL HOSPITAL. THEY ARE SPECIFICALLY AND PURPOSEFULLY LOCATED IN LOW RENT AND HIGH-RISK AREAS THAT DO NOT ATTRACT THE PRIVATE HEALTH SECTOR. WHAT WE ARE REALLY REFERRING TO IN THIS CATEGORY IS THE WORKING POOR-THE PERSON OR FAMILY STRUGGLING TO MAKE ENDS

MEET WHO CAN NOT AFFORD TO TAKE FROM THE FAMILY BUDGET THE COST OF HEALTH INSURANCE PREMIUMS.

WE OFFER PUBLIC ASSISTANCE TO OUR CITIZENS; HOWEVER, WE ONLY PAY AT 68% OF THE 1975 COST OF LIVING STANDARD. MEDICAID IS PROVIDED TO SUCH PERSONS AND CURRENTLY TO THOSE NOT ON PA BUT WHOSE INCOME IS WITHIN "101 %" OF THE PA PAYMENT LEVEL i.e., AT ABOUT THE SAME LEVEL. ADDITIONALLY WE OFFER A PROGRAM OF MEDICAL CHARITIES WHICH TAKES IN A SEGMENT OF THE POPULATION AT THE SAME LEVEL AS THE MEDICALLY NEEDY BUT WHO ARE NOT CATEGORICALLY RELATED TO THE MEDICAID PROGRAM.

IN EFFECT, MR. CHAIRMAN, WE DELUDE OURSELVES INTO THINKING THAT SIMPLY BECAUSE THESE PERSONS DO NOT QUALIFY FOR MEDICAID OR MEDICAL CHARITIES THAT THEY HAVE THE ABILITY TO PAY FOR THE VAST MAJORITY OF SUCH PERSONS - DUE TO THE EXTREME LOW LEVEL OF OUR ASSISTANCE PROGRAMS ARE THEMSELVES BELOW THE POVERTY LINE.

WE RECOGNIZE OUR RESPONSIBILITY TO COLLECT WHERE POSSIBLE, AND WE WILL DO SO, HOWEVER, OUR POSTURE, AS I'M SURE YOURS WOULD BE, IS TO PROVIDE ESSENTIAL HEALTH SERVICES TO THOSE IN NEED.

SUMMARY OF STATEMENT

Mr. YELDELL. Mr. Chairman, what I have attempted to address in my statement is the state of the health picture as we see it in the District of Columbia, as well as addressing the peculiarities of the relationship between both the public and private sector.

What I intend to do is make it extremely clear that the private sector is not excluded from health planning as it relates to the Department of Human Resources.

Rather, they are encouraged to participate. I think one of the things that bothers us the most is an assumption that the private sector is willing to move into the area of health care that is largely being met by the Department of Human Resources, primarily because the people that are being served are those who are the working poor.

I think that we can substantiate the position we have taken. Further, there have been several efforts involving both the private sector and the public sector, for a study that has been completed and does make specific recommendations.

In summary, Mr. Chairman, the Department accepts the position of the Nelson Commission study and the position advanced by the committee to the maximum extent possible we do not have duplicative services. We don't want separate levels of health services.

BILLINGS AND COLLECTIONS

In the areas of billing and collection, we did go through a discussion here with the comments generated by the committee. We make it extremely clear our intent to move as vigorously as possible to implement a smooth billing and collection system as you would have us do.

I would point out, within our judgment, we are within $2 to $3 million of the collections that we consider possible.

Senator CHILES. You are within $2 to $3 million dollars?

Mr. YELDELL. We think we are within $2 to $3 million on the maximum collectibility.

Senator CHILES. Earlier, Arthur Andersen's people said you have $100 million in delinquent accounts from the Community Health and Hospital Administration on the books, and that they had from your Department a statement that $10 to $20 million of that could be collected.

Mr. YELDELL. I think the $100 million figure has been around for a long time. It covers a long period of time. It involves bills that were generated without any considerations of payability.

We have taken two steps in that regard. One is we have done a 10-percent sampling of those bills, as we mentioned to the committee previously. The results were almost completely negative. However, we also pursued it with a firm that specializes in moving through bills of this nature on a percentage of the collectibility rate, and we have been negotiating a contract with such a firm now.

However, Mr. Chairman, I would say, quickly, that a vast majority of those bills are for services rendered in the neighborhood health centers at a time when the existing Commissioners' order made such services in the public interest. Moreover, that such bills are generally for services to people in the medical charity or in the working poor category.

Senator CHILES. What about the figure of $10 to $20 million that was given to Arthur Andersen that was collectible?

Mr. YELDELL. I have no idea where they got such a figure. I don't know who they talked with to get such a figure. It certainly was not me. I have serious problems with this $10 to $20 million collectibility.

However, I would be prepared to pursue that with Arthur Andersen, but that would not change the underlying factor. I think the data will demonstrate we are well within $2 to $3 million of the maximum collectible amount.

I would also say, Mr. Chairman, that the biggest problem here is people are assuming that the personal-pay patients are really in a position to pay. I think this can be quickly discounted if one recognizes that our current payment level for AFDC is at about 68 percent of the 1975 cost-of-living standard. The medically needy portion of the medicaid program only goes 101 percent above that. The medical charities program covers about the same group of people, except they are not categorically related to the medicaid program. We are dealing with a defined segment, who have the capability to pay, but don't have it.

ARTHUR ANDERSEN AND GAO FINDINGS

Senator CHILES. We are also dealing with Arthur Andersen's findings, and GAO's findings, that the city is not presently billing the third-party payment under medicare, under medicaid and under insurance.

Mr. YELDELL. I do take exception to that, sir.

Senator CHILES. That is interesting, Mr. Yeldell, if you take exception to that. Arthur Andersen is a fairly reputable accounting company. They have spent $45,000 of the taxpayers' money, doing the survey of what the needs of the city are. That report comes up with a plan to spend approximately $20 million to help solve the city's problems.

The General Accounting Office is a fairly reputable operation. It also makes audits and estimates for the entire Federal Government. Both GAO and Arthur Andersen have found there are moneys that are not being collected and can be collected, and you can come here and say you just take issue with this?

What this committee wants to find out is what can be collected. We are not as interested, really, in their opinions or your opinions. We want to see that every effort is being made to collect this additional reserve that is available to the city.

And right now you are not doing the kind of interviews you need to be doing with your people under medicare, and medicaid and insurance. We are not talking about people that can't afford to pay, now, but money that is going to come to you from the Federal Government, and money from private insurance companies, and money from people that are not poor and can afford to pay.

Mr. YELDELL. Let me try again. I don't disagree there are additional resources. What I was saying is that we are within $2 to $3 million of the collectible amount. That amount is largely in the medicaid and third-party area.

You will note from my statement where we make it very clear, we are not satisfied with the interviewing or the billing and collections processes. Indeed, we make it extremely clear if 98 people are employed we can get this additional resource.

When I take exception, I take exception to people saying larger amounts are there. If the estimate exceeds $3 million, that is what I take exception to. If we can be moving up to the $3 million capability, then I am in agreement.

Mayor WASHINGTON. Mr. Chairman, my motion is this: There are assumptions by both Arthur Andersen and GAO. What we are looking at, and I think is the nature of your inquiry, is whether or not there are additional efforts which can be expended, both in medicare, medicaid and the third-party areas, and in defining public interest and beyond, that establish some rational procedure for billing and collection.

What I came to say to you is that I am prepared to support any effort, whatever it may be, to make sure that every dollar is in the till that is collectible, and that a billing process is effected that will be known to everybody.

I have seen the Arthur Andersen and GAO reports, and I have heard enough about them. We are dealing in some instances with assumptions.

I think what you have to do is face the facts of the matter and go forward, both with legislation and with a new billing system—which is expected to start in October—and move to get every dime that is out there. That is what I came to say to you.

Senator CHILES. I appreciate that attitude, Mr. Mayor, and that is exactly what I think we are looking for in this committee.

PROPOSED LEGISLATION

I would have to point out, though, I don't think the draft of the bill submitted to us, and again, this is the bill that we have been looking for for a long, long time—the GAO report was done in 1972. Since I have been on this committee, which is a couple of years now, I have been talking about it and trying to see something done to require those people who could afford to pay that go to the outpatient clinics and get the other city services, that they would pay a fair share so the regular taxpayer is not taking on all the burden.

And now we are told by Mr. Yeldell's statement that the bill is taking so long because of its complicated drafting procedures. When I read that bill, and I see that it doesn't even mention billing patients who would be able to pay; it does not establish any guidelines for determining which patients should be billed; it does not give guidelines for establishing charges for services; and all that bill does, as I read it, is just to one more time say that we are going to provide some free care.

It enumerates the present free care, it says how we can add to that free care every year, and it says in spite of the free care we have enumerated here, if the director thinks anything else should be added, they can add that, and if we think there is any kind of hardship to anybody on the basis of collection, we won't collect from them.

Mayor WASHINGTON. I think there are two aspects to it. The bill itself, should define what services are in the public interest and what services will be billed.

The second is the billing process which is not dealt with in the legislation.

SPECIFICS OF PROPOSED LEGISLATION

Senator CHILES. I wish Mr. Yeldell or someone could read to me anything in this bill that intimates we are going to charge anybody for services. The only thing I find in there is where we are not going to charge.

Mr. YELDELL. Mr. Chairman, the bill is addressing the definition of "in the public interest." There are established regulations for bills that set the rate of charge for services.

Once this bill is approved through the Congress, and it is decided what services are going to be in the public interest, it's a simple matter of taking existing authority and expanding it for the charges for other services. There was no attempt in the bill to define charges. It's already done. There is a mechanism for that already in place.

Senator CHILES. You really confused me now, because what I have been hearing for 2 years is you couldn't charge for these services until we got something through the Congress permitting the city to start charging for the services, because the policy—based in existing law—is that we are going to provide free care.

We started talking about the necessity of some things being free. Treatment of communicable diseases, we all agreed on that being free to everyone; treatment of any kind of disease that might spread or be infectious; many other things like tuberculosis, we kind of agreed that these items should be free. So we started talking about the position that some kinds of services and treatments should be free to everyone. But other services—all the other services—should be charged for.

But the city told us that before we can charge for some services we have to have a bill through the Congress. That policy has to be defined in law. Now you are telling me we are defining "public interest" and that the authority already exists for billng for services.

Mr. YELDELL. I think we got off on the wrong foot. Let me try again.

We have defined in this bill eight areas of service to be in the public interest. All the other services are to be charged for.

Senator CHILES. The bill doesn't say that. How are you going to charge, under what authority?

Mr. YELDELL. The existing authority is a commissioners' order that addresses the fact that all services provided in the neighborhood health centers are to be in the public interest. This bill would change that and say only eight services are to be in the public interest. If the Council accepts that and adopts the bill, then we get away from the issue of not charging for services for personal-pay patients in the neighborhood health centers.

We have already billed medicaid and medicare since 1972. If the Council adopts this legislation, then all services outside of these eight would be billed for. Anybody who came into a neighborhood health

center would be billed for those services at a rate to be decided in separate legislation. This is the pattern it has always followed.

There is existing legislation that sets the rate structure for health services. That would simply be amended to include the other services.

Senator CHILES. What you are saying is there will have to be another bill?

Mr. YELDELL. The Congress could deal with it almost at the same time because it must first decide if it concurs with us, that these eight areas are indeed in the public interest, and limit it to those eight areas. Charges would be established for everything else.

There was no attempt to put that in this legislation because we don't know the conditions that are going to occur. Once that is done, all they have to do is adopt the rate structure, which they do anyway.

Senator CHILES. For the life of me, I can't understand why you are separating this. You are going first into the area where we never charged and you are not charging now, and dealing with the area where you are talking about making charges.

I don't know why it has to be two separate things. Now I see what is going to happen. We are going to spend a few more months on this and come back and start talking about drafting a bill for charges. I don't know how many years we are going to spend on that.

Mr. YELDELL. The fee schedule is adoptable every year. All we would do is add the other elements to the fee schedule.

DELAY IN SUBMITTING PROPOSED LEGISLATION

Senator CHILES. It is not that I want to sound impatient, but on April 8, you said we are preparing legislation to be forwarded through the Mayor and City Council, which should be there by May 21.

Mr. YELDELL. That is correct.

Senator CHILES. This isn't May 21. We are in August, and it's still not there, and now when I read the bill I don't find anything there that relates to what I thought we were talking about.

Mr. YELDELL. Mr. Chairman, I think you are mixing two elements. The legislation defines what is in the public interest.

Senator CHILES. In looking at your testimony, it says—this is your testimony in April—

> We are preparing legislation to be forwarded through the Mayor to the City Council, which would be there by May 21, which would ask a regulation to specifically outline those functions in the public interest and to establish rates for those that would be a charge basis for an individual not covered by either medicare, medicaid, or third-party.

I don't find anything that talks about rates in the legislation that you have come up with.

Mr. YELDELL. We never put fee schedules in that type of legislation.

Senator CHILES. Why didn't you tell me in April?

Mr. YELDELL. There are established fees, already in other areas. It is simply a matter of putting the two together. Now, the legislation specifically defines areas that would be in the public interest. All others are chargeable. I think the legislation does answer that point as it relates to fee schedules. They are always handled as a separate piece of legislation in which the Council adopts them and sets them

at a certain point in time. What we talk about is a bill to allow the modification of this bill should there be a requirement outside the area defined here from the beginning.

Senator CHILES. I don't agree and I don't concur, and I don't think what you have told me in April you have done.

I certainly don't see why the time delay has been here. I read this bill, and if that takes a lot of legislative drafting, then you better get yourself another legislative drafter, because I have drafted a few bills in my time and I don't see anything complex about that.

In fact, Mr. Yeldell, if we don't have something moving on this, I will show you how to draft a bill because we can draft one, and go through the Authorizing Committee and draft a bill here.

I don't want to do that. I would much rather see you do that and go through your Department, but this thing has just gone on too long, from 1972 when the GAO report came out and the last 2 years that I have been harping at you, and your April testimony to now, and we still don't have anything; we are still at an open ended bill that doesn't talk about charges.

At some stage you are just going to have to find out sooner or later what we are talking about here, and what you are telling us you are going to do.

Mr. YELDELL. If you will note in my statement, we had to go through seven pages of Federal regulations. We just can't make a whole bill without consideration of the Federal impact. The District gets hundreds of millions of dollars of grant funds that has statements as to what we can and can't do, and we must make sure we are not violating a Federal requirement.

It is not a simple matter to take those elements and simply write a bill without looking at the conflicts between the elements. I didn't like the draft in May and sent it back for more work.

The bill addresses in concrete terms the only eight areas we will consider in the public interest.

STATEMENT OF HON. CHARLES MCC. MATHIAS, JR., U.S. SENATOR FROM MARYLAND

Senator MATHIAS. As I walked in the room, I got notice from the chairman of the full committee that he has called an emergency meeting of the full committee. Before I leave, I want to submit for the record a brief statement. I am supportive of the chairman's efforts here today, and I recognize the enormous difficulty of it, and the challenge that is involved.

I regret I am unable to stay longer.

Senator CHILES. Thank you for your appearance here. And if necessary, I will try to come over, too.

Senator MATHIAS. It may be necessary.

Senator CHILES. Your statement will be included in the record.

[The statement follows:]

PREPARED STATEMENT OF SENATOR MATHIAS

I would like to commend the Chairman of the Subcommittee, Senator Chiles, for undertaking this review of the health care system operated by the District of Columbia. A comprehensive review of the city's health care system is a formidable challenge that Senator Chiles has accepted without hesitation. His efforts to look out for the

physical health of the residents of the Nation's Capital as well as the financial health of their local government should be supported and applauded by city and Federal officials alike.

The problems of increasing health care costs that confront the District are the same problems that confront the Nation as a whole. In Fiscal Year 1975 the Nation spent more than $118 billion on its health care system. While costs continue to increase by about 14 percent per year, the question of whether we are actually getting a healthier population remains unanswered. Access for all of our citizens to the highest possible quality of health care may be considered a basic right. However, in this era of limited resources we must determine the point where additional expenditures for health are no longer benefiting the people who are sick, but instead are benefiting only the providers of health services with additional profits. Similarly, we must decide what types of health services can best be provided by the private sector and what services must be provided by the public sector.

While many of the problems that confront the medical care system in the District are tied to national trends in health care costs, it is especially important to look at the Nation's Capital in its metropolitan context. Most of the health services provided by the District government go directly to District residents. But at the same time, it is clear that public health services and disease control are matters of concern to the metropolitan area. Diseases are not confined by Western Avenue, Eastern Avenue, or even the Potomac River. Similarly, the overall quality of medical care in the District can have direct impacts on the residents of suburban jurisdictions and the costs they must pay for health care. The fact that almost 50 percent of suburban Maryland residents who needed hospital care were treated in D.C. hospitals emphasizes my own personal concern about this issue.

The lack of coordinated health facility planning in the Washington metropolitan area is a matter that effects residents of Maryland and Virginia just as it effects District residents and the budget of their local government. In February of this year the Senate District Committee held hearings, which I chaired, on some of the metropolitan dimensions of problems confronting the District. I was distressed to learn from the Council of Governments that excess hospital construction was expected to total almost $120 million by 1980. I understand that the cost of maintaining these unnecessary and under utilized facilities may be as high as $70 million per year. As long as each jurisdiction continues to plan and develop its health care system without adequate coordination, this type of waste that we clearly cannot afford is bound to persist.

I hope that todays hearing will serve to shed some light on where the health programs operated by the District Government are heading. Implementation of some of the city's own billing policies as part of our efforts to improve financial management practices must be thoroughly explored as we review the budget requests for Fiscal Year 1977. I certainly share the Chairman's desire to assure that those in need of health care services from the D.C. government are being adequately served. If we can find room for the private sector to take on more responsibilities in providing health care and free some local funds for higher priority programs, then we will have made some real progress in our efforts to help protect the financial health of the Nation's Capital. Even further, we may be able to establish a model for the other metropolitan areas throughout the country that are facing financial pressures.

REVENUE ESTIMATES OF COLLECTIONS

Senator CHILES. Mr. Yeldell, in working on the billing problem we have had difficulty in trying to come up with anything because the numbers that you all have submitted kept changing starting with the response to the subcommittee's questions from a hearing back in April.

We were told that revenues to be raised by the health and hospital administrator for 1977 would be $43,560,000. Then in the letter of May 6, you said the revenue would be $18,400,000. Your figures for fiscal year 1975—an actual year—then changed from $35 million to $17,523,000. I can't understand how those figures kept moving around.

Mr. YELDELL. I think you are mixing some things. Billing is one issue, and collections are another.

Senator CHILES. These are all revenue estimates. They are not billings or collections.

Mr. YELDELL. They were supplied by us?

Senator CHILES. Yes, sir.

Mr. YELDELL. I know we supplied you revenue estimates in May of $18,400,000. The $43 million figure, I think is a projection used in the calculations made by your staff in saying what would be billable. I don't think that is our figure. The $18,400,000 figure is the one we stand on. I met with your staff on Friday, and indicated we made assumptions based on figures covering a given month which we modified later by figures that covered a year's experience.

I apologize for the confusion in figures, but I think the explanations were rather clear.

[CLERK'S NOTE: The $43 million figure was supplied to the subcommittee in response to question 12 found on page 494 of the fiscal year 1977 hearing record. The subcommittee was initially given the figures in the following table:

	Actual fiscal year 1975	Estimated fiscal year 1976	Estimated fiscal year 1977
Medicare	$5,127,701	$5,690,000	$6,000,000
Medicaid	27,468,503	31,097,506	32,000,000
Insurance	1,623,263	2,434,000	2,500,000
Individuals	1,247,486	3,053,000	3,060,000
Total	35,466,953	42,274,506	43,560,000

Subsequently, the subcommittee was given a different set of figures in response to the same question. The second set of figures is found on page 494 of the fiscal year 1977 hearing record.]

Senator CHILES. We asked in the April hearing to be answered for the record, what amount of revenue was raised through fees in fiscal year 1975, and what amounts were received through medicaid and medicare and third-party insurance, and what are anticipated revenues from these sources in fiscal year 1976 and 1977. We received an answer, as I said originally, that $35 million was raised in 1975, that was changed later to $17,522,000.

Mr. YELDELL. This is an accurate experience, Mr. Chairman, $17,523,000. I am not sure who provided those answers.

Senator CHILES. That was the answer we received for the record, $5 million for medicare; $27 million for medicaid.

Mr. YELDELL. That is a billing figure, not a collection figure. I think that is the difference, right there. That is the billings.

Senator CHILES. The question we asked you was revenue, and so you are saying they gave us billing?

Mr. YELDELL. They gave you a billing figure for medicaid.

Mayor WASHINGTON. Mr. Chairman, while you are running them down, I would like to hear the ones you ran down, to see how they comport with mine. You were giving what you had there.

Senator CHILES. Yes.

Mayor WASHINGTON. At least we would all be talking about a figure——

Senator CHILES. I was reporting what was the answer given to us in writing.

Mayor WASHINGTON. I did have figures and was just trying to follow the——

Senator CHILES. I guess that is what happened. I guess you gave us collection figures the first time, and when you got the revenue figures, then the collection figures had been changed—I mean its actual receipt.

Mayor WASHINGTON. Were these annual figures?

Mr. YELDELL. Annual figures and the difference in what the chairman read is the medicaid billings rather than medicaid collection.

Mayor WASHINGTON. Up to 1977, still had $18,400,000.

ADDITIONAL REVENUES TO BE COLLECTED

Senator CHILES. Mr. Yeldell, we have had several statements on what additional revenue the city would raise if the present billing system were put in place to implement the city's policy. What is your statement of the additional revenue that would be raised from all the various sources including medicaid-medicare, third-party insurance and individuals paying?

Mr. YELDELL. With an additional 98 people, we are saying $2½ to $3 million.

Senator CHILES. Would you break that down?

Mr. YELDELL. Mostly from the medicaid area, Mr. Chairman.

Mayor WASHINGTON. I am not sure that is the answer. I thought the answer to the question was what do you estimate as the collectible amount in each category.

Mr. YELDELL. New revenue.

Senator CHILES. Yes; I want collectible amounts, revenue.

Mr. YELDELL. What I am saying is the $18,400,000 figure could probably go to perhaps $22 million, from all sources, and the largest percentage of that would be in the medicaid area. We would have an increase of about a little over $2 million. We would expect medicare to also increase somewhere less than $1 million and the balance to come in the personal-pay area, which is so nebulous.

BILLINGS AND COLLECTIONS IN PERSONAL-PAY CATEGORY

Senator CHILES. What do you expect in the personal-pay area?

Mr. YELDELL. We would hope to collect from between 4½ to 5 percent of those persons who received services.

Senator CHILES. Are you talking about 4½ to 5 percent of those paying for the services?

Mr. YELDELL. In the personal-pay category. We worked with your staff and we gave them a breakout showing that 32 percent of all persons we served are not covered by either medicaid, or medicare or third-party coverage.

Senator CHILES. Thirty-two percent?

Mr. YELDELL. Thirty-two percent. This is based on the only experience we can get, which is a year's experience at District of Columbia General, fiscal year 1976. Of those 32 percent, we would expect 4½ to 5 percent collectibility out of that 32 percent of the total population served.

Senator CHILES. Are you saying that the other 27 percent are being treated free under the "public interest" category?

Mr. YELDELL. No. What I am saying, Mr. Chairman, is we would generate bills for all of that 32 percent. However, collections from that 32 percent would roughly be from about 4½ to 5 percent of those people.

We would bill all of them because they would be getting services for which they should be billed. We would not generate a bill if the service was in the public interest.

Senator CHILES. So you are talking about 32 percent you would actually be billing?

Mr. YELDELL. Thirty-two percent would be billed.

Senator CHILES. Where is the area in the public interest?

Mr. YELDELL. When the service is provided in the public interest, Mr. Chairman, we would not generate the bill. We would bill all of those people of the 32 percent. We would expect a return of 4½ to 5 percent of those bills.

Senator CHILES. As I understand Mayor Washington's statement, you are collecting approximately 3 percent now.

Mr. YELDELL. That is correct, and we would expect the increment to go to 4½, perhaps to 5.

Senator CHILES. I can't understand why it is only going to go up one-half of a percent.

Mr. YELDELL. Not in bills, but collections.

Senator CHILES. In collections?

Mr. YELDELL. We are all guessing. We have no way to know but our experience is these people are not able to pay. But what we are suggesting is there would be an improvement, and data would be generated and the bills mailed out. But we must estimate the yield we expect.

Senator CHILES. You haven't been making much of an effort in the past to collect these bills and getting only 3 percent doesn't sound very high.

Mr. YELDELL. We have not been billing, Mr. Chairman, in the neighborhood health centers, those persons in the personal-pay area.

Senator CHILES. So you haven't been billing anything. Where are you getting the 3 percent from?

Mr. YELDELL. Using the situation at District of Columbia General, where people come in, in the same category, is the only experience we can go on. We wouldn't know until we get this under our belt and monitor it from the historical point of view.

BILLING AND COLLECTON PERCENTAGES OF PERSONAL-PAY CATEGORY

Senator CHILES. Again in your figures, in what you gave us back in April, you told us that individual pay billings comprised 27 percent of the total billings, with only a 3-percent collection rate. Now you have raised that figure from 27 to 32 percent?

Mr. YELDELL. Because we have much more refined data.

It is a full year's experience at District of Columbia General. I made that clear to your staff when I gave the data. The fact of the matter is you can take any given month at District of Columbia General and get different figures.

What we did was take a full year and give you the experience, based on those categories over a full year. Mr. Chairman, you are aware we are already billing these people for medicaid-medicare and third-party insurance, and we are really addressing those persons in the personal-pay area and that is where I am saying the real difference comes.

I think people are assuming a large collectibility from that. We agree they should be billed and intend to bill them. I am telling you what we estimate the yield to be. That could change, based on experience, once we get it in place and observe it for a year or two. The situation may well change.

Senator CHILES. I agree that we are working with estimates. All of us are. I know that the GAO has given us an estimate of anywhere from $3 to $8 million, based on assumptions about increased collections from third-parties; increased collections from those that can pay.

The GAO estimate is anywhere from $1,790,000 to $3,580,000 for increased collections from third parties; increased collections from those who can pay GAO estimates to be anywhere from $460,000 to $920,000; and in savings due to decreased patient load, as more people are required to pay for the use of the District services, therefore, picking up those services on their own decreases, the city's load, anywhere from $700,000 to $3.5 million.

Mr. YELDELL. The last item is what bothers us the most. Those people have no where else to go. They are going to come for services and, frankly, treating them in the neighborhood health center is going to avoid more costly treatment later and could cause problems.

If they find they can't go for routine service, they may also feel they can't go with a communicable disease.

Senator CHILES. You are basing it on the indigents with a true need. I agree. But there has to be somebody that knows that charge is completely free and has a dollar in his pocket and decides, "I might as well go there. Because it is free."

Mr. YELDELL. Mr. Chairman, we will have at each of our centers people who scrutinize anyone who comes for service; if the person has an economic capability to pay, we are going to bill them and pressure them to pay that bill. However, we must be very clear that most of those facilities are located in the lower economic areas where the people who have a capability to pay are not utilizing those facilities. This is where we get the biggest concern with the assumptions made by Arthur Andersen, GAO, and others.

We have the same interest that you have. We feel once the services are defined, we have a responsibility to bill anyone who comes in and gets those services. The problem is you are dealing with a population that can't afford the cost of health care. We shouldn't ignore that factor. I don't think any of us wants to deny these people services.

PRESENT BILLING AND COLLECTION SYSTEM

Mayor WASHINGTON. Mr. Chairman, there is one thing I did want to say. That last breakdown, it seemed to me, came pretty close to what we are saying here. What I want to say again, categorically, is that in the areas of medicare-medicaid, and third-party insurance

I think we have billed and collected and there may be improvement there. In the area of medicare, medicaid, medical charities and the third-party insurance where you have several assumptions, I think we have to deal with those assumptions in the four areas.

We bill and collect whatever we can, and I think we ought to address that problem in terms of improving it and examining the man with a dollar. Moreover, we should develop a system that does this. However, it somewhat concerns me as to how we come with some of those assumptions.

In other words, as Mr. Yeldell pointed out, we are working in the personal-pay area and in the medical charities area pretty much with people who are not able to pay based on the poverty level. I don't intend and I don't think you are suggesting that someone in these areas be refused service. I think we are together on that, and I think we are together on our approach.

Senator CHILES. I am going to have to excuse myself to go make a quorum for the full committee, and I will come right back.

[Brief recess.]

STATEMENT OF COMMITMENT

Senator CHILES. Mr. Mayor, I think we can start, again, now. I wonder, Mr. Mayor, if you would get me a statement or commitment? We are going to get something done on this billing process in order to get legislation through and, if we have to have two pieces of legislation—I can't understand why—that we are going to start billing those people who can pay, and some idea when we can start doing it.

Mayor WASHINGTON. I would like to say without specifying a time that my commitment is to move expeditiously in the area. What I do understand is that we are collecting substantially from medicare, medicaid and third-party insurance at a rate of about 87 percent. Our area of grave concern, here——

Senator CHILES. I think there is money to be picked up, there, Mr. Mayor.

Mayor WASHINGTON. We may be able to. I want to examine that. I think we ought to have an adequate, good and improved billing system and to the extent that we can aggressively move, to collect in the personal-pay area.

Now you are at the level—and as you left, we talked about that—where you are squeezing, and neither you nor I want to be in a position to deny anybody any treatment.

Senator CHILES. Yes.

Mayor WASHINGTON. But I do think we have the opportunity to improve it, if it takes $1 or $2 million. I would say on the return of the Council, we are going to move in aggressively, and I think the billing program, in the public interest, should be defined and the matters of billing and collectibility should be defined to the extent we can; whether it takes two or three pieces of legislation. It is a priority. I don't want to say, "When you get back in September."

You realize what that is, but it will be a priority in our legislative package to move it as quickly as we can, whether it is one or two bills, that define public interest and a fee schedule. I see no reason

why they can't go along together as one or two pieces and I would propose that.

Senator CHILES. It just seems to me, it isn't as necessary to have a fee schedule as it is to have a policy statement, that indicates we are going to charge those people that can afford to pay. The city can develop a fee schedule off line to implement the policy.

Mayor WASHINGTON. It's as simple as that, from my standpoint, and that is what I was trying to say. I know there is some relationship between that and medicaid. I think that ought to be behind us. The simple policy I envision, without giving specifics and details, that those people in the personal-pay category that can pay should pay. I really think that.

On the other hand, if there is a determination that someone can't pay, then, as I said, I don't think any of us want to find ourselves denying health service to people who can't pay.

I agree with you. I think this matter has come to me and I am prepared to move it aggressively. You have brought it to me so I am responding to you in an aggressive and affirmative way in terms of commitment.

SURPLUS OF HOSPITAL BEDS

Senator CHILES. Mr. Yeldell, the 1976 Hill-Burton plan identified a 562 bed surplus in the District. Blue Cross has predicted a 1,700 bed surplus in the metropolitan area by 1980.

Do you agree there is a surplus of hospital beds in the District?

Mr. YELDELL. Mr. Chairman, the answer is "Yes." There is a surplus of hospital beds, based on the HEW definition in relation to population.

Senator CHILES. Based on your knowledge of construction plans in the District and the suburbs, do you recognize that the trend of that surplus is going to be toward a growing surplus?

Mr. YELDELL. I think everybody is taking every step they can now not to appropriate any additional beds.

Senator CHILES. What we already know about what is underway in Maryland; what we already know is underway in Virginia, and what we already know is started.

Isn't it pretty clear that trend is toward a growing surplus of beds?

Mr. YELDELL. There is a great deal of difficulty in trying to get any additional beds. If you take the 1,700, I think all three jurisdictions are trying to make sure that figure does not increase. The trend would be to try and hold the line and, indeed, to reduce any of the outstanding 1,700 beds that can be reduced.

HEALTH PLANNING ADVISORY COMMITTEE

Senator CHILES. Would you describe for the committee your role as chairman of the Mayor's Health Planning Advisory Committee?

Mr. YELDELL. I am not really the chairman. That is held by Dr. Bette Catoe, a pediatrician, and is set up through the Mayor and advises me on health issues. It is my role to take recommendations from that committee, and, if in disagreement, to work out the disagreement.

Senator CHILES. Who issues the certificate of need now in the District?

Mr. YELDELL. I do that, based on the recommendations.

CONSTRUCTION OF ADDITIONAL HOSPITAL BEDS

Senator CHILES. I noticed in an article of the Post of June 15, 1976, that you had approved the construction of an additional 567 hospital beds in the District. How does that decision relate to the fact that there is a growing surplus of beds in the District?

Mr. YELDELL. I think there are several things wrong with the statement. One is talk about the bed shortage—we are talking about acute-care beds. The total listed in that article relates to approval of both acute care and long-term beds.

What happened on that date, June 15, is that I renewed the certificate of need for the Doctors Hospital, an existing facility, to build a new facility. It had an existing certificate of need for 385 beds. I reduced that to 321 beds. That left a surplus and I allocated 60 of those beds to the greatly unserved area east of the Anacostia River, so the actual approval on those acute-care beds totaled 381. These beds are accounted for, and there is nothing added in this count at all.

At the same time, I approved 186 long-term care beds for the Greater Southeast Hospital. At the same time I approved the 186, I denied Greater Southeast's application for 120 acute-care beds. I did not do anything except to get a better distribution of beds and shift 60 out of Northwest into the Southeast corridor.

Senator CHILES. Is the headline correct where it says, "Hospital Facilities to Get $49 million"?

Mr. YELDELL. I don't know where they are going to get it. There was no money associated with our approval.

Senator CHILES. I still get the feeling somewhere in the District, $49 million is going to be spent on additional hospital beds, acute, or chronic, at a time in which we have got a surplus of beds.

Mr. YELDELL. I think it is accurate. Doctors Hospital is a proprietary hospital, and it is probably going to cost them $40 million to build that facility. The District has not given up that money.

COORDINATION AMONG METROPOLITAN AREA

Senator CHILES. I am not talking about whether the District is giving up the money. I know we have several problems. One problem is the lack of coordination in the greater metropolitan area. We have Virginia, that can kind of do what they want to do; Maryland, who can do what they want to do. Many of their residents have been coming to the District for their hospital services, and they are now deciding that they might as well build hospitals out in Maryland and Virginia, and this construction is going on.

At the same time, we are having—whether it be private or public, and in this sense it is private—generally speaking, building additional beds here. We look down the doomsday route, and we can see problems. We have had reports that the cost of hospital care per day is going to go up tremendously because you have a growing surplus of hospital beds.

Mr. YELDELL. I think the problem is that the metropolitan area situation has been fostered on the District, not by the District. We

have not approved additional hospital beds in this city up until those approved on the 15th, for 6 years. These beds have been approved in the Maryland and Virginia locations.

Senator CHILES. I understand that, and that is a problem beyond your doing anything about it right now. I think it is tragic because there is not some kind of coordinated effort of the two States and the District to require some certificate of need for the entire area, some licensing council to require that.

The one thing you do have jurisdiction over is in the District, and I keep coming back to this $49 million being spent for hospital beds when you have a surplus of hospital beds.

Mr. YELDELL. But, Mr. Chairman, we are also dealing with an existing business establishment, which is Doctors Hospital. All we did was allow them to build a new hospital so it can provide better service to the people of the District. They are not new beds. Doctors Hospital is in existence. The 321 beds was to allow them to move 2 blocks and build a modern facility to service our people.

The additional 186 beds were desperately needed because they are long term and we want more of those built. We welcome those.

DISTRICT OF COLUMBIA GENERAL HOSPITAL—A LONG-TERM CARE FACILITY

Senator CHILES. The studies I am looking at are beginning to show District of Columbia General probably ought to be looked at from the possibility of it becoming a long-term care facility and using more of the private hospital facilities for acute care. This would help solve a situation where you have too many acute beds and not enough long-term care beds.

Whether modernization or whatever, it appears we are spending millions of dollars to build additional facilities where we have too many now.

Mr. YELDELL. District of Columbia General is the court of last resort. Patients are shipped to District of Columbia General from other hospitals now in taxicabs, many dying in transit or shortly after reaching the hospital. So we can't eliminate acute care at District of Columbia General. We might address whether or not we can take a portion of District of Columbia General and make it available for long-term care beds and actively pursue that with the PSRO in the Capital area, but that does not eliminate the need for acute-care beds under control of the city.

Senator CHILES. I have some experience with that, having been in an area that had a county hospital and an area that had a charity hospital. As long as you have a charity situation, all of the other hospitals are not going to share their part of the load. They are going to ship them to you, and I don't think that is good patient care.

As you say, they die en route. If you don't have a place where the private hospitals could push those people off to, they would have to do their own work and give the kind of care that they should be giving to these people.

Mr. YELDELL. We are trying to get the private hospitals, to the maximum extent possible, to cooperate. Ten of the hospitals do participate, do take part of this load. Howard University Hospital takes

a major portion of that category outside the control of District of Columbia General Hospital.

I don't think we could sit here now and project the closing of District of Columbia General Hospital with a corresponding pickup by the private sector of the people that need care.

The bottom line, Mr. Chairman, is in the approval here. All we did was allow Doctors Hospital to replace its existing facility and we gave 60 beds to the Southeast corridor where there are not enough beds. That is the extent of the approval we gave. Doctors Hospital had a certificate for 385 beds reduced to 321. So, after the girations, we reduced by an additional four beds rather than increasing.

Doctors Hospital had some major problems in terms of its facility, and now will build a modern facility in the District, and that, too, we want to see.

Now, of the 1,700-bed surplus, over 1,000 are in Maryland.

Senator CHILES. But those extra beds in Maryland means you are going to lose more of your patients in the District of Columbia to those surplus Maryland beds.

Mr. YELDELL. I think they are coming in because of the quality and availability of medical service here. They come to the doctors; more than going to the hospital. Our surplus has been generated by a declining population base. We had an increased bed surplus just this last year because of the new census showing a decline in District population.

So I think we are being unfairly battered here in relation to things that happened in Maryland and Virginia, when the District adopted what you asked for, a hold-the-line policy. We have been in that policy for over 6 years.

COMBINED HEALTH PLANNING AUTHORITY

Senator CHILES. What is the posture of the District in regard to whether a combined health planning authority is necessary in the three States, that would be able to plan and restrict bed construction?

Mr. YELDELL. The District has applied for and has been granted a waiver to the 93–41 legislation. That was done with the full concurrence of the Governors of Maryland and Virginia and the Mayor of the District.

Senator CHILES. Why did the District want a waiver for that?

Mr. YELDELL. I think the District felt it was necessary to get a waiver based on the intent of the legislation and the ability to deal with the District's needs in late 1969 of the peculiar health characteristics of this city.

Senator CHILES. You are never going to get an answer to the problem if everything has a waiver. Virginia can do what they want, and Maryland and the District can——

Mr. YELDELL. There would be no capability in that process to prevent beds in Maryland and Virginia. And, again, the problem is not in the District. We want to get them to do it, but intend to work on a metropolitanwide basis with Maryland and Virginia. But the point is, we have peculiar health needs here not found in Maryland and Virginia.

We addressed this, not unilaterally, but with the cooperation of the States, and they strongly supported that the District ought not to be brought into Maryland and Virginia. You have to look at both cases. There was a concern if the District came in, it could cause problems. The Governor of Maryland made it clear he had strong problems of his people participating in areawide political——

REGIONALISM/COORDINATION AND COOPERATION

Senator CHILES. I understand everybody has problems, and everybody wants to do it in their own way, but you are always going to have this kind of crazy surplus bed problem you have got because of the way the metropolitan area is set up unless everybody agrees they have to look at what their neighbor is doing and agree to more coordination and cooperation.

Mr. YELDELL. We do that today. We are not building new beds. That is my point. If that is the issue, we would agree right now. We are indeed not only agreeing, but have exercised the same moratorium you are asking for, for 6 years.

Mayor WASHINGTON. I think, Mr. Chairman, the problem goes a little deeper than just jurisdictions in terms of trying to reconcile those differences and in real life situations. I think you can effect some kind of coordination and cooperation, but I am just as mindful of that as I am with a so-called commuter tax. I think the basic thing you are striking at is regionalism. This gets into an area of human relations that I am not sure that everybody is prepared to deal with at this time. And it does not mean that it shouldn't be, which is your point.

But I think, unilaterally, you can't demand it. I said that carefully, Mr. Chairman.

RISE IN THE COST OF HEALTH CARE

Senator CHILES. I understand.

It appears to me, though that the District may be doing a better job with regard to plans for hospital bed construction based on the 6-year policy, than the other areas are doing. But if the District is going to argue that there is something particularly unique to us, so let us out of regional planning, give us a waiver, then you are going to find the other areas saying let us out too. Before long everybody gets out for what they will all argue is their own very unique problem. You can make the argument that every problem is unique. It becomes that way.

And yes, probably Maryland doesn't want to hear about the District's special problems and would like not to be bothered with them, so they may be happy to go along with granting you the waiver.

And in some instances, all the jurisdictions are happy this way. But when that happens, you don't have a coordinated metropolitan plan. And when we all see what we are headed for in the 1980's with a surplus of beds, with low occupancy rates I think it is going to end up with the District getting it in the neck.

I may be wrong, and Mr. Yeldell may be right, they will come to the District because of the services. If the general trends are correct, the doctors go where those hospitals are; the doctors build their

offices out where those private hospitals are, and tend to move their practice out there. I think that is what is going to happen here, and they are not going to be hit with an acute shortage as much as you all are going to be hit, and the cost in the District of Columbia is going to go up and up in order to run those facilities as the occupancy rate goes down.

And when you have surplus beds, you are going to have to determine what you are going to do and what you have to discontinue. Maybe you would have to have acute-care facilities, but it seems, facing this down the road, you all have to be more concerned and try to get the other jurisdictions in the box with you.

Mayor WASHINGTON. I think there is some validity there.

On the other hand, Mr. Chairman, I would certainly like to know why those 1,000 beds in Maryland—if that is the number; I just heard it—are vacant and why they remain vacant.

Senator CHILES. Most of them are just coming on-line now.

Mayor WASHINGTON. Most of them have been there, though. My concern is not just availability of excess beds, but the continuous rise of the cost for health care totally. Daily you see the increase in the cost, even in those that are provided here, whether it is in excess or not, of $80 to $100.

You know, I am concerned about that problem, but I am more concerned about the acceleration and continuing acceleration of costs that are unrelated to the problem of excess beds.

Mr. YELDELL. Mr. Chairman, I think the point we need to underscore is the waiver allows us to eliminate what would have been an administrative nightmare. It doesn't get away from regional health planning.

I would say, further, Doctors Hospital is a proprietary hospital run by doctors. One of the advantages not only is the hospital to be built, but a new facility for services will be provided for doctors. We will be carrying the doctors right with the hospital in this particular instance.

Again, the patient-Doctors Hospital relationship is built-in. We have been trying to work with the area on regional matters, and many times unjustly get clobbered for it. In the emergency health area, we found the objections were not our participation but that the system we designed would have become the state of the art and cause Maryland and Virginia to come up to our system. What they wanted was for us to drop our system and come down to theirs.

These are the things that we should be concerned about. It has never been reported that way in the media, but that is the way it is.

PROPOSED MEETING WITH COLLEAGUES

Mayor WASHINGTON. Would it be of some interest if we had a little session with you and some of your colleagues from the States? And I know Senator Mathias has long been interested in every area of regionalism, and we have talked about it and made some progress. We have used interchange of our communication systems; we have developed compacts where the chiefs meet, and with regularity, and so on.

And we have gotten some examples. This doesn't seem to me—and you are interested in it—to be beyond the point of reason. I think there are some unique problems for each of the jurisdictions, but I don't think they are beyond our ability to overcome them.

And I don't know, this may be just simply suggested because of your expressed concern. I think in the proper forum it might overcome some of this.

Senator CHILES. We would be happy to participate in any way we could.

Mayor WASHINGTON. I wouldn't mind setting it up in my office. I have been trying to do that with the cost of Metro. I haven't been too successful, but I tried to get Virginia to transfer entitlements. If you think that might lead us to the relief of a problem you envision down the line——

Senator CHILES. I would be happy to participate with you in that regard.

Mr. Yeldell, back in April we were talking about a discussion regarding $30,000 spent on the Office of the Director of the Payments and Assistance Administration. As I recall, those funds were coming from grants and from the Federal Government. And at that time, I think, because the Federal Government allowed a percentage of those grants to go toward the overhead, that was why those funds were particularly used.

I was very critical of that in telling you I felt that is what hurt many times when grant programs were coming before the Congress, examples like that, and everybody immediately says that is what is happening to the grant money we are putting up, somebody using it to build a plush office.

PROPOSED IMPROVEMENTS TO MR. YELDELL'S OFFICE

I noticed you were starting some improvements on your office. I think that was discontinued now; is that correct?

Mr. YELDELL. It certainly was discontinued.

Senator CHILES. The original estimate was $8,900, and it rose to $15,000, and you discontinued it; is that correct?

Mr. YELDELL. When I got back in town, there was a lot of excitement generated about the issue, and the cost at that point had escalated to $18,000, I was told. That was after we had deleted things in the original plan of operation.

We were simply trying to deal with a situation in my suite in which we do a great deal of work and have a great deal of people visiting, and I was simply installing a rest facility.

The original plan had a shower in it. As soon as I saw that, I eliminated the shower. I was appalled that the cost had escalated rather than decreased. So immediately on seeing that, I ordered the work stopped.

Senator CHILES. Where were these funds going to come from?

Mr. YELDELL. I gave it to the controller to deal with. I expect, the administrative funds I have to run the office.

SOURCE OF FUNDS TO MAKE IMPROVEMENTS

Senator CHILES. As I understand it, the funds were to come from social and welfare grants from the Federal Government.

Mr. YELDELL. I think it may have come from earnings on social and welfare grants, but not the grants themselves. The District receives earnings for services it provides to the Federal Government. I think the reference should be more properly for the earnings that have come back to the city for those services and not the grant funds.

Senator CHILES. This appears to me to be in the same category as that problem we were discussing at the April hearings. I think this is where you do a disservice to the city to get Federal grant funds and to misuse these funds for questionable purposes. When publicity like this occurs, everyone says you are taking grant money that is intended for social welfare programs and all that money is being used for is to plush up somebody's office.

If you are going to do anything to your office, it ought to be a part of the city budget and go through the Council and be cleared through the budget process. Just because you found surplus funds in a Federal grant——

Mr. YELDELL. That wasn't the case here. This was well planned and not something for my office, but rest facilities for the suite.

I saw absolutely nothing wrong with construction of a rest room facility in the area available to everyone that comes in that suite. That is all we were doing. There were no grant funds devoted to that at all. The District earns money, and it was a source from which to take it.

Senator CHILES. The source is what I am challenging. The purpose is if you want a kitchen in your office and the city agrees——

Mr. YELDELL. We already had a kitchen there, and that came out in the media. The city gets a great benefit from it because most of my people eat there rather than go out to lunch. We work long hours there.

Senator CHILES. It's the source of the funds.

Mr. YELDELL. I am sure the comptroller is here. Mr. Cohen were there grant funds associated with that?

Mr. COHEN. No, sir.

Mr. YELDELL. So my concern is, and I will document for the record, we were not using grant funds for that purpose.

Senator CHILES. DHR transferred $9,000 to DGS to fund this project.

REIMBURSEMENTS FROM HEW

Mr. YELDELL. The $9,000 was transferred from reimbursements received from the Federal Government for social and welfare programs performed on contracts from the Department of Health, Education, and Welfare. Those are earnings we get for administering programs for the Federal Government. They are not grant funds.

We receive a negotiated rate for services we provide for the Federal structure. Those come in as earnings to the city. Once in the city, they are usable as the city sees fit. All we were doing was allocating those funds for this purpose, but they are not grant funds.

Senator CHILES. Aren't they usable to administer the grants?

Mr. YELDELL. They are usable for administering the grants, and payable for administering the grants.

Senator CHILES. You think a new kitchen range helps administer the grants?

Mr. YELDELL. Mr. Chairman, you know the District gets these funds for services it performs. The point I am making, those funds were perfectly proper to be used and available for a project planned for a facility needed in the suite.

We have meetings in that place all the time, and people coming in from all over to meet there. It was not for my personal use. It was for the use of the entire suite and its operation.

Here was a project that was perfectly proper and using funds available for that purpose. That is no more than is done all the time.

Senator CHILES. It may be done all the time, but I think it hurts your credibility in the grant process. I think it can only hurt your ability to get Federal funds when you use the funds for these kind of projects.

You would be better off if you used some kind of city budget funds rather than using administrative or earnings funds off of a Federal project.

Mr. YELDELL. I just don't know what to say. These are not the actual grant funds themselves. Everything for the grant was used for the grant. These are indirect or overhead cost funds. That is what the Government pays us for providing the service.

Senator CHILES. When the Federal Government gives the city funds to administer a grant, I don't think anybody believes that those funds are going to be used to plush up an office. I think you are going to hurt the debate for that overhead percentage. I think when somebody can say that, well, $30,000 of the overhead was used to fix somebody's office, another $15,000 of that was used to fix the suite in Mr. Yeldell's office or something else, I think that is going to hurt.

That is what I am telling you. In trying to get that reimbursement, or trying to get those kinds of funds, if it is revealed that it was used for those purposes——

Mr. YELDELL. I thought it was too much anyway. That is why I stopped the project. I thought it was an excess expenditure for that purpose and didn't use the funds at all. I support your position in terms of the process, if you want to call it that.

Senator CHILES. I think that is all the questions I have. I have a few more questions to submit in writing.

Mr. Mayor, thank you for your courtesies.

Mayor WASHINGTON. Thank you, Mr. Chairman. I want to thank you kindly for your position on the legislative office.

[The questions and answers follow:]

COST OF HOSPITAL BEDS

Question: What is the per day average cost of a hospital bed in the District?

ANSWER: On the average, the D.C. medicaid program on June 30, 1976, paid $191.42 per diem. This included all necessary hospital services except private physician services. This ranges from a low per diem of $131.73 for Providence Hospital to a high of $237.91 for Children's Hospital.

Question: What do you expect the per day cost of a hospital bed in the District to be by 1980?

ANSWER: Assuming a 12-percent inflationary factor each year by 1980, the per diem rate should be $301.00.

Question: What policies is the city adopting to help control the per day cost of a hospital bed in the District?

ANSWER: The Department has adopted the policy of controlling hospital beds for many years through relating its certificate of need program, under the D.C. Hospital regulations, to the criteria and standards set forth in the State Facilities Construction (Hill-Burton) Plan. Additionally, the District has adopted the policy, through the Hill-Burton Plan, of assigning priorities in awarding construction funds to facilities for outpatient (primary care) and long-term care, thus lessening the need for acute hospital beds. This, in turn, tends to control the cost of health care delivery.

The Department's long-term thrust in this direction is now mandated in Public Law 93-641 which will be implemented in the District by the Department's designation as the D.C. State Health Planning and Development Agency under that statute. The existing certificate of need provisions will be expanded and the mandates for priorities for lesser levels of care, when appropriate, will be enforced, thus controlling the number of beds and lessening health care delivery costs.

Question: The medical charities program run by the city pays for the cost of indigent people to use private hospitals. There is currently a $76 legal limit placed on what the city may pay to hospitals for this service. In view of the per day average cost of hospital beds that you just quoted to the subcommittee, how willing are the hospitals to provide these services for $76 a day?

ANSWER: The hospitals are unquestionably opposed to providing these services for $76 a day and have exerted all efforts to have this rate increased to reasonable cost.

Question: Do you feel that the limit should be raised to more closely reflect hospital costs?

ANSWER: The rate should at least be increased to reasonable rates. However, this means that additional moneys would have to be available to the District.

Question: Doesn't this limitation also have the effect of reducing the use by the indigent of private hospitals and at the same time increase the use by the indigent of D.C. General?

ANSWER: The private hospitals do tend to send indigent patients to D.C. General rather than provide the service at reduced rates and hence there is an increased demand made upon D.C. General.

D.C. GENERAL HOSPITAL

Question: When will D.C. General regain its accreditation?

ANSWER: D.C. General Hospital was surveyed in October 1975 by the Joint Commission on Accreditation of Hospitals. Based on 14 major deficiencies the Joint Commission disaccredited the hospital in December 1975. Action was taken immediately by hospital staff to correct the deficiencies cited. At the request of the hospital, the Joint Commission survey team was requested to resurvey the

hospital in May of this year. We are awaiting the results of this resurvey. However, we are confident that the hospital will regain its accreditation. The report from the joint commission is due any day now.

Question: In view of the reported surplus of hospital beds in the District, is D.C. General needed as an acute care hospital?

ANSWER: Over the past 4 fiscal years, D.C. General Hospital has admitted 66,150 inpatients, provided 833,075 inpatient days of care, as well as provided 751,016 outpatient and 397,501 emergency room visits. D.C. General currently has 646 adult and pediatric beds and 54 bassinets. There has been a decline in the utilization of inpatient beds at D.C. General over the years. However, D.C. General continues to provide a great deal of inpatient, as well as outpatient care to a large number of indigent citizens of the District of Columbia. Last fiscal year alone, D.C. General Hospital had 14,031 admissions. At the present time, the average daily census at the hospital is between 500 and 515 inpatients. The volume of patient activity at D.C. General clearly establishes its need.

AREA OF SERVICE

Question: What specifically is the need for D.C. General and who should it serve?

ANSWER: The charter under which D.C. General Hospital was established requires that the hospital serve the residents of the District of Columbia without regard for their ability to pay. As you know, there are a large number of our citizens who, for one reason or another, do not have any form of health insurance. At present, D.C. General Hospital serves approsimately—

	Percent
Medicaid patients/medicare patients	50
Medical charities	8
Other third-party insurance patients	10
Self-paying patients	32

This data is based on percent of billings going to each service.

Many of the patients who have some form of health insurance coverage (medicaid, medicare, or private insurance) do not have a private physician and therefore seek their medical care at D.C. General Hospital. Many other patients have had a tradition of going to D.C. General Hospital for their medical care and even though they have some options, continue to obtain their care from D.C. General Hospital.

It is estimated that D.C. General serves about 180,000 citizens of the District of Columbia; however, as the provider of the largest amount of emergency care, DCGH potentially serves the entire population of the District. Without D.C. General Hospital, a large number of residents of the District of Columbia would not be able to receive adequate medical services.

Question: You and others in the city have told the subcommittee that there is a shortage of long-term care facilities in the city. Based on this fact and some of the other trends that we have discussed, some have argued that D.C. General should continue its outpatient services, but be converted into a long-term care facility. What is your reaction to this proposal?

ANSWER: As indicated in the responses to preceding questions, the admission of 14,031 patients to D.C. General Hospital last fiscal year, as well as the over 66,000 admissions to this hospital during the last 4 fiscal years, suggest that a large number of people receive their acute inpatient hospital care at D.C. General Hospital. In spite of the decline in utilization of inpatient services at D.C. General the hospital continues to meet a need in this community.

I would be strongly opposed to the suggestion that D.C. General Hospital be converted to a long-term care facility because (1) there is a need for acute inpatient hospital care for the patients served by D.C. General Hospital, and (2) due to the nature of medical problems presented at D.C. General Hospital, outpatient

services alone would not be sufficient to meet the health needs of citizens who use the hospital.

When a patient who has an acute medical problem comes to D.C. General Hospital, the hospital must have the capability to be able to promptly diagnose and treat that patient based on the patient's needs.

DECLINE IN ADMISSIONS

Question: Between 1971 and 1975 there was a 26 percent decline in admissions at D.C. General. In your opinion, what explains this decline at D.C. General?

ANSWER: With the establishment of medicaid and medicare this has provided many poor and elderly patients a broader choice of where they can receive their medical care. Throughout the country there has been a continuing decline in the use of inpatient facilities due to greater medical technology, new and more effective medications, and an expansion of insurance coverage for outpatient procedures. I suggest that these factors, combined with the fact that as more indigent and elderly patients become aware of their choices, many have chosen to seek care from hospitals nearer their homes.

Question: The subcommittee has been informed by the city's Professional Standards Review Organization that 80 percent of all unnecessary admissions of medicaid and medicare patients in the city over the last 6 months occurred at D.C. General. Can you help explain why there is such a large denial rate by medicaid and medicare for patients admitted to D.C. General?

ANSWER: We have no way of verifying the above statement at this time. However, so as to put the above allegation into some perspective, D.C. General Hospital had 6,700 admissions for the first 6 months of this year and only 231 of which were denied payment; i.e. 3.4 percent of the admissions to D.C. General Hospital during that period. So that the committee can fully understand why there were 231 admissions to D.C. General Hospital, for which payment was denied, you should be aware of the three basic reasons:

(a) A large number of patients are transferred to D.C. General Hospital from other hospitals in the District for a variety of reasons, but mainly because these patients do not have medicaid, medicare or any private insurance. During the first 6 months of this year, 521 patients were transferred to D.C. General Hospital an average of 86 per month.

(b) Many of these patients need only a limited amount of acute hospital care, but due to their financial and social circumstances, become what is known as social dispositions; i.e. they no longer require hospitalization in an acute care hospital but still require some form of either chronic, skilled or intermediate nursing care or personal care. Most of these patients either have no family or their families are unable to provide this care.

(c) There simply are not enough alternate facilities for these patients so that either they could be transferred directly by other hospitals in the city or that are available to D.C. General Hospital when they are no longer in need of acute hospitalization.

Question: During fiscal year 1975, patients aged 65 and over had an average length of stay of 27 days at D.C. General compared to an average length of stay of 11.5 days in private hospitals. In your opinion, what is the explanation for the fact that patients aged 65 and over stay more than two times longer at D.C. General than they do at private hospitals?

ANSWER: I have given you some idea of the complex economic, medical, and social nature of the problem of delivering hospital care to the population served by D.C. General. The patients who use the hospital are generally sicker and have difficult social circumstances. The patients over 65 years of age served by D.C. General come from a lower socioeconomic segment of the population of the District. Frequently their needs are greater, but probably more importantly, the alternative for them, once they reach the point where they have received the maximum benefit from acute hospitalization, are more limited than elderly patients from higher socioeconomic circumstances.

Due to the limited capacity of both D.C. Village and Glenn Dale Hospital, as well as the shortage of nursing homes in the metropolitan area, it is more difficult for D.C. General to either discharge these patients or transfer them to a more appropriate facility as it is with other hospitals whose patients have less social, financial, and medical problems.

Question: How many patients at D.C. General should more appropriately be cared for at a long-term care facility?

ANSWER: At any given time there are between 60 and 100 patients at D.C. General who could be more appropriately cared for at another facility if—

(a) There were other facilities available with the capacity to provide this care;
(b) The patients had financial resources and/or family circumstances to give them other choices.

Presently we have 78 patients who are hospitalized at D.C. General who are no longer in need of acute hospitalization, but require some other form of care and are awaiting placement.

7—awaiting placement in a skilled nursing care facility.
53—awaiting placement in an intermediate care facility.
16—awaiting placement in a chronic or rehabilitation care facility.
2—awaiting child placement.

AVERAGE PER DAY COSTS

Question: What are the per day average costs of keeping a person at D.C. General compared with keeping the person at one of the city's chronic care facilities—D.C. Village or Glenn Dale?

ANSWER: The average cost per day at D.C. General Hospital for an adult in either the medical or surgical services is $160 per day and the average cost of pediatric patients is $230 per day. The average cost per day for skilled care is $57 per day and for intermediate care is $47 per day at D.C. Village. The average cost per day for chronic and rehabilitative care is $54 per day at Glenn Dale Hospital.

I wish to point out that both the $160 and $230 per diem cost includes hospital as well as physician services; therefore, the per diem cost for D.C. General cannot be compared to the per diem cost at the private hospitals in the city which do not include the cost of physician services.

NEIGHBORHOOD HEALTH CENTERS

Question: Do we need a city owned and operated system of clinics?

ANSWER: Yes. The current organization of health services in the District of Columbia and the methods of financing create a maldistribution of health services and private physicians which deny the accessibility of health care, other than that provided at public clinics, to large segments of the population of the city.

Question: How many of the clinics are located in the Northeast section of the city and in Anacostia where many report there is a shortage of doctors and out-patient services?

ANSWER: There are 23 neighborhood-based ambulatory clinical facilities operated by the D.C. Department of Human Resources. These clinics vary in nature from highly specialized programs to family oriented neighborhood health centers. The distribution by services is as follows: Six geriatric, six clinics for mothers and children, eight family-oriented neighborhood health centers, one handicapped and crippled children's unit, one venereal disease clinic, and one chest clinic.

These clinics are located throughout the city, and their sites are determined by the demographic nature of the community which they serve. Fourteen of these clinics are located in the Northeast and Southeast areas of the city. The distribution of these clinics by services is as follows: Four clinics for mothers and children, one geriatric clinic, six family-oriented neighborhood health centers, one handicapped and crippled children's unit, one venereal disease clinic, and one chest clinic.

There are eight family-oriented neighborhood health centers operated by the D.C. Department of Human Resources and six of these clinics are located in the Northeast and Southeast areas of the city, where health services are inadequate by previous reports. The Anacostia Neighborhood Health Center is located at 11th and W streets SE. Five of the facilities previously listed are located east of the Anacostia River. This includes two centers for mothers and children and three family-oriented neighborhood health centers.

ALTERNATIVES CONSIDERED

Question: Have you considered alternatives other than outpatient services provided at city facilities by city employees in order to help insure adequate outpatient services are provided to all sections of the city?

ANSWER: Yes. There are three methods of financing health services: (a) fee for service; (b) capitation; and (c) salary. All of these methods have been explored and are inuse as well as the utilization of trainees to augment the staff in the city-operated programs. The fee-for-service provided to medicaid providers requires a significant commitment of resources by the D.C. Government. The capitation program is utilized at the Edgewood Terrace Health Center, which is under the auspices of Georgetown University Medical School. A similar program was developed with George Washington University and residents of Service Area 9. The East of the River Health Center, which is a private HMO, has been under development for several years.

The philosophy of the administration had been to withdraw public-supported facilities once other mechanisms of health care have been developed in a community. Universities and private groups have been encouraged to establish health centers in underserved communities. Efforts to withdraw services from communities once other methods of health care have been introduced have been met by protests from the residents served by the public facilities. Past examples include the Center for Mothers and Children at 13th street and Rhode Island avenue NE and the Parkside Neighborhood Health Center at 701 Kenilworth Terrace NE. A large proportion of the patients who were served are unable to pay private physicians, and need a great deal of support services which are provided at a clinic and not in a private practitioner's office. Private insurance companies do not pay for routine visits, only for special studies that are provided, such as electrocardiograms, laboratory studies, et cetera. Recently, an agreement was signed with George Washington University which will entail physicians' assistant trainees to receive their preceptorships in neighborhood health centers operated by the Bureau of Clinical Services. These trainees are in their last stages of preparation and will augment the staff operating in the neighborhood health centers. Agreements are being developed with Georgetown University and Howard University for similar programs with other trainees.

Through the maternal and child health Federal funds under title V of the Social Security Act, contracts are provided for comprehensive children and youth services by Children's Hospital National Medical Center and for family planning services by Howard University College of Medicine. Additional services are provided by Homemaker Services and the Visiting Nurses Association.

CLINIC USAGE RATE

Question: The subcommittee has been told that the usage rate at many of the clinics has gone down in recent years, especially since medicaid and medicare programs were started. What have the trends been for the last several years? Please supply for the record the location and usage rate of each of the city's clinics over the last 10 years.

ANSWER: The usage rate at clinics varies with the size of the population and the demographic indices of the community. Many of the patients with medicaid and medicare utilize the city-operated facilities, primarily because there are no other resources located in their communities. The factor most responsible for any reduction in clinic usage relates more to factors such as the reduced birth rate which is national, introduction of family planning services, and legalization of abortion and the changing nature of the services provided.

Many years ago, the services provided by the clinics were primarily services to well children or well-baby clinics. Now, the clinics are providing services to sick patients who require more time; subsequently, fewer can be seen. The community has finally been educated to seek medical care early before patients become severely ill. By early intervention and treatment of the initial stages of disease, patients who formerly required extensive medical care or were critically ill upon arrival at the hospital have been reduced. Although medicaid has provided the opportunity for many individuals to seek medical care at other than city-operated facilities, historically fee-for-service is the most expensive method of providing health care. The eligibility for the medicaid program fluctuates with the family income. We do not have two groups of patients, the medicaid patients and the nonmedicaid patients. Rather, there are individuals who, at given points of time, are eligible for medicaid, and at other times, because of employment situations, are ineligible for medicaid. This fluctuation of eligibility for services causes patients to freely flow between the private and public sectors of health care.

CITY CLINIC LOCATIONS AND USAGE RATE

Question: Please supply for the record the location and usage rate of each of the city's clinics over the last 10 years.

ANSWER: For the majority of clinics data are not available prior to 1973. See attached table for data covering fiscal year 1973 to fiscal year 1976.

The primary reason we did not go beyond 1973 was due to loss of data during the conversion of categorical clinics to neighborhood health centers. During this transition period some services provided by the neighborhood health centers were not reported. During their early years, comparable data was not submitted by individual neighborhood health centers. These clinics include Maternal and Child Health, Upsher Clinic, and others.

NUMBER OF VISITS TO CHHA OUTPATIENT CLINICS BY LOCATION

Name of Facility	F.Y. 1976	F.Y. 1975	F.Y. 1974	F.Y. 1973
Grand Total	837,066	675,189	651,102	557,593
Division North - Sub Total	118,793	123,760	108,929	115,596
Northwest Health Center	87,778	90,933	64,581	73,426
Adams-Morgan	1,072	1,013	525	904
Center 2	5,928	5,098	7,712	8,983
Center 10	5,026	4,628	6,450	6,395
Claridge Towers	1,499	1,581	2,667	2,169
Garfield Terrace	3,333	3,878	3,662	3,972
Fort Lincoln	373	448	1,041	527
Regency House	469	568	1,023	629
Adams School Dental Clinic	1,292	1,211		
Burroughs School Dental Clinic	616	879		
Mamie D. Lee School Dental Clinic	146	579	21,268	18,591
Raymond School Dental Clinic	836	1,005		
Sharpe Health School Clinic	841	377		
Terrell School Dental Clinic	889	1,026		
Georgetown Health Center	1,465	1,901		
Support services (visits not counted by facility)	7,230	8,635	NA	NA
Division South - Sub Total	172,861	173,091	262,972	202,297
Parkside	15,777	16,871	26,127	18,762
Potomac Gardens	12,753	12,122	19,475	12,696
Southwest Health Center	21,169	21,316	22,948	20,733
Arthur Capper	10,692	9,994	13,476	11,634
H Street	12,407	18,250	33,542	21,515
Congress Heights	16,203	19,073	24,016	18,966
Anacostia	15,044	16,281	28,514	16,747
Ridge Road	7,566	6,886	7,216	9,496
55th Street	1,144	1,445	1,526	1,115
Area C Chest Clinic	13,027	12,222	7,437	6,805
Area C VD Clinic	12,903	14,836	15,049	10,144
Dermatology Clinic	3,945	3,352	1,299	-
Merritt School Dental Clinic				
Hart School Dental Clinic	8,672	10,084	24,699	22,650
Douglas School Dental Clinic				
Buchanan School Dental Clinic				
Support Services (visits not counted by facility)	21,559	10,359	37,648	31,034
MCH Division - Sub Total	375,146	192,444	88,220	66,446
Gales Health Center[1]	24,053	21,000[3]	22,776	22,848
15th Street Clinic (Center #17)	23,987	22,861	12,630[4]	12,750[4]
Hunt Place Clinic (Center #18)	26,361	22,928	11,963[4]	12,648[4]
Crippled Children Unit at DCGH	78,315[2]	50,655[2]	40,851[5]	18,200[5]
Physicians School Service	86,936	75,000[3]	NA	NA
Support Services (visits not counted by facility)	135,494	NA	NA	NA
Chronic Disease Division - Sub Total	7,799	12,423	12,781	10,440
Multiphasic Screening	7,799	12,423	12,781	10,440
D.C. General Hospital - All Outpatient Clinics	162,467	173,471	178,200	162,814

[1]Includes Developmental Evaluation Clinic.

[2]Includes Occupational Therapy and Physical Therapy at Sharpe Health School Clinic.

[3]Estimated.

[4]Pediatric visits only.

[5] Excludes O.T. and P.T. visits for 1973 and Speech and Hearing, Psychiatric and Social Service visits for F.Y. 1974 because they are not available.

NA-Not Available.

MEDICALLY NEEDY

Question: As a part of the fiscal year 1977 city budget decisions I understand that under the medically needy program, the city has decided to no longer give program beneficiaries the choice of using private sector services. Instead, all of these people will be required to use city health care facilities. What is the reason for this decision to no longer permit the individual to choose where he will get his services?

ANSWER: As we prepared for our fiscal year 1977 budget, it became apparent that if we maintained the medicaid program as currently structured, it would require an expenditure of approximately $19 million in additional services, or an increase in District of Columbia appropriated funds of $9.8 million. Revenue projections for fiscal year 1977 as conveyed to the Department, indicated that the mandatory needs of the Department could not be met while at the same time accommodating such a large increase in the medicaid program.

A detailed examination of the medicaid program led to the inescapable conclusion that there was no way that we could continue the program without substantive changes in its composition. After examining all options, with the view toward minimum disruption of service, it was concluded that our only course of action was to transfer the medically needy out of the medicaid program and to provide health care to these clients through the DHR health resource system. It is felt that this change will, at the same time, continue to make health services available to this population, while at the same time drastically reduce costs.

Question: Is there a budget savings associated with this decision? Where does it come from?

ANSWER: No; there will not be a budget savings associated with this decision. In order to continue operating the medically needy program, an increase of $13.6 million over the $19.4 million requested for fiscal year 1977 is required.

Question: Does the fact that these people will be absorbed at city facilities project productivity improvements for the city facilities?

ANSWER: If the medically needy program were to operate in fiscal year 1977, projected costs to serve the anticipated 40,000 eligibles would be $29 million. However, if terminated, an additional $6.3 million will be required to meet the increased service demand on our facilities.

Question: Won't this decision result in greater usage of city facilities and some reduction of projected use for private sector facilities?

ANSWER: Yes; this diversion of funds will permit the Department of strengthen and expand health services in CHHA and will enable these clients to have their medical needs met through such facilities.

HEALTH CARE PLANNING

Question: Please describe for the subcommittee the city's role in health care planning under the Health Planning and Development Act.

ANSWER: The District of Columbia, in addition to being a State agency under the act, received an exemption from the Secretary of the Department of Health, Education, and Welfare under section 1536 of the act from establishing a health systems agency. This permits the District of Columbia State agency to perform the health systems agencies functions as well as the State agency function.

Question: How many health planning groups are established in the metropolitan area by the act?

ANSWER: There are four health planning groups established in the metropolitan Washington area by the act, as follows: (1) The District of Columbia section 1536 State agency performing both State and health systems agency functions; (2) the Northern Virginia Health Systems Agency; (3) the Montgomery County, Md., Health Systems Agency; and (4) Southern Maryland Health Systems Agency.

THREE STATES COORDINATE PLANNING

Question: What are the effects of not having the Metropolitan-wide Health Care Plan or Planning Agency?

ANSWER: The Secretary authorized the Metropolitan Washington Standard Metropolitan Statistical Area (SMSA) to be split along State boundaries—Virginia, Maryland, and the District of Columbia—following justifications submitted by the Governors of Maryland and Virginia and the Mayor. The three States have agreed to coordinate planning in the Metropolitan Washington SMSA in accordance with the requirements of DHEW for achieving coordination among SMSA health planning agencies split in accordance with the Secretary's authorization.

In essence, there will be coordination effected throughout the Washington Metropolitan SMSA. Therefore, the absence of a common plan will not deter a metropolitanwide planning process. A metropolitanwide plan was determined by the Secretary to be infeasible in the Washington Metropolitan SMSA because of varying State laws, State funding constraints, and differing needs of the populations.

BILLINGS AND COLLECTIONS

Question: Mr. Yeldell, as you remember back in April at hearings on the fiscal year 1977 budget, we discussed implementing a proper billing and collection system for the Community Health and Hospital Administration. I expressed the view, and I believe you agreed, that the city can no longer afford to give away free health care at city facilities to those people who are not indigent and who do have the ability to pay. The subcommittee was told that the city's policy was to provide treatment for venereal disease, tuberculosis, prenatal care, family planning, screening for lead poisoning, diabetes, and immunizations free to all District of Columbia residents regardless of their income and to bill everyone else for all other services at cost recovery fees. You indicated to us that you could not implement the policy until the City Council had passed a bill clarifying that policy. You indicated that you would submit a bill to the City Council by May 25. Has that bill gone to the City Council? When will it go to the City Council? When do you expect the City Council to act on it?

ANSWER: The bill entitled, "Health Services in the Public Interest," has been fully developed and forwarded to the Mayor's office. It is anticipated that the City Council will act on the proposed legislation immediately upon resumption of legislative sessions next month.

Question: Have you changed your mind at all on what the city policy should be in this area since we talked last?

ANSWER: No. The services to be provided in the public interest have been modestly expanded with the provision of annual review for the purpose of effecting timely changes as indicated.

Question: We have had several estimates on what additional revenue the city would raise if a proper billing system were put in place to implement the city's policy in this area. What is your estimate of the additional revenue that would be raised from all the various sources, including medicaid, medicare, third-party insurance, and individual pay? Would you submit for the record a paper that documents and details your estimate of the additional revenue that would be raised by having a proper billing system in place to implement the city's policy for services provided by the Community Health and Hospital Administration?

ANSWER: The department cannot accurately project the amount of additional revenue that could be generated by having a proper billing system. Only until the new system is implemented and the department has had 1 or 2 year's experience with it can we accurately project the amount of additional revenue.

District of Columbia Council

Prepared Statement of Polly Shackleton, Member, District of Columbia Council

Senator Chiles. I would like at this time to place in the record a statement by Mrs. Polly Shackleton, a member of the District of Columbia Council.

[The statement follows:]

I appreciate this Committee's invitation to testify on District provided health care, and I regret a long-standing commitment to be out of the city with my family precludes my delivering this statement in person.

As Chairperson of the Council's Committee on Human Resources and Aging, I welcome your decision to examine both the costs and the long-term role of our city-operated health facilities. Fifteen or twenty years ago most cities had two health systems -- the public one (clinics, hospitals, nursing homes) for the poor, and the private one (private doctor, hospital, and nursing home) for those who were wealthy or had adequate insurance. With Congressional passage of the Medicare and then, Medicaid statutes, the poor were released from total reliance on the public system.

Today the Medicaid patient "shops" for quality medical care, just as the Blue Cross enrollee does. The group of persons having no potential coverage from insurance, Medicare, or Medicaid is a tiny percentage of the population. Most of them are between 21 and 62, have no dependents, and are either unemployed or employed where no group insurance program is offered. They are the only "sure" market for the public health facility. The rest of its patients will come through its doors for convenience, tradition, and/or quality of the care it offers. In general, the public facilities in major cities have not competed successfully for the Medicaid/Medicare patient, and their recent histories show a marked decline in utilization. 1/

1/ See D. C. General Hospital, Research Report, D. C. Municipal Research Bureau, June 1975, pp. 8-10.

At the same time use of public facilities has declined the private sector has blossomed. The cities find themselves in the unenviable position of supporting both an underused but expensive public health system, and a rapidly growing Medicaid budget for private providers. Further, the costs of the private providers are not readily controlled, although some states are finding prospective rate mechanisms promising. The state and Federal governments must continually work together to develop further methods of controlling Medicaid costs without sacrificing quality.

Faced with tight budgets, legislators, such as our Council, are now taking a careful look at the cost-effectiveness of the operation of the public health facility. Our taxpayers grow particularly impatient with reports that city medical institutions make little attempt to collect all potential revenues. A lawyer telephones me to say he cannot get a bill from D.C. General for treatment of an accident victim -- a bill the insurance company is perfectly willing to pay. A newspaperman comments a colleague sought to pay for a clinic visit, and payment was refused. Our area mental health clinics only began systematically to seek to establish Medicaid eligibility for their clients in January 1975. Hundreds of thousands of potential reimbursements have been lost. This must not be allowed to continue.

In one area -- neighborhood clinics -- we do not capture all potential revenues because an old D. C. health regulation sets the maximum fee for services at $3. (Chapter 7, D.C. Health regulations, Article H-710) I was in the audience when Mr. Yeldell told this committee legislation would soon be forwarded to the Council to establish a realistic fee schedule for our clinics. The bill has not yet arrived, but I fully support such a measure and will give it high priority in our Committee's work when it comes.

I would hope such legislation would provide, at no charge to anyone, the following:

-- screening for hypertension, lead poisoning, tuberculosis, and VD:

-- pre-natal care, infant immunizations, and family planning services;

-- emergency treatment due to a disaster or threatened epidemic such as the "swine flu".

I would expect all other services would be rendered at a fee reasonably related to the cost of the service. I do not think we need to develop some elaborate catalogue of fees, varied according to what services the patient requires. Neither do I believe, however, that we should charge a single flat fee. A throat culture or flu shot should not cost the same as a physical. How much of the fee the patient pays would be determined according to his income. A similar sliding scale system should be developed for the outpatient clinics at D. C. General Hospital.

There is a second point I wish to make to this Committee in connection with revenues earned by public facilities. It is relevant to the fiscal 1977 budget currently before you.

The first is the continued inclusion in our state Medicaid plan of the group called the "medically needy." These are persons or families who do not receive public assistance checks, but whose incomes are not sufficient to pay their medical expenses. Many of these are persons at Forest Haven, Glen Dale and D. C. Village having modest Social Security benefits. Many are Medicare recipients who cannot pay the "deductibles" required under Medicare, so the city pays them and Medicare covers the rest. Still others -- perhaps the most sympathetic cases of all --- are families who suffer a medical catastrophe that will consume all their assets and income unless they can obtain Medicaid assistance. This category of working poor or retirees it seems to me should not be penalized and should have the same choices as those on public assistance.

In the fiscal 1977 budget the Mayor proposed to drop the medically needy program. The Council voted 12 to 1 to continue it, and we believed we had approved sufficient funds to continue it through fiscal 1977. Data for the first half of FY 1976 suggested payments to private vendors would average $5.5 million per month for the year, for a total of approximately $66 million. Acquisition of the Metropolitan Hotel would give us 100

additional skilled and intermediate care beds into which we would move patients presently in acute care institutions merely because no SNF or ICF bed is available. Since an acute care bed costs about $200 a day, and a SNF bed between $30 a day (proposed rate for private facility) and $57 a day (D. C. Village), these additional beds, we believe, could mean a savings in the Medicaid program of up to $6.2 million in fiscal 1977.

In reviewing this issue again this month, however, I conclude our estimates may have been too optimistic. We were not allowed by the Congress to purchase the Metropolitan facility in FY '76, although I hope you will approve it in this budget. The payment to private vendors totalled $74 million, rather than $66. If we are to continue the medically needy program more resources will be needed, and Council staff has already been working with the DHR staff to determine how much and what revenue sources we might identify. Clearly clinic fees are one potential revenue source. I understand a fee for ambulance service is also under consideration.

I also conclude, however, that we cannot afford to terminate the medically needy program. About 1/3 of the total program cost is generally attributed to use of Medicaid by the medically needy. In Fiscal 1976 this amounted to approximately $34 million. The Federal government reimbursed us for half this cost, or $17 million. If we terminate the medically needy, we give up at least $17 million in Federal reimbursements in Fiscal 1977. Much of this reimbursement is for services rendered the medically needy by our own institutions, (possibly as high as $7 million) We are committed to giving these persons the medical care they need. Thus, the $17 million D.C. dollars we would be saving by dropping the medically needy must be stretched to buy $34 million worth of care. Clearly this is impossible. 2/

2/ See the plaintiff's comments, filed July 30, 1976, on defendants' July 1, 1976 study and report in the D.C. General suit (Greater Washington, D.C. Area Council of Senior Citizens v. D.C. Government), pp. 32 and 33. Plaintiffs contend eliminating the medically needy program would result in an increased patient load of about 50%, which the hospital could not handle within its proposed staff resources.

Looking beyond this year, it is difficult to predict how major a role the public sector will continue to play in the delivery of health care to our citizens. If Federal Funding for Medicare or Medicaid is reduced, or presently covered services eliminated, a larger burden will fall on the public institutions. If the Federal participation does not change, or it grows, I envision the ultimate merging of the public and private systems. Most persons will seek primary care from a physician or an HMO, instead of a public clinic. Our hospital and long-term care institutions could well become non-profit community facilities with the city contracting for a certain number of beds for patients who had absolutely no means of payment. Whether a facility will exist will depend more upon its location and the quality of its service than on whether it is public or private. Relative cost is not a significant factor, for Federal Medicare and Medicaid certification standards guarantee all institutions in the same area will incur similar costs for staffing and operation. Given very careful monitoring to insure no one is denied necessary care, the resulting structure should mean quality medical care, for all our citizens.

SUBCOMMITTEE RECESS

Senator CHILES. I would like to recess by thanking all those who appeared and testified at this hearing today.

The hearing is recessed.

[Whereupon, at 1:23 p.m., Tuesday, August 10, the hearing was recessed, to reconvene at the call of the Chair.]

DISTRICT OF COLUMBIA APPROPRIATIONS FOR FISCAL YEAR 1977

WEDNESDAY, SEPTEMBER 22, 1976

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, D.C.

The subcommittee met at 2:35 p.m., in room 1114, Everett McKinley Dirksen Office Building, Hon. Lawton Chiles (chairman) presiding.

Present: Senators Chiles and Mathias.

GENERAL ACCOUNTING OFFICE

STATEMENT OF VICTOR L. LOWE, DIRECTOR, GENERAL GOVERNMENT DIVISION, GENERAL ACCOUNTING OFFICE

ACCOMPANIED BY FRANK MEDICO, ASSISTANT DIRECTOR, GENERAL GOVERNMENT DIVISION, GENERAL ACCOUNTING OFFICE

VIOLATION OF FEDERAL GRANT REGULATIONS BY DISTRICT OF COLUMBIA DEPARTMENT OF HUMAN RESOURCES

OPENING REMARKS OF SENATOR CHILES

Senator CHILES. This afternoon the subcommittee will focus its attention on a recent General Accounting Office letter report to Mayor Washington dated September 8, 1976. In that report, GAO indicated that the Department of Human Resources had apparently violated Federal grant regulations by spending $8,740 of Department of Health, Education, and Welfare grant funds for the purpose of leasing two air-conditioned cars which were not used for grant purposes.

CITYWIDE STUDY OF DISTRICT OF COLUMBIA MOTOR VEHICLE MANAGEMENT ACTIVITIES

The GAO is currently conducting a citywide study of the District's motor vehicle management activities to determine how effectively and economically the city acquires and maintains its vehicles. During this study, the irregularities concerning the two air-conditioned cars were discovered. While this subcommittee did not request the GAO to conduct this particular study, we look forward to receiving the completed report when it is available.

This subcommittee has always held a great respect for the very difficult job that Mayor Washington has assigned to Mr. Yeldell. I

have become very concerned, however, about what appears to be a pattern exhibited by Mr. Yeldell and his department with regard to the misuse of Federal funds.

REMODELING OF OFFICE SUITE

On April 9, 1976, during a public hearing, I discussed with Mr. Yeldell the report that one of Mr. Yeldell's principal assistants had spent approximately $30,000 of Department of Labor funds to remodel her office suite.

On August 10, 1976, again during public hearings, I asked Mr. Yeldell about his use of Federal grant funds for the purpose of starting to remodel the kitchen adjoining his office and beginning work on the installation of a private washroom, also adjoining his office. In both of these cases, Mr. Yeldell argued strongly that there was nothing wrong with using Federal funds for these purposes

USE OF CITY CARS BY CITY OFFICIALS

During the House-Senate conference on the fiscal year 1976 Appropriations bill, the merits of a city request to provide Sterling Tucker, Chairman of the City Council, with a car and chauffeur was discussed. After Mr. Tucker learned of the strong feelings within the Congress on the question of city officials other than the Mayor having cars provided entirely for their own personal use, Mr. Tucker agreed to withdraw his request and to have his transportation needs met through the city carpool.

I was surprised to learn that after these two discussions with Mr. Yeldell regarding the questionable use of Federal funds and after the Congress made clear its position on the use of city cars by city officials—I might add parenthetically that a former chairman of this subcommittee, Senator Inouye of Hawaii, at the time he was chairman of this subcommittee had a study done and found that at that time that a number of city officials had limousines and chauffeurs; and at that time Senator Inouye restricted the use of those cars and knocked out the use of those cars, except the car that is used by the Mayor and except for the permissible use under the motor pool—that we again learn of Mr. Yeldell's misuse of Federal grant funds to provide himself and his immediate staff the use of two air-conditioned cars.

PURCHASE OF AMBULANCES

The fact that there are a large number of problems in Mr. Yeldell's department is nothing new to this subcommittee or to any citizen that has followed city news. Just within the last week alone, four additional problems have been brought to our attention.

First, in a letter report issued by GAO on September 17, 1976, GAO reported that the Department of Human Resources has purchased two ambulances with Health, Education, and Welfare grant funds which have remained idle for the last 17 months. During this period of time, the fire department which operates the city's emergency ambulance service has had to turn away calls.

Second, on the televison news on Monday night, I noticed that the Department of Human Resources also purchased two large medical

vans with HEW grant funds which also have never been used since they were purchased in January of 1975.

SUBSTANDARDS AT DISTRICT OF COLUMBIA VILLAGE

Third, also on television news Monday night, the fact that an HEW audit team has found that District of Columbia Village does not meet Federal standards and may, therefore, lose its medicaid and medicare reimbursements was reported.

OVERPAYMENT AND INELIGIBILITY RATES OF WELFARE CASES

Finally, as GAO will report later today, the inability of the Department of Human Resources to reduce high overpayment and ineligibility rates of its welfare cases has cost the city $26 million in unnecessary expenditures between October 1970 and December 1975.

This subcommittee has had some sympathy for Mr. Yeldell with regard to the large numbers of management problems that plague his Department. The difficulty of running a large city department like Mr. Yeldell's is well known and similar city agencies around the country are also riddled with problems.

On the other hand, this subcommittee has very little sympathy with regard to Mr. Yeldell's apparent misuse of Federal grant funds to obtain two air-conditioned cars for his use and the use of his personal staff.

The subcommittee will now hear from Mr. Lowe, Director of the General Government Division of the GAO.

STATEMENT OF VICTOR L. LOWE

Mr. LOWE. Thank you, Mr. Chairman.

Mr. Chairman and members of the committee, we are here at your request to present our observations on problems at the District's Department of Human Resources involving, one, improprieties in the acquisition and use of certain automobiles and ambulances obtained under Federal grants, and, two, weaknesses in the administration of public assistance.

OBSERVATIONS ON PROBLEMS OF DEPARTMENT OF HUMAN RESOURCES

Specifically, we noted that two automobiles leased with grant funds were used for nongrant purposes, contrary to Federal regulations;

The lease and the proposed purchase of these cars with grant funds for nongrant purposes circumvents the statutory prohibition limiting the purchase of vehicles with appropriated funds as well as the statutory ceiling on the amount to be spent on each vehicle;

The Department failed to comply with Federal regulations requiring the acquisition of the most economical vehicle needed to accomplish the intended purpose under the grant; the use of the two cars was not recorded in travel logs, contrary to the Department's own regulations; two ambulances acquired by the Department under a Federal grant have been unused since their receipt 17 months ago—despite a District-wide shortage of such vehicles; the Department's prolonged failure to act effectively on knowledge that over a third of its welfare recipients were being paid erroneous amounts has resulted in signifi-

cant unnecessary expenditures. Among those overpaid, we estimate that people willfully misrepresented their eligibility received about $26 million to which they were not entitled between October 1970 and December 1975; and, finally, the Department has been very slow in adjusting or terminating payments in those instances where it became aware of errors, resulting in further unnecessary expenditures.

GAO FINDINGS ON PROBLEMS OF DEPARTMENT

The balance of my presentation will briefly summarize our findings concerning these matters. They are discussed in detail in the attachment to this statement.

We have been studying the District's motor fleet management program to determine if benefits would accrue from a centrally managed operation and how effectively and economically city-owned vehicles are acquired and maintained.

We selected several major Departments, including the Department of Human Resources, for our study. Problems with the District's motor fleet management have been longstanding.

FINDINGS OF 1972 NELSEN COMMISSION

Since 1959, GAO and others have criticized the District for not having an efficient and economical vehicle fleet management program. In 1972, the Nelsen Commission—the most recent group to study the District's motor fleet—made the following two recommendations to resolve longstanding management problems:

1. Establish a single organization to be responsible for motor equipment management, including maintenance, repairs, utilization, acquisition, replacement, and disposal; and
2. Establish a central information system for the surveillance, scheduling, and control of vehicle maintenance.

The District's fleet management is not centralized. Each major city Department has its own maintenance facilities, personnel, and operating policies and practices.

Centralized motor fleet management with the necessary authority and responsibility could help prevent the kinds of problems that we are discussing today.

We intend to report to the Congress on our review of the District's motor fleet management when we complete our work in the major Departments. To minimize delays in obtaining correction of problems, we have been discussing our findings with Department officials during the course of our work and issuing a formal report to each Department at the conclusion of our review of its activities.

One report has been issued and others will follow. That report was one covering the environmental services, issued in July 1976.

GAO FINDINGS ON DISTRICT OF COLUMBIA MOTOR FLEET MANAGEMENT PROBLEMS

Let me now discuss our findings at the Department of Human Resources concerning the aforementioned cars and ambulances.

In May 1974, the Department of Human Resources informed the Department of Health, Education, and Welfare that two automobiles would be purchased with grant funds awarded for maternity-infant

care and children-youth projects. The justification for acquiring the vehicles stated that they would be used for grant purposes, and acquisition of the vehicles was approved on that basis.

In November 1974, the Department requested the Department of Health, Education, and Welfare's permission to lease rather than purchase the vehicles. The Department stated that it was impossible to purchase an automobile within the purchase price limitation imposed by District regulations.

The automobiles selected were intermediate sedans equipped with air-conditioning, AM–FM radios, deluxe wheel covers, and radial tires.

The Department of General Services requested that the Department of Human Resources reconsider its plan to acquire the vehicles inasmuch as they were performance-oriented vehicles of a type used primarily by police, and cost more to operate and maintain than smaller cars.

The initial purchase price of the vehicles was about $5,300 each, according to a leasing company official. The annual lease cost was about $3,900 each. The grants provided $3,000 each for vehicle leasing and in March 1975, a 1-year contract was entered into for lease of the automobiles. The Department's Director told the Director of General Services that any funding required for the lease in excess of the grant authorization would be provided by other funds.

The grantor authorized continued lease or purchase of the two vehicles in July 1976, again on the premise that they would be used for grant purposes. By August 1976, the total costs of the lease and proposed purchase of the two vehicles amounted to $16,240 or about $8,100 each.

Despite the Department's justification that the two cars were to be used for grant purposes, they were not. We were advised that one vehicle was assigned to the Director of the Department of Human Resources for his exclusive use, including commuting between his home and office; the other was used by the Director's headquarters staff.

FAILURE OF DEPARTMENT TO MAINTAIN TRAVEL LOGS

Travel logs were not kept on the vehicles, although the Department's own regulations require them. Without these records, we could not verify the nature of vehicle usage. Use of the vehicles for nongrant purposes violated the conditions of the grant as well as Federal and Department of Health, Education, and Welfare regulations.

The Department of Human Resources now proposes to buy the two used vehicles at a discounted price of $2,900 each. Assuming these vehicles continue to be used for nongrant purposes, their acquisition would be an improper use of grant funds in an apparent further attempt to circumvent the statutory prohibition in 31 U.S.C. 638a against the purchase of vehicles with appropriated funds as well as the statutory ceiling on the amount to be spent on each vehicle.

Further, the acquisition of the two performance-oriented, air-conditioned vehicles circumvents the intent of the Federal regulation, again fully applicable to the District, that only vehicles with minimum body and engine size and maximum fuel efficiency be acquired.

AUTHORITY TO EXPEND GRANT FUNDS

Finally, aside from the misuse of grant funds, the potential exists for violation of 31 U.S.C. 638a, which states that no appropriations shall be expended to purchase or hire passenger motor vehicles unless specifically authorized.

The District is without such authority for the Department and so to the extent that grant funds are not adequate to cover the entire cost of purchasing the vehicles, the Department is without authority to pay for the difference from appropriations.

PURCHASE OF AMBULANCES

In April and May 1975, the Department of Human Resources received two ambulances purchased in June 1974 with funds provided by a Department of Health, Education, and Welfare maternity and infant care grant.

The ambulances, which cost a total of $37,000, were supposed to be used to transport maternity patients and their newborn infants to, from, and among District hospitals. The grant justification stated that many patients do not have adequate transportation and that the response from taxi firms for service was very poor.

Between April 1975 and July 20, 1976, when we observed the two ambulances parked on a lot at District of Columbia General Hospital, they had been driven a total of 312 miles. We were told by Department officials that the ambulances had never been used because of insufficient funds to staff them, and that the mileage had been accumulated by driving the vehicles around the parking lot each week to warm the engine and by taking them to the inspection stations.

We observed that the patient compartments in the ambulances were not equipped, paint was peeling off one of the vehicle's fenders, some tires on both vehicles were partially deflated.

On August 4, 1976, the ambulances were taken to a District maintenance facility for repairs. On September 2, 1976, the ambulances were again observed parked on another District of Columbia General Hospital lot; one ambulance's odometer showed 200 miles and the other 145 miles or an increase of 33 miles over the previous total.

While these two expensive vehicles remained idle, the District's fire department, which is responsible for the District of Columbia emergency ambulance service, was reportedly short at least four ambulances.

We wrote to the City Administrator on August 13, 1976, requesting a review of this matter. Our letter was referred to the Director, Department of Human Resources, for action. As of today, we have not been informed of any action taken.

Thus, more than 30 days have elapsed since we brought the matter to their attention and the ambulances still remain idle, while there is a stated need for such equipment in the fire department.

AFDC CASELOAD IN DISTRICT

The major form of public assistance in the District of Columbia is the program for Aid to Families with Dependent Children (AFDC). In fiscal year 1975, the average monthly caseload was about 30,200.

Payments in that year totaled about $86 million. Program costs are shared equally between the District and the Department of Health, Education, and Welfare.

Mr. Chairman, We have not officially issued a report. However, a draft of it was delivered to the Director, the Department of Human Resources, in early August and discussed with him and, last week I believe it was, we received his written comments which we will incorporate in our final report.

In a program of this nature, in any locality, it is inevitable that some people will try to beat the system and errors will occur that result in some recipients being over and under paid.

HEW has set standards providing that the maximum incidences of error for ineligibility and incorrect payment are, respectively, 3 percent and 5 percent. It requires establishment of procedures for periodically testing the correctness of the payments being made.

DEPARTMENT'S QUALITY-CONTROL PROGRAM

The Department of Human Resources' current quality control program dates back to October 1970. Between that date and December 1975, the quality-control group, which is responsible for monitoring the program, reviewed 7,484 cases. It found that erroneous payments were being made to 2,872 recipients, 38 percent of those tested. That percentage includes overpayments and underpayments.

Our review was focused on those erroneous payments made to people who were trying to beat the system through willful misrepresentation. The findings of the quality-control group show that the incidence of willful misrepresentation nearly doubled between October 1970 and December 1975—from 7.4 percent to 13.5 percent of the cases tested.

Based on the group's tests, we estimate that during this period, a total of $26.6 million was paid to recipients whose eligibility was based on incorrect information.

Let me emphasize, Mr. Chairman, that these people were only part of the problem. As I stated earlier, erroneous payments were being made to about 38 percent of all recipients.

DEPARTMENT REVIEW OF ALL AFDC CASES

The Department of Human Resources started taking effective action on this problem in November 1975 when it began a 100-percent review of all cases. Through April 23, 1976, it had reviewed 7,800 cases. The results confirm how bad the situation is—21 percent of those reviewed were ineligible; an additional 27 percent were overpaid.

When I was before your subcommittee some time ago, I mentioned it seems that the GAO and the District are always fighting each other. I don't think that is quite true.

COMPUTER IDENTIFICATION OF HIGH-RISK WELFARE CASES

We have a cooperative project right now with the Director of the Department of Human Resources in trying to establish a system which, by use of computers, will identify the high-risk welfare cases. The Director of Human Resources has assigned manpower to this project.

It should help improve the selection of high-risk cases to be reviewed. We are hopeful that the computer model would have nationwide applicability.

What concerns us, Mr. Chairman, is that the gravity of errors in the welfare caseload was known to the Department of Human Resources in 1971–74. Yet, no effective corrective action was taken.

The Department's eventual action deserves recognition, but I don't think we can be accused of abusing the privilege of hindsight when we express the opinion that a more prudent manager would have moved out on this problem at an earlier date.

TERMINATION OF ERRONEOUS WELFARE PAYMENTS

Finally, the Department of Human Resources has been very slow in adjusting or terminating payments in those relatively few instances where it became aware of errors, resulting in further unnecessary expenditures.

In fiscal year 1975, the Department identified 226 instances of willful misrepresentation, of which 165 were resolved through March 1976. Some cases took up to 9 months to resolve and additional overpayments of about $33,000 were made. Out of the 165 cases, only 2 appeals were made. One was resolved and one remained open as of March 1, 1976. Thus, appeals did not account for processing delays.

The Director of the Department of Human Resources has expressed general agreement with our findings. He pointed out that a shortage of staff has hampered the Department's ability to effectively manage welfare activities.

He provided information contrasting the growth in the Department's public assistance responsibilities with the relatively static size of the work force. We have not reopened our review to verify his figures, but readily concede that staffing could have been a factor.

ATTACHMENT TO STATEMENT

On the other hand, we believe that more could have been done with the resources available; indeed, as is being done in connection with the ongoing 100-percent verification of open cases. We are preparing a report on these matters, which we expect to issue shortly.

That concludes my statement, Mr. Chairman.

Senator CHILES. Thank you, Mr. Lowe. We will include the attachment to your statement.

[The attachment follows:]

LEASING OF AUTOMOBILES

In May 1974, the Department of Human Resources informed the Department of Health, Education, and Welfare that two automobiles would be purchased with grant funds awarded for maternity-infant care and children-youth projects. The stated purpose of acquiring the automobiles was to provide the staff and project director with transportation to health clinic sites and project related meetings within the Department of Human Resources and the District community.

In November 1974, the Department requested the Department of Health, Education, and Welfare's permission to lease rather than purchase the vehicles. The Department stated that it was impossible to purchase an automobile within the purchase price limitations imposed by District regulations. The Department of Health, Education, and Welfare approved the request with the stipulation that it be carried out within approved budget limits. Each of the project's budgets were subsequently revised to allot $3,000 for an automobile.

The automobiles to be leased were intermediate sedans (Ford Torinos), equipped with air-conditioning, AM-FM radios, deluxe wheel covers, and radial tires. In reviewing the lease proposal in December 1974, the District's Department of General Services asked the Department of Human Resources to reconsider its plans because (1) the requested vehicles were performance-oriented, used primarily by police, and cost more to operate and maintain than smaller cars (Federal Management Circular 74-1 which the District follows suggests that only vehicles with minimum body and engine size and maximum fuel efficiency be acquired) and (2) air-conditioning had to be specifically authorized by either the grant or by the Director,

Department of General Services. Full supporting evidence of the intended use of the vehicles was also requested.

The Director, Department of Human Resources, responded by saying that an urgent program requirement existed for the two vehicles, and asked that arrangements be made for lease with option to purchase, telling the Department of General Services that funding required for the lease in excess of grant authorization would be provided by other funds. Department of General Services' officials said that although the requested documentation was not submitted, bids on the lease were solicited because the Department of Health, Education, and Welfare had granted permission to acquire the vehicles, and that the air-conditioning had been approved as a result of a misunderstanding among Department of General Services staff members.

In March 1975, a 1-year contract was entered into for lease of the automobiles at an annual cost of $7,878, and through April 1976, the Department of Human Resources paid $8,470 to lease the vehicles. The agreement included an option to renew the lease for two 1-year-periods.

In July 1976, the Department of Health, Education, and Welfare authorized purchase or continued leasing of the automobiles. On July 30, 1976, we met with the Director, Department of Human Resources, and questioned the lease arrangement and the vehicles' use in relation to that authorized by the grants. In August 1976, the Department of Human Resources made arrangements to purchase the two automobiles with grant funds for $2,900 each. Along with the lease payments of $1,970 for May through July 1976 which were being processed at that time, the total cost for leasing and purchasing the vehicles will be about $16,240 or about $8,100 per vehicle. The leasing company indicated that if the vehicles had been

initially purchased rather than leased, the unit cost would have been about $5,300, well in excess of the $2,100 limitation on the purchase of vehicles with appropriated funds then in effect. Since the appropriation for the Department does not authorize the purchase of passenger vehicles, the planned acquisition of the two used vehicles if used for nongrant purposes would circumvent the statutory prohibition against the lease or purchase of motor vehicles without specific authorization (31 U.S.C. 638a, 89 Stat. 458).

Moreover, the District recognized the limitation on the purchase price of passenger vehicles of $2,100, derived from the Federal limitation then in effect. The intent of this limitation was also circumvented by the lease of the performance-oriented vehicles at a cost in excess of $3,900 each. In addition, the Department of General Services pointed out to the Department of Human Resources, in its annual report on motor fleet operations, that 12 sedans and station wagons were, by District standards, underutilized during fiscal year 1976. One of these vehicles accumulated 627 miles, compared to a 12,000-mile District standard, over the 12-month period. Thus the need for the two sedans seems questionable.

The Department of Health, Education, and Welfare approved the initial request to acquire the vehicles based on the Department of Human Resources' statement that the vehicles would be used in connection with maternity-infant care and children-youth projects. Authority to either continue to lease or purchase the vehicles was granted on the basis that the vehicles would be used for grant purposes.

The Acting Chief of the Maternal and Child Health Division, who oversees the projects, said that the vehicles had never

been used by the project staff, and the former Chief who initiated the request said that these specific vehicles were never intended for exclusive use in the project. The former Chief said that when transportation was needed, the District or the Department's motor pools were used. It was reasoned that by assigning these vehicles to a motor pool the projects would, in effect, be paying for their transportation. The vehicles, however, were never assigned to a motor pool.

The Director, Department of Human Resources, told us that the vehicles were used by personnel from his offices in the District Building. The Department's Transportation Officer stated that one is used for the Director's home-and-work commuting because he is on 24-hour call. The Director told us that no travel logs were kept because the varied use of the vehicles made it impracticable. The Department's Standard Operating Procedures Handbook (Section II, Part II, Vehicle Daily Utilization Record) requires maintenance of a travel log. On July 26, 1976, the vehicles' odometers showed that they were driven 18,622 and 12,198 miles, respectively, but we could not verify actual usage in the absence of travel logs.

According to the Director, informal operating arrangements with the Department of Health, Education, and Welfare permit grant-funded equipment to be used in other Department operations; he did not, however, provide us with any documentation to substantiate such an arrangement. He said also that because his office has responsibility for overseeing programs, including those funded by the grants in locations around the city, the deployment of the vehicles is justified. The grant approvals, however, do not authorize use of the vehicles for general Department program purposes.

It is our position that unless the vehicles are used primarily for grant purposes it is inappropriate to charge lease or purchase costs to grant funds. Federal and Department of of Health, Education, and Welfare regulations (Federal Management Circular 74-4 and 45 Code of Federal Regulations 74, Appendix C) state that in order to be allowable under a grant program, costs must "be necessary and reasonable for proper and efficient administration of the grant program * * * and, * * * not be a general expense required to carry out the overall responsibilities of State or local governments."

By funding and using the vehicles as discussed, the Department violated Federal regulations and the terms of the maternity-infant care and children-youth grants. Unless the vehicles are used as authorized by the grants, the violation continues. Furthermore, by leasing the "performance-oriented" vehicles at an annual cost in excess of $3,900 each and then using them for nongrant purposes, the Department of Human Resources circumvented the statutory prohibition against purchasing vehicles with appropriated funds without specific authorization, and failed to acquire the most economical vehicle possible as required by FMC 74-1. The planned acquisition would also circumvent the statutory prohibition unless the vehicles are used only for grant purposes. The use of appropriated funds for lease or purchase costs could lead to violations of this statutory prohibition (31 U.S.C. 638a) since the District's fiscal year 1976 budget and proposed fiscal year 1977 budget do not request authority to rent passenger vehicles for the Department of Human Resources. The proposed fiscal year 1977 budget does not either provide funds or request authority for the purchase of motor vehicles for the Department.

We recommended to the Mayor that the Department of Human Resources be required to

--provide adequate justification and obtain required approvals before acquiring vehicles and related accessories,

--arrange for reimbursing the grant accounts for the vehicle costs incurred while they were used for non-grant project purposes,

--adhere to Federal and Department of Health, Education, and Welfare requirements governing vehicle use and acquisition,

--adhere to regulations requiring travel logs to be maintained for each vehicle,

--obtain congressional approval if appropriated funds are to be used for vehicle costs, and

--determine whether there is an actual need for the vehicles and, if so, acquire more economical vehicles than the existing ones.

We had originally addressed our report to the City Administrator. We delivered it to him on September 2, 1976, and he returned it the same day, saying that he had no responsibility for the matters discussed in the report.

We have requested that a response from the Mayor be made 30 days from the date of our report.

TWO EXPENSIVE AMBULANCES NOT USED

During our study of District-wide motor fleet management, which is not yet complete, we noted that in June 1974 the Department of Human Resources acquired two ambulances for use in its maternity-infant care project. They were received in April and May of 1975, respectively. The ambulances have been parked on the D.C. General Hospital parking lot. On

July 20, 1976, one ambulance's odometer showed 191 miles and the other 121 miles. A Department official said that the mileage had been accumulated by driving the vehicles around the parking lot to warm the engine and by taking them to the inspection stations. On August 4, 1976, the ambulances were taken to a District maintenance facility for repairs which included new mirrors and lights. On September 2, 1976, the ambulances were parked on another D.C. General Hospital parking lot and one ambulance's odometer showed 200 miles and the other 145 miles.

Department of Human Resources' officials told us the ambulances were not used between April 1975 and July 1976 because trained personnel were not available to staff the vehicles. During this period, according to a private firm's study results, the Fire Department could have used more ambulances than it had, to respond to requests for services in the District during this period. We were told that the Department was short of ambulances.

AMBULANCE PURCHASE

Since 1965 the maternity and infant care project has been funded by Department of Health, Education, and Welfare grants to provide (1) comprehensive health care to eligible patients residing in the District of Columbia, (2) family planning services to any female resident of the District, and (3) health care services for District infants up to age 1.

Between July 1, 1973, and June 30, 1975, the Department of Human Resources was authorized about $2.7 million for the project. The grant provided $37,000 for the acquisition of two ambulances. The ambulances were to transport maternity patients and newborn infants, who have no other means of transportation to or from the hospital.

The Department of Human Resources in its justification to the Department of Health, Education, and Welfare for grant funds, stated that many patients do not have adequate transportation and that the response from taxi firms for service was very poor, creating a long waiting period for the patients. In some cases taxis failed to respond to calls for service.

The Department of Human Resources requested the District's Department of General Services to acquire two ambulances for the project. A Department of General Services official told us that the acquisition of the ambulances was authorized because the Department of Human Resources said they were urgently needed for the project. The official told us that the Department of Human Resources determined such need but documentation to support the Department of General Services' decision was not available.

A Department of Human Resources official told us that the Department did not know how often the vehicles would be used or how many patients the vehicles would transport. The official stated the vehicles may transport 1,000 maternity patients and their newborn infants a year to, from, and among District hospitals; however, these vehicles would only be available upon request to eligible participants.

Ambulance use

The ambulances were not received until about 1 year after purchase (April and May of 1975) because of contractor's delays. They were purchased in June 1974. Between April 1975 and July 20, 1976--15 months--the vehicles were driven a total of 312 miles. A Department of Human Resources official told us the vehicles had not been used because of lack of funds to staff the vehicles. On July 20, 1976, we observed that the

patient compartments in the vehicles were not equipped, paint was peeling off one of the vehicle's fenders and some of the tires on both vehicles were partially flat.

On July 22, 1976, the Department of Human Resources was negotiating a contract with a local suburban ambulance firm to staff the two ambulances for 6 months, 24-hours a day. However, according to a Department of Human Resources official, only one ambulance will be staffed during this period and the other will be used as backup. The official said that the Department still has not determined frequency of use or the number of patients the vehicles would handle. On September 14, 1976, the contract had not been executed.

Established ambulance service

In August 1957, Commissioner's Order 57-1667 established the District of Columbia Emergency Ambulance Service. The Fire Department was mandated to coordinate the supervision of the Service and was authorized to enter into cost reimbursement agreements with other District departments for services rendered to such departments.

A Department of Human Resources official told us that the existing ambulance service was inadequate because the ambulances were not equipped nor were the ambulances' personnel qualified to handle newborn infants and their mothers. Also, she said that the ambulances did not provide an uncontaminated environment which is vital to a newborn and its mother. However, the official said there is no scientific evidence that shows that newborn infants and their mothers cannot be transported and, when needed, provided treatment in ambulances which are used for others.

The emergency telephone number for ambulance service in the District is handled by the Fire Department and not the

Department of Human Resources. Between July 1, 1975, and June 30, 1976, the Fire Department responded to over 75,000 calls, including about 2,200 maternity calls, or 2.9 percent of the total calls. In 87 of the maternity calls, the child was born at home and both mother and child were transported to the hospital in a Fire Department ambulance. During this period the Fire Department had 10 ambulances.

We were told by Fire Department officials that their ambulances were equipped with the necessary maternity instruments and the attendants have been trained to care for newborns and their mothers. An official stated that special equipment such as incubators would be in the ambulances if funds had been available to procure such equipment. The official also told us that department ambulances and attendants that become contaminated after a response for service are decontaminated while at the hospital. The official estimated this process requires the vehicle and staff to be out of service for about 1-1/2 hours.

Ambulance needs

An April 1975 study report by a private firm on the Fire Department ambulance service showed that the probability of not being able to obtain a Department ambulance would be 4 out of 100 requests for service. The study showed that during the peak hours of 2 p.m. and 10 p.m. the Fire Department needed 14 ambulances to meet the city's demands; however, it only had 10 at that time.

At the time the Fire Department reportedly needed more ambulances, the Department of Human Resources' ambulances costing $37,000 remained idle. On July 20, 1976, when we inspected the ambulances, they had not been moved for some time according to the D.C. General Hospital assistant transportation foreman.

Department of Health, Education, and Welfare regulations

The Department of Health, Education, and Welfare grant regulations (45 CFR 74.134) state that the grantee takes title to equipment, such as the ambulances, acquired under grant at the time of acquisition. The grantee may use the equipment as long as there is a need for such equipment to accomplish the purpose of the project, whether or not the project continues to be supported by Federal funds. When there is no longer a need for the equipment to accomplish the purpose of the original project, the grantee must use the equipment in connection with other Federal awards it has received. If the equipment is not needed for any federally financed activities, the grantee can retain it for its own use, but must make fair compensation for the Federal share of the equipment. However, if the equipment is no longer needed, the grantee must request disposition instructions from the Department of Health, Education, and Welfare.

Conclusions and recommendations

Federal grant funds were used to acquire two ambulances which remained idle for about 17 months. The need for the ambulances for the grant project, therefore, is questionable. According to a private firm's study report of the Fire Department ambulance service and District officials, there is an ambulance shortage in the city. The Department of Human Resources could make arrangements with the Department of Health, Education, and Welfare to allow the Fire Department to use the two ambulances purchased with grant funds to help meet the District's stated ambulance need.

We recommended that the Department of Human Resources:

1. Evaluate and document the need for the two ambulances in the grant project and, if found to be unneeded in that project, arrange for their use in another program or, if no use can be found, ask the Department of Health, Education, and Welfare for disposition instructions.

2. If the ambulances are found to be necessary for the grant project and funds are not available to staff the ambulances, the Department of Human Resources should explore with the Department of Health, Education, and Welfare available alternatives for using the ambulances to accomplish the grant project purposes.

3. The Department of Human Resources formally advise the Department of Health, Education, and Welfare of the nonuse of the ambulances over a 17-month period, so that the Department of Health, Education, and Welfare can determine the appropriate corrective action.

OVERPAYMENTS TO WELFARE RECIPIENTS

We have made a limited review of the Department of Human Resources procedures for handling certain cases on the welfare rolls where information indicated that the recipients were either ineligible or their public assistance payments were incorrect. We limited our test to identified cases where the recipients had willfully misrepresented the facts concerning their eligibility for public assistance. A report to the Mayor on our findings and conclusions will be issued shortly.

The Department of Human Resources did not effectively act to correct the welfare rolls when information became

available indicating that many welfare recipients were ineligible for welfare or were receiving incorrect welfare payments. As a result, the District Government made overpayments totaling millions of dollars.

Aid to Families with Dependent Children (AFDC) program

AFDC is the major public assistance program in the District of Columbia. Since fiscal year 1971, the District's AFDC caseload has almost doubled and total payments have more than doubled. In fiscal year 1971, the average monthly caseload was about 16,800 and payments totaled about $40.8 million. In fiscal year 1975 the average monthly caseload increased to about 30,200 and payments increased to about $86 million. The Department of Health, Education, and Welfare (HEW) shares in the cost in furnishing financial assistance--50 percent--under the AFDC program.

Quality control

As a means of monitoring the AFDC program and maintaining continuous and systematic control over the incidence of ineligible recipients and incorrect payments in the public assistance caseload, HEW requires the District to have a quality control program. The quality control program has the primary purpose of holding the incidence of errors in AFDC to HEW's tolerance levels.

HEW's maximum acceptable error level for ineligible cases is 3 percent of the caseload; for either overpayments or underpayments it is 5 percent of the caseload.

HEW requires the District to randomly sample and review, every 6 months, a minimum number of cases based on its AFDC average caseload, and which are statistically representative of all its cases. The current quality control program became effective October 1970.

Results of quality control reviews

From October 1970 through December 1975, the Quality Control Group made 11 reports on its reviews of the AFDC program. Of the 7,484 welfare cases reviewed, the Quality Control Group found that 2,872 cases, or 38 percent, were in error. They found that

--782 were ineligible for welfare,

--1,599 were overpaid, and

--491 were underpaid.

Cases indicating willfull misrepresentation--
a continuing problem

Many erroneous cases involved welfare recipients willfully misrepresenting the facts concerning their eligibility. For the period from October 1970 through December 1971, 145 or 7.4 percent of the cases reviewed indicated willful misrepresentation; in calendar year 1975, the percent of indicated willful misrepresentation cases--226--almost doubled to 13.5 percent.

DHR was aware since 1971 that many indicated willful misrepresentation cases were on the AFDC welfare rolls but did not effectively act until November 1975 to identify these and other instances of erroneous payment. Also, DHR did not either promptly remove such cases from the rolls or adjust the welfare payments of those determined to be still eligible. In some cases as long as 9 months elapsed from the time the cases were reported until the payment was stopped or adjusted.

DHR's failure to take prompt effective action to identify willful misrepresentation cases resulted in overpayments exceeding $26 million from October 1970 through December 1975. In calendar year 1975 alone, we estimate that over 4,200 potential willful misrepresentation cases were on the rolls each month. Overpayments for these cases totaled about $8.7 million.

Special review project

In November 1975, DHR started a Special Review Project of all AFDC cases. The purpose of this review was to identify and correct all cases where the recipient was ineligible for welfare or where the amount paid was incorrect. One hundred and fifty people were assigned to make the review which DHR expects to be completed by November 1976.

As of April 23, 1976, the Special Review Project had completed its review of about 7,800 cases. The results showed that 21 percent of these cases were ineligible for welfare and 27 percent were overpaid. Thus, 3,746 recipients received money to which they were not entitled. The Special Review Project has reported savings of over $510,000 as a result of terminating payments or adjusting overpayments.

Although the Special Review Project will purify the welfare caseload at this time, the review will not insure that the type of errors found will not continue to occur. DHR has not established procedures to analyze the errors in order to determine the reasons which contributed to the errors and to report this information to management and caseworkers for use in the day-to-day administration of the AFDC program.

For instance, before January 1974, under HEW's requirements, people were enrolled in the AFDC program primarily by declaring a need for public assistance. Beginning in January 1974, as a means of reducing the number of ineligible welfare recipients, DHR procedures required a 100-percent verification of all data provided by the person applying for welfare. No provision was made however to provide management with the effect this procedure had on reducing the errors in the welfare caseload. Information available for 34 indicated willful misrepresentation cases where a 100-percent verification was supposedly made showed

that 18 were in error at the time the recipient was approved for welfare.

The Department of Human Resources needs to:

--develop a system that will insure prompt review of all cases to guard against erroneous payments.

--improve its procedures for verifying information at the time the recipients apply for welfare to minimize placing on the welfare rolls persons who may be ineligible.

--collect, analyze, and report to management on the results of the 100-percent review for use in improving its procedures for handling welfare cases and payments.

The Director, DHR, in commenting on a draft of our report said that he had no substantial disagreement with our findings. He said that because available staff has not kept pace with rising caseloads, the likelihood of high error rates will continue. He said also that the Department has determined that a total additional staff requirement of 180 positions is needed. We have not reviewed the staff requirements of DHR.

VIOLATION OF REGULATIONS

Senator CHILES. Mr. Lowe, would you please restate briefly for the subcommittee all the violations of law, Federal regulations and city regulations, that are involved in the case of the two cars?

Mr. LOWE. 31 U.S.C. 638a states that no appropriations shall be expended to purchase or hire motor vehicles unless specifically authorized by the appropriation concerned.

Public Law 79–600, section 18 made this legislation apply to the District. Because the Department of Human Resources used the vehicles for nongrant purposes, but in actuality used grant funds to cover the vehicles' costs, the above legislation was circumvented.

Federal Management Circular 74–4 and HEW regulations (45 CFR 74), appendix C, state that in order to be allowable under a grant program, costs must "be necessary and reasonable for proper and efficient administration of the grant program * * * and, * * * not be a general expense required to carry out the overall responsibilities of a State or local government."

DHR violated these regulations because the vehicles were used for nongrant purposes and yet were funded through HEW grants; 31 U.S.C. 638a(c) states that no appropriation available for any department shall be expended to purchase any passenger motor vehicle completely equipped for operation at a cost in excess of the maximum price therefor, if any, established pursuant to Public Law 93–381 (88 Stat. 613) fixed a maximum amount allowable to purchase a passenger motor vehicle in fiscal year 1975, the year in which the DHR acquired the sedans, at $2,100 plus the cost of appropriate accessories.

ACTUAL WORTH OF AUTOMOBILE

Senator CHILES. How much was the car actually worth if purchased?

Mr. LOWE. $5,300, I believe, for the new Ford Torino automobiles.

Senator CHILES. And they paid $3,900 a year for the lease?

Mr. LOWE. Right.

Senator CHILES. What period was the lease?

Mr. LOWE. One year, from April 21, 1975, through April 20, 1976, with an option to renew the lease for two 1-year periods.

Senator CHILES. How many years was it renewed?

Mr. LOWE. The Department, as of August 1976, was in the process of purchasing the two used cars.

TOTAL PAYMENT MADE UNDER LEASE AGREEMENT

Senator CHILES. How much have they paid for the automobiles to date, under the lease price?

Mr. LOWE. Through April 1976, $8,470 and since then, through July 1976, another $1,970, for a total of $10,440 for both vehicles.

Senator MATHIAS. Mr. Chairman, had Mr. Lowe completed his answer to your question?

Mr. LOWE. Of the legal ramifications? No, sir. They seem to go on forever. Public Law 94–91 fixed the fiscal year 1976 purchase price limit at $2,700, plus the cost of accessories deemed appropriate by the Administrator of General Services.

Unless the vehicles are to be used for grant purposes, DHR's plans to purchase the previously leased cars for $2,900 each, including an assigned cost of about $350 for accessories, considered inappropriate by the District Director of General Services, would be an improper use of grant funds for the apparent purpose of circumventing the existing purchase price legislation.

Federal Management Circular 74–1, attachment A, requires that all vehicles acquired by executive departments and establishments be limited to the minimum body size, maximum fuel efficiency, and operational equipment necessary to fulfill the operational need for which a vehicle is required. DHR violated these regulations when the vehicles were acquired in spite of the District's Department of General Services objection that the vehicles were more costly to operate and maintain than smaller cars.

Finally, the District's Management Manual, part 4, Motor Vehicle Fleet Management, page 51, requires prior approval from the District Office of Budget and Financial Management Systems for vehicles to be acquired equipped with air-conditioning. That approval was not obtained.

Senator MATHIAS. The Proxmire rule is the unwritten law? You are supposed to jog to work and back, instead of using a car to go back and forth. That one doesn't apply?

Mr. LOWE. No, sir.

DISTRICT ORDER ON USE OF GOVERNMENT-OWNED MOTOR VEHICLES

Senator CHILES. Does the city have any rules or regulations or are there any rules and regulations in regard to the use of automobiles to and from work?

Mr. LOWE. Yes, Mr. Chairman, the latest information we had on——

Senator MATHIAS. That is the Proxmire rule.

Mr. LOWE. It was before this committee in the spring, I believe.

Senator MATHIAS. We passed it in this committee. We passed it in the Senate, I believe; but the House didn't concur in it.

Senator CHILES. We can find that out.

[CLERK'S NOTE: Section 5 of District of Columbia Order No. 67–133, printed on the following pages, provides the city policy with regard to the use of city automobiles to and from work.]

Order No. 67-133

GOVERNMENT OF THE DISTRICT OF COLUMBIA
EXECUTIVE OFFICE
WASHINGTON, D. C.

January 24, 1967

SUBJECT: Use of Government-owned Motor Vehicles
ORIGINATING DEPARTMENT: Department of General Administration

ORDERED:

It is the purpose of this Order to establish the policies and conditions under which officers and employees may use District-owned vehicles to perform the public business. It is incumbent on all officers and employees of the District Government to see that the spirit as well as the letter of the applicable statutes and this Order are strictly observed. It is therefore

ORDERED THAT:

Section 1. All previous Orders of the Board of Commissioners authorizing the use of District-owned vehicles for transportation of officers and employees to or from their domiciles (including retention of vehicles at employees' domiciles) are rescinded.

Section 2. In keeping with the general conditions prescribed in Section 16 of the Act of August 2, 1946 (U.S.C. 77,78) governing the use of all motor-propelled passenger-carrying vehicles (including watercraft) owned by the District of Columbia Government requiring that said vehicles shall be used for official purposes, it shall be the policy of the Board of Commissioners that no District-owned vehicle shall be used by any officer or employee of the District Government for any purpose which is not directly related to his assigned duties. The annual Appropriation Acts prescribe that "Official purposes" shall not apply to the Commissioners of the District of Columbia or in cases of officers and employees the character of whose duties makes such transportation necessary, but only as to such latter cases when the same is approved by the Commissioners.

Section 3.a. The necessity for using District-owned vehicles in carrying out assigned duties must be clearly in the best interest of the District Government, considering such factors as propriety, economy and efficiency. Accordingly, heads of departments and agencies are directed to bring the following provisions of Public Law 600, 79th Congress, and the provisions of paragraph 3b, to the attention of their subordinates:

"Any officer or employee of the Government who wilfully uses or authorizes the use of any Government-owned passenger motor vehicle...for other than official purposes...shall be suspended from duty by the head of the department (including independent establishments, other agencies, wholly-owned government corporations and the District of Columbia Government) concerned, without compensation, for not less than one month, and shall be suspended for a longer period or summarily removed from office if circumstances warrant."

b. The provisions of Public Law 600, 79th Congress cited in paragraph 3a apply only to passenger motor vehicles. Therefore, the Commissioners have established a policy that any officer or employee of the District Government who wilfully uses or authorizes the use of any District-owned vehicle other than a passenger motor vehicle for other than official purposes shall likewise be suspended from duty, without compensation, for not less than one month and shall be suspended for a longer period or removed from office if circumstances warrant.

Section 4. Within the general policies regarding use of District vehicles outlined in this Order, heads of departments and agencies, their designated principal assistants, and the Assistants to the Commissioners, are hereby permitted to authorize their own use of District-owned motor vehicles.

Section 5. Heads of departments and agencies are hereby made responsible for the proper use of District-owned motor vehicles entrusted to the use and supervision of their respective departments and agencies. For their guidance, the following policies are hereby established for determining when the transportation of officers and employees to or from their domiciles (including retention of vehicles at their domiciles) may be permitted or directed by an authorized superior:

a. A District employee or official who regularly or for stated periods of time is required to have a vehicle available for use in responding to emergency calls during off-duty hours when subject to and alerted to be available to receive emergency calls may have a District vehicle at his domicile and use the vehicle between his domicile and place of work.

(NOTE: The simple chance of an occasional emergency call does not constitute a basis for such use of a District vehicle.)

b. A District employee or official who has essential "field" work that requires use of a motor vehicle earlier or later than could be accomplished by starting or ending his "field" work from his office during his scheduled tour of duty may, if necessary, have a District vehicle at his domicile on such occasions and use the vehicle between his domicile and place of work.

c. Authorization for "a" and "b" above, on a protracted basis, shall be in advance and in writing and shall summarize duties and responsibilities requiring use of a vehicle between domicile and place of work, and list periods of time involved. Such authorizations shall be signed by the head of the department or agency concerned.

d. Occasional use for official purposes of a District vehicle between the domicile and place of work is excepted from this written advance authorization requirement; however, such use shall be in conformance with the foregoing policies and shall be recorded by the officer or employee using the vehicle on the official vehicle dispatch form and filed at the District garage where the vehicle is regularly kept.

Section 6. Heads of departments and agencies may delegate to their principal assistants authority to approve use of District vehicles pursuant to section 5.

Section 7. In the application and use of the foregoing policies, non-chauffered vehicles shall be used wherever practicable.

Section 8. When an officer or employee keeps a District vehicle at his domicile overnight, he will be held responsible for the proper use and protection of the vehicle, which shall be kept in a garage if practicable.

Section 9. Records of vehicle dispatch and authorization concerning use of motor vehicles pursuant to Section 5, shall be checked at frequent intervals by immediate supervisors and shall be periodically reviewed by a representative of the head of the department or agency. Vehicle dispatch records shall identify the car, person using car, date of use, and nature of use, and shall be in such form as prescribed by the Department of General Administration. In addition, the Internal Audit Office shall periodically review records relating to the use of District vehicles both as to adequacy of records maintained and authorized use.

Section 10. The head of the department or agency shall investigate questionable uses, and shall take or initiate such disciplinary actions as are appropriate.

By order of the Board of Commissioners.

E. E. Ropshaw
Secretary to the Board

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Senator CHILES. When you say that the Department's Director said the leased cars were to be purchased for about $2,900 each, and you said something about the Director of General Services requested the Department to reconsider its plan to acquire vehicles inasmuch as they were performance-oriented vehicles of a type primarily used for police and they cost more to operate and maintain than smaller cars, were you referring to the Department of General Services in the city?

Mr. LOWE. Yes.

Senator CHILES. What was the result of that request?

Mr. LOWE. As I recall from the report, the response was that the cars were urgently needed for the grant project. The Director, Department of Human Resources went ahead and leased them.

Senator CHILES. Even though they had police engines?

Mr. LOWE. Whatever engine a Torino has, yes.

TOTAL COST TO DEPARTMENT OF AUTOMOBILE PURCHASES

Senator CHILES. How much has the Department of Human Resources spent on these cars?

Mr. LOWE. $10,440 through July 1976. If they are purchased for what we understand is the price of $2,900, the cost of the two automobiles would total $16,240.

Senator CHILES. Are there any penalties for violation of the statutes or the rules that you have cited as being violated? What are the penalties?

Mr. LOWE. Not that I am aware of, Mr. Chairman.

Senator CHILES. Does this endanger the issuing of grant funds when the grant funds are misused?

Mr. LOWE. It should. I think that the grantor has an obligation to make sure that grant funds are used in accordance with the terms of the grant. In other words, I think HEW has an obligation to review the grants that they make, and I am sure they do. Whether they audited this particular grant or not, I am not sure.

CARS PURCHASED FOR OTHER THAN GRANT PURPOSES

Senator CHILES. The GAO letter report stated that while the cars were requested specifically for grant purposes, they were never used for those grant purposes. That is what your investigation brought out, is that correct?

Mr. LOWE. That is correct.

Senator CHILES. I think it further indicated that the cars were never intended for exclusive use in the grant project. What is the basis for that statement in your report?

Mr. LOWE. That is what we were told by the former Chief of the Division of Maternal and Child Health. That person occupied the position at the time the cars were being considered, and as I understand, that person originated the request.

ASSIGNMENT OF CARS TO DISTRICT OF COLUMBIA MOTOR POOLS

Senator CHILES. As your report indicated, the cars were never assigned to either the city or the Department of Human Resources motor pool. Who made the decision not to assign the cars to the motor pool?

Mr. LOWE. We were unable to establish whether there was a decision.

Senator CHILES. But there is a motor pool in the Department of Human Resources?

Mr. LOWE. That is right.

Senator CHILES. And there is the motor pool that the city has?

Mr. LOWE. Yes, the Department of Transportation.

Senator CHILES. Is there transportation available in both of those motor pools?

Mr. LOWE. There is.

CITY OFFICIALS USING ASSIGNED AUTOMOBILES

Senator CHILES. To your knowledge, do you know of other city officials, other than the Mayor, who have cars assigned to them for their own home-to-office use?

Mr. LOWE. We have not made a study of that, Mr. Chairman. The latest information was in the 1976 budget hearings held this spring before your subcommittee.

In response to your questions, the District informed the subcommittee that there were 63 employees, I believe, including 4 department heads who were authorized to use cars for travel from home to work and back.

Those four included, according to the District, the Director of the Department of Environmental Services, the Director of the Department of Corrections, the police chief, and the Director of the Department of Human Resources.

TOTAL CARS IN CITY MOTOR POOL

Senator CHILES. I understand that GAO is now making a study of the motor pool management activities of the city. How many cars are there in the city motor pool?

Mr. LOWE. In the Department of Transportation's city motor pool, there are 43 vehicles which includes 38 automobiles and 5 other type vehicles.

Senator CHILES. Are any of the cars in the motor pool of the weight and specifications of these cars that we are talking about, the two in question?

Mr. LOWE. Not that we know of.

TOTAL CARS ON HUMAN RESOURCES MOTOR POOL

Senator CHILES. How many cars are there in the Department of Human Resources motor pool?

Mr. LOWE. There are 75 vehicles in total, according to the latest information we had, 25 cars and 50 station wagons.

Senator CHILES. How extensively are the cars used that are in the Department of Human Resources motor pool?

Mr. LOWE. We indicated in our report that a study report by the Department of General Services of the DHR motor pool showed that some cars were underutilized. There were one or two cars with very low mileage on them.

Senator CHILES. From that study, in your opinion, could Mr. Yeldell have had his transportation needs met by the motor pool?

Mr. LOWE. Sure.

CURRENT STATUS OF TWO NEW CARS

Senator CHILES. What is the current status with regard to the two cars?

Mr. LOWE. I understand that DHR is going ahead, with its plan to purchase the two cars. I understand the price is about $2,900 an automobile. The purchase had not been consummated as of today.

Senator CHILES. Does that plan violate Federal statute?

Mr. LOWE. Unless the cars are to be used for grant purposes, the $2,900 price, including the cost of accessories, as I understand it, would be in excess of that allowed under Federal law for purchase of passenger motor vehicles.

Senator CHILES. Is it not also then the use of money not appropriated for that particular purpose?

Mr. LOWE. Yes.

Senator CHILES. That also would be a violation?

Mr. LOWE. If they did not use it for grant purposes and it was bought with grant money, yes.

CURRENT STATUS OF NEW AMBULANCES

Senator CHILES. Going to the ambulances. In a GAO letter report of September 17, it was indicated that the Department of Human Resources purchased two ambulances with HEW grant funds and did not use them for 17 months. What is the current status of these ambulances now?

Mr. LOWE. The last information we had, they were still behind D.C. General Hospital.

Senator CHILES. The fire department still has to turn away calls at this time, is that correct?

Mr. LOWE. As of this morning, some of our people talked to the battalion chief who is in charge of the emergency ambulance service. He estimated that 20 percent of the 75,000 calls received last year, could not be answered in what he considered a reasonable length of time. The standard he used is a 5-minute response time. The response time was averaging about 8 minutes.

STATUS OF MEDICAL VANS

Senator CHILES. The same thing is true of the two medical vans. What are they being used for now?

Mr. LOWE. The medical vans are news to me as of this morning. I would like Mr. Medico to talk on that.

Mr. Medico. As of a couple of days ago, they were still parked on the D.C. General Hospital lot.

Senator CHILES. How long have they been there?

Mr. Medico. About 18 months.

CONCLUDING REMARKS

Senator CHILES. The matter of high overpayment and ineligibility rates in the welfare program is a serious matter that this subcommittee has been concerned with for some time.

The fiscal year 1977 appropriation bill includes funds for 50 new caseworkers to help bring down these high overpayment and ineligibility rates and prevent this unnecessary expenditure of funds.

I thank you for giving us the advance summary of the report. We look forward to receiving it when you finish with it.

Mr. LOWE. Mr. Medico, I appreciate your appearance here today.

Mr. LOWE. Thank you, Mr. Chairman.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

COMMUNITY HEALTH SERVICES

STATEMENT OF DR. EDWARD MARTIN, DIRECTOR, COMMUNITY HEALTH SERVICES, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

ACCOMPANIED BY:

O. EUGENE TRIVITS, DEPUTY REGIONAL HEALTH ADMINISTRATOR, REGION III, HEW
MICHAEL STURMAN, DIRECTOR, DIVISION OF BUDGET REVIEW, OFFICE OF THE SECRETARY, HEW
RALPH PARDEE, DEPUTY DIRECTOR, MATERNITY AND INFANT CARE PROGRAM, HEW
THOMAS SHOE, DIRECTOR, GRANT CONTRACTS, OASH, HEW

MATERNAL AND CHILD HEALTH PROGRAM

Senator CHILES. The subcommittee will now hear from Dr. Edward Martin, the Director of the Bureau of Community Health Services.

Dr. MARTIN. I am Edward Martin, Director of the Bureau of Community Health Services, the unit within the Public Health Service which is responsible for the administration of the Maternal and Child Health program authorized under title V of the Social Security Act.

The Maternal and Child Health program includes the special project grants for maternity and infant care (M. & I.), and the special project grants for health of school and preschool children (C. & Y.), which are of primary concern to these hearings.

INTRODUCTION OF ASSOCIATES

Accompanying me is Mr. Eugene Trivits, Deputy Regional Health Administrator for Region III, Philadelphia, who has direct administrative responsibility for these specific grants and Mr. Michael Sturman, Director, Division of Budget Review, Office of the Secretary; Mr. Ralph Pardee, who is the Deputy Director of the Maternal and Child Health (MCH) program and Mr. Thomas Shoe, who is the Director of the Division of Grants and Contracts.

I would like to summarize as you requested, the statement I submitted.

Senator CHILES. Your report in total will be included in the record, if you could summarize.

HEALTH SERVICES FOR MOTHERS AND CHILDREN

Dr. MARTIN. The maternal and child health program authorized under title V of the Social Security Act is the Federal focal point for providing health services for mothers and children.

The purpose of the program is to assist States and health jurisdictions insofar as possible to reduce the incidence of infant and maternal mortality and morbidity, including mental retardation and to provide health care such as inpatient hospital care, ambulatory health care services such as medical, dental, nutrition, nursing, and social work to mothers, their infants and children.

These services are made available particularly for low income families, for mothers and children whose health has been determined to be at risk and for those who have afflictions which lead to handicapping or potentially handicapping conditions.

MATERNITY AND INFANT CARE PROGRAM

The maternity and infant care program was authorized in 1963 under Public Law 88–156 and the children and youth program was authorized in 1965 under Public Law 89–97. Both programs have been in continuous operation in the District of Columbia since shortly after their authorization. They were operated as discretionary projects until the beginning of fiscal year 1975, when the funding was changed from project grants to formula grants as provided for under Public Law 93–53.

Since the inception of the program, guidance materials have been made available to all grantees in the form of policy and procedure manuals which set forth the purpose and expectations of the projects, including the use of funds.

Specifically, the policies clearly state: "When approved in the plan and budget, funds may be used for direct costs of operating and maintaining the project. Included in these direct costs is 'travel of personnel, consultants and specialists' and 'special equipment * * * when it is required for the operation of the project.'"

FUNDING AMOUNTS FOR PROGRAMS

Concerning the issues being addressed in these hearings, the maternal and child health programs were funded in the following amounts:

	1974	1975	1976
MCH Formula including Sec. 516 Supp	246,100	477,500	497,000
	.....	3,282,814	4,437,134
M. & I. (D.C.)	1,778,055	[1] 687,554	.....
C. & Y. (D.C.)	1,193,000	[1] 687,555	.....
(Children's Hospital)	1,292,000	.....	.....
Total	4,509,155	[2] 5,135,423	[2] 4,934,134

[1] Released fiscal year 1973 funds.
[2] Includes M. & I. and C. & Y. project grants.
Note: M. & I. and C. & Y. project funds became part of the MCH formula in fiscal year 1975.

VEHICLE AND AMBULANCE PURCHASES

In 1975–1976, it should be noted that the programs were included in the formula grant allocation.

As a result of the GAO letter to Mayor Washington, we have reviewed the Department of Human Resources program as it relates to title V activities and particularly to transportation. There were found two items about which the committee requested discussion.

The first is the lease-purchase arrangement for the two vehicles which is the subject of this hearing and the second is the purchase of two ambulances with funds from the same grant projects. Both of these transactions are within the policies and regulations which govern these programs.

I would then like to outline for the committee the action we propose to take, based on the information available and the efforts that have been made in recent months to improve the grants management activities within the Bureau of Community Health Services, the Public Health Service, and the Department of Health, Education, and Welfare.

The two automobiles which were acquired with 1974 approved grant funds were approved specifically for use in carrying out project activities. They were a legitimate direct project expense and, therefore, the costs were charged to project funds.

The acquisition of the automobiles was approved by the project officer in March 1974 for use by project personnel in carrying out the program as described in the plan and approved in the budget.

It was our expectation that these cars would be purchased in accordance with the District of Columbia regulations and policies covering such vehicles. Because of problems internal to the Department of Human Resources and the Division of General Services, DGS, the request for approval to purchase the vehicles was changed to a request to lease the autos.

The request to lease was approved by the project officer in November 1974, with the same proviso that the vehicles were to be used for project purposes. In July 1976, the regional office received a telephone request to continue the lease agreements and possibly to purchase the two automobiles.

With the understanding that the cars would continue to be used by the projects, approval to use existing funds for that purpose was given on July 21, 1976. These approvals were in keeping with long-standing policies of the program.

On August 27, 1976, the regional office received a letter from the Department of Human Resources requesting that we change the justification of the two vehicles from the "currently approved use to a more comprehensive * * * use."

QUESTIONS SUBMITTED BY SENATOR MATHIAS

Senator MATHIAS. I had some questions for Mr. Lowe. I would like permission to submit those questions to him for the record. I would like the record to show that.

Senator CHILES. We will be delighted to have those questions submitted in writing. We will have them answered for the record.

Senator MATHIAS. Since I have interrupted the witness at this point, I just had a call from Senator Eastland. There is a need for a quorum in the meeting of the Judiciary Committee. I might ask the same privilege with respect to other witnesses.

Senator CHILES. Certainly.

[The questions and answers follow:]

MISUSE OF GRANT FUNDS IN OTHER CITIES

Question: Is there reason to believe that the problems you found in the District of Columbia with respect to use of grant funds for leasing of automobiles and purchase of equipment that was not utilized could be found in many other cities?

ANSWER: The General Accounting Office's continued reviews of the operations of the Federal grant programs administered by Federal agencies, such as the Departments of Labor and Health, Education, and Welfare could show that equipment purchased with grant funds was not used.

Question: Do your findings in the District of Columbia lead to any suggestions about the need for changes in HEW or other agency grant regulations, especially with respect to billings for Project Overhead costs?

ANSWER: The problem in this case apparently arose not because of inadequate regulations but because the existing regulations were not followed. The applicable regulation requires that to be allowable under a grant program costs must be "necessary and reasonable for proper and efficient administration of the grant program . . . and . . . not be a general expense required to carry out the overall responsibilities of State and local governments." Basically, the same general rule applies to the expenditure of funds from a grant overhead account for indirect costs that applies to the expenditure of funds from a specific grant program account for direct costs. This rule precludes the use of grant funds to lease or purchase the cars for nongrant purposes.

SHORT-TERM LEASING OF MOTOR VEHICLES

Question: Are there any sections of HEW or District regulations that allow for the short-term leasing of motor vehicles for urgent program requirements? Please submit relevant excerpts.

ANSWER: The Department of Health, Education, and Welfare and District of Columbia regulations allow for the short-term leasing of motor vehicles under special circumstances, among which could be urgent program requirements. However, based on the manner in which the vehicles were used, we seriously question whether the urgent program requirements actually existed. The relevant regulation excerpts follow:

Department of Health, Education and Welfare "Department Staff Manual—Grants Administration"

Chapter 6-10 — "Charges for Leased Facilities and Equipment"

6-10-00

A. Activities supported by HEW grants are normally performed in or with facilities and equipment owned by the performing organization. The costs of these facilities and equipment are generally charged to the grants through depreciation or use charges as provided for in the cost principles applicable to the particular type of organization involved."

B. In some cases, however, the leasing of facilities or equipment is more economical or is otherwise necessary in light of the particular circumstances involved; for example, where:
   1. A project is of short duration and space or equipment is not available in owned facilities;
   2. There are specific program objectives or requirements which cannot be met with owned facilities;
   3. Cost reductions will materialize which will produce identifiable savings in direct or indirect costs; or
   4. There is an increase in workload volume which cannot be accommodated efficiently by modifying or augmenting owned facilities.

6-10-30

A. Short-Term Leases—Rental costs under short-term leases are allowable to the extent that:

1. The rates are reasonable at the time of the decision to lease in light of such factors as rental costs of comparable property, if any; market conditions in the area; the type, life expectancy, condition, and value of the property leased; alternatives available; etc.; and
2. They do not give rise to a material equity in the property but represent charges only for the current use of the property including, but not limited to, any incidental service costs such as maintenance, insurance, and applicable taxes.

District of Columbia's Materiel Management Manual

Section 2620.22—Rental of Equipment

When a requirement for equipment is for a short period of time is intermittent, or is in connection with an emergency situation, rental of equipment may be procured in the same limitations as for supply needs. Term contract for rental of heavy motorized equipment, with or without operators, may be obtained through the D.C. Materiel Management Office.

Question: Is there any evidence that less expensive cars were available for leasing when the contract in question was approved.

ANSWER: An official of the company which leased the automobiles to the Department of Human Resources said that it would not be possible to determine now what vehicles were available for leasing 17 months ago. He said that it is possible that the Department would have had to wait for less expensive cars to be delivered. He added, however, that the Department had to wait for the vehicles which were leased. And, according to the District Department of General Services' Director, there is no doubt that the companies submitting bids on the lease would have had ample time to make less expensive cars available.

COMPARISON OF LEASE PRICE WITH OUTRIGHT PURCHASE

Question: What items did the costs of the lease in question include? If a lease includes insurance, maintenance, registration, and other operating costs, how is it possible to compare lease price with outright purchase?

ANSWER: The lease agreement called for the contractor to provide, at his expense, vehicle registration and insurance. Our report, dated September 8, 1976, showed the initial lease contract included $840 for 1 year's insurance. However, related costs for such items as maintenance and operation were to be borne by the District.

From the inception of the lease agreement in March 1975 through April 1976, DHR paid $8,470 for rent of the vehicles. In August 1976, DHR made arrangements to purchase with grant funds the used sedans for $2,900 each. Along with the rental payments of $1,970 including $210 for insurance, for May-July 1976 which are now being processed, total costs for leasing and purchasing the vehicles will be $16,-240. If insurance costs of $1,113 are subtracted, the total would be $15,127 or about $7,600 a vehicle. An official of the leasing company told us that if the automobiles initially had been purchased rather than leased the cost would have been $5,300 per vehicle.

Question: During your testimony a number of statutes and regulations were cited that may have been circumvented or violated. Has GAO received a formal response from the District government about these specific allegations? In the absence of a detailed response by the city that could contain further explanations is it not the case that there are only allegations and potential violations of regulations and statutes? To date, is there any final conclusion possible that criminal violations did occur?

ANSWER: No. Certain statutory provisions restricting the use of appropriated funds to purchase or hire motor vehicles were apparently circumvented by using grant funds to lease and possibly purchase vehicles which would not be used entirely for grant purposes. Also, we found that the Department of Human Resources did not adhere to regulations stating that costs which are not for grant purposes may not be charged to a grant, and other regulations requiring that only the most economical vehicles needed to accomplish the intended operational purpose should be acquired. However, neither the statutes which were circumvented nor the regulations which were violated involve criminal penalties. In any event, no suggestion was ever made that any criminal violations were involved. We do not have any jurisdiction over criminal violations, and therefore would not in any circumstances conclude that criminal violation took place.

Question: With respect to ambulances purchased by DHR, is there any evidence that personnel were available to operate the vehicles that remained idle for several months?

ANSWER: A DHR official told us the Department's ambulances acquired for the maternity and infant care grant program remained idle for several months because of the lack of funds to staff the vehicles.

FIRE DEPARTMENT LACKS ADEQUATE PERSONNEL

Question: Is there evidence that the D.C. Fire Department had adequate personnel to use the ambulances?

ANSWER: A Fire Department official told us that the Department does not have adequate personnel to currently staff the ambulances acquired for the maternity and infant care program. The official told us that if he had known that the vehicles were available to the Department he would have requested necessary staffing to operate them. He said if they were made available now they would be used to replace wornout and broken-down existing ambulances.

Question: Do Federal regulations allow for the retention of equipment purchased with grant funds for some specific period of time if there is a temporary or unanticipated personnel shortage that precludes utilization of that equipment?

ANSWER: We are not aware of any Federal regulations that deal specifically with whether equipment purchased with grant funds can be retained by the grantee if there is a temporary or unanticipated personnel shortage that precludes utilization of that equipment. However, if property is not being used to carry out the purpose of a grant, for reasons within the control of the grantee, the grantor should consider whether the costs should be allowable. In addition, the failure to use the property for the intended purpose may, depending on the terms of the grant, constitute a material violation of those terms which would justify the grantor's action to suspend or terminate the grant.

AMBULANCE PURCHASES

Senator CHILES. Go ahead, Doctor.

Dr. MARTIN. The regional office was in the process of denying that request when we were overtaken by the events which led to this hearing, and this matter came to our attention.

The second acquisition of vehicles was the purchase of two ambulances made from title V grant funds in fiscal year 1975. These vehicles were for the transportation of patients to and from clinics and hospitals on an emergency basis. A particular need was for the transportation of newborn infants in need of intensive care and of highly specialized services.

To the best of our knowledge, there has been no question as to the propriety of this acquisition. The vehicles were to have been used for emergency transportation of mothers and children who are provided care under the District of Columbia's program. A contract was to have been negotiated with a private ambulance company to provide maintenance services and personnel to operate the vehicles on an around-the-clock basis.

The Public Health Service, through the GAO report and these hearings, has been made abundantly aware of the existing problems.

Based on the information in the report and the information we have obtained and reported to you today, it appears that there may have been misrepresentation of the use of certain grant funds to the regional office by the Department of Human Resources.

If there have in fact been funds expended for purposes other than those for which the grant was approved, those costs will be disallowed. This will mean that the disallowed costs will have to be refunded in full to the Federal Government. We will carefully consider the response from the D.C. Government to the GAO report before any final action is taken by the department.

In addition, the background and circumstances of this situation raise the more serious question of misrepresentation. I will also, after reviewing the D.C. Government's response, ask the Regional Health Administrator to have the regional auditors conduct a careful review of both projects to determine if there is any indication of other potential questions of impropriety in the use of funds or in the manner in which the programs are operated.

If audits show any improper use of Federal funds, related expenditures will be disallowed and the necessary steps taken to have the money refunded to the Federal Government.

In addition, we will be immediately requesting that any vehicles acquired directly from title V funds be removed from the general motor pool and be reassigned to the program activities of the maternal and child health projects.

NEED FOR OVERALL REPORTING SYSTEM FOR PROGRAMS

The Public Health Service has over the past year moved in several ways to strengthen the management aspects of the large number of grant programs it administers. These activities include the development of a common reporting system for all Bureau of Community Health Services activities, including Maternity and infant care and children and youth grants, which is designed to improve management practices

and afford specific management information regarding the program operation. We are now developing improved management reporting requirements for formula grants which we administer.

The Public Health Service has provided the Regional Grants Management Office material and technical assistance to build their capacity to provide guidance to the States and projects.

BUSINESS MANAGEMENT IMPROVEMENTS BY PHS

In addition, a guidance manual is now at the printers which will set standards and assist the regional staff and the providers in improving the quality of management of the grants. Some of the actions taken by the Public Health Service to improve business management by grantees are:

1. Issuance July 1, 1974 of a comprehensive grants policy statement presenting a compilation of the salient features of applicable laws, regulations, and policies. This document, which is for use by grantee institutions, is the first such Public Health Service issuance which is applicable to all types of grants.

2. Issuance of policies expanding the role of grants management officers to encompass responsibility for evaluating the business management capability of applicant organizations and monitoring their performance. Prior to issuance of these policies, these responsibilities had not been clearly assigned.

3. Adoption of policies requiring onsite preaward evaluation of grantee business management capabilities when an applicant institution has not had a government grant or contract within preceding 2 years or known management deficiencies exist.

4. Expansion of monitoring activities by grants management offices. During fiscal year 1977 regional grants management staff will conduct 1,500 monitoring visits of the approximately 6,500 grants they administer. This, along with visits by Public Health Service program staff and various auditors, will result in over one-half of these grants receiving onsite assessments during the company fiscal year.

5. Development of a regular audit system to track followup activities by Public Health Service staff and to analyze audit deficiencies. This latter feature allows us to determine the effectiveness of our preaward evaluations and monitoring activities.

6. Issuance of policies insuring more comprehensive and objective program evaluations of all grant applications received by the Public Health Service.

SUMMARY

In summary, Mr. Chairman, we have reviewed our documents relating to the circumstances described in the GAO letter and find that the approval to obtain the two automobiles was appropriate and according to our requirements.

After consideration of the response of the District of Columbia to the GAO report, the Department will take direct, prudent, and appropriate corrective action in this matter based upon the actual use of the vehicles.

PROBLEM DETECTION BY REGIONAL OFFICE

Senator CHILES. Dr. Martin, if the General Accounting Office had not done this study, how would the HEW regional office be able to find out what the facts were in this case, that the two vehicles, for example, were not being used for the specifically stated purpose for which the grant was awarded and that the two ambulances were not being used and were sitting idle? How would the regional office be able to determine that?

Dr. MARTIN. In the normal process of management, for programs, there are two mechanisms which might have detected this kind of problem.

The first mechanism is the normal program management review where regular site visits are conducted and specific activities proposed by the project manager are discussed with the project officers.

In the case of discrepancies such as this and in other cases which have been detected across the country, they are referred to the audit office within the regional office.

MISLEADING INFORMATION FILED BY DIVISION OF NURSERY SERVICES

Senator CHILES. You have got the Division of Child and Nursery Services here in the city that obviously filed some misleading information when they requested the cars and when they requested the continuation of the funds for that project.

So if they continued to tell you that they were using funds for a particular purpose when in fact they were not, it still wouldn't come to your attention, would it?

Dr. MARTIN. In that case, if enough misrepresentation were made, you are correct. It would be difficult to assure detection.

The second mechanism, however, is a more narrow mechanism used on a regular basis, which is the audit mechanism. Based upon DHR policy, it will be implemented for grantees at a minimum of every third year when a very specific audit is undertaken. As a part of that audit, there is a major equipment-capital inventory.

AUDITS

Senator CHILES. When was the last time you performed this kind of audit or have you performed audits on the Department of Human Resources?

Mr. STURMAN. At the present time, the HEW audit agency has 13 audits underway in the District of Columbia. Most of these are audits of the Department of Human Resources. Last year they concluded 12 audits. Most of them were of the Department of Human Resources.

None of the audits that were undertaken last year or which are underway this year are in the maternal and child health program, specifically, but they do cover most of the other programs administered by Human Resources.

I don't know when the last audit of that program was taken.

Dr. MARTIN. These specific project grant activities haven't been audited in the last 2 years, largely because of the change in activities. These were direct project grants administered directly with the regional office where there was considerable interface between the project staff and the program.

Two and a half years ago, that change brought about their inclusion under a formula grant mechanism for the District of Columbia. During that period of transition, a number of similar projects throughout the country have not been audited. Their plans for this and next year remain as stated.

PENALTIES TO PERPETRATORS OF MISREPRESENTATIONS

Senator CHILES. Other than the fact that you require funds to be paid back when you find a discrepancy like this or when you find that false information was given, do you impose any other penalties? When you find out that the vehicles were in fact not assigned for the purpose for which they were requested, is there any other penalty on the perpetrator of that kind of misrepresentation?

Dr. MARTIN. In the case where there is a clear suspicion of misrepresentation, the matter is referred to the office of investigations in Department of HEW if that office feels there has been willful misrepresentation, can substantiate that or find reasonable cause, the matter is referred to the Department of Justice.

In the Department of justice under applicable local and Federal statutes, there are other civil courses to deal with misrepresentation and fraud. The specific statutes there would have to be requested from the Department of Justice. There have been those kinds of referrals before, though.

INTENDED ACTIONS

Senator CHILES. Based on the review that you have made of the General Accounting Office letter report, what action do you intend to take in this connection?

Dr. MARTIN. We will await a formal response from the District. Upon receipt of that response, we will make a determination whether in fact there was a misuse of the automobiles. In fact, if the GAO report is corroborated or the city can't present a clearly different picture, then we will proceed with the disallowing.

Further, during that process, if it is clear that there has been misrepresentation, it will be referred to the Office of Investigations with potential referrals to the Department of Justice.

Senator CHILES. Are you also awaiting response from the city in regard to the two ambulances?

Dr. MARTIN. Yes, sir. The fact that they are not being used fully represents a potential misuse of the funds. The clear intent of the grant awards and provision of those funds was for active use of the ambulances, and the grants, guidance and policy clearly cover the expectation that there will be a reasonable use of the equipment or other capital items acquired under the grant.

MATERNAL AND INFANT CARE PROGRAM

Senator CHILES. I understand that the maternal child health program was started in 1963, with an amendment to title V of the Social Security Act, is that correct?

Dr. MARTIN. The MCH program began in 1935 with the passage of the Social Security Act, title V. The maternal and infant care is one of the special categories of projects which were authorized

in 1963 with amendments to title V in the Social Security Act. The first project grants were awarded in 1964.

Senator CHILES. How much money has gone into this program since 1963?

Dr. MARTIN. We have presented testimony data for the last 3 years. We will determine the exact levels of fundings for these activities for that period and submit it to you.

[The information follows:]

Project grant funding for the fiscal years 1971–74 are as follows: 1971 $1,677,659; 1972 $1,786,630; 1973 $2,004,274 and 1974 $1,778,055. From 1975 on, the Maternal and Infant Care Project became part of the overall formula grant to the District and its funding was not granted separately. The operational level has remained approximately the same as that supported in previous years. Records for years prior to 1971 have been retired to permanent storage.

Senator CHILES. What has this money been used for, specifically?

Dr. MARTIN. Based on the specific statutory activity under the Maternal and Child Health Act, it has been used for a broad series of programmatic service, some training, and other activities related to improved care for mothers and children.

It includes maternal and infant care projects, special outreach efforts, the necessary transportation for some of those activities. This title is supposed to provide a broad reasonably flexible capability to address the special problems of mothers and children.

It is used quite broadly, but specifically to provide care and services for that population.

HEW AUDIT OF CITY-USED FUNDS

Senator CHILES. Has HEW ever conducted an audit of the city's use of these program funds?

Dr. MARTIN. Not within the last 3 years. It is our understanding prior to 3 years ago that there were no audits.

We are looking into whether there were possibly any audits in the sixties. At the present time we are unaware of any specific audits undertaken.

Senator CHILES. It seems like an awful long time not to have an audit.

Dr. MARTIN. Yes, sir.

Senator CHILES. Does HEW have some kind of process that within a certain number of years you should perform an audit?

Dr. MARTIN. Yes, sir. During the last 3 years, the Public Health Service established a policy in regards to audit expectations of grantees.

For city and State agencies this policy requires audit at least every 2 years. This is present policy. In general, there is a policy in the Public Health Service of regular audits. It depends largely on the program area.

In our program area, there is now a policy for annual project grant audits and each 2 years for State and local government.

Senator CHILES. How long has that policy been in effect?

Dr. MARTIN. Since publication of the PHS policy July 1, 1974.

Senator CHILES. I understand that HEW grants to the District of Columbia totaled $170 million in 1976, and are expected to grant a total of $177 million in 1977.

MONITORING OF GRANT FUNDS BY HEW AUDITORS

How many HEW auditors are specifically assigned to monitor the use by the District of Columbia of HEW grant funds?

Dr. MARTIN. Again, there are two different activities. One, the actual program management carried out by the technical and professional staff monitoring specific grants wherein there is a single individual who assumes the responsibility for coordinating each specific grant.

We can prepare for the record, those numbers of individuals having responsibility in the program area.

[The information follows:]

In the Regional Office there are two officials, a Regional Program Consultant and a Project Officer, who have specific responsibility for the Maternal and Child Health grant supported activities in the District of Columbia. These officials may call upon the Grants Management Office as well as the Health Services Division for additional technical or professional assistance required in the administration of their program.

Dr. MARTIN. The specific auditors in the Philadelphia office, I would like Mr. Sturman to respond to.

Mr. STURMAN. We currently have 19 auditors assigned to that responsibility out of Region III. That contingent represents one-fourth of the number of auditors out of Region III.

Our audit agency does consider the District as a high risk audit area and assigns proportionately a higher percentage of available staff to D.C. than other jurisdictions.

Senator CHILES. Do you have 19 for the District of Columbia or 19 for the District of Columbia and a number of other areas?

Mr. STURMAN. Just the District of Columbia.

Senator CHILES. How many audits were made in 1976?

Mr. STURMAN. There were 12 completed, sir.

HEW AUDITS OF CITY GRANT FUNDS

Senator CHILES. I would like you to provide the subcommittee with copies of all the audits made by HEW with regard to the use by the city of HEW grant funds.

Mr. STURMAN. Be happy to do that.

Senator CHILES. Thank you, Dr. Martin.

[The information follows:]

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
REGION III
3535 MARKET STREET
PHILADELPHIA, PENNSYLVANIA 19101

APR 23 1976

Mr. Joseph Yeldell, Director
Department of Human Resources
District of Columbia
1350 E Street, N. W.
Washington, D. C.

Dear Mr. Yeldell: Re: Audit Control Number 60010-03

The HEW Audit Agency has reviewed the Program for Handicapped Children operated under Title I of the Elementary and Secondary Education Act of 1965 by the Forest Haven Institution for the Mentally Retarded, District of Columbia. During our review, we noted that the success of the Institution's Vocational Rehabilitation (VR) Program is being hampered primarily because of lack of funds.

At the time of our review, one VR counselor was assigned to Forest Haven. For fiscal year 1975, the VR counselor expended about $26,000 in providing services to 300 clients who were residents of the Institution. This amount represented less than $90 for each client. Despite the lack of funds, the VR program achieved some success. During fiscal year 1975, 20 clients at Forest Haven were successfully rehabilitated and were released from the Institution. These individuals were gainfully employed and were living independently in the community.

We believe that the VR program can be more successful and more clients can be released from the Institution if additional funds are made available. We noted several problems that if resolved would improve the effectiveness of the VR program. Specifically, VR training courses were not available to or utilized by Forest Haven residents, and evaluations and tests to determine the clients' potential were delayed.

Availability and Use of Training Courses

The types of training available to Forest Haven residents are severely limited. There are no facilities available in the District that can provide the highly specialized training that would enable many VR clients to realize their full employment potential. According to the VR counselor, many clients could be placed in better jobs if provided appropriate work skill training. Since this training is not available, the clients are generally restricted to such fields of employment as messengers, kitchen helpers and janitors. Even this type training is severely limited since an intensive three month training program can cost as much as $600 for each client.

One training course that was available to Forest Haven residents was not being utilized. A training program located in the District offered a special training program for epileptics. To successfully complete this training program, strict daily attendance is required. According to the VR counselor, about 30 Forest Haven residents could have benefitted from this training.

The Institution did not send any of its residents to this training course, primarily because it could not provide the needed transportation to the training site. There was only one bus available to meet the transportation needs of all VR clients at Forest Haven, and it was often unavailable because of mechanical failures. Because of this lack of transportation, the 30 residents were denied the best possible training available to them.

Delays in Testing

There are two series of evaluations performed on each VR client at Forest Haven. Both relate to determining the maximum work potential of the client. One series of tests- a work adjustment evaluation - is performed within the District. Advance appointments must be scheduled for the evaluation. Because of the above mentioned transportation problem, appointments often must be cancelled. This causes substantial delays in rescheduling the appointments and subsequently in providing service to clients.

The second series of tests requires a medical and psychological evaluation of clients. The evaluations would cost at least $60 for each client if purchased from sources outside of Forest Haven. Because of the lack of funds, the evaluations are performed "inhouse" by physicians and psychologists employed by Forest Haven. The Institution, however, has a severe shortage of such staff and, as a result, the evaluations are often delayed for as long as six months.

Conclusions and Recommendations

The VR program at Forest Haven has succeeded in removing residents from the Institution, placing them in employment, and allowing them to live independently within the community. In fiscal year 1975, 20 clients were successfully rehabilitated at a total cost of about $26,000; or $1,300 for each client returned to society. In comparison, we estimate it would have cost about $160,000 or $8,000 for each client if they had remained institutionalized for the year. In our opinion, more residents of Forest Haven could be successfully rehabilitated and released to live in the community if additional funds were made available to provide them the necessary VR training. Increased VR training would not only allow Forest Haven residents to attain their maximum employment potential, but it would also allow the Forest Haven staff to devote more time to those residents that need the most care. This could also result in a more effective use of funds directed toward the handicapped population of the District.

We therefore recommend that consideration be given to:

1. assigning additional VR staff to Forest Haven and making additional funds available to provide clients needed services

2. establishing in conjunction with Forest Haven and other facilities of the D. C. Children Center, a specialized vocational training facility on the grounds of the Center, or

   a) establishing and maintaining a reliable system for transporting clients to training facilities located elsewhere, and

   b) arranging with such facilities to provide Forest Haven clients any specialized training necessary to enable them to realize their maximum employment potential

3. providing the required tests and evaluations timely.

State Agency Comments

By letter dated March 25, 1976, the State Agency replied (see Exhibit A) to a draft of this report. State Agency officials noted that the audit report recognized that the VR program achieved some success in rehabilitating residents even though resources were severely limited. They also stated that the fiscal year 1977 budget will provide some measure of relief to Forest Haven. With regard to providing the required tests and evaluations, State Agency officials indicated that they will attempt to correct the situation.

Final determinations as to actions to be taken on all matters reported will be made by the HEW official named below. We request that you respond to each of the recommendations in this report within 30 days from the date of this letter to the HEW official named, presenting any comments or additional information that you believe may have a bearing on his final determination.

In accordance with the principles of the Freedom of Information Act (Public Law 90-23), HEW Audit Agency reports issued to the Department's grantees and contractors are made available, if requested, to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act, which the Department chooses to exercise. (See Section 5.71 of the Department's Public Information Regulation, dated August 1974, as revised.)

To facilitate identification, please refer to the above audit control number in all correspondence relating to this report.

Sincerely yours,

G. A. Rafalko
Regional Audit Director

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HUMAN RESOURCES
WASHINGTON, D. C. 20004

MAR 25 1976

Mr. G. A. Rafalko
DHEW Audit Agency
P. O. Box 13716
Philadelphia, Pennsylvania 19101

Dear Mr. Rafalko:

Re: Audit Control Number 60010-03

The following comments are offered in response to the referenced audit report concerning the review of the Program for Handicapped Children, Title I, Forest Haven:

Audit Recommendation 1
The F.Y. 1977 Budget will provide some small measure of relief as regards the needed services to clients.

Audit Recommendation 2 a., b.
While this recommendation is an acceptable one, it would be more realistic to secure funding to support the training of residents in already existing facilities and conceivably develop our own limited program over a period of time if necessary, to service those individuals whose needs cannot be met through outside agencies.

Audit Recommendation 3
Providing the required tests and evaluations will continue to remain a problem because of budgeting restraints. Unless additional persons can be hired in this shortage category from 1977 funds, assistance from our Social Rehabilitation Administration's Bureau of Rehabilitation Services will be sought in this regard.

While the audit report notes that resources to implement a program of vocational rehabilitation was severely limited, it also noted that this department did achieve some success in rehabilitating residents and consequently releasing these individuals from Forest Haven.

Sincerely,

Joseph P. Yeldell

Joseph P. Yeldell
Director

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
REGION I
3535 MARKET STREET
PHILADELPHIA, PENNSYLVANIA 19101

MAR 16 1976

Superintendent of Schools
Public Schools of the District of Columbia
Presidential Building
415 12th Street, N. W.
Washington, D. C. 20004

Dear Superintendent: Re: Audit Control Number 60052-03

The purpose of this letter is to provide you with the RESULTS OF OUR AUDIT of the ADMINISTRATION OF THE EMERGENCY SCHOOL AID ACT (ESAA) in the District of Columbia.

Background

In June 1972, Congress enacted the Emergency School Aid Act (ESAA) to be administered under Title VII of the Education Amendments of 1972 (Public Law 92-318). This Act was a continuation of the Emergency School Assistance Program created in August 1970 when Congress appropriated funds to provide grants to school districts and community groups to defray the cost of eliminating special problems caused by the desegregation of schools. The purpose of the Act is to achieve one or more of the following objectives:

1. To meet the special needs incident to the elimination of minority group segregation and discrimination among students and faculty in elementary and secondary schools.

2. To eliminate, reduce, or prevent minority group isolation in elementary and secondary schools with substantial proportions of minority group students.

3. To aid school children in overcoming the educational disadvantages of minority group isolation.

ESAA assists various Local Educational Agencies (LEAs) in achieving the above objectives by contributing to the costs of new and expanded activities designed to achieve successful desegregation and to eliminate discrimination.

The Commissioner, Office of Education (OE), Department of Health, Education and Welfare, is responsible for the overall conduct of ESAA programs on a national basis. The Commissioner carries out this responsibility through the resources of OE. OE makes funds available for the programs and approves plans submitted by LEAs for participation in the program.

The Washington, D. C. School District, a LEA, is headed by a Superintendent who is responsible for the administration and operation of the public school system. Responsibility for carrying out policy and technical administration of ESAA is delegated to the Director of ESAA.

Scope of Audit

Our review of the ESAA project activities was made in accordance with standards for governmental auditing, and covered the period July 1, 1973 to March 31, 1975. We compared activities conducted by the LEA with those included in the approved proposals, and held discussions with LEA officials and project staff. Federal funds allocated to the LEA during the period of our audit totalled about $5.7 million.

Results of Audit

The ESAA activities conducted by the LEA were generally in accordance with the proposals approved by OE. Among the projects implemented in the School District were Career Education, Special Remedial Services, and the 2-W Component (named for the two high schools, Wilson and Western, in which it was operated). Services provided to students ranged from career guidance and counseling to remedial instruction in reading and mathematics.

We did note that one school in the Special Remedial Services Component, the Woodward School, was encountering difficulties in meeting program objectives. However, the Woodward School was closed in July 1975, and is no longer operational.

Since the activities we reviewed were generally conducted in accordance with approved proposals, we are making no recommendations at this time. We will again review these activities during our next regularly scheduled audit of the ESAA program.

In accordance with the principles of the Freedom of Information Act (Public Law 90-23), HEW Audit agency reports issued to the Department's grantees and contractors are made available, if requested, to members of the press and general public.

Should you have any questions or comments concerning the matters discussed in this report, please direct them to the HEW official named below. To facilitate identification, please refer to the above audit control number in all correspondence relating to this report.

Sincerely yours,

G. A. Rafalko
Regional Audit Director

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
REGION III
3535 MARKET STREET
PHILADELPHIA, PENNSYLVANIA 19101

AUG 2 7 1975

Mr. Joseph Yeldell
Director, Department of Human Resources
Room 418, District Building
14th and E Streets, N.W.
Washington, D.C. 20004

Dear Mr. Yeldell: Re: Audit Control Number 60157-03

Enclosed for your information and use is a copy of an HEW Audit Agency report titled, "Report on Practices and Procedures Relating to The Level of Care Provided Medicaid Patients in State and Private Nursing Homes in the District of Columbia". Your attention is invited to the audit findings and recommendations contained in the report. The below named official will be communicating with you in the near future regarding implementation of these items.

In accordance with the principles of the Freedom of Information Act (Public Law 90-23), HEW Audit Agency reports issued to the Department's grantees and contractors are made available, if requested, to members of the press and general public.

To facilitate identification, please refer to the above audit control number in all correspondence relating to this report.

Sincerely yours,

G. A. Rafalko
Regional Audit Director
HEW Audit Agency

ABBREVIATIONS

FFP	Federal Fianancial Particination
ICP	Intermediate Care facility
LSD	Licensing and Standards Division
SRS	Social and Rehabilitation Service
State Agency	District of Columbia Department of Human Resources

REPORT ON PRACTICES AND PROCEDURES RELATING TO LEVEL OF CARE PROVIDED MEDICAID PATIENTS IN STATE AND PRIVATE NURSING HOMES IN THE DISTRICT OF COLUMBIA

INTRODUCTION

BACKGROUND

Title XIX of the Social Security Act, established in 1966 to assist States in providing medical care to low income people, makes such care available to categorically and medically needy individuals who are (1) under the age of 21, (2) the needy parent or relative with whom an eligible child is living, (3) 65 years of age or older, (4) blind, or (5) 18 years of age or older and permanently and totally disabled. Medicaid is financed jointly by the Federal Government and the States and is administered on the national level by the Social and Rehabilitation Service (SRS), Department of Health, Education and Welfare.

A State wishing to participate in the program must submit to SRS a State Plan presenting its commitment to administer the program in accordance with the provisions of the Plan, Title XIX, and related Federal regulations and policies. SRS is responsible for reviewing and approving State Plans and for providing guidance and assistance to State Agencies responsible for administering the program.

The District of Columbia Plan designated the Department of Human Resources as the single State Agency with authority to administer the Plan and to determine eligibility for medical assistance under the Plan. As part of its administrative responsibilities, the State Agency pays nursing homes as providers of services and bills and collects reimbursement from the Federal Government. In the District of Columbia, the Federal share of the cost of medical services is 50 percent; the District of Columbia pays the other 50 percent. For the period January 1, 1972 through March 31, 1974, the State Agency paid about $7,045,000 for skilled nursing services and $12,927,000 for intermediate nursing services. The State Agency is also responsible for determining that each Medicaid nursing home patient receives only the services needed.

The District of Columbia Medicaid Program has provided skilled nursing care services to eligible beneficiaries since inception of the program in 1968. On January 1, 1972 the State Plan was amended to include intermediate nursing care services as provided by Public Law 92-223. Prior to January 1, 1972 these services were provided only to eligible individuals as defined by Title XI of the Social Security Act.

SCOPE OF AUDIT

Our review was made in accordance with standards for governmental auditing, and was directed towards an evaluation of State Agency policies, procedures, and controls over the level of nursing care provided to eligible recipients. We also reviewed the method used by the State Agency to determine the amount of Federal financial participation (FFP) in the cost of nursing care.

Our review was concentrated on Medicaid recipients residing in nursing homes during the period January 1, 1972 through May 31, 1974, to determine whether (1) patients were receiving the required level of care, and (2) FFP was claimed for levels of care received. We made our review at the State Agency, and one State and five private nursing homes.

HIGHLIGHTS OF AUDIT RESULTS

Although the State Agency had paid about $20 million for nursing home services from January 1, 1972 through March 31, 1974 effective procedures had not been established to determine if (1) eligible nursing home patients received the level of care required by their physical condition and (2) claims for FFP were accurate and in accordance with Federal regulations. Our review showed that 88 homes received $744,704 in Federal funds to which they were not entitled, because they were not able to provide the degree of nursing care required by the patients. For example, 50 personal care homes could provide only room and board care to 119 Medicaid patients and 37 personal care homes provided a lower level of intermediate care than required by 150 Medicaid patients. Moreover, one facility that housed up to 19 Medicaid patients was unlicensed for several years because of serious and repetitive deficiencies.

The State Agency erred when claiming FFP. As a result, the State Agency received excess reimbursements of at least $194,685 because (1) intermediate care patients at D.C. Village were claimed at the skilled care rate and (2) room and board patients were included in the claim for FFP.

We are recommending that the State Agency establish procedures to (1) insure that Medicaid recipients are placed in licensed homes that are capable of meeting their needs and provide a level of care above room and board, (2) review past and future claims for FFP to ensure that care is being charged at the proper rate. We are also recommending that the State Agency reimburse the Federal government $939,389 for erroneous and ineligible claims.

During an exit conference held with State Agency Officials on May 22, 1975, oral and written comments were furnished to a draft of this report. The full text of the written comments are included as Appendix 1 to this report. State Agency officials stated that action was being taken to ensure that patients were placed in homes capable of meeting their needs. Generally, the State Agency did not agree that FFP should be refunded for the patients in the 88 homes not providing proper care because these homes met the provisions of the State Plan.

FINDINGS AND RECOMMENDATIONS

OVERALL ADMINISTRATION OF MEDICAID PROGRAM NEEDS IMPROVEMENT

The State Agency needed to improve its overall administration of the Medicaid program. We identified 288 Medicaid patients who were not receiving the level of care required because they were housed in (1) personal care homes not qualified to provide services above the room and board level, (2) personal care homes not qualified to provide the level of intermediate care required, and (3) a facility that was unlicensed because of serious and repetitive deficiencies. The nursing homes received $744,704 in Federal funds for providing services not sufficient to meet the health needs of the 288 patients.

Moreover, the State Agency did not always claim the proper FFP for services provided to patients who were receiving the proper level of care. Because the State Agency did not have a procedure for periodic quality control checks, a supervisor's error in interpreting level of care codes was allowed to continue for 11 months. The supervisor's error resulted in the D.C. Village being reimbursed at the skilled nursing care rate for services provided to intermediate care patients and vice versa. Our review of payments made to

the D.C. Village for a 3 month period showed that the home received excess reimbursements totaling $170,185 because of the error in reversing per diem rates. Also, the State Agency claimed FFP of $24,500 for 21 patients who required and received room and board care. This occurred because the State Agency had not established procedures to transfer those patients to appropriate public assistance programs for which they were eligible.

State Agency Controls
Over Personal Care Homes

At the time of our review, there were 114 personal care homes that participated in the Medicaid Program in the District of Columbia. These homes were generally "family residence" types of dwellings and housed no more than four patients at any one time. Our review showed that State Agency controls over personal care homes were inadequate to prevent Medicaid recipients from being admitted into homes incapable of providing the level of care required by their physical condition. As a result, Medicaid recipients were not being adequately cared for and the State Agency made erroneous payments of:

...$424,551 in Federal funds to 50 personal care homes capable of providing only room and board services to 119 Medicaid patients, and

...$279,353 in Federal funds to 37 personal care homes capable of providing an intermediate level of care lower than that required by the 150 patients.

Personal care homes
providing room and board care

Interim Policy Statement No. 23 dated September 12, 1963 and Federal regulations (45CFR 234.130(D) (3)) dated June 24, 1969, defined an intermediate care home as one that does not provide the degree of care required to be provided by a skilled nursing home but regularly provides a level of care and service beyond board and room. The regulations also recommended certain minimum standards that a nursing home should meet to qualify as an intermediate care facility. These standards were established to maintain and safeguard the health of intermediate care patients.

The State Agency responded to the Interim Policy Statement by submitting a State Plan for Assistance in the form of Institutional Service in Intermediate Care Facilities effective January 1, 1969. According to the Plan, there were two types of institutions that could qualify as intermediate care facilities. (See Exhibit D)

Intermediate Care Facility A Provides a full range of services such as personal care and protective services, social services, food services and health services including the provision that the facility's health services be supervised by a registered nurse or a licensed practical nurse employed full time in the facility and on duty during the day shift.

Intermediate Care Facility B Provides the same services of an "A" type facility other than the necessity for a full time nurse. In no case shall the term intermediate care facility include an institution which does not regularly provide a level of care and service beyond room and board.

The Licensing and Standards Division (LSD) was responsible for determining those nursing homes qualifying either as an intermediate A or intermediate B facility. The following determinations were made for each nursing home:

1) Was the facility currently licensed?

2) Was a house physician available for emergency care?

3) Did the facility provide continuing supervision by a physician as needed, but no less than quarterly?

4) Were only those patients accepted whose needs could be met?

5) Was a medical treatment program followed for each patient?

6) 24 hour responsible staff coverage?

7) Were medical records complete and current?

8) Were social services available?

9) Did the facility meet changing medical needs of patients by transfers to hospitals, or other appropriate facilities?

10) Were recreational and rehabilitation activities provided regularly?

11) Were regular and special diets provided?

12) Were living conditions comfortable and safe?

13) Did the facility provide a sanitary environment?

14) Was the administration and management of the nursing home responsible?

If the nursing home could not meet any of the above standards, LSD would not certify the home as qualifying as an intermediate care facility. Instead it was classified as a "C" facility meaning that it was capable of providing room and board only.

On December 28, 1971, the President signed Public Law 92-223 providing for inclusion as an optional service under the Medicaid program, care provided in intermediate care facilities after January 1, 1972. SRS guidance to states in January 1972 was that until new regulations and supporting standards were issued, existing approved intermediate care facility (ICF) programs will be accepted for FFP under Title XIX. Consequently, the provisions of the State Plan effective January 1, 1969 including the designation of Intermediate "A" and "B" facilities were the determining factor in qualifying for Federal financial participation.

Personal care homes and requirements of the State Plan

To determine if the 114 personal care homes participating in the Medicaid program met the minimum certification standards established by the State Agency, we reviewed the LSD's inspection results. The inspection results showed that 50 personal care homes which received $424,551 in Medicaid funds (Exhibit B) did not qualify as intermediate care homes and were classified as custodial (room and board) homes.

Consequently, these 50 personal care homes that housed 119 Medicaid patients should not have been allowed to participate in the Medicaid program because they did not meet the standards established by the State Plan and therefore, could not meet the medical needs of patients requiring intermediate care. The following schedule lists the 50 custodial homes and the number of standards that were not met.

Number of Homes	Standards in State Plan Not Met
14	10 - 14
11	7 - 9
11	4 - 6
14	1 - 3
50	

Exhibit A to this report lists the 14 standards and the number of homes failing to meet each of them. Specific examples of deficiencies noted by inspections from LSD in 5 of the 50 homes are shown below.

...Home A received $16,200 in Medicaid funds from January 16, 1972 to May 15, 1974. LSD reported 10 standards not met and made following comments: "Recent serious complaint of neglect resulting in hospitalization of patient."

...From January 16, 1972 to May 15, 1974 Home B received $27,333 in Medicaid funds. LSD reports 12 standards not met and noted repeated violations regarding medical supervision of patients, unsanitary environment, and complaints dealing with physical abuse, care, food. LSD unsucessfully recommended denial of 1972 license:

...LSD reported Home C could not meet 11 standards and had never exhibited ability to provide care above room and board level; Home C was unsanitary and had a cluttered environment. This home received $25,454 in Medicaid funds from January 16, 1972 to May 15, 1974.

...Home D received $16,565 in Medicaid funds from January 16, 1972 to May 15, 1974. LSD reported 12 standards not met and commented on complaints of inadequate care and unsanitary conditions. Licensee stated she "complies with regulations when the spirit moves me."

...Home E received $14,163 in Medicaid funds during period January 16, 1972 to May 15, 1974. LSD reported 12 standards not met and according to the inspector, the operator had impaired vision, poor comprehension, and appeared physically unable to give care above room and board.

Patients admitted to personal care homes providing lower level of intermediate care

During the period January 16, 1972 through May 15, 1974, the State Agency claimed $279,353 in Federal funds for services provided to 150

patients in personal care homes not capable of providing the level of intermediate care required (Exhibit C). Patients were admitted into these homes because the State Agency did not have an effective procedure to compare the level of care provided by the home to the level of care required by the patient.

According to the State Plan, the State Agency assumes the responsibility for placing recipients according to their nursing needs. As part of the State Agency's application process for nursing home care under Medicaid, applicants were required to have medical evaluations performed by their private physicians. The results of the evaluations were forwarded to the State Agency to determine the level of care the applicant was eligible for. The level of care determination was returned to the applicant for placement by a social worker from the State Agency, hospital administrative personnel or the applicants relative. The State Agency was to facilitate placement to ensure that the recipient received the level of care needed.

Although the State Agency was determining the proper level of intermediate care needed by patients, there were no procedures to ensure that patients were placed in homes that were capable of providing the level of care required. The State Agency's list of nursing homes identified the homes as providing either skilled or intermediate care. The list did not distinguish between Type "A" and Type "B" intermediate care. Therefore, personnel responsible for placing the Medicaid patient could not determine if the personal care home selected could meet the nursing needs of the patient.

We reviewed payments made to 37 intermediate "B" homes during the period January 16, 1972 through March 31, 1974. Our review showed that 150 patients who required the higher level of intermediate care were placed in intermediate "B" care and remained there for over 52,000 patient days. Consequently, these patients who were determined to need regular care by a full time nurse were not receiving the medical care needed and the nursing homes received $279,350 for providing a lower level of care than required.

Medicaid Recipients Admitted To An Unlicensed Home

The Gordon Convalescent Home, an intermediate facility that was built over 100 years ago and in operation as a nursing home since 1942, has not been licensed since regulations were promulgated in 1955 requiring the licensing of nursing and convalescent home facilities. Nevertheless, the State Agency continued to place Medicaid recipients in the home and claim FFP totaling about $40,800 from January 16, 1972 through May 15, 1974.

According to Public Law 92-223, to be approved for participation in the Medicaid Program, a nursing home must be licensed under applicable State Law. Federal regulations (45CFR 249.10) as well as State Agency policy prohibited Medicaid payments to non-licensed, non-certified facilities. State licensing laws required an annual inspection of each nursing home to determine if the home complied with District of Columbia Housing Code Regulations. The inspection was designed to measure the nursing home's adequacy of housing and health care of patients. The results of the inspections were forwarded to the Department of Economic Development, which was responsible for issuance of a license.

Generally, licenses were not granted to the Gordon Convalescent Home because of numerous structural and housing deficiencies. In 1970, LSD inspectors found 66 violations or deficiencies in the 100 year old facility. In 1972, the number increased to 103. Examples of violations or deficiencies found in the 1972 inspection are: porch floor has rotted parts, walkways have cracks and missing parts, and eating room window has broken glass. Deficiencies such as these, in our opinion, represented potential health hazards to the residents who were, for the most part, over 80 years old.

Sources outside of the State Agency were also aware of the problems concerning the Gordon Convalescent Home. For example, on January 14, 1971, the Director of Professional Services of the American Nursing Home Association testified before the District of Columbia City Council. In his testimony the Director reiterated that it was the Association's stated policy that ..."no nursing home in the county should remain in operation if it is not fully licensed". He recommended that (1) standards for licensure of nursing homes should be equally applied to all facilities, (2) the decisions of licensure be made fairly based on fact and (3) the District government cease immediately making welfare payments unlawfully to unlicensed nursing homes. Although the Director did not mention the Gordon Convalescent Home by name, it was quite obvious that it was one of the two homes that were the subject of his testimony.

The State Agency, however, has continued to make Medicaid payments to the home. Our review of Vendor's Payroll for the months of January 1972 through May 1974 showed that the Gordon Convalescent Home received $81,600 (Federal share $40,800) in Medicaid payments for 19 patients, 12 of whom were still residents at the time of our review. In our opinion, the home was not eligible to participate in the Medicaid program because of its unlicensed status.

Rates Claimed For
Medicaid Patients

State Agency personnel erred in computing monthly Medicaid reimbursements to the D.C. Village, a State-operated nursing home. Because of an apparent judgemental error of a State Agency supervisor, services provided to intermediate care patients were reimbursed at the higher skilled care rate. Conversely, services provided to skilled care patients were reimbursed at the lower intermediate care rate. Our review of reimbursements made to D.C. Village for a 3 month period showed that as a result of this error the nursing home was overpaid Federal funds of $170,185. Had the State Agency established an independent quality control system requiring periodic reviews of reimbursements to the D.C. Village, these overpayments would have, in our opinion, been obvious to State Agency officials.

The State Agency's Special Collection Unit was responsible for monitoring reimbursements to nursing homes. To assist the Unit, State operated nursing homes were required to submit a monthly patient population report. This report listed all the Medicaid patients in the facility as well as the level of care each patient was receiving. The level of care designators as shown on the D.C. Village report were "S" for skilled care and "ICF" for intermediate care. This distinction was necessary because of the difference in per diem rate applicable to the levels of care, - $32.25 for skilled care and $21.00 for intermediate care.

In July 1973, a new supervisor was appointed to the Special Collection Units. Apparently, the supervisor was not familar with the level of care designators shown on the D.C. Village patient population report. He mistakenly interpreted the "ICF" designator to mean an intensive care facility. He, therefore, took the necessary steps to change the monthly reimbursements to reflect his misinterpretation of the level of care designators. Consequently, after July 1, 1973, and up to the time of our review in May 1974, D.C. Village was reimbursed at the skilled care rate for intermediate care services and vice versa.

To determine the impact of reversing reimbursement rates on Federal funds, we reviewed reimbursements made to D.C. Village for the months of July 1973, December 1973 and May 1974. For each of the months reviewed, the nursing home was overpaid as shown on the following page.

Month Reviewed	Overpayments: Intermediate Care Patients	Overpayments: Amount	Under Payments: Skilled Care Patients	Under Payments: Amount	Net Overpayment
July 1973	346	$ 56,604	109	$17,972	$ 38,632
December 1973	433	74,717	20	3,324	71,393
May 1974	350	61,031	5	872	60,159
		$192,352		$22,168	$170,184

Because the number of intermediate care patients greatly exceeded the number of skilled care patients, the error in reversing the intermediate care and skilled care rates caused an overpayment of $170,184 in Federal funds. By projecting this overpayment to the period July 1973 through May 1974, we estimate that D.C. Village was overpaid about $624,000 in Federal funds. In our opinion, this error would have been detected had the State Agency periodically reviewed the activities of the Special Collections Unit.

Room and Board Patients Included in Medicaid Program

Under Federal regulations (45CFR 249.10), patients requiring room and board are specifically excluded from the Medicaid program primarily because they are not in need of medical care. Our review showed, however, that 21 room and board patients were included in claims made by the State Agency for Federal funds. During the period January 16, 1972 through May 15, 1974, about $24,500 was erroneously claimed by the State Agency. The number of room and board patients and the nursing homes they resided in are shown below:

Nursing Home	Custodial Patients In Medicaid Program
Washington Home for Incurables	1
National Lutheran Home	16
Little Sister of the Poor	3
Thelma Randolph	1
	21

State Agency Comments

In a written reply to a draft of this report and at an exit conference held on May 22, 1975, State Agency officials stated that action was being taken to establish procedures to ensure that Medicaid recipients were placed in nursing homes capable of meeting the physical needs of the patients. They also agreed to periodically review the activities of the Special Collection Unit. With regard to the overpayment of $170,185 to the D.C. Village, the State Agency agreed to make a refund to the Federal Government upon reviewing our audit workpapers. Furthermore, the State Agency will make a special review of all Medicaid reimbursements to the D.C. Village and make an appropriate refund to the Federal Government.

Regarding the personal care homes providing only room and board care, the State Agency Officials stated that the homes are being phased out in accordance with the new Federal regulations governing ICF facilities. During the period covered by the audit the 50 personal care homes qualified as room and board and limited medical care facilities licensed by the District of Columbia.

We agree that the 50 personal care homes were licensed by the State Agency. However, the Public Assistance State Plan (See Exhibit D) which was made an amendment to the Title XIX Plan (See Exhibit E) specifically excluded homes that did not regularly provide a level of care and service beyond room and board. Furthermore, Federal Regulations (45CFR 234.130

(D)(3)) concerning intermediate care dated June 24, 1969, June 10, 1970 and Interim Policy Statement No. 23 dated September 12, 1968 also specifically excluded homes that did not regularly provide a level of care and service beyond room and board from Federal Financial Participation.

The State Plan also required that ICF homes had to meet the standards listed in attachment 2 to the State Plan before they could participate in the predecessor Public Assistance program or the current Medicaid program. Since the Licensing and Standards Division determined that the 50 personal care homes did not meet the State Plan standards, it is our opinion that the 50 homes did not qualify as limited medical care facilities in accordance with the State Plan. Therefore, these homes were not eligible to participate in the Medicaid program since they did not meet the Federal regulation or the State Plan.

The State Agency Officials did not agree that a refund should be required for patients admitted to personal care homes providing a lower level of care than the patient required. It was their position that the claims were legal and valid.

Federal regulations (45CFR 234.130(C)) state that FFP is available in vendor payments for institutional services provided to individuals who are eligible under the respective State plan and who are residents in intermediate care facilities. The term "institutional services" means those items and services furnished by the institution in connection with providing the required range or level of care services.

The State Agency determined that the 150 patients were in need of the immediate supervision by a registered professional nurse or licensed practical nurse (Intermediate Care Facility A). However, these patients were placed in Intermediate Care Facilities B, a facility that does not have the immediate supervision by a registered professional nurse or licensed practical nurse. Therefore, in our opinion these patients did not receive the required level of care and FFP is not available in these cases.

In regards to the unlicensed facility, the State Agency Officials replied that the home was denied a license to operate and the denial is being litigated. The D.C. Corporation Counsel issued an opinion that payments must continue if a license is in litigation until it is finally adjudicated. This was the justification for the State Agency continuing payments to the operator.

This home has been operating for 20 years without being issued a license. In our opinion, this home is not eligible to participate in the Medicaid program and should not have been permitted to enter the program in 1972. Therefore, we believe that the home was ineligible for all Medicaid reimbursements, and that a refund should be made to the Federal Government. Furthermore, new Medicaid patients should not be placed in the home and those already there should be transferred to a licensed facility as soon as possible.

In the opinion of State Agency Officials the payment of $24,500 for 21 room and board patients was legal and proper.

> Federal Regulations (CFR 249.10(15)(i)) specifically exclude room and board care from the intermediate nursing home care program. Therefore, the payments for 21 room and board patients were not proper and an appropriate refund should be made to the Federal Government.

Conclusions and Recommendations

Our review disclosed weaknesses in the State Agency's practices and procedures for (1) assuring that Medicaid patients receive the level of care required by their physical conditions and (2) claiming FFP. Patients in 87 of the 114 personal care homes were not receiving the proper level of care. Another nursing home was allowed to participate in the Medicaid program even though it was denied an operating license for years because of services and repetitive deficiences. The State Agency also erred in claiming FFP. Per diem rates applicable to skilled care and intermediate care patients in the D.C. Village nursing home were reversed causing intermediate care patients to be claimed at the skilled care rate. Moreover, costs of care for some room and board patients were also included in the State Agency's claims for FFP. We believe that because of the weaknesses in the State Agency's practices and procedures, it received $939,389 in Federal funds to which it was not entitled.

We therefore recommend that the State Agency:

(1) establish procedures to assure that Medicaid recipients are placed in nursing homes capable of meeting the physical needs of the patients. As a minimum these procedures should include

   (a) furnishing the people responsible for the actual placement of patients a list identifying the level of care each home is capable of providing,

   (b) monitoring actual placements to assure that the proper nursing homes were chosen,

   (c) transferring patients to nursing homes capable of providing the proper kind of care,

   (d) documenting on a case by case basis problems relating to level of care required and received by each Medicaid patient.

(2) exclude the unlicensed nursing facility from the Medicaid Program, and transfer existing Medicaid patients to licensed facilities,

(3) periodically review the activities of the Special Collection Unit,

(4) discontinue claiming FFP for room and board patients,

(5) reimburse the Federal Government $939,389 as follows:

...$424,551 for personal care homes not qualifying as intermediate care facilities,

...$279,353 for personal care homes providing an intermediate level of care lower than required by the patients,

...$40,800 for an unlicensed facility,

...$170,185 for reversing the per diem rates of the D.C. Village,

...$24,500 for including custodial patients in claims for FFP.

(6) Review all Medicaid reimbursements made to the D.C. Village for the 8 months not specifically reviewed by the auditors and make an appropriate refund to the Federal Government.

(7) Provide SRS a plan of action for implementing all of the above recommendations. The plan should include details or procedures to be established, reviews to be made as well as a timetable for completion.

(8) Refund to the Federal Government all payments of FFP received since May 1974 for (1) personal care homes not qualifying as intermediate care facilities, (2) patients in a lower level of care than required, (3) custodial (room and board) patients.

SCHEDULE OF STANDARDS
AND NUMBER OF HOMES
NOT MEETING STANDARDS

Standard	Number of Homes Not in Compliance
1) Facility currently licensed,	0
2) house physician available for emergency care,	4
3) continuing supervision by a physician as needed, and no less than quarterly,	24
4) only those patients are accepted whose needs can be met by the operator,	41
5) physicians initial and revised treatment program followed,	38
6) 24 hour responsible staff coverage,	26
7) complete and current medical records,	43
8) availability of social services,	28
9) meets changing medical needs of patients such as transfer to hospitals, or other appropriate facilities,	27
10) recreational and rehabilitational activities provided regularly,	47
11) regular and special diets,	19
12) comfortable and safe living conditions	25
13) sanitary environment,	17
14) responsible administration and management of the nursing home.	37

EXHIBIT A

PERSONAL CARE HOMES CAPABLE OF
PROVIDING ROOM AND BOARD CARE ONLY

Personal Care Home	Total Medicaid Payments	Federal Share
1	$ 17,013.00	$ 8,507.00
2	7,426.00	3,713.00
3	11,230.00	5,615.00
4	7,490.00	3,745.00
5	14,162.00	7,081.00
6	16,555.00	8,278.00
7	10,710.00	5,355.00
8	27,096.00	13,548.00
9	30,136.00	15,068.00
10	14,530.00	7,265.00
11	28,812.00	14,406.00
12	6,583.00	3,292.00
13	12,444.00	6,222.00
14	25,302.00	12,651.00
15	25,062.00	12,531.00
16	7,350.00	3,675.00
17	25,464.00	12,732.00
18	32,481.00	16,240.00
19	24,925.00	12,462.00
20	27,472.00	13,736.00
21	7,456.00	3,728.00
22	18,756.00	9,378.00
23	9,570.00	4,785.00
24	21,805.00	10,903.00
25	31,151.00	15,575.00
26	5,477.00	2,739.00
27	17,850.00	8,925.00
28	6,300.00	3,150.00
29	21,242.00	10,621.00
30	20,685.00	10,342.00
31	28,666.00	14,333.00
32	28,869.00	14,434.00
33	11,259.00	5,630.00
34	6,340.00	3,170.00
35	18,217.00	9,108.00
Subtotal Carried Forward	$625,836.00	$307,993.00

EXHIBIT B

PERSONAL CARE HOMES CAPABLE OF
PROVIDING ROOM AND BOARD CARE ONLY

Personal Care Home	Total Medicaid Payments	Federal Share
Subtotal Brought Forward	$625,886.00	$307,993.00
36	16,200.00	8,100.00
37	24,898.00	12,449.00
38	27,333.00	13,667.00
39	6,581.00	3,291.00
40	20,998.00	10,499.00
41	25,553.00	12,777.00
42	23.419.00	11,710.00
43	21,372.00	10,686.00
44	10,102.00	5,051.00
45	22,400.00	11,200.00
46	5,760.00	2,880.00
47	2,400.00	1,200.00
48	2,155.00	1,077.00
49	8,814.00	4,407.00
50	5,231.00	2,615.00
Total	$849,102.00	$424,551.00

PERSONAL CARE HOMES NOT CAPABLE OF
PROVIDING THE REQUIRED LEVEL OF INTERMEDIATE CARE

Personal Care Home	Total Medicaid Payments	Federal Share
1	$ 25,721.00	$ 12,860.00
2	5,550.00	2,775.00
3	16,690.00	8,345.00
4	17,796.00	8,898.00
5	17,844.00	8,922.00
6	7,349.00	3,674.00
7	15.350.00	7,675.00
8	21,534.00	10,767.00
9	22,711.00	11,356.00
10	30,976.00	15,488.00
11	5,777.00	2,889.00
12	14,176.00	7,088.00
13	4,016.00	2,008.00
14	23,928.00	11,964.00
15	5,025.00	2,513.00
16	29,661.00	14,830.00
17	9,942.00	4,971.00
18	6,614.00	3,307.00
19	27,462.00	13,731.00
20	8,967.00	4,483.00
21	20,264,00	10,132.00
22	17,212.00	8,606.00
23	16,137.00	8,069.00
24	4,508.00	2,254.00
25	12,724.00	6,362.00
26	24,182.00	12,091.00
27	17,990.00	8,995.00
28	6,491.00	3,245.00
29	7,390.00	3,695.00
30	14,021.00	7,011.00
31	20,268.00	10,134.00
32	16,551.00	8,275.00
33	27,904.00	13,952.00
34	6,600.00	3,300.00
35	12,040.00	6,020.00
36	13,215.00	6,608.00
37	4,120.00	2,060.00
Total	$558,706.00	$279,353.00

EXHIBIT C

EXHIBIT D

DISTRICT OF COLUMBIA
ASSISTANCE IN THE FORM OF INSTITUTIONAL SERVICES IN
INTERMEDIATE CARE FACILITIES

A. General

The District of Columbia Department of Public Welfare provides benefits in the form of institutional services in intermediate care facilities effective January 1, 1969.

Benefits under this plan are provided only to individuals who

(1) are entitled (or would, if not receiving institutional services in intermediate care facilities, be entitled) to receive assistance, under the State plan, in the form of money payments; and

(2) because of their physical or mental condition (or both) require living accommodations and care which, as a practical matter, can be made available to them only through institutional facilities; and

(3) do not have such an illness, disease, injury, or other condition as to require the degree of care and treatment which a hospital or skilled nursing home (as that term is employed in the title XIX) is designed to provide.

B. Application of Available Income

The District of Columbia Department of Public Welfare provides that, in determining financial eligibility for benefits in the form of institutional services in intermediate care facilities, available income will be applied, first, for personal and incidental needs including clothing, and that any remaining income will be applied to the costs of care in the intermediate care facility.

C. Methods of Administration

The State agency will provide methods of administration that will include

(1) placing of responsibility, within the State agency, with one or more staff members who devote full time to direction and guidance of the agency's activities with respect to services in intermediate care facilities including arrangements for consultation and working relationships with the State standard-setting authority and State agencies responsible for mental health and for mental retardation;

D. Review and Evaluation

The State agency will provide

(1) for evaluation by a physician of the individual's physical and mental condition and the kinds and amounts of care he requires; evaluation by the agency worker of the resources available in the home, family, and community; and partici-

pation by the recipient in determining where he is to receive care.

(2) that such evaluation will be made immediately prior to authorization of the benefits originally, and that re-evaluations will be made as indicated by changes in the condition or circumstances of the recipient and, in no case, at intervals longer than quarterly.

(3) Effective July 1, 1959, provisions for regular, periodic review and re-evaluation (by or on behalf of the State agency administering the plan and in addition to the activities described in D-1 and D-2 above) of recipients in intermediate care facilities to determine whether their current physical and mental conditions are such as to indicate continued placement in the intermediate care facility, whether the services actually rendered are adequate and responsive to the conditions and needs identified, and whether a change to other living arrangements, or other institutional facilities (including skilled nursing homes) is indicated. Such reviews will be conducted by or under the supervision of a physician with participation by a registered professional nurse and other appropriate medical and social service personnel not employed by or having a financial interest in the facility. Such reviews will be followed by appropriate action.

E. Social Services

The State agency will make available all of the social services under the Old Age Assistance, Aid to the Blind, and Aid to the Permanently and Totally Disabled programs (titles I, X, XIV) to applicants and recipients of benefits under this plan and will extend the full scope of these services to applicants and recipients of benefits under this plan.

F. Other Requirements

Except when inconsistent with purposes of section 1121 of the Social Security Act or contrary to any provision therein, any modification, pursuant thereto, of an approved State plan will be subject to the same conditions, limitations, rights and obligations as obtain with respect to such approved State plan. Included specifically among such conditions and limitations are the provisions of titles (I, X, and XIV) relating to payments to or care in behalf of any individual who is an inmate of a public institution (except as a patient in a medical institution).

G. Payments

The State agency will provide for methods of determining amounts of vendor payments to independent operators of intermediate care facilities which will be related to the kinds, level, and amount of services provided to the recipient by the institution and the reasonable cost of such services. The method to be used to determine the amount of the vendor payments to the intermediate care facilities is as follows: Intermediate care cases are classified according to the type and extent of care required, on which the rates of pay are based. Criteria have been established by which

the individual's limitations and the extent of care required can be evaluated. Evaluation and classification are the responsibility of the Health and Medical Care Branch, Public Assistance Division.

Rates of payment for care at D. C. Village are established annually by Order of the Commissioner.

H. Standards for Participation

1. Institutions licensed in accordance with standards and requirements (for nursing homes, homes for the aged, rest homes, convalescent homes) established by the District of Columbia Department of Licensing and Inspections will qualify as intermediate care facilities subject to the conditions stated herein. Attached and made a part of this plan are the States' requirements for licensing of facilities, however described, that will qualify under the State plan for participation as intermediate care facilities. (See attachment No. 1)

2. The following are the types and kinds of institutions which will qualify for participation as intermediate care facilities as defined in Attachment No. 2:

   Intermediate Care Facility (A)
   which includes D.C. Village

   D. C. Village is a public medical institution. All patients at the village are classified as skilled nursing care patients or as intermediate care patients. The one exception to this would be the infrequent occasion when a patient might be admitted on an emergency basis either overnight or for a few days while other plans are made for them. There would be no claim for Federal reimbursement in this instance.

   When a patient at D. C. Village recovers to the extent he can manage on a room and board basis in the community, immediate plans will be made for him to do so.

   Intermediate Care Facility (B)

3. Attached and made a part of this plan is a description of the requirements imposed by the State in addition to licensing which will qualify licensed facilities for participation as intermediate care facilities. (See attachment No. 2) √

I. Definitions

For the purpose of this plan the definitions applicable to intermediate care facilities in SRS Interim Policy Statement No. 23 will apply.

Attachment No. 2

DISTRICT OF COLUMBIA
DEPARTMENT OF PUBLIC WELFARE

Definitions for Intermediate Care Facilities and Range or Level of Required Services

I. Institutional Services

The term, "institutional services", means those items and services furnished by the institution in connection with providing the required range or level of care and services as hereafter defined; and other services provided by or under the auspices of the institution which contribute to the health, comfort, and well-being of the residents thereof; except that the term, "institutional services", does not include allowances for clothing and incidental expenses for which money payments to recipients are made under the plan, nor does it include medical care, in a form identifiable as such and separable from the routine services of the facility, for which vendor payments may be made under a State plan approved under title I, X, XIV, or XIX.

II. Distinct Part of An Institution

A "distinct part" of an institution is defined as a part which meets the definition of an intermediate care facility and the following conditions:

(1) Identifiable unit. The "distinct part" of the institution is an entire unit such as an entire ward or contiguous wards, wing, floor, or building. It consists of all beds and related facilities in the unit and houses all residents, except as hereafter provided, for which payment is being made for intermediate care. It is clearly identified and is approved, in writing, by the agency applying the definition of intermediate care facility herein.

(2) Staff. Appropriate personnel are assigned and work regularly in the unit. Immediate supervision of staff is provided in the unit at all times by qualified personnel.

(3) Shared facilities and services. The distinct part may share such central services and facilities as management services, building maintenance and laundry, with other units.

(4) Transfers between distinct parts. In a facility having distinct parts devoted to skilled nursing home care and intermediate care, which facility has been determined by the appropriate State agency to be organized and staffed to provide services according to individual needs throughout the institution, the foregoing paragraphs shall not be construed to require transfer of an individual within the institution when in the opinion of the individual's physician such transfer might be harmful to the physical or mental health of the individual.

III. Intermediate Care Facility

An intermediate care facility is an institution or a distinct part thereof which

(1) is licensed, under State law; or is recognized under State law and is operated to provide the residents thereof, on a regular basis, the range or level of care and services which is suitable to the needs of individuals who

(a) because of their physical or mental limitations or both, require living accommodations and care which, as a practical matter, can be made available to them only through institutional facilities, and

(b) do not have such an illness, disease, injury, or other condition as to require the degree of care and treatment which a hospital or skilled nursing home (as that term is employed in title XIX) is designed to provide.

(2) does not provide the degree of care required to be provided by a skilled nursing home furnishing services under a State plan approved under title XIX;

(3) meets such standards of safety and sanitation as are applicable to nursing homes under State law;

(4) provides the range or level of care and services described below.

(a) Intermediate Care Facilities No. (A) shall be as defined under I through III and will provide at least the services listed under IV (1-9)

(b) Intermediate Care Facilities No. B shall be as defined under I through III and will provide at least the services listed under IV (1 - 9), excluding IV(9a); and there will be a determination by a physician that recipient of services in Intermediate Care Facility No. B does not require immediate supervision by registered professional nurse or licensed practical nurse as described in 9(a) below; and

(5) meets the requirement that in no case shall the term "intermediate care facility", include an institution which does not regularly provide a level of care and service beyond board and room.

IV. Range or Level of Care and Services:

The range or level of care and services suitable to the needs of the individuals described above is defined as including, as a minimum, the following items.

1. Admission, transfer, and discharge of residents: The admission, transfer, and discharge of residents of the facility are conducted in accordance with written policies that include at least the following provisions.

(a) Only those persons are accepted into the facility whose needs can be met within the accommodations and services the facility provides;

(b) As changes occur in their physical or mental condition, necessitating service or care not regularly provided by the facility, residents are transferred promptly to hospitals, skilled nursing homes, or other appropriate facilities;

(c) The resident, his next of kin, and the responsible agency if any, are consulted in advance of the discharge of any resident, and casework services or other means are utilized to assure that adequate arrangements exist for meeting his needs through other resources.

2. Personal care and protective services: The types and amounts of protection and personal service needed by each resident of the facility are a matter of record and are known to all staff members having personal contact with the resident. At least the following services are provided.

(a) There is, at all times, a responsible staff member actively on duty in the facility, and immediately accessible to all residents, to whom residents can report injuries, symptoms of illness, or emergencies, and who is immediately responsible for assuring that appropriate action is taken promptly.

(b) Assistance is provided, as needed by individual residents, with routine activities of daily living including such services as help in bathing, dressing, grooming, and management of personal affairs such as shopping.

(c) Continuous supervision is provided for residents whose mental condition is such that their personal safety requires such supervision.

3. Social Services: Services to assist residents in dealing with social and related problems are available to all residents through one or more caseworkers on the staff of the facility; and/or, in the case of recipients of assistance, through caseworkers on the staff of the assistance agency; or through other arrangements.

4. Activities: Activities are regularly available for all residents, including social and recreational activities involving active participation by the residents, entertainment of appropriate frequency and character, and opportunities for participation in community activities as possible and appropriate.

5. Food services: At least three meals a day, constituting a nutritionally adequate diet, are served in one or more dining areas separate from sleeping quarters, and tray service is provided for residents temporarily unable to leave their rooms.

6. Special diets: If the facility accepts or retains individuals in need of medically prescribed special diets, the menus for such diets are planned by a professionally qualified dietitian, or are reviewed and approved by the attending physician, and the facility provides supervision of the preparation and serving of the meals and their acceptance by the resident.

7. Living accommodations: Space and furnishings provide each resident clean, comfortable and reasonably private living accommodations with no more than four residents occupying a room, with individual storage facilities for clothing and personal articles, and with lounge, recreation and dining areas provided apart from sleeping quarters.

8. Administration and management: The direction and management of the facility are such as to assure that the services required by the residents are so organized and administered that they are, in fact, available to the residents on a regular basis and that this is accomplished efficiently and with consideration for the objective of providing necessary care within a homelike atmosphere.

   Staff are employed by the facility sufficient in number and competence, as determined by the appropriate State agency, to meet the requirements of the residents.

9. Health Services: Whether provided by the facility or from other sources, at least the following services are available to all residents:

   (a) Immediate supervision of the facility's health services by a registered professional nurse or a licensed practical nurse employed full time in the facility and on duty during the day shift;

   (b) Continuing supervision by a physician who sees the resident as needed and, in no case, less often than quarterly;

   (c) Under direction by the resident's physician (and general supervision by the nurse in charge of the facility's health services in the case of Intermediate Care Facilities A) guidance and assistance for each resident in carrying out his personal health program to assure that preventive measures, treatments, and medications prescribed by the physician are properly carried out and recorded;

   (d) Arrangements for services of a physician in the event of an emergency when the resident's own physician cannot be reached;

   (e) In the presence of minor illness and for temporary periods, bedside care under direction of the resident's physician (to also include nursing service provided by, or supervised by, a registered professional nurse or a licensed practical nurse in the case of an Intermediate Care Facility A);

   (f) An individual health record for each resident including: the name, address, and telephone number of his physician; a record of the physician's findings and recommendations in the preadmission evaluation of the individual's condition and in subsequent re-evaluations and all orders and recommendations of the physician for care of the resident; all symptoms and other indications of illness or injury brought to the attention of the staff by the resident, or from other sources, including the date, time, and action taken regarding each.

STATE PLAN FOR MEDICAL ASSISTANCE UNDER TITLE XIX
OF THE SOCIAL SECURITY ACT

STATE OF DISTRICT OF COLUMBIA

PLAN AMENDMENT: PAYMENT FOR CARE IN INTERMEDIATE CARE FACILITIES; P. L. 92-223, DECEMBER 28, 1971

1. EFFECTIVE JANUARY 1, 1972, THE STATE PLAN PROVIDES FOR INTERMEDIATE CARE FACILITY SERVICES IN ACCORDANCE WITH THE PROVISIONS RELATING TO SUCH SERVICES UNDER THE STATE PLANS UNDER TITLES I, X, AND XIV, OR UNDER TITLE XVI, OF THE SOCIAL SECURITY ACT, AS IN EFFECT ON DECEMBER 31, 1971.

2. THE STATE AGENCY WILL COMPLY WITH THE PROVISIONS OF SECTION 4 OF P. L. 92-223.

3. INTERMEDIATE CARE FACILITY SERVICES IN INSTITUTIONS FOR THE MENTALLY RETARDED OR PERSONS WITH RELATED CONDITIONS ARE INCLUDED UNDER THE PLAN.

/X/ YES

/ / NO

4. (APPLICABLE ONLY IF THE STATE TITLE XIX PLAN INCLUDES THE MEDICALLY NEEDY)
THE STATE PLAN INCLUDES INTERMEDIATE CARE FACILITY SERVICES FOR THE MEDICALLY NEEDY.

/X/ YES

/ / NO

EXHIBIT E

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HUMAN RESOURCES
WASHINGTON, D. C. 20004

Mr. G. A. Rafalko
Regional Audit Director
Department of Health, Education
and Welfare
Audit Agency
P. O. Box 13716
Philadelphia, Pennsylvania 19101

Dear Mr. Rafalko:

Transmitted herein are comments concerning the DHEW Audit Agency's review of "Practices and Procedures Relating to Level of Care Provided Medicaid Patients in State and Private Nursing Homes in D. C.

Audit Recommendation (1), a, b, c, d

Action is being taken to comply with this recommendation.

Audit Recommendation (2)

The one facility in question was denied a license to operate and the denial is being litigated. The D. C. Corporation Counsel isssued an opinion that payments must continue if a license is in litigation until it is finally adjudicated. This is the justification for our continuing payments to this operator.

Audit Recommendation (3)

The responsibility for this has been placed with the State Agency.

Audit Recommendation (4)

The personal care homes are being phased out in accordance with the new federal regulations governing I. C. F. facilities. However, during the period covered by the audit the 50 personal care homes qualified as room and board and limited medical care facility licensed by the District of Columbia.

APPENDIX I

75-744 Pt. 2 O - 76 - 20

Audit Recommendation (5)

Exception is taken with this recommendation as regards reimbursement of $424,551, $279,353, and $24,500. It is the position of the Department that these claims are legal and valid.

The sum of $40,800 is addressed in the response to recommendation (2).

The amount of $170,185 to be reimbursed cannot be substantiated until this Department can review the workpapers of the Audit Agency.

Recommendation (6)

This recommendation is concurred in and action regarding this matter has already begun. Upon completion of this review a financial adjustment will be made.

Recommendation (7)

This recommendation shall be complied with and forwarded to the Audit Agency.

Sincerely,

Joseph P. Yeldell
Director

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
REGION III
3535 MARKET STREET
PHILADELPHIA, PENNSYLVANIA 19101

NOV 7 1975

Joseph Yeldell, Director
Department of Human Resources
District Building, Room 420
14th and E Streets, N.W.
Washington, D.C. 20004

Dear Mr. Yeldell: Re: Audit Control Number 60257-03

The purpose of this letter is to provide you with the RESULTS OF OUR AUDIT OF COSTS CLAIMED by the Washington D.C. Department of Human Resources (State Agency) UNDER THE PUBLIC ASSISTANCE TITLES OF THE SOCIAL SECURITY ACT FOR OPERATION OF THE U.S. DEPARTMENT OF AGRICULTURE (USDA) FOOD STAMP AND FOOD DISTRIBUTION PROGRAMS. Our review covered the period July 1, 1973 to June 30, 1975 and was made to determine if amounts claimed for Federal Financial Participation (FFP) were limited to only those costs incurred in determining the eligibility of public assistance recipients for surplus foods and food stamps as provided by Department of Health, Education and Welfare (DHEW) regulations.

The Food Stamp Program, authorized by the Food Stamp Act of 1964, as amended (7 U.S.C. 2011) is a mandatory nationwide program designed to help low-income households obtain nutritionally adequate diets by supplementing their food budgets. The program is administered nationally by the Food and Nutrition Service, USDA. State and county social service agencies administer the program locally, including certifying eligible households and issuing food stamps. Eligible participants include households in which members are recipients of public assistance (assistance households), and households in which no members receive public assistance (non-assistance households). The purchase price of the stamps is based on household income and size; however, extremely low-income households receive stamps free.

Prior to October 1, 1974 costs incurred in the certification of non-public assistance households, fair hearings, and outreach activities were reimbursed by USDA at a rate of 62.5 percent. FFP was not available for costs incident to the acceptance, storage, protection, issuance of, and accountability for food coupons, and the costs of storage, packaging and distribution of foods under the surplus food program. On July 12, 1974 Congress enacted Public Law 93-346 which provided, in part, that effective October 1, 1974, all State administrative costs related to the Food Stamp Program be Federally reimbursed by USDA at the 50 percent FFP rate. However, only those administrative costs incurred in determining the eligibility of public assistance recipients for surplus food and food stamps are eligible for FFP under the public assistance titles of the Social Security Act and DHEW regulations. Therefore, cost allocation procedures must be developed and implemented to accurately segregate costs eligible for reimbursement from USDA from costs eligible for reimbursement from DHEW.

Our examination showed that the State Agency had developed and implemented procedures to segregate cost associated with the Food Stamp Program reimbursable from USDA from those costs reimbursable from DHEW. Amounts claimed for FFP were limited to costs incurred in determining

the eligibility of public assistance recipients for surplus foods and food stamps as provided by Federal Regulations. Therefore, we have no recommendations to make.

The designation of financial and/or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of the HEW Audit Agency. Final determinations of these matters will be made by authorized HEW principal operating component officials named below.

In accordance with the principles of the Freedom of Information Act (Public Law 90-23), HEW Audit Agency reports issued to the Department's grantees are made available, if requested, to members of the press and general public.

To facilitate identification please refer to the above audit control number in all correspondence relating to this report.

Sincerely yours,

G. A. Rafalko
Regional Audit Director

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
REGION III
3535 MARKET STREET
PHILADELPHIA, PENNSYLVANIA 19101

AUG 17 1976

Mr. Joseph P. Yeldell, Director
Department of Human Resources
1350 E Street, N.W.
Washington, D.C. 20004

Dear Mr. Yeldell: Re: Audit Control Number 03-60274

The purpose of this letter is to provide you with the RESULTS OF OUR AUDIT OF ADMINISTRATIVE COSTS CLAIMED UNDER THE PUBLIC ASSISTANCE PROGRAMS in the District of Columbia.

Background

The Social Security Act, as amended (42 U.S.C. 301), authorizes funds to assist States in administering public assistance programs under the various titles of the Act - Old Age Assistance, Aid to Families with Dependent Children (AFDC), Aid to the Blind, and Aid to the Permanently and Totally Disabled. Except for AFDC, responsibility for administering the programs was transferred from the States to the Federal Government effective January 1, 1974.

In the District of Columbia, the Department of Human Resources (State Agency) is responsible for administering the public assistance programs. The State Agency also administers other Federal programs as well as State programs and hospitals. This multi-functional agency is composed of five operating organizations and a centralized administrative division.

Direct responsibility for operating the public assistance programs is assigned to two of the operating organizations, the Social Rehabilitation Administration for social services activities and the Payment Assistance Administration (PAA) for income maintenance activities.

During fiscal years 1974 and 1975 the State Agency claimed and was reimbursed $29,453,413 for costs of administering public assistance programs. These costs consisted of

...$24,490,167 for direct salary and wages of employees in the two operating divisions

...$4,517,971 for expenses of other State Agency organizational units that provide general support or supervision to the two operating divisions

...$445,275 for support services provided by central service agencies.

Scope of Audit

Our examination into State Agency policies and procedures for claiming costs incurred in the administration of the public assistance programs was made in accordance with standards for governmental auditing. Our review was directed primarily towards determining the allowability and allocability of certain administrative costs claimed during the period July 1, 1973 to June 30, 1975. This report does not cover the results of our review of amounts claimed for support services provided by central service agencies.

Results of Audit

Procedures followed by the State Agency to accumulate, classify and claim costs of administering the public assistance programs were generally adequate. Through selected field tests conducted at the State Agency's local offices, we verified that service and income maintenance workers properly performed their respective duties. As a result, except for $75,358 that was erroneously claimed in fiscal year 1975, the $24,490,167 of direct costs and the $4,517,971 of indirect departmental costs were proper and in accordance with established criteria.

Incorrect Unit Costs
Used to Determine FFP
Under Public Assistance Programs

The State Agency's Financial Management Branch was responsible for preparing the Quarterly Statement of Expenditures (OA-41) for claiming Federal Financial Participation (FFP) under the public assistance programs. To determine the amount of the quarterly claim, branch personnel prepared worksheets showing, in total, costs of the organizational units within the Department. Each organizational unit's costs were then allocated among the various Federal and State Programs. The resultant amounts shown on the worksheets were used to claim FFP on the quarterly report for each program.

Costs of $115,165 were shown on the worksheets as the fiscal year 1975 costs of the Office of the Chief of the Self Support Division. Based on this amount, the State Agency allocated $110,588 to the public assistance programs and claimed these costs at the 75 percent Federal participation rate. The State Agency subsequently was reimbursed $82,920 for the cost of the Division.

The amount shown on the worksheets, however, was in error. Accounting records show that the fiscal year 1975 costs of this division were only $34,072 rather than the $115,165 shown on the worksheets.

We reallocated the $34,072 to the various Federal and State programs in accordance with the approved allocation methods and determined that $10,083 of the $34,072 was allocable to public assistance programs and reimbursable at the 75 percent FFP rate. At the 75 percent FFP rate, the State Agency was entitled to $7,562 rather than the $82,920 received. Consequently, the State Agency received excess reimbursement of $75,358.

State Agency Comments and
HEW Audit Agency Recommendations

By letter dated July 13, 1976, the State Agency replied to a draft of this report. The State Agency agreed that $75,358 was erroneously claimed as expenses of the Office of the Chief of the Self Support Division.

We, therefore, recommend that

(1) Procedures be established to specifically compare amounts claimed for unit costs with total unit costs shown in the accounting records.

(2) Make a financial adjustment to the Federal Government for the $75,358 erroneously reimbursed for cost of operating the Office of the Chief of Self Support Division.

The below named official will be communicating with you in the near future regarding implementation of these items.

In accordance with the principles of the Freedom of Information Act (Public Law 90-23), HEW Audit Agency reports issued to the Department's grantees and contractors are made available, if requested, to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act, which the Department chooses to exercise. (See Section 5.71 of the Department's Public Information Regulation, dated August 1974, as revised.)

To facilitate identification, please refer to the above audit control number in all correspondence relating to this report.

Sincerely yours,

G. A. Rafalko
Regional Audit Director
HEW Audit Agency

APPENDIX

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HUMAN RESOURCES
WASHINGTON, D. C. 20004

JUL 13 1976

Mr. G. A. Rafalko
Regional Audit Director
Audit Agency, DHEW
P.O. Box 13716
Philadelphia, Pennsylvania 19101

Re: DHEW Audit 60274-03

Dear Mr. Rafalko:

Pursuant to your correspondence dated May 12, 1976, transmitting the referenced draft report entitled "Administrative Cost Claimed under the Public Assistance Programs," the following comments are proffered for your consideration.

The subject report has been reviewed by appropriate Administrations/ Offices. We concur that $75, 358 was erroneously claimed as expenses to the Office of the Chief of the Self Support Division.

"HEW Audit Agency note--Comments have been deleted at this point because they pertain to material not included in this report."

Sincerely,

Joseph P. Yeldell

Joseph P. Yeldell
Director

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
REGION III
3535 MARKET STREET
PHILADELPHIA, PENNSYLVANIA 19101

MAY 22 1978

Joseph Yeldell, Director
Department of Human Resources
Room 420 District Building
Washington, D. C. 20004

Dear Mr. Yeldell: Re: Audit Control Number 60275-03

The purpose of this letter is to provide you the RESULTS OF OUR AUDIT of the DISTRICT OF COLUMBIA DEPARTMENT OF HUMAN RESOURCES' TRAINING AND STAFF DEVELOPMENT PROGRAMS Under the PUBLIC ASSISTANCE TITLES I, IV, VI, X, XIV and XVI of the SOCIAL SECURITY ACT as amended. Our audit covered the period July 1, 1974 to June 30, 1975, and was directed primarily towards determining if such programs were established in accordance with Federal requirements. We also examined into the allowability of costs charged to the programs and the reasonableness of amounts claimed for Federal Financial Participation (FFP). The Department of Human Resources (State Agency) reported expenditures under the Public Assistance Titles of the Social Security Act totaling $463,717 for training and staff development activities during the period covered by our review. The Federal share of the reported expenditures totaled $347,789.

The Social Security Act, as amended, authorizes annual appropriations for Federal grants, including payments for administrative expenses, to assist States in furnishing financial assistance and other services to certain categories of needy persons. Under the Act, States have primary responsibility to administer these programs; and, in the District of Columbia, the Department of Human Resources is the responsible State Agency. The public assistance programs are administered at the Federal level by the Social and Rehabilitation Service (SRS), Department of the Health, Education and Welfare (HEW).

Under the provisions of the Act, States must provide for a staff development program for personnel in all classes of positions and for volunteers, to improve the operation of the State program and to assure high quality service. The staff development program must include (1) an orientation program for new staff; (2) a program of continuing training opportunities, held under expert leadership at suitable intervals; and (3) provision for paid educational leave to enable subprofessionals, technical and professional staff to improve their performance and to advance to more responsible positions. The Federal government shares in the cost of training and staff development activities at the 75 percent rate.

The State Agency's training and staff development programs were generally adequate and conducted in accordance with Federal regulations and guidelines. Training and staff development activities included (1) orientation of new staff, (2) continuing training, and (3) provisions for educational leave. However, training and staff development costs were not equitably distributed among the State Agency's organizational divisions and, contrary to Federal regulatory requirements, such costs were allocated exclusively to Federally assisted programs. As a result, during fiscal

year 1975, the State Agency erroneously claimed under the Public Assistance Titles of the Social Security Act $103,331 for costs of training and staff development activities. The State Agency was reimbursed, at the 75 percent participation rate, $77,498 for this excessive claim.

To train and conduct staff development activities the Office of Training and Career Development incurred costs of $684,590 during fiscal year 1975. These costs were allocated to the six divisions within the State Agency on the basis of a combination of student hours and teacher hours. Using this method, $463,717 of the $684,590 was allocated to two divisions - Payments Assistance Administration (PAA) and Social Rehabilitation Administration (SRA) - that administer the welfare programs.

In reviewing the quarterly allocations made during fiscal year 1975, we noted that student hours were used whenever the number of students in a class did not exceed 50 percent from any one of the six divisions. When 50 percent or more of the students in a class were from one of the six divisions, total course costs were charged to that division. In our opinion, this method does not provide an equitable basis for allocating such cost among the six divisions. Instead, we believe that student hours should have been used without considering the 50 percent criteria. The ratio of student hours from each division to total student hours would provide a more equitable distribution of training and staff development costs among the divisions and would be in compliance with Office of Management and Budget Circular, A-87, which requires that cost be allocated on the basis of relative benefits received.

We reallocated to the six divisions the $684,590 incurred for training and staff development activities during fiscal year 1975 on the basis of student hours. This reallocation resulted in reducing the amount allocated to the PAA and SRA divisions from $463,717 to $419,890, a reduction of $43,827. The Federal share of this amount is $32,870.

Also, total training and staff development cost allocated to the two divisions was charged exclusively to the Federally assisted program categories. However, a portion of the total caseloads represented recipients under State programs who, similar to recipients under Federally assisted programs, required eligibility determinations and service considerations. Therefore, since the training and staff development programs conducted contributed to the efficient and economical management of the State Programs as well as the Federally assisted programs, the State programs should absorb a portion of the costs associated with activities designed to train and develop their staffs.

Title 45, Part 205.150 of the Code of Federal Regulations effective February 27, 1971, specifically requires that costs benefiting both Federally-funded and non-Federally-funded programs be allocated between the respective programs. In accordance with these provisions we reallocated, using caseload statistics, the $463,717. This reallocation resulted in $59,504 being allocated to State programs. The Federal share of this amount is $44,628.

By letter dated March 8, 1976 (See Appendix) the State Agency replied to a draft of this report. The State Agency agreed to follow our recommendations in the draft report with the following exceptions:

(1) Allocation of costs between State and Federal programs be based on service rather than caseload statistics, and

(2) Regarding refunding the $44,628 the State Agency reserved comment until a decision is rendered on the use of service rather than caseload statistics.

We do not have any objections to the State Agency using a service base rather than a caseload base provided the State Agency can demonstrate to SRS that the method used results in an equitable distribution of costs between State and Federal programs.

We, therefore, recommend that the State Agency

(1) Discontinue charging total course cost to Divisions on the basis of the 50 percent criteria and establish procedures to allocate such costs on the basis of the ratio of the number of students from each division to total students.

(2) Discontinue allocating training and staff development costs to Federally assisted programs exclusively, and establish procedures to allocate such costs between Federal and State programs based on case load, unless the State Agency can demonstrate to SRS that another method would result in a more equitable distribution of costs.

(3) Make a financial adjustment to the Federal Government for the $32,870 that should have been allocated to the other divisions.

(4) Obtain approval from SRS if it decides to use a service base rather than a caseload base to allocate costs to State programs and calculate the amount of refund accordingly. If the caseload base is required by SRS, the amount of refund should be $44,628.

Final determinations as to the actions to be taken on all matters reported will be made by the HEW official named below. We request that you respond within 30 days from the date of this letter to the HEW official named, presenting any comments or additional information that you believe may have a bearing on his final determination.

In accordance with the principles of the Freedom of Information Act (Public Law 90-23), HEW Audit Agency reports issued to the Department's grantees and contractors are made available, if requested, to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act, which the Department chooses to exercise. (See Section 5.71 of the Department's Public Information Regulation, dated August 1974, as revised).

To facilitate identification, please refer to the above audit control number in all correspondence relating to this report.

Sincerely yours,

G. A. Rafalko
Regional Audit Director

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HUMAN RESOURCES
WASHINGTON, D. C. 20004

MAR 8 1976

Mr. G. A. Rafalko
Regional Audit Director
DHEW Audit Agency
P. O. Box 13716
Philadelphia, Pa. 19101

Dear Mr. Rafalko:

This is in reply to the draft audit report entitled "Training and Staff Development Programs Under the Public Assistance Titles of the Social Security Act," received by this Department on January 28, 1976.

The following comments are herein transmitted in response to the recommendations contained in the audit report:

Recommendation (1)

The practice of charging total course cost to Divisions on the basis of the 50 per cent criteria has been discontinued as of 7/1/75. Procedures have been implemented to allocate such costs on the basis of the ratio of the number of students from each division to total students.

Recommendation (2)

The practice of allocating training and staff development costs to Federally assisted programs exclusively, has been discontinued. In establishing procedures to allocate such costs between Federal and State programs this Department requests that such costs be based on service rather than caseload Statistics as recommended.

Recommendation (3)

This Department agrees to refund the Federal Government $82,870 as it relates to allocating costs to other Divisions (Recommendation 1). As regards refunding the $44,628. the Department reserves comment until a decision has been rendered as to DHR's use of service rather than caseload statistics for allocating costs to State programs.

Sincerely,

Joseph P. Yeldell

Joseph P. Yeldell
Director

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
REGION III
3535 MARKET STREET
PHILADELPHIA, PENNSYLVANIA 19101

NOV 5 1975

Mr. Joseph Yeldell, Director
Department of Human Resources
District Building, Room 420
Washington, D. C. 20004

Dear Mr. Yeldell: Re: Audit Control Number 62305-03

The purpose of this letter is to provide you with the RESULTS OF OUR AUDIT OF COSTS CLAIMED by the District of Columbia Department of Human Resources (State Agency) for the CONVERSION TO THE SUPPLEMENTAL SECURITY INCOME (SSI) PROGRAM. Our review covered the period July 1, 1973 to December 31, 1974, and was made to verify the accuracy and allowability of the $162,136 claimed for reimbursement by the State Agency. We also examined into whether the costs were incurred in accordance with the terms of the agreement with the Secretary, Department of Health, Education and Welfare (DHEW) and the reimbursement principles of the Federal Regulations (41 CFR 1-15.7).

The SSI program was established by Public Law (P.L.) 92-603 and amended by P.L. 93-66, 93-233, 93-256, and 93-335. This new program replaces the former Federal grants to States for Aid to the Aged, the Blind, and the Disabled Programs. SSI is administered by the Social Security Administration (SSA) and financed from general funds of the U.S. Treasury and the States.

The purpose of the program is to assure a minimum income level for people who are 65 years of age, or blind, or disabled, and who do not have sufficient income and resources to maintain a standard of living at the established Federal minimun income level. State funds are required to supplement the SSI benefits of those persons who would otherwise be adversely affected by their conversion from the welfare programs to the SSI program.

Conversion to the SSI program necessitated that the States provide SSA with certain information for recipients on the State welfare rolls in December 1973. Each State entered into a contractual agreement with the Secretary, DHEW whereby they agreed to compile and transmit conversion data to meet SSA's requirements. The agreement provides that the expenses incurred to convert the records would be reimbursed on the basis of the cost principles contained in the Federal Procurement Regulations. States were required to submit a certified report of total expenditures for conversion costs within 120 days of the expiration of the original agreement (December 31, 1973). However, enactment of P.L. 93-233 on December 31, 1973 (which changed the criteria for determining disability) necessitated an extension of the expiration date. The extensions were granted for varying periods of time depending on the impact the law had on the State disability rules. A final expiration date of December 31, 1974 was established with an additional 120 days for the final accounting.

Our examination showed that the $162,136 claimed and reimbursed the State Agency was $3,461 in excess of cost actually incurred because of a mathematical error made by a State Agency employee

in preparing the final expenditure report. We brought this matter to the attention of State Agency officials who agreed that a mathematical error had been made. We therefore, recommend that the State Agency submit a revised final expenditure report and refund the $3,461. It is our opinion that the remaining $158,675 was incurred in accordance with the terms of the agreement and was presented in the final financial report (see Exhibit A) fairly and in accordance with generally accepted accounting principles.

The designation of financial and/or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of the HEW Audit Agency. Final determinations of these matters will be made by authorized HEW principal operating component officials named below. We request that you respond to this report within 30 days from the date of this letter to the HEW official named presenting any comments or additional information that you believe may have a bearing on his final determination.

In accordance with the principles of the Freedom of Information Act (Public Law 90-23), HEW Audit Agency reports issued to the Department's grantees are made available, if requested to members of the press and general public.

To facilitate identification, please refer to the above audit control number in all correspondence relating to this report.

Sincerely yours,

A. J. McDevitt
for G. A. Rafalko
Regional Audit Director

STATEMENT OF CONVERSION COSTS

BY OBJECT CLASS CATEGORY

DISTRICT OF COLUMBIA

	Amount Reported by State (Per Form SSA 2669A)	Recommended Adjustments
Personnel	$ 122,313	($ 2664)
Fringe Benefits	4,757	(103)
Travel	66	-0-
Communications		
Supplies		
Office Space		
Data Processing		
County & Municipal Contracts		
Other	3,105	-0-
Indirect Charges	31,895	(694)
Unpaid Obligations		
Total Gross Expenditures	$ 162,136	($ 3461)
Miscellaneous Receipts Per Form SSA 2669 Line 3		
Total Net Expenditures	$ 162,136	($ 3461)

Exhibit A

REPORT ON REVIEW OF DIRECT COSTS INCURRED BY FEDERAL CITY COLLEGE UNDER DEPARTMENT OF HEALTH, EDUCATION AND WELFARE RESEARCH AND TRAINING GRANTS AND CONTRACTS

FOR THE PERIOD
JULY 1, 1968 TO JUNE 30, 1975

AUDIT CONTROL NUMBER 61000-03

ABBREVIATIONS USED IN REPORT

APBU - Accounts Payable and Billing Unit
ARRU - Audit Reconciliation and Report Unit
DHEW - Department of Health, Education and Welfare
FCU - Fund Control Unit
FCC - Federal City College

The designation of financial and/or management practices as questionable, or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represents the findings and opinions of the HEW Audit Agency. Final determinations on these matters will be made by authorized HEW operating component officials.

HEW Audit Agency
Philadelphia Regional Office
March 1976

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
REGION III
2535 MARKET STREET
PHILADELPHIA, PENNSYLVANIA 19101

MAR 9 1976

Wendell P. Russell, President
Federal City College
1420 New York Avenue, N. W.
Washington, D. C. 20005

Dear Mr. Russell: Re: Audit Control Number 61000-03

Enclosed for your information and use is a copy of an HEW Audit Agency report titled "Report on Review of Direct Costs Incurred by Federal City College Under Department of Health, Education and Welfare Research and Training Grants and Contracts For the Period July 1, 1968 to June 30, 1975". Your attention is invited to the audit findings and recommendations contained in the report.

Final determinations as to actions to be taken on all matters reported will be made by the HEW official named below. We request that you respond to each of the recommendations in this report within 30 days of the date of this letter to the HEW official named, presenting any comments or additional information you believe may have a bearing on his final determination.

In accordance with the principles of the Freedom of Information Act (Public Law 90-23), HEW Audit Agency reports issued to the Department's grantees and contractors are made available, if requested, to members of the press and general public.

To facilitate identification, please refer to the above audit control number in all correspondence relating to this report.

Sincerely yours,

G. A. Rafalko
Regional Audit Director
HEW Audit Agency

REPORT ON REVIEW OF DIRECT COSTS INCURRED BY
FEDERAL CITY COLLEGE
WASHINGTON, D. C.
UNDER
DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
RESEARCH AND TRAINING GRANTS AND CONTRACTS

FOR THE PERIOD
JULY 1, 1968 TO JUNE 30, 1975

INTRODUCTION

Background

Federal City College (FCC) was established by an act of Congress in 1966, and in 1968 became the first urban land grant college in the nation. The college is composed of four undergraduate schools and one graduate school that provide education in the Arts, Humanities, Basic and Applied Sciences and Professional Curriculum. FCC is also involved in research activities and training programs designed to promote creative scholarship.

FCC's Vice President for Business and Finance's Department is responsible for the administration and control of expenditures for all Federal grants and contracts awarded to the college. During the period July 1, 1968 to June 30, 1975, FCC incurred $12,462,949 of direct costs under grants and contracts (Exhibit A) awarded by the Department of Health, Education and Welfare (DHEW).

Scope of Audit

In November 1972, the HEW Audit Agency began a review of costs incurred under DHEW grants and contracts awarded to FCC. Prior to completion of this review, both the Dean and the Assistant to the Dean of FCC's School of Education were indicted by a Federal grand jury on 30 counts of criminal activities (forgery, larceny, aiding and abetting theft, obstruction of justice, false statements and conspiracy). The indictments related primarily to the fraudulent use of Government funds. In August 1973, both the Dean and the Assistant to the Dean pleaded guilty to several counts listed in the indictments. In December 1973, we were informed that the Department of Justice was performing a detailed investigation at FCC. For this reason, our detailed audit was curtailed prior to its completion.

In June 1975, we began an "updated" review of the internal control and procedures that FCC was using to administer DHEW grant and contract funds. Our review was made in accordance with the standards for governmental auditing. The primary purpose of this review was to determine the adequacy of actions taken by FCC to improve its internal control and procedures subsequent to the Department of Justice's investigation and our earlier survey. As a part of our examination, we reviewed and tested FCC's system of internal accounting control to the extent we considered necessary to evaluate the system as required by governmental auditing standards.

We have not recommended that any financial adjustments be made as a result of our review primarily because (1) of the several reviews made at the institution by the Justice Department and DHEW organizations, and (2) for the most part, costs charged to DHEW grants and contracts were incurred for grant or contract purposes. This fact does not preclude appropriate HEW Awarding Agencies from disallowing costs on the basis of information developed through separate evaluations and/or monitoring efforts.

IMPROVEMENTS IN FCC'S INTERNAL ACCOUNTING CONTROLS

The objective of internal accounting control is to provide reasonable, but not absolute, assurance that assets are protected against loss from unauthorized use or disposition, and that financial records are reliable for preparing financial statements and maintaining accountability for assets. The concept of reasonable assurance recognizes that the cost of a system of internal control should not exceed the benefits derived, and also recognizes that the evaluation of these factors necessarily requires estimates and judgments by management.

There are inherent limitations that should be recognized in considering the potential effectiveness of any system of internal accounting control. In the performance of most control procedures, errors can result from misunderstanding of instructions, mistakes of judgment, carelessness, or other personal factors. Control procedures whose effectiveness depends upon segregation of duties can be circumvented by collusion. Similarly, control procedures can be circumvented intentionally by management with respect to the execution and recording of transactions or with respect to the estimates and judgments required in the preparation of financial statements. Further, projection of any evaluation of internal accounting control to future periods is subject to the risk that the procedures may become inadequate because of changes in conditions and that the degree of compliance with the procedures may deteriorate.

Giving due consideration to the inherent limitations of any internal control system, we believe that FCC has made improvements in its system during the last two years. The internal control improvements can be traced to the complete reorganization of the Accounting Department.

Prior to July 1, 1974, the monitoring of accounting transactions and the maintenance of necessary supporting documentation for DHEW grants and contracts were basically the responsibility of an accounting technician. Our survey made in 1973 showed that many of the accounting technicians as well as other personnel in the Accounting Department knew very little about DHEW grant and contract procedures. In fact, many of the employees were not even familiar with FCC's own accounting system and procedures. This personnel situation contributed to several accounting deficiencies such as:

...costs were charged to wrong cost objectives,

...supporting documentation for grant and contract expenditures was either missing or incomplete,

...fund obligations (representing purchases) remained open up to two years,

...final Grant and Contract Expenditure Reports were not being submitted to appropriate DHEW officials on time, if at all.

On July 1, 1974, FCC began to reorganize its Accounting Department by establishing the following three units: Fund Control Unit (FCU), Accounts Payable and Billing Unit(APBU), and Audit Reconciliation and Report Unit (ARRU). The primary purpose of this reorganization was to (1) establish more centralized control, (2) provide FCC accounting personnel with more specialized skills, (3) give additional authority to the Accounting Department and (4) have more than one person who has special knowledge with respect to individual grant or contract transactions.

One of the most apparent improvements resulting from the reorganization was in the area of personnel. In late 1974, several new officials, having prior experience at other educational institutions, were hired by FCC's Division of Business and Finance. Actions taken by the new management personnel have resulted in less personnel turnover, better trained staff, fewer vacant positions and more clearly defined duties and responsibilities. Because of better supervision, the staff has become more familiar with FCC's accounting system and DHEW grant and contract procedures.

The reorganization also resulted in improved record maintenance. Individual accounting technicians are no longer responsible for maintaining FCC's grant and contract files. Under the reorganization, the ARRU was given responsibility for monitoring all grant and contract files and assuring that all pertinent documentation was filed in a timely manner. This system was an improvement over the one used in the past. We had little trouble obtaining necessary correspondence and supporting documentation for the 1975 expenditures included in our review.

Our test of selected fiscal year 1975 transactions showed that the reorganization resulted in additional improvements in FCC's internal accounting controls.

1. All purchase orders required the approval of the applicable department head.

2. Prior to approving an expenditure, the availability of funds and the allowability of the costs were reviewed by the FCU.

3. The FCU monitored month to month transactions and assured that grant and contract budgets were not exceeded.

4. APBU maintained records of open obligations and took appropriate follow-up action when receiving reports were not received.

5. ARRU selectively reviewed financial transactions and verified that established FCC procedures were being followed.

6. ARRU also assured that interim and final expenditure reports were submitted.

FINDINGS AND RECOMMENDATIONS

Need to Improve Control Over Check Disbursements

FCC needs to improve its internal control over the distribution of checks issued to consultants and students working on DHEW grants and contracts to ensure that the payees (individuals to whom the checks are made out) actually receive them.

As part of our audit, we reviewed 67 consultant and 37 student service transactions charged to various DHEW grants and contracts during fiscal year 1975. The purpose of this review was to determine if the internal controls established by FCC to issue the checks for these services were adequate.

In our opinion, the internal controls were not adequate to ensure that the payees actually received the checks. In 14 cases, the Project Director, who had initiated the purchase order and authorized payment after certifying that the services had been performed, had signed for the check. In 6 other cases, there was no signature evidencing receipt of the checks. We selectively contacted some individuals who, according to FCC records, should have received the checks. The individuals assured us that they had received the checks.

In our opinion, the above condition violates basic internal control principles. Under no circumstances should the individual who purchases services and authorizes payment for such services sign for the receipt of the check. We are, therefore, recommending that all checks disbursed by the FCC Cashier's Office be either (1) mailed directly to the payee or (2) signed for by the payee upon receipt.

FCC Comments

FCC responded to a draft of this report by letter dated February 19, 1976. In the reply, the President of FCC concurred with our findings, and stated that corrective action had been instituted. As evidence of the action taken, FCC submitted, with the reply, revised school procedures dealing with the matters discussed. FCC's response to our draft is included as Exhibit B to this report.

FEDERAL CITY COLLEGE
WASHINGTON, D. C.
STATEMENT OF DIRECT COSTS INCURRED
AND RECOMMENDED ADJUSTMENT UNDER
DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
RESEARCH AND TRAINING GRANTS AND CONTRACTS

FOR THE PERIOD
JULY 1, 1968 TO JUNE 30, 1975

GRANT/CONTRACT NUMBER	PROJECT PERIOD FROM	TO	COSTS INCURRED
OFFICE OF THE SECRETARY (OS)			
HEW-OS-71-165	7/1/71	5/31/73	$ 18,604
HEW-OS-72-11	8/9/71	6/30/72	1,413,711
HEW-OS-72-72	6/21/71	8/31/72	24,830
HEW-OS-72-182	3/20/72	11/20/72	46,612
HEW-OS-72-202	12/1/71	7/30/72	369,383
HEW-OS-72-216	7/1/72	6/30/73	418,234
HEW-OS-73-16	8/22/72	8/31/73	2,008,037
HEW-OS-73-60	10/2/72	8/31/73	79,801
HEW-OS-74-58	9/19/73	8/31/74	163,978
HEW-OS-74-49	9/19/73	8/31/74	1,672,192
Upward Mobility 1975	9/1/74	8/31/75	1,156,698
Project Start	1/1/75	8/31/75	41,784
Total OS			$ 7,413,864
OFFICE OF HUMAN DEVELOPMENT (OHD)			
94-P-15149/3-04	7/1/74	6/30/75	97,472
90-A-295/01	7/1/74	6/30/75	37,456
94-P-15149/3-03	7/1/71	6/30/74	299,793
Total OHD			$ 434,721

GRANT/CONTRACT NUMBER	PROJECT PERIOD FROM	TO	COSTS INCURRED
OFFICE OF EDUCATION (OE)			
8326	7/1/68	6/30/72	192,197
OEG-0-9-180-760-0707	1/9/68	11/30/70	195,469
OEG-0-72-1357	6/1/69	6/1/71	376,064
OEG-3-9-188014-0030(095)	3/6/69	2/3/70	10,657
OEG-0-70-1485	10/27/69	8/31/70	84,829
OEG-0-71-6115(314)	6/17/69	6/30/73	16,224
OEG-0-70-2012(725)	4/3/70	11/1/72	23,848
OEG-0-70-5077	7/1/70	6/30/71	716,257
OEG-0-71-4212	7/1/70	6/30/73	662,973
OEG-0-70-1622(335)	3/6/69	8/30/73	197,917
Grant No. 16	7/1/70	6/30/72	20,866
OEG-0-70-2347	6/1/71	6/30/72	14,259
OEG-0-71-3602	6/15/71	8/31/72	185,319
OEG-0-71-4587(6116)	6/30/71	6/29/74	11,516
OEG-0-72-1701	7/1/72	12/31/73	18,024
OEG-0-72-0152(725)	6/26/72	6/30/73	18,555
OEG-0-71-4559(616)	6/30/71	6/29/74	203,763
OEG-0-72-6102(314)	6/30/72	6/30/73	38,402
OEG-0-73-2755	7/1/73	6/30/74	17,854
OEG-0-74-0552	10/5/73	9/30/74	107,382
75020001(Trans. No.)	8/31/73	8/31/74	21,380
OEG-0-74-1445	7/1/74	6/30/75	82,494
OEG-0-74-2430	7/1/74	6/30/75	19,427
OEG-0-74-6180	6/28/74	6/30/75	387
OEG-0-74-2686	5/1/74	5/31/75	29,405
Total OE			$ 3,265,668
SOCIAL REHABILITATION SERVICE (SRS)			
Manpower Training and Development (No number)	9/1/74	8/31/75	6,058
Total SRS			$ 6,058
HEALTH RESOURCES ADMINISTRATION (HRA)			
1E04NU00194-01	7/1/73	6/30/74	11,846
Total HRA			$ 11,846
National Institute of Health (NIH)			
1-D-10-NH-00544-01	6/1/70	5/31/75	$ 734,314
1506-RR-08005-01	6/1/72	5/31/77	42,802
5506-RR-08005-02	6/1/72	5/31/77	152,630
5-506-RR-08005-03	6/11/72	5/31/77	104,686
030-005304-05	6/1/70	5/31/75	222,008
5-506-RR-08005-04	6/1/72	5/31/77	24,718
Total NIH			$ 1,281,158

GRANT/CONTRACT NUMBER	PROJECT PERIOD FROM	TO	COSTS INCURRED
ALCOHOL, DRUG ABUSE AND MENTAL HEALTH ADMINISTRATION (ADAMHA)			
1-R03-MH18651-01A1	9/1/70	8/31/71	$ 5,831
1T02-MH12835-01	7/1/72	6/30/74	23,821
IR01-MH23232-01-MH5R	6/1/72	8/31/73	11,147
5T21-MH-12835-02	7/1/72	6/30/75	8,835
Total ADAMHA			$ 49,634
Total DHEW Costs Incurred			$12,462,949
Recommended Adjustments			$ -0-

THE FEDERAL CITY COLLEGE
OFFICE OF THE PRESIDENT
1420 new york avenue, n.w., washington, d.c. 20005
(202) 727-2448

February 19, 1976

Mr. G.A. Rafalko
Regional Audit Director
Department of Health, Education and Welfare
Region III
3535 Market Street
Philadelphia, Pennsylvania 19101

Re: Audit Control No. 61000-03

Dear Mr. Rafalko:

The purpose of this letter is to acknowledge receipt of the draft "Report on Review of Direct Costs Incurred by Federal City College under Department of Health, Education and Welfare, Research and Training Grants and Contracts for the period July 1, 1968 to June 30, 1975," dated January 17, 1976 and identified as referenced as above.

We have reviewed your findings and recommendations included in the report. We accept your report as presented without appeal. We would, however, like to subait the attached copies of the Federal City College Instructions 420.1 dated August 20, 1974 and 220.1 dated February 17, 1976 as evidence of our postive efforts to address the deficiencies in check distribution, which was the major recommendation in your report. We would appreciate any additional comments or recommendations on the adequacy of our actions, if these are found to be inadequate or inappropriate.

In closing, we would like to express our sincere appreciation for the assistance that your staff provided in updating and correcting our practices. We look on visits such as yours as a valuable adjunct to our continuing efforts to be responsive and responsible in our accountability for execution of our grant programs and in effective utilization of the resources provided by our sponsors in support of these programs.

Please advise if there are further actions or information required in this matter.

Sincerely yours,

Wendell P. Russell
President

Exhibit B

INSTRUCTION 220.1
NOTICE
MEMO

February 17, 1976

FEDERAL CITY COLLEGE INSTRUCTION 220.1

SUBJECT: Procedures for Disbursement of Checks from the Cashier's Office (Athletic, Financial Aid, and Outside Scholarships)

1. This Instruction informs you of the Procedures for Disbursement of Check from the Cashier's Office. All checks not included in the Subject above will be mailed to the individuals home address.

2. Procedures.

Athletic - The Cashier will release checks only to the Director or the designee. A memorandum from the Director naming the designee will be kept on file in the Cashier's Office. The Director or designee will be required to present a valid FCC Identification Card and sign the check register beside the check owner's name and check number indicating receipt of same.

In the case of the Director or designee not being the lawful owner of the check, the lawful owner will be required to sign a check register upon receipt of same from the Director or the designee.

Financial Aid - The Cashier will release checks only to lawful owners (students). Each student will be required to present a certification card stamped with the Financial Aid stamp and signed by authorized Financial Aid Officer for each transaction involving payment. The certification card will contain student's name, social security number, and the amount of money to be received under each program. (Institutional Grant, Supplemental Education Opportunity Grant IY & RY, Nursing Scholarship, Nursing Loan, National Direct- Student Loan and Emergency Loan). A valid FCC Student Identification Card must also be presented for payment.

Upon receipt of these documents, the Cashier will verify that the check is for the amount shown on the certification card. If there are no discrepancies, the student will sign the back of the certification card and return it to the Cashier for forwarding to the Financial Aid Officer. The student will then be required to sign the check register beside his/her name and check number indicating receipt of check.

In cases of discrepancies, such as over-payment or under-payment, the Cashier will refer the student to the Financial Aid Officer for corrective action. If the Financial Aid Officer determines that there is an over-payment, he will notify the Cashier in writing to cancel the check and will prepare a new voucher for the correct sum.

In cases of under-payment, the Financial Aid Officer will issue a new certification card for the amount shown on the check and will prepare a voucher for the difference. A new certification card will also be issued to the student indicating the difference due.

Outside Scholarships - The Cashier will release checks only to lawful owners (students). Each student will be required to present a Federal City College Trust Fund Slip obtained through the Financial Aid Office and signed by that Office. A valid FCC Student Identification Card must also be presented to the Cashier.

Upon receipt of these documents, the Cashier will require the student to sign the check register by his/her name and check number indicating receipt of check.

Larry Wilson
Vice President for Business & Finance

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
REGION III
3535 MARKET STREET
PHILADELPHIA, PENNSYLVANIA 19101

AUG 1 4 1975

Ms. Barbara Sizemore
Superintendent of Schools
The Presidential Building
415 Twelfth Street, N.W.
Washington, D.C. 20004

Dear Ms. Sizemore: Re: Audit Control Number 61462-03

Enclosed for your information and use is the HEW Audit Agency report titled, "Report On The Administration Of The Response To Educational Needs Project Under Grant OEG-0-72-0168 By The District Of Columbia Public Schools For The Period March 15, 1972 Through June 30, 1974". Your attention is invited to the audit findings and recommendations contained in the report. The below named National Institute of Education official will be communicating with you in the near future regarding final determination as to actions to be taken on all matters reported.

In accordance with the principles of the Freedom of Information Act (Public Law 90-23), HEW Audit Agency reports issued to the Department's grantees and contractors are made available, if requested, to members of the press and general public.

To facilitate identification, please refer to the above audit control number in all correspondence relating to this report.

Sincerely yours,

G. A. Rafalko
Regional Audit Director

ABBREVIATIONS

DCPS	-	District of Columbia Public Schools
DHEW	-	Department of Health, Education and Welfare
NIE	-	National Institute of Education
OE	-	Office of Education
RENP	-	Response to Educational Needs Project
ROE	-	Report of Expenditures

REPORT ON THE ADMINISTRATION OF THE RESPONSE TO EDUCATIONAL NEEDS PROJECT UNDER GRANT OEG-0-72-0168 BY THE DISTRICT OF COLUMBIA PUBLIC SCHOOLS WASHINGTON, D. C.

FOR THE PERIOD
MARCH 15, 1972 THROUGH JUNE 30, 1974

INTRODUCTION

Background

In June 1972, the Office of Education (OE), Department of Health, Education and Welfare (DHEW), awarded $764,578 under Grant Number OEG-0-72-0168 to the District of Columbia Public Schools (DCPS) to design and implement a project entitled "Response to Educational Needs Project" (RENP). Effective September 11, 1972, OE transferred its grant administration responsibility to the National Institute of Education (NIE).

RENP was to be implemented in two phases. Phase I was the planning phase and was to be completed by September 30, 1972. Funds of $100,000 were allotted for this work. DCPS was to submit an interim report to NIE by September 30, 1972, describing (1) planning accomplishments in such areas as staff hiring, and orientation of project and school site staff, and (2) planned project activities for the period October 1, 1972 through June 30, 1973. Phase II was the implementation phase and was dependent on NIE's acceptance of the interim report. Release of the balance of the grant funds was also contingent on acceptance of the interim report.

DCPS experienced severe difficulties in designing an educational project acceptable to NIE. Because of these difficulties, Phase I was extended to June 30, 1974 and the grant amount was increased to $2,898,096. In February 1974, DCPS submitted a plan entitled "Proposal for a Corporate School - Community Program to Foster Improved Academic Achievement Among the Children of Anacostia". NIE accepted the proposal and effective June 1, 1974 extended the grant to September 30, 1975. Federal funds were increased to $5,046,896.

Scope of Audit

Our audit was made in accordance with standards for governmental auditing. The purposes of our review of the RENP grant awarded to DCPS were to determine if costs claimed under the grant were (1) reasonable and allowable under DHEW regulations and terms of the grant, and (2) accounted for in accordance with generally accepted accounting principles. We also reviewed the effectiveness of DCPS' actions in implementing Phase II of the grant.

Our review of costs covered the period March 15, 1972 through June 30, 1974. This coverage was necessary because (1) pre-award expenditures were authorized under the terms of the grant and (2) monthly financial reports after June 30, 1974 were not available at the time of our audit. We expanded our review of program operations to October 31, 1974 so as to include the most current actions taken by DCPS with regard to implementing RENP.

We followed our normal practice of providing DCPS officials our draft audit report on April 7, 1975, and requesting their comments within 30 days. On April 17, 1975, we contacted grantee officials to arrange for an exit conference. We were informed we would be contacted during the week of April 28; however, we were not contacted. We telephoned grantee officials again on May 5, 1975, to inquire about an exit conference. We were informed that more definite information would be provided us the same day. On May 9, 1975, we followed-up our telephone conversation with a letter to grantee officials. However, no response was received from the grantee until July 24, 1975, when written comments were received.

HIGHLIGHTS OF AUDIT RESULTS

DCPS did not effectively manage the RENP to ensure that costs claimed by project personnel were actually incurred on behalf of the project. DCPS permitted RENP personnel to submit Reports of Expenditures to NIE without first reconciling the reports to the official accounting records. Consequently, RENP personnel overstated by $110,591 the cost of conducting the project.

We are recommending that DCPS establish controls to ensure the accuracy of costs claimed by RENP personnel. We are also recommending that the $998,624 of costs claimed be adjusted by $110,591 (See Appendix A).

By letter dated July 18, 1975, DCPS replied to a draft of the report. DCPS agreed with the direct cost finding but disagreed with the indirect cost finding. The full text of the reply is included in the report as Appendix B and excerpts from the reply are included in the auditee comment section of the report.

FINDINGS AND RECOMMENDATIONS

COSTS REPORTED TO NIE WERE OVERSTATED

RENP project personnel, in reporting to NIE, overstated by $110,591 the costs of conducting the project from March 15, 1972 through June 30, 1974. The overstated costs consisted of direct costs of $92,918 and indirect costs of $17,673. Errors in reporting costs occurred because DCPS had not established procedures to ensure that project personnel (1) used the official accounting records maintained by DCPS to prepare the financial reports and (2) adjusted overhead costs claimed to actual.

Direct Costs Reported Overstated by $92,918

Under the terms of the grant, DCPS was required to submit a monthly financial report - Report of Expenditures (ROE) - showing monthly and cumulative expenditures for 10 budget line items. DCPS, in turn delegated this responsibility to the RENP project staff.

RENP project officials prepared the ROEs using their own records. However, their records were inadequate to support the costs claimed on the ROEs. Moreover, since DCPS was the grantee of record, and since all RENP expenditures were processed through the DCPS' accounting system, we believe the ROEs should be prepared using DCPS' records. Our comparison of the costs recorded on DCPS' accounting records to the ROEs submitted by project personnel showed discrepancies in each of the 10 budget line items (see Appendix A). The com-

parison showed that direct costs claimed by RENP from inception of the grant through June 30, 1974 were overstated by $92,918.

RENP officials could not explain the differences between the accounting records and the ROEs. The project's Financial Officer stated that since he did not maintain detailed accounting records, he often had to estimate the RENP costs on the ROEs. He also stated that RENP rarely received copies of DCPS' official accounting records. Therefore, he could not reconcile reported RENP costs to the accounting records. He further stated that DCPS did not review the ROEs prior to submission to NIE.

Indirect Costs
Overstated By $17,673

RENP did not adjust overhead costs claimed to actual. Overhead costs claimed through May 1974 were computed at 8.0 percent of total direct costs. However, DCPS' negotiated rate for the period of the grant was 6.7 percent. DHEW regulations pertaining to training grants such as the one awarded to DCPS provide that indirect costs will be reimbursed at 8 percent of total allowable direct costs or actual rate, whichever is less. Based on our review of actual direct costs and overhead rates, we believe that overhead expenses claimed should be reduced by $17,673 for the reasons stated below.

1. Total direct costs used by RENP personnel in computing overhead was $925,189. We are recommending that this amount be reduced by $92,918. Therefore, we used direct costs of $832,271 in our computation of allowable overhead expenses.

2. RENP officials used the maximum 8.0 percent overhead rate in computing indirect costs. However, DCPS' negotiated DHEW indirect cost rate for the period July 1, 1971 through June 30, 1974 was 6.7 percent. Although RENP started using the 6.7 percent rate in June 1974, it did not adjust previous overhead claims.

Based on adjusted direct costs of $832,271 and the final overhead rate of 6.7 percent, we believe that overhead expenses should be $55,762 or $17,673 less than claimed by RENP.

Auditee Comments

DCPS officials agreed with the direct cost finding. However, the officials disagreed with the indirect cost finding stating that allowable indirect costs should be $186,226 based on the negotiated indirect cost rate, instead of the $73,435 claimed.

We do not agree with DCPS. Their claim that indirect costs should be $186,226 is based on grant awards totaling $2,898,096 rather than direct costs incurred of $832,271. Our recommended adjustment of $17,673 is based on allowable direct costs incurred and represents the difference between indirect costs claimed and allowable indirect costs.

Conclusions and Recommendations

DCPS had not reviewed financial reports prepared by RENP to ensure that costs claimed by project personnel were accurate. As a result, RENP personnel claimed $92,918 in direct costs that could not be supported

by official accounting records and $17,673 in indirect costs that could not be supported based on negotiated overhead rates. We therefore recommend that DCPS:

(1) establish procedures to ensure that monthly financial reports submitted to NIE are accurate. The direct costs claimed on the ROEs should agree with the amounts recorded on DCPS' accounting records; and indirect costs claimed should be based on DCPS' negotiated overhead rate.

(2) adjust costs claimed by (i) $92,918 for direct costs and (ii) $17,673 for indirect costs.

(3) review the accuracy of ROEs submitted after June 30, 1974 and make appropriate financial adjustments.

(4) Furnish NIE a plan of action describing the proposed method of implementing the above recommendations.

OTHER MATTERS

Program Implementation

Amendment 9 to the grant funded and authorized implementation of Phase II of the BEMP for the period June 1, 1974 through September 30, 1975. Our review showed that actual implementation of the program began in October 1974. Since we performed our review in November 1974, the program had not been operational long enough to produce substantive results for evaluation. We did note, however, that DCPS had encountered some initial delays in implementing the program. Special conditions of the grant award required that key staff positions be filled by September 1, 1974. However, three key positions - the Assistant Director for the Reading Component, the Assistant Director for the Mathematics Component, and the Associate Director for Formative Evaluation - were still vacant as of October 31, 1974. The lack of key personnel has, in our opinion, impeded achievement of program objectives. For instance, implementation of the following program components were behind schedule:

a. training teachers in new instructional approaches in reading and mathematics,

b. pretesting target students, and

c. determining special material requirements of target schools.

Plans were in process for implementing these components as expeditiously as possible and revised target dates were submitted to NIE.

APPENDIX A

DISTRICT OF COLUMBIA PUBLIC SCHOOLS
WASHINGTON, D.C.
SCHEDULE OF EXPENDITURES UNDER
GRANT NUMBER OEG-0-72-0163
RESPONSE TO EDUCATIONAL NEEDS PROJECT

FOR THE PERIOD
MARCH 15, 1972 THROUGH JUNE 30, 1974

	RENP Reports of Expenditures	Per Audit of DCPS Records	Recommended Adjustments
Salaries	$571,698	$536,335	$ 35,363
Benefits	55,577	37,924	17,653
Consultants	120,324	61,636	58,688
Travel	25,459	19,468	5,991
Office Supplies	13,374	3,845	9,529
Instructional Supplies	155	940	(785)
Contracts and Training	56,224	94,648	(38,424)
Space and Equipment	39,623	41,986	(2,363)
Stipends	28,925	27,213	1,712
Substitutes	13,830	8,276	5,554
Total Direct Cost	$925,189	$832,271	$ 92,918
Indirect Cost	73,435	55,762	17,673
Total Cost	$998,624 (1)	$888,033	$110,591

( ) Denotes increase

(1) The reported expenditures were adjusted to eliminate mathematical errors on the ROEs.

PUBLIC SCHOOLS OF THE DISTRICT OF COLUMBIA
SUPERINTENDENT OF SCHOOLS
PRESIDENTIAL BUILDING
415 - 12TH STREET, N. W.
WASHINGTON, D. C. 20004

July 18, 1975

Appendix B

Mr. G. A. Rafalko
Regional Audit Director
HEW Audit Agency
P. O. Box 13716
Philadelphia, Pennsylvania 19101

RE: Audit Control # 51162 - 03

Dear Mr. Rafalko:

The draft report titled "Report on the Administration of the Response to Educational Needs Project under Grant OEG-0-72-0168 by the District of Columbia Public Schools for the period March 15, 1972 through June 30, 1974" has been reviewed. Our comments, based on a review of the document, as they apply to the various sections follow:

Highlights of Audit Results

The official fiscal records for the Response to Educational Needs Project are maintained by the District of Columbia Accounting Office and are provided to the District of Columbia Public Schools' Division of Control for the purpose of financial maintenance and control. These records reflect all transactions which pertain to the program. In order to assure that costs claimed conform to the actual operation of the Project, all future financial reports relative to the operation will be prepared by the Division of Control, District of Columbia Public Schools in lieu of financial reports being prepared by the Project Office based on these memorandum records and supplementary material maintained by the Project.

Costs Reported to HEW Were Overstated

The Public Schools concur in the indication that some costs were overstated as reported by the Response to Educational Needs Project personnel. The District of Columbia Public Schools do not concur that the overstatement is $110,591. Errors in reporting costs will be alleviated by the instituting of procedures to assure that (1) the official accounting records maintained by the Public Schools are used to prepare the financial reports and (2) overhead costs claimed will conform with actual assessments levied.

Direct Costs Reported Overstated by $92,918

The Public Schools concur in the indication that the direct cost as reported on the financial report prepared by the Response to Educational Needs Project Director is overstated in the amount of $92,918. Based on the official accounting records of the Division of Control, District of Columbia Public Schools and the District of Columbia Accounting Office, the financial reports as submitted will be corrected and resubmitted to the National Institute of Education.

Indirect Costs Overstated by $17,673

A review of the accounting records indicated that the Indirect Cost assessed against the Response to Educational Needs Project for

the period covered by the audit was $136,226 which represented an assessment rate less than the 6.7% allowable under the Department of Health, Education and Welfare regulations. The reports as submitted claimed an Indirect Cost amount on a variable basis of $73,435 or an 8.0% rate.

Based on the negotiated rate in compliance with the Department of Health, Education and Welfare regulations of 6.7% for the period covered by the audit, the Indirect Cost rate figures will be adjusted on the corrected reports which are to be filed and will reflect the 6.7% negotiated rate or the actual rate assessed.

The Indirect Cost rate is considered as a fixed rate applicable to the program for the fiscal year in which it is assessed by the District of Columbia Public Schools Board of Education, and is applied in the claims of the fiscal year in which assessed; therefore, the overstatement as indicated in the amount of $17,673 is incorrect and should be adjusted to reflect a fixed overhead Indirect Cost of $136,226 for the grant period covered which is less than the 6.7% allowable rate. Based on the 6.7% approved rate, the assessments should have been as follows:

Fiscal Years	Grant Amount	Amount Assessed	Indirect Cost Rate at 6.7%	Assessment Over or (Under)
FY 1973	$ 764,578	$ 51,226	$ 51,226	$ - 0 -
FY 1974	2,133,518	135,000	142,945	(7,945)

Based on the recommendations in your draft report, the following actions will be initiated:

1. The Division of Control, District of Columbia will prepare all future financial reports for the Project based on the Public Schools' accounting records, including claimed costs based on the Public Schools negotiated overhead rate.

2. The District of Columbia Public Schools will prepare and submit revised financial reports to reflect the adjustment for direct costs of $92,948 and the claim for Indirect Costs based on the Indirect Cost assessment at the negotiated rate.

3. The District of Columbia Public Schools' Division of Control will review the accuracy of FCR's submitted and make appropriate financial adjustments.

4. A conference, at the Superintendent's level, was conducted with appropriate administrative staff for the purpose of taking action to implement the above changes.

The proposed method to implement the changes involved the assignment of responsibility for the preparation of FCR's, with necessary coordination of data with project personnel.

Sincerely,

Barbara A. Sizemore
Superintendent of Schools

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
REGION III
3535 MARKET STREET
PHILADELPHIA, PENNSYLVANIA 19101

APR 3 0 1976

Mr. William A. Crunk
Assistant Regional Director
Office of Human Development
Department of Health, Education
and Welfare
P.O. Box 13716
Philadelphia, Pennsylvania 19101

Dear Mr. Crunk: Re: Audit Control Number 61706-03

The purpose of this letter is to advise you of the RESULTS OF OUR FOLLOW-UP AUDIT of GRANT NUMBER H-0380 issued to the UNITED PLANNING ORGANIZATION (UPO) for the program year ended June 30, 1973. Our review was performed to determine whether (1) recommended actions have been implemented or are in process and (2) such action has led or will lead to resolution of known problems.

The Department of Health, Education, and Welfare (HEW), Office of Human Development (OHD) awarded this grant to UPO for $4,199,296; this included $2,946,980 of Federal funds and $1,252,316 of non-Federal shared costs. The grant, effective from July 1, 1972 to June 30, 1973, provided for the establishment of a FULL YEAR HEAD START PROGRAM of full and part day sessions for the pre-school development of underprivileged children in the District of Columbia.

In order to accomplish the program objectives UPO contracted with four delegate agencies (Capital Head Start, Inc., the Anacostia and Model Schools Divisions of the District of Columbia, and National Capital Area Child Day Care Association, Inc.) to administer parts of the program. UPO was, however, responsible for performance of the grant's overall objectives.

On May 7 and 15, 1974, Peat, Marwick, Mitchell & Company, Certified Public Accountants (CPAs) issued financial and management audit reports for three of the four delegate agencies. A consolidated report titled "Financial Statements and Supplementary Data, September 30, 1973, with Accountants Report Thereon" was issued by the CPAs on May 24, 1974 (reference audit control number 56455-03). The consolidated report was based on the three previously issued reports and a report dated December 18, 1973, on the National Capital Area Child Day Care Association, Inc., that was prepared by S.S. Abensohn and Company, Certified Public Accountants.

Our follow-up audit was limited to an assessment of corrective action taken in response to the CPA report issued on May 24, 1974. This review was limited to an analysis of three delegate agencies (Capital Head Start, Inc., and Anacostia and Model Schools Divisions of the District of Columbia). In addition, we reviewed the management findings concerning UPO operations. Additional weaknesses in UPO operations are reported in audit report 61701-03. We excluded from our review the delegate reviewed by S.S. Abensohn and Company because no costs were questioned and the reported management findings were very minor. Our review was made in accordance with standards for governmental auditing, and accordingly included such tests of the accounting records as we deemed necessary.

The CPAs in their report questioned $27,936 of claimed Federal funds and $916,789 of non-Federal shared costs (See Appendix I). The questioned Federal funds were attributable to (1) time and attendance reports not signed or available, (2) lack of adequate documentation for non-labor costs, (3) invoices not paid within 90 days of end of grant and (4) excessive purchases near end of grant. Non-Federal costs were questioned because (1) contributions were recorded but not documented and (2) time and attendance reports were lacking. In addition to these financial adjustments, various management recommendations were made to UPO and the various delegate agencies.

Action Taken By UPO and OHD

UPO never submitted a response to OHD concerning the actions it planned to take to resolve the questioned costs and management findings. On January 17, 1975, OHD issued an audit clearance document for this grant. OHD took no position with regard to the specific findings and recommendations included in the CPA report. Instead, OHD stated in the audit clearance document:

> "This audit report is totally unacceptable and should not have gone into the system."

The OHD official who issued the audit clearance document stated that the audit report was unacceptable because the findings and recommendations did not correspond with the grant period. That is, the grant year ended June 30, 1973 but the CPA report covered the fiscal year ended September 30, 1973.

We do not agree that the CPA report was unacceptable. The approved budget and costs incurred and questioned included in the CPA report referred to the period July 1, 1972 to June 30, 1973. The grant period was clearly footnoted in the CPA report. Equally important is the fact that OHD overlooked the causes of the findings, which have nothing whatsoever to do with the confusion surrounding the grant year versus the fiscal year.

As a result of OHD's taking no action on the audit report, UPO reinstated all the costs questioned by the CPA firm; also the delegate agencies have not taken all the required actions to eliminate the management weaknesses that caused the matter to be initially reported by the CPA firm.

Conclusions and Recommendations

In our opinion, OHD needs to reassess its position on the CPA report and to instruct UPO accordingly. Furthermore, although we did not perform a detailed review of OHD's procedures for processing and following up on audit reports, the actions taken by OHD with regard to this CPA report indicate that an overall weakness may exist.

We therefore recommend that OHD:

(1) Reassess its position on the CPA report and instruct UPO accordingly. In addition to requiring refunds, OHD should ensure that UPO improve its procedures to prevent these findings from reoccurring.

(2) Review its own procedures with regard to processing and following-up on CPA reports. These procedures should

a. be in writing,

b. clearly delineate responsibility, and

c. provide for timely and thorough follow-up to ensure that recommendations are adhered to by the auditee.

Please advise us, within 60 days of the date of this report, of action taken or planned by your office concerning the matters discussed. To facilitate identification, please refer to the above audit control number in all correspondence relating to this report.

Sincerely yours,

G. A. Rafalko
Regional Audit Director

NOTICE

"This document is for internal HEW use."

SUMMARY OF QUESTIONED COSTS
BY TYPE OF DEFICIENCY AND DELEGATE AGENCY

DEFICIENCY REPORTED BY CPA	DELEGATE AGENCY			TOTAL
FEDERAL	CHS	DCA	DCM	
1. Time and Attendance Reports not Signed or Available	$1,167	$ 9,992	$ 1,851	$ 13,010
2. Invoices not Paid Within 90 Days.				
a) Consultants and Professional Services Costs	$2,479			
b) Travel	1,334			
c) Space and Rental Costs	130			
d) Consumable Supplies	1,536			
e) Lease and Purchase of Equipment	1,461			$ 6,940
3. Lack of Supporting Documentation				
a) Consultant and Professional Services Costs		$ 505		
b) Travel			$ 450	
c) Space and Rental Costs			4,174	
d) Consumable Supplies		2,375	50	$ 7,554
4. Excessive Purchases Near End of Grant	$ 432			$ 432
TOTALS	$8,539	$ 12,872	$ 6,525	$ 27,936
NON-FEDERAL				
1. Contributions Recorded but not Documented		$272,138	$564,645	$836,783
2. Time Reports not Available		25,887	54,119	80,006
TOTALS		$298,025	$618,764	$916,789

CHS - Capital Head Start, Inc.
DCA - Anacostia Division of the District of Columbia
DCM - Model Schools Division of the District of Columbia

APPENDIX 1

APPENDIX I

UNITED PLANNING ORGANIZATION
FOLLOW-UP AUDIT REVIEW
GRANT NUMBER H-0380

FOR THE PERIOD
JULY 1, 1972 TO JUNE 30, 1973

QUESTIONED COSTS REPORTED BY
PEAT, MARWICK, MITCHELL & COMPANY
FOR THE
DISTRICT OF COLUMBIA SCHOOLS DIVISIONS

TIME AND ATTENDANCE REPORTS

Statement of Condition and Recommendation

The CPAs questioned $91,849 of claimed costs because time and attendance reports were not prepared properly or were not available for review. Costs questioned consisted of the following elements:

	Schools Divisions		
	Anacostia	Model	Totals
Federal	$ 9,992	$ 1,851	$11,843
Non-Federal	25,887	54,119	80,006
	$35,879	$55,970	$91,849

Based on prior year recommendations made by the CPA firm, a sign-in and sign-out procedure was established to document Federal labor costs. However, this procedure was not consistently followed during the program year ended June 30, 1973. Accordingly, it was recommended that the project director ensure that this procedure be followed as part of the regular payroll routine.

UPO's Response

Even though this delegate has not responded to the CPA report, we were advised that UPO intends to reinstate these questioned costs.

Corrective Action Taken

No corrective action has been taken to have the time sheets signed by employees. We were advised that the delegate's operating procedures do not require the employee to sign the time and attendance reports; only supervisors are required to approve these reports. Employees are required to initial the time sheets for unproductive hours (e.g. sick, vacation, etc.).

Current Status of Condition

We selectively reviewed 25 time and attendance records from the Anacostia and Model Schools Divisions for the pay period ended January 15, 1976. Our review showed that (1) employees did not sign time reports and (2) supervisors do sign and approve these reports.

DOCUMENTATION FOR CLAIMED COSTS

Statement of Condition and Recommendation

The CPAs questioned $7,554 of claimed Federal funds because costs were not adequately documented, and $836,783 of recorded non-Federal contributions because data was not available to support the claimed amount. Costs questioned consisted of the following elements:

	Schools Divisions		
	Anacostia	Model	Totals
Federal	$ 2,880	$ 4,674	$ 7,554
Non-Federal	272,138	564,645	836,783
	$275,018	$569,319	$844,337

Even though the CPA report did not contain formal recommendations, we believe that the implied corrective action would include implementation of procedures to ensure that all claimed costs be adequately documented in the future.

UPO's Response

Even though this delegate has not yet responded to the CPA report, we were advised that UPO intends to reinstate these questioned costs.

Corrective Action Taken - Federal Funds

Consultants

The delegate could not provide adequate documentation to support the $505 of consultant and professional services costs which were questioned in the CPA report. We were advised that these charges consisted of (1) medical and dental examinations for pre-school children, and (2) training for teachers. Accordingly, we feel that corrective action has not yet been taken by the delegate.

Travel

We were advised that invoices and vouchers were maintained at the local school offices rather than at a central file location. As a result, the delegate could not provide the necessary documentation for $450 of travel charges when requested by the CPA firm. The delegate advised that the CPAs could have obtained the needed documentation if the CPA firm would have visited the various schools. In order to prevent this situation from occurring in subsequent years, the delegate now requires all supporting documentation to be maintained at its central office.

Space and Rent

The delegate now maintains adequate documentation to support claimed space and rental costs.

Consumable Supplies

The delegate was not able to provide invoices or source documentation which would be needed to adequately support claimed costs. Therefore, no corrective action has been taken in this area.

Corrective Action Taken - Non-Federal Share

Consultant and Other

We were advised that difficulties were experienced in allocating service costs to UPO projects. As a result, the delegate has not developed an expense apportionment schedule or documentation for the $13,550 of questioned costs. However, the delegate now requires documentation from the Department of Human Resources before such costs can be claimed as a non-Federal contribution.

Space

We were advised that $782,959 of space costs were questioned because the delegate applied estimated rental value instead of a standard market rate established by the Department of Buildings and Grounds. As a result, the excess claimed by the delegate over the rental amount was questioned by the CPA firm. Procedures have been established so that input from the Department of Buildings and Grounds will be used as a basis for claiming non-Federal contributions.

Consumable Supplies

The questioned consumable supplies of $40,274 were food items (lunches, etc.) furnished to pre-school children. The CPA firm took exception to this claimed non-Federal contribution because these food items were purchased with funds provided from the United States Department of Agriculture. Therefore, the delegate was applying Federal dollars to meet the 20 percent non-Federal contribution requirement. To prevent this condition from happening in future periods, the delegate has decided to eliminate the consumable supplies category from claimed non-Federal contributions.

Current Status of Conditions - Federal Funds

Consultants

We reviewed the claimed consultant and professional service costs of $11,440 for the year ended June 30, 1975. We were unable to obtain documentation for these costs. The delegate advised us that documentation was available to support the claimed costs; however, when asked to furnish this data, the delegate was unable to comply with our request. Accordingly, we feel that improvements in documentation are still needed to adequately support claimed consultant and professional service costs.

Travel

We reviewed travel vouchers claimed for the three month period ended January 1976. Our review showed that the travel vouchers were (1) maintained at one location and (2) supported by documentation. This review also showed that these reviewed invoices were not accompanied by signatures of authorized personnel who would approve the invoices for payment.

Space

We reviewed the claimed rental costs for the three month period ended January 1976. Invoices were obtained for these transactions and signatures authorizing payment were attached to these source documents.

Consumable Supplies

We reviewed the claimed supplies for the three month period ended January 1976. Our review showed that the amount charged to consumable supplies was not adequately supported by documentation. Invoices were not available to support the claimed supply (food) costs; only an office memorandum was filed listing the amounts to be charged to this project.

Current Status of Conditions - Non-Federal Share

Consultant and Other

We reviewed the consultant and professional service costs for the year ended June 30, 1975. Our review showed that the claimed costs of $10,023 were supported by a memo from the Department of Human Resources documenting the estimated "cost of school health services" to the pre-school program.

Space

We reviewed the space costs claimed for the year ended June 30, 1975. Our review showed that the claimed costs of $353,519 were supported by cost estimates furnished by the Department of Buildings and Grounds.

Consumable Supplies

We reviewed the claimed non-Federal contributions for the year ended June 30, 1975. This review showed that the delegate no longer claims consumable supplies as non-Federal contributions.

QUESTIONED COSTS REPORTED BY
PEAT, MARWICK, MITCHELL & COMPANY
FOR
CAPITAL HEAD START, INCORPORATED

TIME AND ATTENDANCE REPORTS

Statement of Condition and Recommendation

The CPAs questioned $1,167 of personnel costs because time and attendance reports were not prepared properly.

The CPA report noted that time and attendance reports were not always signed by the employee. It was recommended that internal controls be strengthened to ensure that all time and attendance reports are properly signed by the employee and approved by his supervisor.

UPO's Response

UPO accepted explanations furnished by this delegate and reinstated the questioned costs.

Corrective Action Taken

The delegate, by letter dated November 14, 1974, advised UPO that "Capital Head Start has instituted procedures to ensure that all time and attendance records are properly signed and approved by the appropriate supervisor. Each time sheet must now be signed by both the employee and his supervisor before a pay check is issued." A second letter, dated February 12, 1975, stated that "measures have been taken to insure that all Social Service Aides, who are generally in the field, sign their

time sheets before a check is issued. The questioned time sheets have been signed."

Current Status of Condition

We selectively reviewed time sheets for the pay period ended January 30, 1976. Based on our review of 23 submitted time sheets, 60 percent were not properly prepared. The review showed that (1) twelve time sheets were signed by the employee but not approved by the supervisor, (2) one was neither signed nor approved, and (3) another was approved but not signed. In our opinion, improvements are still needed in this area.

PAYMENT OF INVOICES WITHIN 90 DAYS

Statement of Condition and Recommendation

The CPA report questioned $6,940 because invoices were not paid within 90 days after the program year as noted in OHD's Financial Reporting Requirements. Even though the CPA report does not contain formal recommendations, we believe that the delegate should initiate procedures to pay invoices in a prompt manner.

UPO's Response

UPO accepted explanations furnished by this delegate and reinstated the questioned costs. The delegate, by letter dated February 12, 1975, advised that "invoices were not paid within 90 days because of lack of funds. Invoices will never be paid within 90 days as long as CHS does not promptly receive funds from UPO for prior periods." Even though these questioned costs were reinstated, UPO later disallowed $5,462 of these charges because this delegate would then have exceeded the maximum dollar amount stipulated in its cost-reimbursement agreement. Accordingly, there was no reduction to the Federal funds expended for this project as a result of "disallowing" the overrun costs.

Corrective Action Taken

Based on the delegate's response, no corrective action has been taken to ensure that invoices are paid within 90 days from the end of program year.

Current Status of Condition

We selectively reviewed 27 percent of accounts payable dollars for the last complete program year. This sample review included a timing comparison between date of purchase and date of payment for $17,410 of accounts payable as of June 30, 1975. Our review showed that 63 percent of the accounts payable dollars were not liquidated within a 90 day period. Accordingly, the condition reported by the CPA firm still exists at this delegate.

EXCESSIVE PURCHASES NEAR END OF GRANT

Statement of Condition and Recommendation

The CPA report questioned $432 of consumable supplies because these charges were considered as excessive purchases made near the end of the program period. It was recommended that purchases of supplies be controlled in a manner to avoid significant purchases close to the end of the grant period.

UPO's Response

UPO accepted explanations furnished by this delegate and reinstated the questioned costs. The delegate, by letter dated November 14, 1974, advised that "supplies were purchased at the end of the contract year out of necessity. It was impossible to stock up on classroom and office supplies during the year because of the limited funds available. All lapsed money was to be reprogrammed into the Classroom Renovation category so as to bring centers into compliance with health regulations". A second letter, dated February 12, 1975, stated that "supplies were purchased at the end of the contract year out of necessity, not to merely spend funds."

Corrective Action Taken

Based on the delegate's response, no corrective action has been taken to eliminate excessive purchases near the end of the grant year.

Current Status of Condition

We prepared monthly comparisons of supplies purchased for the last complete program year. Average monthly purchases for office, custodial and classroom supplies were $874 for the first eleven months of the program year, but were $2,592 for June 1975, which is the last month of the grant period. We expanded this analysis to include all purchases. Our expanded review showed that average monthly purchases for the first eleven months were $9,374, but were $37,314 for June 1975. Because of our limited audit scope, we were not able to determine the causes for this significant increase in purchasing activity during the last month of the grant period. The review did show, however, that a $11,450 food purchase in June was a contributing factor.

APPENDIX II

MANAGEMENT FINDINGS REPORTED BY
PEAT, MARWICK, MITCHELL & COMPANY
FOR THE
DISTRICT OF COLUMBIA

FINANCIAL RESPONSIBILITY

Statement of Condition and Recommendation

There were no defined lines of financial responsibility for the project. In addition, the financial reporting and administration was performed by individuals with limited financial background. These adverse conditions resulted in (1) cost reports that were not reconciled to the general ledger and (2) reported expenditures that were not supported by proper documentation. It was recommended that a specific individual in the finance division be assigned the financial responsibility for future projects. Furthermore, this individual should insure that proper documentation standards be applied for claimed costs.

UPO's Response

UPO has made no formal response to OHD concerning this condition. However, UPO has an internal audit staff which maintains a close rapport with the various delegates. Even though formal positions are not necessarily established by UPO for all management findings, this internal audit group works with the delegate to correct the various deficiencies contained in the CPA report.

Corrective Action Taken

One individual from the finance department of the District's Public Schools has been assigned financial responsibility for the Anacostia project; another person for the Model Schools program.

Current Status of Condition

Financial responsibility has been established in accordance with the CPA's recommendation.

BUDGET REVISIONS

Statement of Condition and Recommendation

Budget revisions for travel (Anacostia) and space (Model Schools) costs were not approved by UPO. It was recommended that budget revisions be submitted to UPO for approval prior to incurring obligations in excess of the stipulated budget cost categories.

UPO's Response

Refer to "UPO's Response" under "FINANCIAL RESPONSIBILITY" for this delegate.

Corrective Action Taken

No corrective action has been taken by the delegate.

Current Status of Condition

The delegate is not given budgetary data until well into the fiscal year. As a result, expenditures are incurred in various cost categories without knowing what the formal budget has established for each element of cost. UPO, however, feels that there is no real deficiency because budgetary line items of costs can be realigned during the year to eliminate over-expenditures of various budgeted cost categories.

EXHIBIT II

MANAGEMENT FINDINGS REPORTED BY
PEAT, MARWICK, MITCHELL & COMPANY
FOR
CAPITAL HEAD START, INCORPORATED

BUDGETARY CONTROLS

Statement of Condition and Recommendation

Bugetary controls were not maintained in a manner which would preclude the incurring of expenditures in excess of the approved budget. Appropriate budgetary controls should be adopted and followed in order to ensure that expenditures do not exceed budget limitations.

UPO's Response

UPO has made no formal response to OHD concerning this condition. However, UPO has an internal audit staff which maintains a close rapport with the various delegates. Even though formal positions are not necessarily established by UPO for all management findings, this internal audit group works with the delegate to correct the various deficiencies contained in the CPA report.

Corrective Action Taken

The delegate employed the use of budgetary control procedures furnished by UPO. By means of a budget request form, the delegate must know the expenditures for each cost category on a monthly basis.

Current Status of Condition

As a result of the present use of this budget control system, no expenditure above the budgeted amount will be made without knowledge of the delegate's director.

AUDIT OF FEDERAL ADMINISTRATION
OF
SUPPLEMENTAL SECURITY INCOME PAYMENTS
BY THE
SOCIAL SECURITY ADMINISTRATION

WASHINGTON, D. C.
FOR THE PERIOD JANUARY 1, 1974 THROUGH JUNE 30, 1974

AUDIT CONTROL NUMBER 03-62300

ABBREVIATIONS

SSI	--	Supplemental Security Income
HEW	--	Department of Health, Education and Welfare
SSA	--	Social Security Administration
DO	--	District Office
SCPM	--	State Conversion Procedures Manual

The designation of financial and/or management practices as questionable as well as other conclusions and recommendations in this report, represents the findings and opinions of the HEW Audit Agency.

HEW Audit Agency
Philadelphia Regional Office
April 1976

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
REGION III
3535 MARKET STREET
PHILADELPHIA, PENNSYLVANIA 19101

APR 26 1976

Mr. Joseph P. Yeldell, Director
Department of Human Resources
1350 E Street N. W.
Washington, D. C. 20004

Dear Mr. Yeldell: Re: Audit Control Number 03-62300

Enclosed for your information and use is a copy of an HEW Audit Agency report titled "Audit of Federal Administration of Supplemental Security Income Payments, Washington D. C. for the period January 1, 1974 through June 30, 1974." We are recommending that Washington, D. C. and the Secretary of Health, Education and Welfare use our audit results to negotiate settlement of liability for the six-month period ending June 30, 1974.

In accordance with the principles of the Freedom of Information Act (Public Law 90-23), this report will be made available, if requested, to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act, which the Department chooses to exercise. (See Section 5.71 of the Department's Public Information Regulation, dated August 1974, as revised).

To facilitate identification, please refer to the above audit control number in all correspondence relating to this report.

Sincerely yours,

G. A. Rafalko
Regional Audit Director
HEW Audit Agency - Region III

INTRODUCTION

Background

The Supplemental Security Income (SSI) program was established by provisions of Title XVI of the Social Security Act as amended by Section 301 of Public Law 92-603 enacted October 30, 1972. Title XVI of the Act was further amended by Public Laws 93-66, 93-233, 93-256 and 93-335. As of January 1974 the formal financial assistance programs contained in titles I, X, XIV, and XVI were repealed and replaced by the new Title XVI SSI program. The basic purpose underlying the SSI program is to establish a national and uniform set of eligibility and payment standards to replace the various State standards and payments which existed prior to January 1974. The states, to the extent they elect to supplement the basic Federal payment to meet specifically defined needs (optional supplementation) and to the extent they are required under Public Law 93-66 to maintain the December 1973 income level of converted recipients, share in the costs of the program.

The provisions of the Act made it possible for states to choose to administer the program themselves or to have it administered by the Federal Government. For those states, including Washington, D. C., who elected Federal administration, the Department of Health, Education and Welfare (HEW) administers the program through the Social Security Administration (SSA). Prior to making the first payment in January 1974, SSA received information from all states regarding individuals eligible for state payments under the former titles I, X, XIV, and XVI of the Act. Initial SSI payments to these "converted" individuals were based on this information. SSA District Offices (DO) were given responsibility for accepting new applications and obtaining updated information on converted cases.

Federal SSI payments provide a basic level of income throughout the nation. States are required to provide mandatory minimum state supplementary payments to aged, blind or disabled recipients who received state assistance under these categories in December 1973 and whose December 1973 income as defined in section 212 of Public Law 93-66 exceeded the January 1974 Federal benefit plus other income. In addition, each state may choose to provide as an optional payment more than the Federal supplemental security income and/or mandatory minimum state supplementary payment to whatever extent it finds appropriate.

The District of Columbia granted an optional supplement to all SSI recipients who were residing in an approved foster care home. The optional supplement consisted of $30.00 per month and was included as a part of the regular SSI check to the recipient.

The District of Columbia Department of Human Resources (State Agency) entered into an agreement with the Secretary of Health, Education, and Welfare which provided for Federal administration of the optional and mandatory minimum supplemental payment portion of the program by SSA. The State is billed monthly for its share of SSI payments. The Form SSA-8700 (Financial Accountability Statement) reflects both monthly and year-to-date program costs. For the six months ended June 30, 1974, the first contract period subject to audit, the total cost of the SSI program, as shown on the Form SSA-8700, was $10,462,258. The Federal and State shares were shown as $9,680,089 and $782,169 respectively.

Under the terms of the agreement each state has the right to audit the Federal Government's administration of State funds. At the completion of the audit a settlement of the Federal/State liability will be undertaken by the Secretary and the State. Because of the potential impact on SSA

operations and duplication of audit effort that would result if each of the states exercised their right to audit, SSA requested that the HEW Audit Agency conduct a single audit for Federal/State settlement purposes. An audit surveillance committee comprised of State auditors was established to work with the Audit Agency in the development and implementation of the audit program.

Scope of Audit

Our audit of the Federal administration of SSI payments was made in accordance with standards for governmental auditing. The purpose of the audit was to determine whether basic Federal payments and State supplementary payments made during the first contract period (January 1 - June 30, 1974) were correct and whether the liability for such payments was accurately divided between the District of Columbia and the Federal Government. Payment computation was made for 300 statistically selected sample cases, of which 281 were conversions from the State Welfare system. This computation necessitated a review of the case files maintained at either the State Welfare offices and/or SSA District or Branch Offices. In a limited number of cases, individual recipients were contacted directly by letter or telephone.

Our sampling plan was established at a national level and implemented in Washington, D. C. in accordance with all centrally established guidelines. Our audit included a review of a statistical sample of SSI payment records between January 1, 1974 and June 30, 1974. The universe from which the sample was selected included all recipients who had an SSI record established on SSA's computer files as of May 22, 1974. The universe did not include: (1) recipients who received an initial payment between June 2, 1974 and June 30, 1974, (2) recipients who received one-time payments and for whom an SSI record was not created as of May 22, 1974, and (3) recipients who moved from Washington D. C. to a non-Federally administered State prior to May 22, 1974. We did not perform separate samples of payments made to these three groups of SSI recipients. We applied the results of our audit of the sample of SSI records that existed as of May 22, 1974 to the three unaudited categories of payments to estimate the total amount of Federal/State payments that should have been made.

Cases where the initial SSI payment was made after June 1, 1974 are referred to in this report as unaudited data. The total value of these payments, while a small part of the total payments, represents a correct part of the total liability for the period. In order to include this data in the liability estimates, mathematical relationships between the statistical portion of the liability and the value of the universe were applied to arrive at an estimate of the actual liability for the unaudited data.

HIGHLIGHTS OF AUDIT RESULTS

While SSA was able to meet its statutory target date for making initial SSI payments, many errors were made in the payment amount. "Error", as used in this context, does not include incorrect payments that were made and subsequently corrected within the six month period of audit. However, it does include those payment errors that existed during that period even though they may have been corrected subsequent to June 30, 1974. The total reported Federal and State disbursements made during the audit period were $9,680,089 and $782,169, respectively. We estimate that Federal and State disbursements for the period should have been $9,053,508 and $372,510, respectively or $626,581 and $409,659 less than reported. Estimates of Federal and State disbursements that

should have been made are based on our recomputation of all sample cases. We calculated the sample mean and the sample standard deviation and then projected these to the universe of 15,179 cases. The projection of audit adjustments as they affect reported payments are shown in Exhibit II and supporting schedule.

Of the 300 cases sampled, 119 (40 percent) had an error in the SSI payment amount. In total, 150 cases (50 percent) had either an error in the payment amount or in the accounting for Federal and State amounts within the overall payment. SSA, in commenting on our report, expressed concern over the use of case error percentage rates. It should be recognized that percentages expressed in this report pertain to the audit sample and are not comparable with percentage rates developed by other review procedures. This is particularly true with regard to rates reported under SSA's Quality Assurance program. Quality assurance reviews cover periods of time subsequent to the audit period and it is unlikely that conditions would remain unchanged from one period to the next. More important, however, is the basic difference in the universe from which the sample units were selected for review. For audit purposes, a sample of payment records was selected from the total number of cases in payment status for one month or more during the sample period. These payment records or cases and transactions affecting them over the six month period of time from January - June 1974, were reviewed. Under quality assurance procedures, the sample for review is selected in monthly increments from the cumulative total of payments (payment transactions) occurring in any six month sample period. Because of the differences in approach, and particularly the difference in the denominator for calculating percentage of error, the same number of errors would be expressed as markedly different error rates if the audit, or alternatively, the quality assurance procedure is followed.

Our audit adjustments are summarized below and discussed in greater detail in the Results of Audit section of this report.

...Incorrect December 1973 State Welfare grant. State welfare workers failed to accurately compute the welfare grant in accordance with the State Plan in 35 cases. The projected effect is $154,215 of overpayments to recipients.

...Allocation of payments between Federal and State funds. Adjustments were needed in sample cases when the SSI system corrected recipient payment errors for previous months, but did not properly adjust the amount of Federal/State funds involved. The projected effect of these adjustments was to record an overstatement of State supplementation and an understatement of Federal benefits.

...Ineligibile for conversion. State welfare workers did not report recipient status changes which occurred after submission of the initial conversion data and prior to December 31, 1973. Status changes in 8 of our cases resulted in the individual being ineligible for SSI. The projected effect is $126,310 in overpayments to recipients.

...Untimely Corrective Action. SSA did not always act timely in making corrections submitted by the State Agency that had a bearing on a recipient's SSI payment. There were 28 cases in our sample where SSA did not act timely. The projected effect is $62,245 in overpayments to recipients.

...Incorrect income. SSA did not always identify through its SSA/SSI interface system the correct Title II amounts being

received by recipients in our sample cases. The projected effect of this error is an overpayment of $426,128 to SSI recipients. In an additional 2 of our sample cases, the State Agency did not report the proper amount of recipient income even though this information was available in the case files. The projected effect of the 2 errors is an overpayment of $2,019 to SSI recipients.

...Living Arrangements. There were 20 cases in our sample which included some type of error in living arrangements. In our opinion, SSA caused errors in six cases as a result of (1) conflict between the conversion manual and Federal regulations and (2) not considering information provided by the State Agency. The projected effect of the six errors is an overpayment of $74,468 to SSI recipients. The 14 cases involving State Agency errors dealt primarily with the State reporting erroneous data and not providing needed data per the conversion data record. The projected effect of the 14 errors is an overpayment of $72,027.

...Missing cases. SSA could not locate two case files of recipients who entered into the SSI program after January 1, 1974. Although we attempted to contact these recipients, we did not get sufficient information to determine their eligibility. These cases have been referred to SSA for further action; but for projection purposes, we considered these recipients to be ineligible for SSI. The projected effect of this condition is an overpayment of $41,793 to recipients.

...Unexplained errors. In 16 of our sample cases, there were errors where we could not determine a cause. Examples of these errors are one-time payments and changed payment amounts. We found no indication that these errors were attributable to the State Agency. The projected effect of these errors is an overpayment of $123,166 to recipients.

...Other errors. In 33 of our sample cases, there were various errors which were infrequent in number and of relatively minor dollar value. In one case, SSA did not terminate a recipient who died in January 1974. In two other cases, SSA incorrectly applied a $20 monthly exclusion to a recipient's VA pension. The projected effect of these errors is an underpayment of $32,230 to recipients.

SSA did not agree with our use of the terms "Federal liability" and "State liability" in the report narrative and on EXHIBIT II. As shown in our scope statement, our audit was to determine whether the correct payment was made and whether the liability for payment was accurately divided. Where SSA made a payment, Federal and State liability existed for that disbursement, right or wrong. On EXHIBIT II and in the report narrative, we are showing what SSA said the Federal/State liability was for disbursements made and, if the errors had not been made that resulted in our adjustments, what SSA should have shown as the disbursement liability. We are not establishing final fiscal liability. This will be arrived at through negotiations. To assist SSA and the State in reaching a final decision on the extent of liability each party will accept for the payments made, we are indicating what, in our opinion, causes an error in payment or an inaccurate allocation of payments.

The results of our audit should be used to negotiate the amount of the Federal and State liability for the first six months of the SSI program. Recommendations pertaining to SSA's current operating procedures are contained in separate audit reports on SSA District Office and Central Office operating procedures.

RESULTS OF AUDIT

AUDIT ADJUSTMENT TO SSA STATEMENT OF LIABILITY

Since the point estimates for the correct State and Federal payments were considerably under the amounts billed by SSA for the SSI program, we segregated the reasons for errors and/or incorrect allocations into nine major catagories and grouped them by: (1) who caused the error, and (2) which liability (State of Federal) was affected. The overall results are outlined in Exhibit II. Each case reviewed was screened against all Federal regulations and guidelines relating to the SSI conversion process and amount of payment.

Incorrect December Grant

The State Agency did not always provide SSA with the proper dollar amount of the State welfare grant allowable under the State plan effective in December 1973. This amount is very important in determining the amount of the SSI payment to the recipient. In 35 of our cases, an erroneous December 1973 State grant amount was used in computing the SSI benefit. As a result, the mandatory State supplement was incorrect in these cases. Based on our sample, we estimate that $154,215 of State funds were overpaid to Washington, D. C. SSI recipients.

In 26 of the 35 cases, the December grant was incorrect because the State Agency failed to change the State grant amount after being notified by SSA prior to December 1973 that the recipient was receiving SSA Title II benefits. The errors in the other 9 cases involved the State: (1) reporting erroneous data and not providing the needed data per the Conversion Data record, (2) failing to report status changes, or (3) not being aware of SSA Title II benefits and not considering them in computing the state welfare grant.

The projected effect of all errors is:

Overpaid Federal Benefits	$ -0-
Overpaid State Supplementation	154,215
Overpayment to Recipients	$154,215

SSA Systems Limitations

The amount of certain SSI benefit payments was incorrectly allocated between the Federal and State government even though the recipient received the correct payment. The misallocation occurred when the system corrected payment errors for previous months but the Federal/State share of the payment was not properly adjusted. These incorrect allocations were due to (1) the lack of sufficient time to incorporate changes in the payment system necessary to reflect increased benefits payable effective January 1, 1974, as authorized by leigslation enacted in December 1973, and (2) the erroneous coding of living arrangements for some converted welfare recipients. SSA advised us that the misallocations

were corrected through a separate "Post Entitlement Adjustments" entry on the SSA-8700 report. However, because we were unable to identify these adjustments on a case-by-case basis, we made an audit adjustment to eliminate their "Post Entitlement Adjustments" entry in total. Based on the occurrence of the adjustments in our sample - 96 cases - we statistically projected the effect of the adjustment as follows:

Underpaid Federal Benefits	$(43,354)
Overpaid State Supplementation	43,016
Underpaid to Recipients	$(338)

Ineligible for Conversion

The State Agency converted 7 of our sample cases to the SSI program although the individuals were not eligible to receive SSI benefits. These errors resulted because the State Agency did not report individual status changes that occurred after the initial conversion data was submitted to SSA and prior to the start of the SSI program. In addition, the error in 1 case of our sample was caused by SSA because they failed to consider the status change submitted by the State. We estimate that recipients received $126,310 in overpayments.

In accordance with SSA's plans for converting eligible welfare recipients into the SSI program by January 1, 1974, Washington, D. C. began supplying SSA with data on welfare recipients in July 1973. Among other things, the data showed recipient income, State grant, living arrangements and marital status. Based on the information and on social security files SSA prepared a Conversion Data record for each welfare recipient. To update these records and reflect changes in a recipient's status prior to the effective date of SSI on January 1, 1974, SSA developed the Status Change Request (SCR) form. These forms were to be prepared by the States and submitted to SSA whenever changes in recipient status required a correction to previously reported information.

Our review showed that overpayments occurred in 7 of our sample cases because the State Agency did not report the required change or did not report it in a timely manner. For example, one recipient's State grant payment was discontinued effective December 1, 1973, because the State Agency was unable to locate this recipient. The State Agency failed to notify SSA of the status change. As a result, SSI payments continued throughout the 6 months of our review. In this case, as well as the other 6 sample cases, we found no evidence in the case files or elsewhere within the State Agency that the revised information was reported to SSA. The one case involving a Federal error resulted because SSA did not notify the State Agency of Title II benefits received beginning in November 1973.

The projected effect of the errors in these 7 cases is:

Overpaid Federal Benefits	$84,264
Overpaid State Supplementation	13,712
Overpaid to Recipients	$97,976

The projected effect of the one Federal error is:

Overpaid Federal Benefits	$28,334
Overpaid State Supplementation	-0-
Overpaid to Recipients	$28,334

The projected effect of all 8 errors is:

Overpaid Federal Benefits	$112,598
Overpaid State Supplementation	13,712
Overpaid to Recipients	$126,310

Untimely Corrective Action

SSA did not always act timely in making corrections submitted by the State Agency that had a bearing on a recipient's SSI payment. We noted 28 cases in our sample where SSA did not act timely on information submitted by the State Agency. For the most part these 28 cases involved the situation where the State Agency submitted necessary changes to SSA timely via Form SSA 2670 yet SSA did not effect the change for at least two months after submission by the State Agency.

The projected effect of the errors in the 28 cases is:

Overpaid Federal Benefits	$ 627
Overpaid State Supplementation	61,618
Overpayments to Recipients	$62,245

Incorrect Income

An important consideration for determining the correct SSI payment due an eligible recipient is the income of the recipient - both earned and unearned. The correct income of the recipient was not considered in 33 of our sample cases. We estimate that errors relating to income resulted in a total overpayment of $428,147 to Washington, D. C. SSI recipients.

In 32 of our sample cases, SSA did not consider the proper income of the recipients. Generally this occurred because SSA did not always identify through its SSA/SSI interface system the correct Title II amounts being received by the recipients.

The projected effect of the errors in the 32 cases is:

Overpaid Federal Benefits	$453,476
Underpaid State Supplementation	(27,348)
Overpayment to Recipients	$426,128

In 2 of our sample cases, the State Agency did not report the proper amount of recipient income even though the proper amount was available in the case files. For example, one individual was receiving $28.00 per month unearned income and this amount was considered in computing the State grant. However, the State Agency failed to report this amount to SSA.

The projected effect of the 2 errors is as follows:

Overpaid Federal Benefits	$2,019
Overpaid State Supplementation	-0-
Overpayment to Recipients	$2,019

The projected effect of the errors in all 33 cases in our sample which related to incorrect income is:

Overpaid Federal Benefits	$455,495
Underpaid State Supplementation	(27,348)
Overpayment to Recipients	$428,147

Living Arrangements

One of the categories of errors having the largest dollar impact on SSI payments involved the living conditions of the recipient. There were 20 cases in our sample where the living arrangements of the recipients were not correctly entered into the SSI system. In our opinion, SSA caused errors involved in 6 of the cases and the State Agency caused the errors in the remaining 14 cases. Based on our sample, we project that recipients received $146,495 in overpayments.

Section 1612(a)(2)(A) of Public Law 92-603, dated October 30, 1972, provides that when any eligible individual (or eligible couple) is living in another person's household and receiving support and maintenance in kind from such person, the standard SSI payment amount is reduced by one-third. A one-third reduction is made in lieu of including the value of the support and maintenance furnished in kind as unearned income of the recipient(s).

Interim Regulation No. 16, Subpart K, 416.1125, published on October 3, 1973, stated in addition:

> ...Such one-third reduction will apply regardless of whether the individual (or eligible individual and eligible spouse) is making any payment for support and maintenance (room and board) to the person in whose household he is living... Such one-third reduction in the payment standard will not apply where only support or maintenance (i.e., room or board) is furnished in kind; both support and maintenance must be furnished for such reduction to apply. Where only support or maintenance is furnished in kind, the value of such support or maintenance will be included as unearned income...

The SSI Handbook further interpreted the one-third reduction provisions in Sections 6071 and 6073 dated November 1973 as follows:

> ...If the claimant does not live in an institution or in a care situation as outlined in SSIH 6069-6070 he will be in a household. If the only other members of the household are related persons whose income is deemed to him (spouse, parents of an individual under age 21) or if the other person is his eligible spouse there will be no reduction in the SPA.
>
> In all other circumstances where the claimant lives with one or more other persons in a household, it will be assumed in the absence of evidence to the contrary, that he is in the household of another, subject to the one-third reduction. This assumption may be overcome where the claimant provides evidence which established that:
>
> (1) he is head (or one of the heads) of the household, or
>
> (2) he has a substantial fiscal interest in the operation of the household, or

(3) he participates in a sharing arrangement with one or more other persons.

A. HEAD OF HOUSEHOLD ---When the claimant has an ownership in the property being used as a residence, or he is the person who made arrangements for the living quarters and is the one to whom the landlord looked for payment of rent, he is considered to be "head" of the household and is not residing in the household of another. Ownership or responsibility for rent payments may be individual or held jointly with others...

B. FISCAL INTEREST IN THE HOUSEHOLD. -- An individual must not only be living in another's household for the one-third reduction to apply, he must also be receiving support and maintenance from the householder. An allegation that the claimant is paying a fixed amount for board and room, if supported by factual evidence, will prevent a one-third reduction if the evidence established that the amount the claimant is paying is approximately equal to what similar accomodations would cost if he rented a room or apartment and had to supply his own meals.

C. SHARING ARRANGEMENT -- If the claimant alleges that he lives with another or other persons and is not head of the household, but shares household expenses, request that he submit evidence of the sharing such as bills and receipts. In order for the one-third reduction to not apply this evidence must establish that the amount he contributes is at least equal to the amount(s) provided by others in the household...

When the one-third reduction does not apply, the value of anything a claimant receives as support must be determined. Where a determination cannot be readily made based on per capita or proportionate expenses because of inadequate or conflicting information, or the claimant is making no payments or clearly inadequate payments for food and lodgings, use the chart below to determine the value of support received.

	Individual	Couple
Shelter	$20	$30
or		
Shelter plus one or all utilities	$37	$55
or		
Shelter plus utilities plus some or all furnishings	$43	$64
Meals (3 a day)	$30	$60

(The above amounts are prorated if less than a full month is involved or if less than 3 meals a day are supplied. If meals and shelter are provided the applicable amounts are added together).

The State converted most of its recipients as "Head of Household". The State based its position on SSA's State Conversion Procedures Manual.

Essentially, the conflict between the Regulations and the SSA State Conversion Procedures Manual (SCPM) involves the circumstances under which the living arrangement miscodings were made. The Regulations state that a recipient living in another's household regardless of any payment for room and board is subject to a one-third reduction. The SCPM states that if the State budgets the recipient for rent, rent and utilities, room and board, or rent and other household expenses, the one-third reduction does not apply.

In five of the six cases involving SSA errors, the State Agency converted recipients to the SSI system as heads of their households in accordance with the Conversion Procedures Manual thus causing the recipients to receive full SSI benefits. However, according to our interpretation of Public Law 92-603 Section 1612(a)(2)(A), and the subsequent Federal Regulations these recipients should have received a one-third reduction in SSI benefits because they were living in the household of another person and were not paying at least a proportionate share of total household expenses. The remaining case involving SSA error was caused by SSA not entering information provided by the State Agency.

The projected effect of the 6 errors is:

Overpaid Federal Benefits	$84,990
Underpaid State Supplementation	(10,522)
Overpaid to Recipients	$74,468

The 14 cases involving State Agency errors dealt primarily with the State reporting erroneous data and not providing needed data per the Conversion Data record. For example, one recipient resided with his mother and received free room and board. The recipient should have been converted as living in the household of another, and the one-third reduction in the payment standard should have been applied. Instead, the State Agency converted the recipient as "Head of Household" and the recipient received the full SSI benefit during the 6 months of our review.

The projected effect of the errors in the 14 cases is:

Underpaid Federal Benefits	$(35,940)
Overpaid State Supplementation	107,967
Overpaid to Recipients	$ 72,027

The projected effect of all 20 errors related to living conditions is:

Overpaid Federal Benerfits	$ 49,050
Overpaid State Supplementation	97,445
Overpaid to Recipients	$146,495

Missing Cases

SSA was not able to locate two case files for recipients in our sample. We attempted to contact the recipients to obtain information necessary to make a determination of their eligibility. For various reasons, we could not obtain the needed data. Since the case files could not be located and because we could not obtain satisfactory information by other means, we considered for projection purposes, that these recipients were not entitled to any benefits.

These two cases have been referred to the Regional Commissioner, SSA for further action. The projected effect of these errors is:

Overpaid Federal Benefits	$ 41,793
Overpaid State Supplementation	-0-
Overpayment to Recipients	$ 41,793

Unexplained

In 16 of our sample cases, SSA made one-time payments, changed payment amounts, withheld payments and deleted recipients for reasons that we could not determine during our review of files at the State Agency and the SSA District Office. Although we do not know the cause for these errors, we found no indication that they were attributable to the State Agency.

The projected effect of these errors is:

Overpaid Federal Benefits	$ 65,285
Overpaid State Supplementation	57,881
Overpayment to Recipients	$123,166

Other Errors

In 33 of our sample cases, there were various errors which were infrequent in occurrence and of relatively minor dollar value. For example, in one case, SSA did not terminate a recipient who died in January 1974. In two other cases, SSA incorrectly applied a $20 monthly exclusion to a recipient's VA pension.

The projected effect of these errors is:

Underpaid Federal Benefits	$(48,213)
Overpaid State Supplementation	15,983
Underpayment to Recipients	$(32,230)

Conclusions and Recommendations

State supplementation and Federal benefits for the six month period January 1, 1974 through June 30, 1974 were overpaid based on a statistical projection of 300 cases over a universe of 15,179. There were many causes for the overpayments, the major ones dealing with incorrect income, incorrect December 1973 State Welfare grants, and problems with living arrangements. We estimate the correct State supplementation for the period to be $372,510. Since the causes for overpayments rested with both the State Agency and SSA, we recommend that this report be used as a basis for negotiation of a final settlement of the liabilities for the period under review.

OTHER MATTERS

Correction of Payment Errors

Examination of updated payment records, dated March 19, 1975, for the 119 cases which contained payment errors, disclosed that correct payments were being made in 8, or 6.7 percent, of the cases. In the remaining 111 cases, payment errors involving overpayments and underpayments continued to exist.

Evaluation of Conversion Process

Our evaluation of the conversion process disclosed deficiencies at both the Federal and State level. State Agency operations resulted in the conversion of erroneous data and in erroneous payment. Problems at the State Agency level were further compounded by untimely and incomplete action at the Federal level. SSA did not always provide the instruction necessary for making a proper conversion. For instance, regulations surrounding the implementation of living arrangements requirements were not clearly interpreted to the State Agency thus resulting in numerous errors in payments to recipients because of miscoding and improper interpretations of the recipients' living arrangements. (Matters pertaining to SSA District and Central Office operation will be presented in separate reports to the responsible officials.)

Explanation of Unlocated Difference in Audit Adjustments on Exhibit II

In comparing the HEW Audit Agency projected estimate of payment liability to that reported by SSA on the Financial Accountability Statement (Form SSA-8700) an "unlocated difference" has resulted. For Washington, D. C. this difference amounts to an underpayment of $44,306 in Federal funds and an overpayment of $11,446 of State funds. This is less than 1 percent of the total payment liability reported on the Form SSA-8700. In the 31 Federally administered States we found that the amount of the unlocated difference ranged from 1 to 6 percent of the total reported payment.

The cause of this difference is basically due to the source of the two compared totals. The HEW Audit Agency figure is based on a projection of what should have been paid to a recipient for the entire six month audit period. In developing the payment, all data found about the recipient (whether it be in central office of district office or State office records) was considered.

Conversely, the Form SSA-8700 total was developed basically by processing an accounting subsystem against the master Supplemental Security Record. To this figure payment data such as refunds, one-time payments and emergency advance payments have been applied. Program and/or systems problems, however, have resulted in these figures being incomplete or inaccurate. The technical problems encountered by SSA in developing the liability figures will not be discussed in this report but will be explained in our report on the SSA Central Office operations.

EXHIBIT I

STATEMENT OF FEDERAL/STATE LIABILITY
WASHINGTON D.C.

FOR THE PERIOD
JANUARY 1, 1974 TO JUNE 30, 1974

		Value of Universe	No. of Occur. b/ In Sample	Standard c/ Deviation	Total Liability Point Est. For Population d/ Federal	State
AUDITED DATA						
Cases Sampled a/	- Federal	$9,591,906	281	322.68	$8,850,330	
	- State	823,455	69	60.54		$370,650
UNAUDITED DATA Note 1						
Value of Initial Claims Note 1 not Sampled	- Federal	169,383			156,288	
	- State	1,587				714
Value of One Time Note 2 Payments	- Federal	48,916			45,134	
	- State	2,218				998
Value of Payment to Recipients Relocated to a Non-Federally Administered State Note 3	- Federal	1,903			1,756	
	- State	328				148
TOTAL POINT ESTIMATE FOR POPULATION					$9,053,508	$372,510

a/ Review of 300 cases from a total population of 15,179 cases.

b/ This is the difference between the total sampling units reviewed (300 cases) and the number of sampling units having a zero value.

c/ A measure of dispersion of the sample values.

d/ Computed by multiplying the population of 15,179 by the arithmetic mean for the sample unit except for recipients relocated to another Federally administered State and unaudited data.

SAMPLING PRECISION

For the cases sampled the lower and upper dollar limits (at the 95 percent confidence level) are as follows: Federal $3,299,310 and $9,401,347 respectively; State $267,264 and $474,036 respectively.

Note 1 - The total liability for unaudited data is a mathematical estimate of payments that we estimate should have been paid these cases using the percent relationship between the point estimate and the total universe of cases sampled. (Federal - $8,850,330 ÷ $9,591,906 = 92.2687%; State - $370,650 ÷ $823,455 = 45.0116%).

The total point estimate of our projection (total liability of cases sampled under "Audited Data") of SSI payments is that amount which we estimate should have been paid for the period January 1, 1974 through June 30, 1974. Our sample was selected from the SSI master file dated May 22, 1974. On this date, all SSI payments had been recorded up to and including the regular monthly payment of June 1, 1974. Payments made between June 2, 1974 and June 30, 1974, were not included in our universe. We subsequently identified the second strata of payments from the SSI Master file dated December 15, 1974, and determined that it represented about 5 percent of the total universe nationally of SSI payments. We believe that these cases would have the same relative Federal/State payment laibilities as the cases sampled.

Note 2 - This amount represents one time payments to those recipients whose records were not included in our sample because: (1) the recipients received only one-time payments or (2) a supplemental security record had yet to be established for the recipients.

Note 3 - This item related to payments made to recipients that relocated out of Washington, D. C. before May 22, 1974 to a non-Federally administered State. These cases did not have a chance of being selected in the sample drawn from Washington, D. C. on May 22, 1974 but are proper payments allocable to the State.

EXHIBIT II

AUDIT RECONCILIATION TO SSA STATEMENT OF LIABILITY
WASHINGTON D.C.
FOR THE PERIOD
JANUARY 1, 1974 THROUGH JUNE 30, 1974

	FEDERAL LIABILITY EFFECT OF AUDIT ADJUSTMENTS				STATE LIABILITY EFFECT OF AUDIT ADJUSTMENTS			
	FEDERAL	STATE	UNDETERMINED	TOTAL	FEDERAL	STATE	UNDETERMINED	TOTAL
Federal/State Liability Per Form SSA 8700 Report				$9,680,089				$782,169
Post Entitlement Adjustment (A)				(20,582)				20,582
				$9,659,507				$802,751
Audit Adjustments (B)								
1. Incorrect December Grant -								
No. of Occurrences in Sample (C)						35		
Point Estimate For Population (D)						154,215		154,215
Standard Deviation (E)						55.26		
2. SSA System Limitations								
No. of Occurrences in Sample (C)	96				95			
Point Estimate For Population (D)	(43,354)			(43,354)	43,016			43,016
Standard Deviation (E)	4.33				4.33			
3. Ineligible For Conversion -								
No. of Occurrences in Sample (C)	1	5				2		
Point Estimate For Population (D)	28,334	84,264		112,598		13,712		13,712
Standard Deviation (E)	32.33	53.71				14.80		
4. Untimely Corrective Action -								
No. of Occurrences in Sample (C)	1				27			
Point Estimate For Population (D)	627			627	61,618			61,618
Standard Deviation (E)	.72				21.08			
5. Incorrect Income -								
No. of Occurrences in Sample (C)	32	2			12			
Point Estimate For Population (D)	453,476	2,019		455,495	(27,348)			(27,348)
Standard Deviation (E)	116.23	1.63			11.18			
6. Living Arrangements -								
No. of Occurrences in Sample (C)	6	10			1	14		
Point Estimate for Population (D)	84,990	(35,940)		49,050	(10,522)	107,967		97,445
Standard Deviation (E)	39.26	62.31			12.01	42.66		
7. Missing Cases -								
No. of Occurrences in Sample (C)	2							
Point Estimate For Population (D)	41,793			41,793				
Standard Deviation (E)	41.04							
8. Unexplained -								
No. of Occurrences in Sample (C)	9				11			
Point Estimate For Population (D)	65,285			65,285	57,881			57,881
Standard Deviation (E)	44.81				49.25			

AUDIT RECONCILIATION TO SSA STATEMENT OF LIABILITY
WASHINGTON D. C.
FOR THE PERIOD
JANUARY 1, 1974 THROUGH JUNE 30, 1974

	FEDERAL LIABILITY EFFECT OF AUDIT ADJUSTMENTS				STATE LIABILITY EFFECT OF AUDIT ADJUSTMENTS			
	FEDERAL	STATE	UNDETERMINED	TOTAL	FEDERAL	STATE	UNDETERMINED	TOTAL
9. Other -								
No. of Occurrences in Sample (C)	8	5			3	26		
Point Estimate For Population (D)	(35,999)	(12,214)		(48,213)	8,672	7,311		15,983
Standard Deviation (E)	61.17	27.94			11.74	12.72		
10. Unaudited Data - (F)								
Initial Claims Not Sampled			13,095	13,095			873	873
One Time Payments			3,782	3,782			1,220	1,220
Recipients Relocated to a non-Federally Administered State			147	147			180	180
11. Unlocated Difference				(44,306)				11,446
TOTAL ADJUSTMENTS				$ 605,999 (G)			(G)	$430,241
FEDERAL/STATE LIABILITY PER AUDIT				$9,053,508				$372,510

(A) Post entitlement adjustments are SSA systems correction of Federal/State liability. The main reason for the adjustment was the ten dollar increase in Federal benefits (and a corresponding decrease in State liability) for the January 1974 payment. Since SSA's adjustment was not supported, we reversed their entry and included our projected amount between Federal and State liability amounts as a separate audit adjustment.

(B) Review of 300 cases from a total population of 15,179.

(C) Represents the number of sampling units reviewed in a sample of 300 cases that have a value greater than zero.

(D) Computed by multiplying the population of 15,179 by the arithmetic mean for the sample unit.

(E) A measure of dispersion of the sample values.

(F) These amounts represent the difference between the value of the universe and the point estimate from Exhibit I under unaudited data.

(G) Details of amounts that make up net adjustments listed above are shown in Schedule 1 to this Exhibit.

GROSS OVER/UNDER PAYMENTS BY AUDIT ADJUSTMENT (1)
WASHINGTON, D. C.
FOR THE SIX MONTHS ENDING JUNE 30, 1974
SUPPLEMENTAL INFORMATION FOR REPORT ON AUDIT OF FEDERAL ADMINISTRATION OF SSI PAYMENTS ACN-62300-03

SCHEDULE 1 TO EXHIBIT II

FEDERAL LIABILITY
EFFECT OF AUDIT ADJUSTMENTS

Audit Adjustments	Federal Caused Errors			State Caused Errors			Cause of Error Undetermined			Total		
	Gross Over Payments	Gross Under Payments	Net	Gross Over Payments	Gross Under Payments	Net	Gross Over Payments	Gross Under Payments	Net	Gross Over Payments	Gross Under Payments	Net
1. SSA Systems Limitation												
No. of Occurrences in Sample		96										
Point Estimate for Population		$(43,354)	$(43,354)								$ (43,354)	$(43,354)
Standard Deviation		4.33										
2. Ineligible for Conversion												
No. of Occurrences in Sample	1			5								
Point Estimate for Population	28,334		28,334	84,264		84,264				112,598		112,598
Standard Deviation	32.33			53.71								
3. Untimely Corrective Action												
No. of Occurrences in Sample	1											
Point Estimate for Population	627		627							627		627
Standard Deviation	.72											
4. Incorrect Income												
No. of Occurrences in Sample	32			2								
Point Est. for Population	453,476		453,476	2,019		2,019				455,495		455,495
Standard Deviation	116.23			1.63								
5. Living Arrangement												
No. of Occurrences in Sample	6			3	7							
Point Estimate for Population	84,990		84,990	62,736	(98,676)	(35,940)				147,726	(98,676)	49,050
Standard Deviation	39.26			45.32	42.13							
6. Missing Cases												
No. of Occurrences in Sample	2											
Point Estimate for Population	41,793		41,793							41,793		41,793
Standard Deviation	41.04											
7. Unexplained												
No. of Occurrences in Sample	7	2										
Point Estimate for Population	84,071	(18,786)	65,285							84,071	(18,786)	65,285
Standard Deviation	41.85	15.59										

GROSS OVER/UNDER PAYMENTS BY AUDIT ADJUSTMENT (1)
WASHINGTON, D. C.
FOR THE SIX MONTHS ENDING JUNE 30, 1974
SUPPLEMENTAL INFORMATION FOR REPORT ON AUDIT OF FEDERAL ADMINISTRATION OF SSI PAYMENTS ACN-62300-03

SCHEDULE 1 TO EXHIBIT II

FEDERAL LIABILITY
EFFECT OF AUDIT ADJUSTMENTS

Audit Adjustments	Federal Caused Errors			State Caused Errors			Cause of Error Undetermined			Total		
	Gross Over Payments	Gross Under Payments	Net	Gross Over Payments	Gross Under Payments	Net	Gross Over Payments	Gross Under Payments	Net	Gross Over Payments	Gross Under Payments	Net
3. Other												
No. of Occurrences in Sample	5	3		3	2							
Point Est. for Population	38,378	(74,377)	(35,999)	16,120	(28,334)	(12,214)				54,498	(102,711)	(48,213)
Standard Deviation	26.01	55.14		11.16	25.53							
Sub-Total	$731,669	(136,517)	595,152	165,139	(127,010)	38,129				896,808	(263,527)	633,281
). Unaudited Data												
Initial Claims Not Sampled							13,095		13,095	13,095		13,095
One Time Payments							3,782		3,782	3,782		3,782
Recipients Relocated to a non-Federally Administered State							147		147	147		147
O. Unlocated Difference								(44,306)	(44,306)		(44,306)	(44,306)
otal Audit Adjustment	$731,669	(136,517)	595,152	165,139	(127,010)	38,129	17,024	(44,306)	(27,282)	913,832	(307,833)	605,999

GROSS OVER/UNDER PAYMENTS BY AUDIT ADJUSTMENT (1)
WASHINGTON, D. C.
FOR THE SIX MONTHS ENDING JUNE 30, 1974
SUPPLEMENTAL INFORMATION FOR REPORT ON AUDIT OF FEDERAL
ADMINISTRATION OF SSI PAYMENTS ACN-62300-03

SCHEDULE 1 TO EXHIBIT II

STATE LIABILITY
EFFECT OF AUDIT ADJUSTMENTS

Audit Adjustments	Federal Caused Errors			State Caused Errors			Cause of Error Undetermined			Total		
	Gross Over Payments	Gross Under Payments	Net	Gross Over Payments	Gross Under Payments	Net	Gross Over Payments	Gross Under Payments	Net	Gross Over Payments	Gross Under Payments	Net
1. Incorrect Dec. Grant												
No. of Occurrences in Sample				33	2							
Point Estimate for Population				$160,112	$(5,897)	$154,215				$160,112	$(5,897)	$154,215
Standard Deviation				54.86	5.97							
2. SSA Systems Limitation												
No. of Occurrences in Sample	95											
Point Estimate For Population	43,016		43,016							43,016		43,016
Standard Deviation	4.33											
3. Ineligible for Conversion												
No. of Occurrences in Sample				2								
Point Estimate For Population				13,712		13,712				13,712		13,712
Standard Deviation				14.80								
4. Untimely Corrective Action												
No. of Occurrences in Sample	27											
Point Estimate For Population	61,618		61,618							61,618		61,618
Standard Deviation	21.08											
5. Incorrect Income												
No. of Occurrences in Sample		12										
Point Estimate for Population		(27,348)	(27,348)								(27,348)	(27,348)
Standard Deviation		11.18										
6. Living Arrangements												
No. of Occurrences in Sample		1		12	2							
Point Estimate for Population		(10,522)	(10,522)	123,274	(15,307)	107,967				123,274	(25,829)	97,445
Standard Deviation		12.01		40.37	13.17							

GROSS OVER/UNDER PAYMENTS BY AUDIT ADJUSTMENT (1)
WASHINGTON, D. C.
FOR THE SIX MONTHS ENDING JUNE 30, 1974
SUPPLEMENTAL INFORMATION FOR REPORT ON AUDIT OF FEDERAL
ADMINISTRATION OF SSI PAYMENTS ACN-62300-03

SCHEDULE 1 TO EXHIBIT II

STATE LIABILITY
EFFECT OF AUDIT ADJUSTMENTS

Audit Adjustments	Federal Caused Errors			State Caused Errors			Cause of Error Undetermined			Total		
	Gross Over Payments	Gross Under Payments	Net	Gross Over Payments	Gross Under Payments	Net	Gross Over Payments	Gross Under Payments	Net	Gross Over Payments	Gross Under Payments	Net
7. Unexplained												
No. of Occurrences in Sample	8	3										
Point Estimate for Population	58,693	(812)	57,881							58,693	(812)	57,881
Standard Deviation	49.24	.66										
8. Other												
No. of Occurrences in Sample	2	1		3	23							
Point Estimate for Population	10,190	(1,518)	8,672	15,464	(8,153)	7,311				25,654	(9,671)	15,983
Standard Deviation	11.60	1.73		11.38	5.59							
Sub-total	173,517	(40,200)	133,317	312,562	(29,357)	283,205				486,079	(69,557)	416,522
9. Unaudited Data												
Initial Claims Not Sampled							873		873	873		873
One Time Payment Recipients relocated to a non-Federally Administered State							1,220		1,220	1,220		1,220
							180		180	180		180
10. Unlocated Difference							11,446		11,446	11,446		11,446
Total Audit Adjustment	$173,517	$(40,200)	$133,317	$312,562	$(29,357)	$283,205	$13,719		$13,719	$499,798	$(69,557)	$430,241

(1) Includes over/under allocation of post entitlement adjustment (Note A to Exhibit II) and net amounts of unaudited and unlocated difference for reconciling purposes

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HUMAN RESOURCES
WASHINGTON, D. C. 20004

NOV 4 1975

G. A. Rafalko, Regional Audit Director
Department of Health, Education and Welfare, Region III
3535 Market Street
Philadelphia, Pennsylvania 19101

Dear Mr. Rafalko:

Staff have reviewed the draft audit report prepared by the DHEW Region III Audit Agency relative to the fiscal liability in the expenditures in the SSI program for the period January 1 through June 30, 1974. The methodology in selecting the sample, its size and characteristics were looked into in detail and staff found no problem in this area.

It is believed that the error areas were categorized in such a manner as to adequately delineate responsibility as related to fiscal liability. The nine major error categories were evaluated individually and staff were satisfied that they covered the required areas.

I am prepared to accept the DHEW Audit Report as the vehicle for determining Federal/State liability for the prescribed period. It is my understanding that, if necessary, staff may have access to the work papers the audit team used to arrive at its conclusion.

Sincerely yours,

Joseph P. Yeldell

Joseph P. Yeldell
Director

APPENDIX A

APPENDIX B

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

TO : Director, DHEW Audit Agency

DATE : JAN 16 1976

REFER TO: ISS-1

FROM : Associate Commissioner for Management and Administration

SUBJECT: SSA Comments on Draft Individual State Audit Reports for Fiscal Year 1974

As indicated in Commissioner Cardwell's December 30, 1975 memorandum to the Assistant Secretary, Comptroller, we are hereby transmitting to you 27 sets of comments on individual State supplemental security income (SSI) audits for the first 6 months of the program. The comments for all of the States for which draft reports have been released are included in this package except Indiana and Utah for which comments will be delivered to you in a separate package in the next week. As you know, we have yet to receive the draft audit reports for the States of Wyoming and South Dakota. We will submit comments to you for these two States within 2 weeks of the date of the exit conferences.

The Commissioner's memorandum of December 30, 1975 highlighted several factors that were common to the majority of the audit reports and should receive serious attention prior to the publication of these audits in their final form. Those items addressed by the Commissioner include:

1. The Inclusion of Case Error Rates. The case error rates reported in the audits are confusing since the readers of these reports are accustomed to the error reporting system in the ongoing quality assurance program. These latter rates are compiled and reported on a much different basis. The quality assurance error reporting system, which has a long history stemming from the AFDC program, is readily understood by the States.

We feel that the best way to avoid this confusion would be to eliminate any case error rates from your reports altogether, since they are not of primary concern in the reports. The primary purpose is to provide the statistical dollar figures in the reports which will be used by the States and SSA in negotiating financial settlements for fiscal year 1974. If you find it unacceptable to remove these confusing rates, we at least feel that the narrative section of each of the final audit reports should make very clear that the two methods of reporting errors are very different and clearly describe the fundamentals of that difference.

2. Postentitlement Accounting Adjustments (Paper Transfers). The audit reconciliation schedule contained in all of the draft reports discounts the postentitlement adjustments shown on the SSA-8700 report and substitutes an audit estimate and an explanatory footnote which indicate that because the postentitlement adjustments were not supportable, they were reversed. These adjustments are supportable and we recommend that, where applicable to sample cases, they should be reviewed by the auditors to determine whether their over/underpayment determinations were appropriate.

If you feel that you cannot undertake such an additional validation of the "paper transfers," we request that you at least clearly treat these postentitlement actions as adjustments rather than errors, especially since they do not involve any incorrect payments to the recipients themselves. These adjustments should be separated entirely from either the error categories or the undetermined fault cases so as not to confuse true errors and simple adjustments.

3. Use of the Terms Federal Liability and State Liability. The terms "Federal liability" and "State liability" which are used to denote the proper amount of Federal and State dollars if all the dollars expended had been correct, are very misleading. We urge the substitution of the words "basic Federal benefits" and "State supplementary benefits" as we have suggested in the individual reports attached.

4. Continuing Error Conditions. The audit reports need to be amended to differentiate between errors in payments that actually continue and those cases in which the error condition has been corrected, but the overpayment has not yet been disposed of through waiver or collection procedures.

In addition to these items, there are several other constant themes which apply to most of the audit reports. It is unclear how the audit agency has classified errors which have occurred but are "unavoidable." This is especially important where a change was not reported in time to affect a person's payment because of the lead time required to make such changes in the system. It is equally as important for those erroneous payments that were discovered but which had to be continued because of the person's hearing and appeal rights under the Goldberg vs. Kelly Supreme Court decision.

Another common theme throughout these audit reports is the use of the term "unlocated difference." This term needs to be more fully explained in all of the individual reports, especially as it relates to the statistical variance within those reports.

In addition to attaching the individual comments that we have made to the final version of that particular State audit, we request that you attach this summary memorandum to each report as well.

Francis D. DeGeorge

Social Security Administration Comments on District of Columbia Supplemental Security Income Audit of Fiscal Year 1974

	HEW Audit Note Reference
1. Page one, paragraph one, lines 1 through 4, should be followed by the sentence, "As of January 1974 the formal financial assistance programs contained in titles I, X, XIV, and XVI were repealed and replaced by the new title XVI SSI Program." Addition of this sentence would complete the historical overview and establish the effective start-up date for the reader. The last sentence of the first paragraph should be eliminated as too general.	A
2. Page one, paragraph one, lines 5 through 9: We suggest the following language, as more accurately defining program philosophy, be substituted for that currently included in the report: "The basic purpose underlying the SSI program is to establish a national and uniform set of eligibility and payment standards to replace the various State standards and payments which existed prior to January 1974. The States, to the extent they elect to supplement the basic Federal payment to meet specifically defined needs (optional supplementation) and to the extent they are required under P.L. 93-66 to maintain the December 1973 income level of converted recipients, share in the costs of the program."	A

3. Page one, paragraph two, first sentence: This sentence is misleading and we suggest that a more descriptive sentence read: "The provisions of the Act make it possible for States to elect either Federal or State administration of the optional and/or mandatory supplemental payments." Also, it would be helpful to add a few sentences to this paragraph explaining the conversion process. SSA prepared the State Conversion Manual. Each State, with technical assistance from SSA, then prepared its own internal conversion procedures manual containing specific instructions to its staff who were to handle the actual data transfer. These State manuals were written and reproduced by the States. D

4. Page two, line 3: The present language implies that State payments prior to January 1974 were funded solely from State funds. This is misleading and we suggest the language be revised beginning with the word "State" as follows: ". . . payments under the former titles I, X, XIV, and XVI of the Act." A

5. Page two, line 4: The sentence beginning "SSI Payments" should be qualified by adding "Initial SSI Payments . . ." A

6. Page two, paragraph one, first sentence: We suggest substitution of the word income for assistance as more in keeping with SSI program philosophy. A

7. Page two, paragraph one, line 4: A more definitive explanation of mandatory supplementation could be obtained by deleting the period and the entire sentence following "1973" and adding: "and whose December 1973 income as defined in section 212 of P.L. 93-66 exceeded the January 1974 Federal benefit plus other income." A

8. Page two, paragraph one, last sentence: Insert "as an optional payment" after the word "provide" and before the word "more" to further establish the two types of payments. A

9. Page two, paragraph three, line 3: Insert the words "optional and" before the word "mandatory" and add an "s" to the word "portion." A

10. Page three, line 1: We recommend that a period be inserted after the word "payments," the word "The" replace the word "on," and in line 2, delete the word "which." Technically, States are not billed monthly via the SSA-8700 report. This report is strictly an accounting statement. Billing occurs via a monthly letter requesting funds to be advanced by the first of the month in which State supplementation disbursements are to be made by SSA on the State's behalf. Final accounting for the fiscal year is made via the final SSA-8700 report. A

11. Page three, paragraph one: In the discussion of State's right to audit it would be worthwhile to mention that SSA's request to DHEW Audit Agency to conduct the audit for Federal/State settlement purposes, was in accordance with the State's acceptance of the Audit Agency as the entity selected to perform such audit on behalf of the States. The audit proposal was developed by the American Public Welfare Association (APWA)/SSA E

Contract Committee and received the full endorsement of APWA, the States, SSA, and the National Intergovernmental Audit Forum. It should also be mentioned that the purpose of the audit, as cited in the agreement, is to determine if the payments were made by SSA in accordance with the agreement.

12. Page three, paragraph two, line 3, of Scope of Audit: We believe it would be proper to more clearly conceptualize the nature of the payments being audited and recommend that the words "SSI payments" be replaced with the words "basic Federal payments and State supplementary payments." A

13. Page four, Scope of Audit: The terms "cases" and "payment records" are used interchangeably throughout this section. The correct term is "record" and it should be used consistently throughout the report. D

14. Page four, paragraph one of Scope of Audit: Here and throughout this report, reference is made to "Federal liability" and "State liability." These terms are misleading and should be replaced with the terms "basic Federal benefits" and "State supplementary benefits" respectively wherever they are used. Although there may be a discrepancy as to the correct amount paid in individual cases, it is still not certain whether the State is liable for part or all of the amount in question. The Financial Accountability Statement, Form SSA-8700, reflects the actual disbursements made, whether the payments themselves were proper or improper. The State is responsible for these payments pending final settlement as to State liability for such payments. A

15. Page six, Highlights of Audit Results: This section should also include the numbers of cases found to be in error as well as the total number of error occurrences lending the monetary results discussed on pages 6 and 7. A

16. Page nine, Findings and Recommendations - Programming Error: We strongly object to the conclusion drawn in this report that the January 1974 SSI benefit increase was not credited to the District of Columbia.

We believe Central Office records will substantiate that the SSI benefit increase of January 1974 from $130 to $140 was properly credited to the District. The April 1974 SSA-8700 reflects a "benefit adjustment" of $44,035 which closely approximates the audit figure of $43,016. A review of computational history on an individual case basis reflects the proper allocation of Federal/State dollars for January 1974. The retroactive rate increase for January 1974, which was implemented in February, was neither a payment error nor did it result in incorrect allocations between Federal and State funds. The bill was signed into law after the January 1 checks were computed, printed, and in the hands of the post office for delivery. The statements that the SSI system did not make required adjustments to the Federal and State liabilities are totally inaccurate. In fact, Footnote (A) on page 21 of the draft audit report confirms that SSA systems corrections of the Federal/State liability were made by post-entitlement adjustments.

Systems adjustments to properly allocate corrected payment errors between State and Federal funds are made continuously through post-entitlement adjustments. The methodology and procedures relating to these systems adjustments were reviewed in SSA headquarters by the DHEW Audit Agency staff and found to be accurate. These post-entitlement accounting adjustments are made in the aggregate to the Federal and State accounts, so the system deliberately does not provide for recording these fund allocation corrections on each individual recipient's payment history record. Therefore, the audit review of individual case payment history records would never reveal whether adjustments to properly allocate corrected payment errors between Federal and State funds had been made for a specific recipient. But this does not mean that proper adjustments were not made to both the Federal and State accounts. We contend they were and continue to be made. B

It is possible through a special program to isolate, on an individual case basis, the fund allocation corrections which make up the aggregate post-entitlement adjustments for a particular State. This was in fact done in five States for the second quarter of calendar year 1974 at the request of the DHEW auditors at SSA headquarters for their use in reviewing the methodology and procedures relating to these systems adjustments. No errors were detected by the audit of these systems accounting adjustments.

We therefore have to object to the erroneous statements under this heading that SSA did not make adjustments to correct improper fund allocations. In addition, these "adjustments" should be separated from any error categories.

17. Page 9, Ineligible for Conversion: We cannot understand how SSA could be responsible for any overpayment relating to "ineligible for conversion" cases. Since SSA did not have any opportunity to review eligibility factors, the total burden should fall on the State. A

18. Pages 9 and 10, Untimely Correction Action: The basis for attributing SSA responsibility for overcharges should be fully explained. The number (or percentage) of cases and the dates of corrective State input (i.e., deletion/changes as of 12/73), as well as the number of cases and dates of any SSA correction, should be stated. This section indicates that there are a significant number of cases involving overpayments or underpayments which the auditors have labeled as "errors." However, we do not know if the auditors have taken into consideration that under the SSI program unavoidable payment changes are an inherent part of the program since we must make payment on the first of the month for the month (e.g., a January payment is for the month of January not December). Therefore, an event that takes place after the SSI payment has been made can cause a payment that was correct at the time it was made to now be retroactively incorrect. This is an unavoidable situation under the present law which cannot be anticipated. Consequently, the SSI system has to process any reductions or suspensions that occur under such circumstances after the SSI payment was made which then results in an overpayment or possible underpayment. F

Furthermore, at times deliberate overpayments must be made because of the Goldberg vs. Kelly Supreme Court decision. This decision requires, under most conditions, to delay taking any adverse action (e.g., a reduction or suspension of benefits) until the individual has been notified of the planned action as well as the opportunity to contest it. This is a time-consuming process which forces SSI into making known and deliberate overpayments for as long as 2 months in many cases. Were such payments considered overpayments and if so, how have they been classified?

19. Pages 10 to 14, Living Arrangements: We reserve the right to comment on your determinations in shared living arrangement cases until a later date. E

20. Page 15, Missing Cases: The description of attempts to obtain information on "missing cases" is vague. We assume that efforts will continue on these cases and that a final conclusion will be drawn. It seems to us, absent evidence to the contrary, that DHEW might just as well have assigned fault to the District of Columbia. C

21. Page 15, Unexplained: If the causes of these errors are unknown, how can the auditers be certain they are attributable to Federal error? At best, these errors should fall under the category of Undetermined Liability. The brief discussion of this most significant category is most difficult to analyze without a review of the pertinent records. We reserve further comment pending a review of the specific cases involved. G

22. Page 15, Other: We would like to obtain more specific data on this category which, from this brief presentation, makes it impossible to provide realistic comment. C

23. Page 16, line 6, Conclusions and Recommendations: The entire sentence beginning with the word "actual" should be replaced as follows: "The audit disclosed that the amount properly payable was $372,510.16." A

We must object to the statement that the actual State liability for the period was $372,510.16. The Form SSA-8700 reflects the actual disbursements made and until a final settlement as to State liability is made, the use of the term State liability in this report is premature.

24. Page 17, Correction of Payment Errors: We are concerned that this information could be misinterpreted to mean that situations which caused erroneous payments continued even after the overpayments/underpayments were discovered. As we understand the audit report, recoupments of overpayments and payments for underpayments were not made through March 19, 1975, for 142 of the 150 sample cases with errors. However, our review of the findings disclose that a large number of these errors involved the January 1974 legislative increase and the Federal/State share was adjusted on the SSA-8700 through post-entitlement adjustments and proper payments were made thereafter. Our post-entitlement adjustments also corrected, to some degree, other error categories listed in the audit report. In other words, further explanation should be provided in the audit report so

that the reader does not out of context assume that either the situations which caused these erroneous payments are continuing or were of the magnitude indicated by this paragraph.

25. Page 21, Exhibit II, Footnote (A): We strongly disagree with the statement that SSA's adjustments were not supported. See our comment number 16.

APPENDIX C

HEW Audit Agency Notes To Appendix B
Audit Control Number 03-62300

NOTE A - Suggested revision or clarification was made in our final report.

NOTE B - A more precise explanation for the "SSA Systems Limitation" is on Page 7 and in footnote A to Exhibit II, Page 2 of 2.

We were unable to identify these adjustments on a case by case basis because (1) the specific orbit file used in the overpayment subsystem program was not operative for the first three months of the program and (2) we could not satisfy ourselves as to the accuracy of the data in the computational quarter and payment history fields on the records.

NOTE C - Supplemental information concerning these areas has been made available to the Bureau of Supplemental Security Income, Region III.

NOTE D - We do not agree with SSA. We believe that comments made clearly reflect the intended meaning.

NOTE E - No HEW Audit Agency response required.

NOTE F - Our examination of case files and payments records for the beneficiaries in our sample who received overpayments revealed no evidence that such overpayments were being continued because of the Goldberg vs. Kelly Supreme Court decision.

NOTE G - These errors were Federally caused because they resulted from one time payment transactions and status changes affecting benefit payments that were processed by SSA.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
REGION III
3535 MARKET STREET
PHILADELPHIA, PENNSYLVANIA 19101

AUG 3 1976

Mr. James J. Mullen
Regional Representative
Bureau of Disability Insurance
Social Security Administration
P. O. Box 8788
Philadelphia, Pennsylvania 19103

Dear Mr. Mullen: Re: Audit Control Number 03-62703

The purpose of this letter is to advise you of the RESULTS of our FOLLOW-UP AUDIT OF OUR REVIEW OF THE POLICIES AND PROCEDURES IN EFFECT AT THE D. C. DEPARTMENT OF HUMAN RESOURCES (STATE AGENCY), DISABILITY DETERMINATION DIVISION (DDD), for administering the DISABILITY DETERMINATION (DD) PROGRAM, (Audit Control Number 52202-03), issued March 21, 1975. Our follow-up audit was performed to determine if (1) recommended actions have been implemented or are in process, and (2) such actions have led or will lead to resolution of known problems.

Our prior review showed that the overall administration of the DD program was satisfactory. We noted, however, that the administration of the program could be improved if the DDD:

...scheduled medical examinations more timely,

...referred all claimants who had potential for vocational rehabilitation,

...charged indirect costs in accordance with the approved indirect cost rate proposal,

...reported to the Internal Revenue Service payments made to physicians in excess of $600 annually.

In their reply to a draft of our prior report DDD officials described the corrective actions taken or planned with regard to scheduling medical examinations, vocational rehabilitation referrals, and submission of reports to the Internal Revenue Service. In our opinion those actions would correct the conditions noted and we made no recommendations concerning these three areas. We did recommend, however, that DDD (1) discontinue making direct charges to the DD program for costs charged indirectly and (2) make a financial adjustment of $43,468 for indirect costs claimed erroneously.

Our follow-up review (See Appendixes I, II, III and IV for details) showed (1) that medical examinations were scheduled more timely, (2) a marked increase in approved disability cases being referred to the State's Vocational Rehabilitation (VR) unit, and (3) compliance with proper procedures for charging indirect costs along with proper financial adjustment to such costs. However, payments made to physicians that exceeded $600 annually were still not being reported to the Internal Revenue Service.

Other Matters

We did not perform an internal review of the Bureau of Disability Insurance (BDI), Social Security Administration's procedures for following up on audit reports covering its grantee agencies. However, our review at DDD indicated that BDI did not sufficiently monitor to ensure that our recommendations were fully implemented. For example, we found a continued lack of reporting to the Internal Revenue Service of those payments made to physicians that exceed $600 annually. Although we were informed by the Program Operation Officer that BDI had agreed with our recommendations and discussed them with the State Agency, the only available correspondence addressing itself to our recommendations was relative to our indirect cost finding (Appendix III).

In our opinion, if our recommendations are upheld by BDI, follow-up, including on-site monitoring visits, should be made to determine if needed changes have, in fact, been implemented. Therefore, we recommend that BDI SSA review its procedures for following up on audit reports, and for ensuring that recommended changes are implemented in an effective and timely manner. We would appreciate being informed, within 60 days of receipt of the report, of the results of this review.

If we may be of further assistance, please contact us. To facilitate identification, please refer to the above Audit Control Number in all correspondence relating to this report.

Sincerely yours,

G. A. Rafalko
Regional Audit Director

NOTICE

"This document is for internal HEW use."

APPENDIX I

D. C. DEPARTMENT OF HUMAN RESOURCES
FOLLOW-UP AUDIT OF
REVIEW OF DISABILITY DETERMINATION DIVISION
AUDIT CONTROL NUMBER 52202-03

FOR THE PERIOD
JANUARY 1, 1970 THROUGH OCTOBER 31, 1974

SCHEDULING OF MEDICAL EXAMINATIONS

Statement of Condition

SSA guidelines require that 90 percent of disability cases, especially those needing additional medical information, including medical examinations, should be processed within 70 days of receipt. Our review indicated that only 71 percent of such cases were processed within 70 days. The primary reason for this delay was the lack of timeliness of medical examinations.

State Agency's Response

At the time of our review DDD officials agreed with our finding and indicated that the delay in processing cases was a result of the inability of DDD to recruit enough physicians to perform medical examinations. This was due to the fact that fees paid physicians by the State Agency were not comparable to fees paid for similar services under other public programs. DDD officials also stated that while a new fee scale proposal had been submitted to the State Agency, no action had been taken to date.

In response to our draft report, State Agency officials submitted a letter dated March 5, 1975 stating that they were in the process of obtaining an increased fee schedule which they anticipated would attract more physicians, as well as retain the physicians currently working for them.

BDI Position

Based on our conversation with the BDI Program Operations Officer, BDI had agreed with our finding and discussed the solution with DDD. However, no written correspondence was made available to us which formalized what action BDI had taken.

Corrective Action Taken and Current Status

We noted that a new fee scale had been approved and the physicians unit fee had increased from $35 to $50. Because of this increase DDD was able to schedule medical examinations more timely. Consequently, the time required to process cases has decreased and the percentage of total cases pending in excess of 70 days from receipt was within the 90 percent SSA Time Processing Guideline. In a sample of cases completed in May 1976, 92 percent were processed within 70 days. This is an increase from the 71 percent in the prior audit. An additional review of Pending Time

Data statistics submitted to BDI for the period subsequent to the audit, which included calendar years 1975 and 1976, indicated that DDD was within the guidelines. As an example the statistics for the week ending June 2, 1976 indicated 94.2 percent of the cases were completed within 70 days.

APPENDIX II

D. C. DEPARTMENT OF HUMAN RESOURCES
FOLLOW-UP AUDIT OF
REVIEW OF DISABILITY DETERMINATION DIVISION
AUDIT CONTROL NUMBER 52202-03

FOR THE PERIOD
JANUARY 1, 1970 THROUGH OCTOBER 31, 1974

VOCATIONAL REHABILITATION REFERRALS

Statement of Condition

Our review showed that 20 percent of claimants approved for disability payments and not referred to the Vocational Rehabilitation (VR) Unit had the potential for rehabilitation. This situation was due to the lack of proper application of the SSA screening guidelines by DD examiners.

State Agency's Response

At the time of our review DDD officials concurred with our finding. In response to our draft report, State Agency officials submitted a letter dated March 5, 1975, stating that the screening criteria for Vocational Rehabilitation referrals had been thoroughly discussed with DDD's staff and they had been instructed to comply with the procedures in the Disability Insurance State Manual 292.

BDI Position

Based on our conversation with the BDI Program Operations Officer, BDI had agreed with our finding and discussed the solution with DDD. However, no written correspondence was made available to us which formalized what action BDI had taken.

Corrective Action Taken and Current Status

We found no formalized plan to correct the deficiency noted in our final report. However, DDD's staff was being instructed to follow SSA screening criteria.

Our review indicated that the screening criteria were for the most part being applied. We reviewed selected cases approved for disability payments but not referred for VR services as of June 1976. It was determined that the screening guidelines were not applied in only 4 percent of the cases we tested. We also noted that for the period immediately preceding the issuance of our report on March 21, 1975, the referral rate was averaging 15 percent while currently it is averaging 24 percent.

Considering these conditions we feel, given the factor of human error in using the screening guidelines, that DDD is adequately remedying this problem.

APPENDIX III

D. C. DEPARTMENT OF HUMAN RESOURCES
FOLLOW-UP AUDIT OF
REVIEW OF DISABILITY DETERMINATION DIVISION
AUDIT CONTROL NUMBER 52202-03

FOR THE PERIOD
JANUARY 1, 1970 THROUGH OCTOBER 31, 1974

INDIRECT COSTS

Statement of Condition

In accordance with the approved indirect cost rate proposal (ICRP), the State Agency applied a cost rate of 25 percent on the direct salaries, wages and fringe benefits to determine overhead costs. Based on this rate, the State Agency charged the Federal account with $67,047 for indirect cost recovery for the first nine months of fiscal year 1974. However, the State Agency also charged the Federal account directly with $43,468 from a miscellaneous account which represented costs already recovered by the application of the cost rate.

State Agency's Response

As a result of our initial review the cognizant State Agency officials agreed that the additional $43,468 of indirect costs were unallowable and that such costs were an overclaim of reimbursement from the Federal Government. They also stated that an adjustment would be made to the Federal account.

Subsequent to issuance of our draft report, the State Agency submitted a letter dated March 5, 1975 which stated they were unable to respond unless detailed data was furnished by HEW.

We met with State Agency officials on March 18, 1975 to discuss this finding. The officials verbally agreed that only $42,500 of our recommended refund of $43,468 was unallowable under Federal reimbursement principles. We reiterated our contention that the entire amount of $43,468 as shown on the Report of Obligations for Disability Program for the period July 1, 1973 through March 30, 1974 was unallowable.

BDI Position

On September 3, 1975 BDI submitted a letter to the State Agency which stated that they agreed that the State Agency should discontinue making direct charges for program costs that are chargeable through negotiated Indirect Unit Rate Proposals. BDI also stated that it was their understanding that accounting procedures had been put into effect to prevent

reoccurrence of such situations. Relative to our recommended adjustment of $43,468, BDI stated that, (1) based on an examination of the State Agency's fiscal records, by members of their Philadelphia regional office staff, they considered $968 of the $43,468 as a proper charge, thereby reducing the adjustment to $42,500 and (2) that the HEW auditor had agreed with their assessment of the incorrect overcharge and that the adjustment of $42,500 had been effectuated.

Corrective Action Taken

We verified that the $42,500 adjustment had been reflected in the Report of Obligation for Disability Program. We also reviewed the State Agency accounts and satisfied ourselves that the remaining $968 was not charged twice to the Federal account as initially indicated in our report.

Current Status

We ascertained that the overcharge had been caused by an erroneous posting by the State Agency's accounting division. Discussions with accounting officials and review of the development of current charges to the Federal account indicated that this error would not occur again.

APPENDIX IV

D. C. DEPARTMENT OF HUMAN RESOURCES
FOLLOW-UP AUDIT OF
REVIEW OF DISABILITY DETERMINATION DIVISION
AUDIT CONTROL NUMBER 52202-03

FOR THE PERIOD
JANUARY 1, 1970 THROUGH OCTOBER 31, 1974

SUBMISSION OF REPORTS TO INTERNAL REVENUE SERVICE

Statement of Condition

The State Agency did not report to the Internal Revenue Service payments to individual physicians in excess of $600 annually as required by Section 6041 of the Internal Revenue Code and corresponding regulation 26 CFR 1.6041. Also, procedures had not been established to provide the information needed for filing such reports.

State Agency's Response

The Acting Chief of DDD and the State Agency's Supervisory Accountant concurred with our finding, but could not explain why the informational tax returns were not prepared. In response to our draft report, State Agency officials submitted a letter dated March 5, 1975 stating that effective January 1, 1975 the District of Columbia Accounting Office would accumulate the information necessary to file the 1099 Informational Tax Returns for physicians who provide professional services on behalf of DDD's clients. Also, D. C. Accounting would be provided with (a) payee's name, (b) payee's social security number, and (c) payee's complete mailing address including zip code.

BDI Position

Based on our conversation with the BDI Program Operations Officer, BDI had agreed with our finding and discussed the solution with DDD. However, no written correspondence was made available to us which formalized what action BDI had taken.

Corrective Action Taken and Current Status

Although the State Agency is providing D. C. Accounting with the information set forth in their March 5, 1975 letter, our review indicated that D. C. Accounting was not instructed to utilize this information and implement it into their system. As a result, the data was not processed into their system and 1099 Informational Tax Returns were not sent to IRS for the DDD physicians who were paid in excess of $600.

DISTRICT OF COLUMBIA

DEPARTMENT OF TRANSPORTATION

STATEMENT OF DOUGLAS SCHNEIDER, DIRECTOR, DEPARTMENT OF TRANSPORTATION

ACCOMPANIED BY:

SAM STAROBIN, DIRECTOR, DEPARTMENT OF GENERAL SERVICES

COMER COPPIE, SPECIAL ASSISTANT TO THE MAYOR FOR BUDGET AND MANAGEMENT SYSTEMS

CITY CARPOOLS

Senator CHILES. We will now turn to city witnesses. I would like to start with some general questions regarding the city carpools.

I think Mr. Doug Schneider, who runs the Department of Transportation is here. Who handles the Department of Human Resources motor pool? Do we have somebody that comes from the motor pool of Human Resources?

Mr. YELDELL. Mr. Chairman, we don't actually have a motor pool. We have cars assigned to locations for individuals. But we don't have a motor pool, per se.

Senator CHILES. Maybe Mr. Schneider could handle those questions as well.

Mayor WASHINGTON. Mr. Chairman, I might say I think we have enough people here to be able to answer the questions.

Senator CHILES. All right, sir. Do you have a statement?

Mr. SCHNEIDER. No, sir.

Senator CHILES. Before we begin any specific questions on the matter of the two cars, I would like to ask some general questions regarding the city's carpool and the city's policy regarding the use of city cars.

Why does the city operate two carpools; one for the Department of Human Resources and one for the rest of the city; and if it is not a carpool for the Department of Human Resources, why do we have two groups of cars?

THE CITY'S MOTOR POOL

Mr. SCHNEIDER. The city motor pool is operated by the Department of Transportation, which is the Department I represent. That is a motor pool which makes transportation available to any city employee who requires it.

There are three levels of transportation available. There is a chauffeur-driven passenger vehicle, of which we have 20. Those are available to anyone at any level in the District government who needs that kind of transportation.

Senator CHILES. Someone has to approve his using that car, isn't that correct? Who makes the approval? No city employee can just call up and order a car?

Mr. SCHNEIDER. He can, but it has to be for an official purpose.

Of course, the driver isn't going to take him home or to a nonofficial place. The driver himself has some control. Then there is a manifest that is kept on each motor pooled vehicle which indicates the destination, the purpose of the trip, and the number of passengers.

There is an additional check there. Of course, there are written policies on the use of motor vehicle cars.

Senator CHILES. Are there written policies on who can use the cars and for what purposes?

Mr. SCHNEIDER. Yes, there are. Generally, they are for official purposes for any employee of the District Government who needs that kind of transportation.

In addition to the chauffeur-driven vehicles, we have a shuttle service that runs between city buildings. At the present time we have five vans providing that service. They are 10 to 14 passenger vans.

We are buying some new ones. You may remember in our 1976 budget we had some replacements there. We also have nine drive-it-yourself cars assigned from that pool to various users, departmental users or general users who would have use for that kind of thing.

I will give you an example. We have four cars assigned to the District building for use by Council staff or, anybody who needs a car that takes him beyond the prudent range of taking a chauffeur-driven car, or who needs it for a longer period.

If you had to go for a day out to Lorton, for example, you might take one of those cars and drive it yourself rather than have a driver drive you out there. The driver is kind of a local taxi service. If you need it for a longer time, you can take one of the drive-it-yourself vehicles. There are nine of those.

We have a total of 34 cars presently assigned to the pool which conflicts with the figure you got earlier from the GAO witness. His number was 43. I think the disparity is due to the fact that some of the vehicles were taken out of service due to age.

NEED FOR CARS BY DHR

Senator CHILES. Why don't you have all the cars in the city motor pool, why does the Department of Human Resources have a group of cars?

Mr. SCHNEIDER. As I understand it, and I think this is typical of many city agencies. The Department of Human Resources probably has a need for frequent mobility for many employees, DHR has more cars in this category than others because of its size.

They have 78 vehicles assigned at various strategic locations where the facilities are so that they again can be available in the manner we have provided vehicles at the District Building.

They have them at such places as the Children's Center at Laurel, Glenn Dale Hospital, the alcohol center at Occoquan, and District of Columbia General Hospital. That is not a motor pool. They have vehicles assigned in that Department strategically located for their special purposes.

I think that is not unusual for a city department to have that need. Some have no need but others have a great need.

Senator CHILES. How do they normally purchase their cars?

Mr. SCHNEIDER. Sometimes they are purchased through the Department of Transportation's budget. But I don't know how they typically do that. We have some in our budget that we purchased through the facilities of the General Services Department, Mr. Starobin's Department. There is a regular procedure, a low bid process and all that. It is an established procedure.

Senator CHILES. Is that the way you purchase cars for the Department of Transportation?

Mr. SCHNEIDER. That is right.

PROCEDURE FOR PURCHASING CARS

Senator CHILES. How is that usually done in the Department of Human Resources, Mr. Starobin?

Mr. STAROBIN. Are you addressing it to me?

Senator CHILES. Yes.

Mr. STAROBIN. All Departments of the District government are queried as to their needs for vehicle purchase at a certain time of the year. We make a general buy of vehicles at a particular time of the year, generally the end of the model run, when we can get the cars most cheaply.

We write to most of the Departments, asking them to state their purchase requirements, specifically those requirements as authorized under the budget.

We aggregate those and then put out invitations for bids. Just recently the bids have come in for this year, which are the buy for all of the Departments of the District government for general purpose vehicles.

Senator CHILES. What are you paying for your general purpose automobiles?

Mr. STAROBIN. I think the current figure is probably between $2,500 and $3,000. I think it is within that range, between $2,500 and $3,000 for a general purpose vehicle. I understand that this year the car purchased is in the Nova class.

LEASING VEHICLES

Senator CHILES. Does the city lease any vehicles?

Mr. STAROBIN. It leases a few. There are very few circumstances under which we lease vehicles. In one case, we lease the Mayor's car. It is a prestige car and we find it most economical to lease it.

Otherwise, the policy of leasing is for a short duration or for unusual purposes.

Senator CHILES. You were contacted in regard to the proposed lease of these particular cars?

Mr. STAROBIN. My Department was, yes, sir.

Senator CHILES. You performed that lease for the Department of Human Resources?

Mr. STAROBIN. Yes, sir, my Department did.

Senator CHILES. On whose authority did you make that lease?

Mr. STAROBIN. I have the authority to enter into the lease. I personally granted the authority to enter into the lease.

REQUEST TO LEASE CARS BY DHR

Senator CHILES. Who authorized you from the Department of Human Resources, or who requested you to do that?

Mr. STAROBIN. The first request that we had that spoke of lease was in a document dated December 5, 1974. It was a document from the Chief of the Procurement and Contracts Branch that asked us to convert the proposed acquisition by purchase of the two vehicles to a lease rental, citing the urgent program requirements for the two vehicles.

Senator CHILES. Does that cite the program requirements?

Mr. STAROBIN. No, it doesn't cite it specifically. The language is, "Due to the urgent program requirements for the two vehicles authorized for purchase under HEW grant transactions," then it lists two numbers, "it is requested that purchase order 11," that is a document that transmits the request to us, "be amended for rental or lease of the two vehicles."

Senator CHILES. When they made the original purchase request, did your Department notify them that they were above the price you normally were paying for cars at that time?

Mr. STAROBIN. Yes, the purchase request that came in asked us to purchase two vehicles of a Ford Torino type at $2,400. The request came in after our end-of-the-year buy.

We would, therefore, have had to buy the cars from local dealers and we could not buy vehicles of that type for that price. At that time it was changed to a lease arrangement.

JUSTIFICATION FOR LEASING CARS

Senator CHILES. Did you question the fact that the Department of Human Resources was requesting vehicles that were performance oriented and not the smaller, more efficient cars as required by the GSA Management Circular 74–1?

Mr. STAROBIN. My Department wrote to the Department of Human Resources on December 17 and asked for that justification. The exact language is, "Your reconsideration for your demand for a Torino is requested." We pointed out that the Torino is used primarily by police and cited the austerity program in requesting the need for justification for those vehicles.

Senator CHILES. What did you get back from that?

Mr. STAROBIN. On December 24, we received a document from the Director of the Department of Human Resources stating again the urgent requirement for these vehicles and requesting specifically that the vehicles be made available by January 2, 1975, approximately 1 week later.

Senator CHILES. Did the Department of Human Resources provide your Department with the requested documentation and justification for these vehicles?

Mr. STAROBIN. No.

Senator CHILES. Why was air-conditioning approved for the cars?

Mr. STAROBIN. As I stated in the last document, I was faced shortly after December 24, with a request from the Director of the Department of Human Resources to meet an urgent requirement. My staff at that point consulted with me. Prior to that time, the actions had been taken through their normal routine and I had not been directly involved. At this point, I became directly involved.

They informed me the only way they could meet that requirement was by leasing cars that were available on a dealer's lot. I was led to believe there were two cars available on a lot to meet the requirement that did in fact have air-conditioning. I felt that the necessity to meet that program requirement gave me the justification to go ahead and authorize the lease of cars with air-conditioning.

Senator CHILES. Was the required request and approval obtained from Mr. Coppie's office for air-conditioning of these cars?

Mr. STAROBIN. Our regulations in this do not make it specific that Mr. Coppie's authority is needed when a grant is involved. I have our directives on that. Under those circumstances when a grant is involved, we look to the grant document to see what it authorizes. In this case, we did not have the grant document available. Essentially, I took it on my own to meet the urgent requirements and to waive the need for further justification.

Senator CHILES. The urgent program requirements were just the statements that you received that these were urgently needed to meet program requirements?

Mr. STAROBIN. That is right, sir.

UTILIZATION RATE FOR CARS

Senator CHILES. Mr. Schneider, does the city maintain an annual utilization rate for cars of 12,000 miles?

Mr. SCHNEIDER. No, sir, generally, the use is less than that. I think primarily because of the geographic area. City cars operate in a small area and they generally don't reach that level of use.

Senator CHILES. What is your average?

Mr. SCHNEIDER. I have some figures on what we have on motor pool cars. It appears to be around 6,000, 7,000 miles annually.

Senator CHILES. I would like you to submit those figures, if you will.

Mr. SCHNEIDER. Those don't represent the total fleet of the city. I don't know if we have that kind of record, but if we have it, we will make it available to you.

[The information follows:]

MILEAGE TABULATION

Following is a mileage tabulation of vehicles assigned to the Central Motor Pool, Department of Transportation:

Tag No.	Type	Mileage
	TAXI CARS	
GF-204	4-door sedan	5,560
GF-206	do	9,473
GF-207	do	5,645
GF-208	do	4,536
GF-211	do	5,066
GF-212	do	4,666
GF-216	do	5,908
GF-219	do	3,552
GF-220	do	6,971
GF-222	do	6,543
GF-223	do	6,036
GF-224	do	PDA
GF-225	do	5,602
GF-226	do	4,894
GF-227	do	4,481
GF-228	do	5,115
GF-229	do	6,673
GF-230	do	6,247
GF-236	do	6,555
GF-247	do	6,145
GF-248	do	1,546
Total		111,214
	DRIVE YOURSELF	
GF-059	4-door sedan	7,701
GF-082	do	7,177
GF-201	do	4,949
GF-209	do	7,534
GF-213	do	6,985
GF-218	do	4,198
GF-231	do	5,616
GF-232	do	4,560
Total		55,993
	SHUTTLE BUSES	
GF-290	10-14 passenger vans	8,166
GF-291	do	7,944
GF-292	do	9,023
GF-293	do	8,316
GF-295	do	7,559
Total		41,008

TRANSPORTATION TO OFFICIALS

Senator CHILES. What is the city's policy regarding providing transportation to city officials?

Mr. COPPIE. Mr. Chairman, the normal policy is that the cabinet range official receive no preferential treatment unless his duties specifically require it. In the case of four District officials, that have been previously referred to in this hearing today, a vehicle has been assigned under the authority of the Mayor for their particular needs because of the indispensable requirements of their jobs.

Senator CHILES. A vehicle is assigned to the head of Environmental Services?

Mr. COPPIE. The Director of the Department of the Environmental Services, the Director of the Department of Corrections, the police chief, and the Director of the Department of Human Resources. I would point out to you that I would qualify my statement regarding the police chief in that he is given specific authority through the appropriation bill to receive both the car and the driver. The others have only the authority for the car.

They drive it themselves. Or if they are with someone, then the other person can drive the car.

Senator CHILES. The Chairman of the City Council uses the carpool, he is not specifically assigned a car?

Mr. SCHNEIDER. That is correct. He uses the motor pool.

Mr. COPPIE. The other city official I would speak to here beyond the four I referred to is the City Administrator. He also receives a car.

Senator CHILES. Under that policy would the head of the Department of Human Resources be assigned a car from the city fleet?

Mr. COPPIE. Or from the available cars to the Department of Human Resources. I believe in that case, it is cars available to the Department of Human Resources. I think it is relevant for me to point out that the city is covered by the governing Federal statute on this which has been referred to today. There is also a provision of the District of Columbia Code, title 4501–A, which places all District of Columbia motor vehicles under the authority of the Mayor.

The Mayor is given authority to delegate automobiles to specific officials of the city, based on the requirements of their particular positions. That has been done in the case of 56 officials of the city, under the Mayor's authority and specifically the four Department heads that I referred to and the City Administrator.

Senator CHILES. Thank you, Mr. Schneider, Mr. Starobin, and Mr. Coppie.

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STATEMENT OF JOSEPH P. YELDELL, DIRECTOR, DEPARTMENT OF HUMAN RESOURCES

ACCOMPANIED BY:

WALTER E. WASHINGTON, MAYOR
JULIAN DUGAS, CITY ADMINISTRATOR
JOHN R. RISHER, JR., CORPORATION COUNSEL
COMER S. COPPIE, DIRECTOR, OFFICE OF BUDGET AND MANAGEMENT SYSTEMS.

SWEARING IN OF MR. YELDELL

Senator CHILES. I would like now to go to Mr. Yeldell.

Mr. Yeldell, would you raise your right hand, please, sir?

Mr. YELDELL. I beg your pardon?

Senator CHILES. Would you raise your right hand? I would like to swear you in.

Mr. YELDELL. I have problems with this. This job is a nice job, but I have never come before this committee with a problem of testimony. I see no other witness being sworn in here today. I see no reason to be sworn in.

Senator CHILES. Mr. Yeldell, we can recess this committee meeting and we could issue a subpena for you.

Mr. YELDELL. I understand that, Senator.

Senator CHILES. And have you come before the committee.

Mr. YELDELL. I have a problem with this because the implication is that there is some illegal action here. You have had other testimony from witnesses here without any of them being sworn in. I have a problem with being sworn in.

Senator CHILES. Mr. Yeldell, we will be happy to recess the subcommittee meeting then.

Mr. YELDELL. Senator, I am afraid that is what you are going to have to do.

SUBCOMMITTEE RECESS

Senator CHILES. We will have you come back. The subcommittee will stand in recess until the call of the chair.

[Whereupon, at 3:50 p.m., the subcommittee was recessed, to reconvene at 4 p.m., the same day.]

(Resumption of Hearing, 4 O'Clock P.M. Wednesday, September 22, 1976)

Department of Human Resources

STATEMENT OF JOSEPH P. YELDELL, DIRECTOR, DEPARTMENT OF HUMAN RESOURCES—(Resumed)

PREPARED STATEMENT

Senator Chiles. We have a vote in progress now. So, I will go and return.

[A brief recess was taken.]

Senator Chiles. I apologize for this kind of delay that we are having in running back and forth. It looks like it will be all day in these votes that we are having. Mr. Yeldell, do you have a statement you would like to make?

Mr. Yeldell. Mr. Chairman, I have a statement, but in the interest of time, I would just as soon submit it for the record.

Senator Chiles. Your statement in full will be included for the record.

[The statement follows:]

PREPARED STATEMENT OF JOSEPH P. YELDELL

Once again I respectfully appear before the Senate Appropriations Subcommittee on the District of Columbia to address the committee's concern in the alleged misuse of Federal grant funds by the Department of Human Resources, along with other allegations of mismanagement.

It is unfortunate that, more often than not, it is necessary for me to appear before this subcommittee to explain the alleged failures or shortcomings of the Department of Human Resources. On the other hand, it is unfortunate that the Department's successes and accomplishments, more often than not, go unmentioned.

The fundamental mission of the Human Resources Department is the establishment of a comprehensive integrated human services delivery system. It is based on the premise that if a service is to be effective, it must be provided in conjunction with other services necessary to an individual's or family's total well being. Rarely do the recipients of one service not require a variety of other equally needed services.

For such a system to be effective, it must be adequately staffed; its programs must be adequately funded; and most important of all, its employees must believe and support the human resources concept.

When I became director in December 1971, the layers of bureaucratic insularity and individual fiefdoms built up over decades were still very much in evidence. The structures had been changed, but in many places the underlying attitudes remained the same. Where there had been neglect and difficulties in the past, these problems continued to exist. Many of the problems we faced then were inherited, not created by DHR. The Department with all its promise could not then, nor now, be regarded as an immediate panacea for these stubborn situations.

As director of the Department of Human Resources, I am responsible for a budget of over $400 million; a staff of approximately 11,000; the administration of 37 State plans for the operation of Federal programs; the administration of the public assistance, food stamp and medicaid programs; the provision of inpatient and outpatient health services, the provision of foster care, juvenile delinquency, day care, social services, adoptions, veterans affairs, and vocational rehabilitation services; the delivery of inpatient and outpatient mental health services; the conduct of medical examinations to determine the cause of deaths; and for the provision of drug and alcoholism treatment services for residents of the District of Columbia.

Under these program categories over 60 distinct major areas of service are delivered. Each major program is governed by separate Federal and local regulations requirements.

Services are rendered from approximately 723 delivery points in over 300 locations. Our facilities are located throughout the District of Columbia, in Maryland as far north as Laurel and in Virginia as far as Occoquan.

Vital services are provided to District residents as follows:

—Medicaid serves approximately 180,000 people a year.
—The food stamp program serves approximately 45,000 households each month.
—Financial aid goes to approximately 40,000 families every month.
—Over 3 million lab tests are performed a year.
—Over 730,000 methodone doses are given a year.
—Over 100,000 emergency cases at D.C. General Hospital are seen each year.
—Over 200,000 clinic visits are made annually at D.C. General Hospital.
—Over 8,250 youngsters who are delinquency prone are served.
—Over 7,000 children are provided day care services.
—Approximately 25,000 calls to our emergency mental health line are received each year.
—We operate 8 institutions on a 24-hour per day basis, 365 days of the year.
—We detoxify approximately 15,000 alcoholics each year.
—15,000 persons are screened for high blood pressure each year.
—7,000 families are provided with protective services each year.

I have given these examples in order to stress the enormous growth which has developed in many areas in the Department's workload. During its 5 years of existence, again despite the sometimes phenomenal increase in workload, the number of District-funded positions, which account for approximately 80 percent of appropriated dollars, has shrunken persistently as the result of base reductions or transfers to other departments. During the period FY 1971 to the current fiscal year, appropriated positions declined from a level of 10,146 to 8,768. With your help, to overcome some of our problems the authorized level for FY 1977 has been increased to 9,317.

In summary, Mr. Chairman, the Department of Human Resources as the largest single agency in the District of Columbia now serves six times as many clients as were served by the four separate departments that existed prior to its formations—but, with about 1,500 fewer staff. In addition, the Department provides more coordinated services to its clients, many of whom have multiple service needs. As I've stated previously, while the shortcomings of DHR are continyously highlighted, rarely, if ever, are its accomplishments recognized.

I recall, as I'm sure the people of this city do, when I first joined the D.C. Government as a member of its first appointed City Council, that welfare mothers were marching all over the city and literally tearing down the doors of our welfare facilities. This pattern continued for several years with a constant demand of welfare mothers to be rendered services to which they were entitled and to be treated with respect. Since becoming director of DHR those problems were eliminated. Welfare organizations now meet with me and my staff on a regular basis to discuss mutual problems. Moreover, the salient principle of the system I have installed is that every client or patient is entitled to readily accessible services provided with courtesy and dignity.

There have been other significant accomplishments:

—A welfare reform program for job training and placement for public assistance recipients has been instituted.
—19 contracts with bargaining units covering 5,000 employees to improve labor-management relations have been enacted.
—DHR employee advisory groups have been established to work directly with management.
—Integrated decentralized service centers functioning directly in the neighborhoods have been established.
—Unified intake procedures were implemented to combine AFDC, medicaid, and food stamp eligibility determination.
—Deinstitutionalization for children and adults was established.
—A conversion from the declaration method of determining eligibility to the verification method of determining eligibility for public assistance recipients was accomplished.
—We established our own SITE (self-improvement through employment) program to complement training opportunities for AFDC mothers who were otherwise ineligible for enrollment in the WIN program.
—A differential detention plan which established different levels of detention for youths was developed to compensate for the loss of the receiving home.
—A comprehensive child care plan for unified comprehensive services to children and their families was developed—a first in the Nation—covering programs for children from prebirth through maturity.
—A District of Columbia identification numbering system for payments and social services clients was implemented.
—A sexual assault program to integrate services to rape and other sexual assault victims was established.
—A human resources management information system task group was established to develop a truly comprehensive data processing information system for the entire department.
—A management planning system to improve the overall efficiency and effectiveness of service delivery was established.
—A 24-hour protective services program for adults and children was established.

It is obvious, Mr. Chairman, that the demands of such a position and its far-flung facilities clearly require immediate access to efficient transportation. I respond to situations throughout the day and many times every day of the year. To me, it comes down to a point of, if such a super-department is to remain and I am to continue as its director, then the very basic tools of the job should be provided. We have checked the practice around the country as relates to the provision of cars for official use—including home to office—for similar positions and clearly the practice followed here in the District not only is repeated throughout, but most often in a more liberal fashion.

While quite properly, questions have been raised about the acquisition of the cars with maternal and child health funds, there should be no question of the requirement of such transportation by the director of this Department.

Mr. Chairman, I am extremely desirous of getting on with the serious business of providing vital services to the poor and deprived of this city, rather than spending my time dealing with issues outside of service delivery. I assure you that I am quite concerned about such issues and will move to solve those now before you and, more importantly, strive to see that no new ones come up. I have no desire to be provided any resources above and beyond those necessary to do my job. Though I view, for instance, air conditioning in a car in Washington, D.C., not a luxury, I assure you that I've done without it before and I can do so again.

Mr. Chairman, with the U.S. Congress and the District of Columbia government working together for a common cause—and not against each other—we can build and produce a prosperous Nation's Capital, a city of hard-working citizens, a city of people striving for the existence of the essentials of democracy and working in the interest of democracy. And more importantly, a city of people who know that their government, Federal and local, executive and legislative, are working for them.

People who have faith and trust that government managers are honest dealing, responsible, and have high, intelligent, worthy ideals and purposes deserving of their support. It is to this end that we seek your support to get on with the business of providing vital services to over 200,000 of our most needy citizens through the Department of Human Resources.

SUMMARY OF STATEMENT

Senator CHILES. Do you want to summarize that for us?

Mr. YELDELL. Mr. Chairman, the statement simply indicates that the Department of Human Resources, is indeed as massive as people have said it is. It does require a great deal of effort to run it. It has locations all over the city of Washington, in Maryland as far north as Laurel, in Virginia as far south as Occoquan.

There are certain tools required to do the job. In addition to this, we run about eight institutions on a 24-hour basis, 365 days a year. I think that the issue of having the necessary tools, one of which in this case is the transportation necessary to move to those locations on a demand basis, including weekends and holidays, is a critical one.

My concern is that those kinds of tools be given. If indeed that is not to be the case, it would seem to me that another approach ought to be taken to this as it relates to the operation of the Department. I think that what I have attempted to do is discharge my duties the best that I can in all of these locations at all times.

It is to that end that the issue comes before you now about the vehicles which I hope will clear up. I am very concerned about running this Department, providing services to over 200,000 people a month. I have been very fortunate in that you have helped us in this just in the last fiscal year.

I believe that the support of the Congress in this effort can get us in the posture where we can do a credible job in the Nation's Capital. It is unfortunate that we are constantly being bombarded by the things that are wrong in the Department with no attention ever being given to those things that are being done with great success and serving this number of people on a regular basis means that we have to be doing some things right.

I am as concerned as you about the propriety of our actions. I am as concerned as you that we exercise good judgment in everything that we do. I would hope that we can resolve this particular issue, all that you have mentioned in this statement today and that we can get on with the business with your help in making this Department one that the Nation can look to as an example of how human resources can work.

WORK EXPERIENCE OF MR. YELDELL

Senator CHILES. Mr. Yeldell, when were you appointed to your present job?

Mr. YELDELL. November 30, 1971.

Senator CHILES. Would you tell the subcommittee of your work experience prior to becoming the Director of Human Resources?

Mr. YELDELL. Yes; I have been trained as a mathematician. I taught school originally for 3 years in Pittsburgh. I came to the District where I taught school for 1 year at Coolidge Senior High School. I stayed there until 1964 when I joined the IBM Corp. I stayed with IBM through 1971.

During that period of time, I was appointed as a member of the first Council, of the District of Columbia. I left IBM permanently in April of 1971. Later that year, I assumed the responsibility as Director of the Department for Human Resources.

Senator CHILES. What were your duties with IBM?

Mr. YELDELL. I started out as a marketing representative in the data processing division. I worked in various Federal posts, including the White House. I also did some special programs for IBM in the area of training the underprivileged in the use of data processing equipment. And I have served as a junior executive and then later in terms of full responsibility for programs dealing with the unskilled, not only here, but in other parts of the country.

PURCHASE OF AMBULANCES FOR MATERNAL AND CHILD HEALTH PROGRAM

Senator CHILES. Mr. Yeldell, would you tell me why the Department of Human Resources purchased the two ambulances with Health, Education, and Welfare grant funds as reported by GAO on September 17, 1976, and then they remained idle for some 17 months?

Mr. YELDELL. Mr. Chairman, I think there are several parts of this that have not been made public as of yet. No. 1, the ambulances were purchased with what is described as year end money from the maternal and child health program. This was not a part of the regular grants program of the maternal and child health effort.

In June, at the end of the fiscal year, the region scouts around the region, sees how much money is remaining. It then contacts the States to see if they can indeed use these funds for a very prudent purpose within the time frame left in the fiscal year. It was in this manner that we received the money for the ambulances for a new program to be instituted at the District of Columbia General Hospital.

I might say that regional personnel had already made reports that this kind of effort was needed to deal with high risk mothers and the whole problem of the infant situation facing the city.

I think it should also be pointed out, Mr. Chairman, that these are not just ambulances that could be turned over to the fire department. These are really nurseries on wheels.

The whole intent of the infant newborn program is to have extremely well-equipped vehicles that can deal in the transport and assistance of a mother in the delivery of a child in the most unusual circumstances.

I think it would be very difficult to sandwich this in between the normal emergency room that the fire department would encounter. It may be necessary to stop the vehicle and assist the mother for some period of time.

As you know, the pattern of use of the fire department ambulances is to transport to the nearest hospital as rapidly as possible and be back in service.

I think that these factors ought to be understood. We are dealing with situations that can mean the life and death of the mother and/or the child.

Senator CHILES. How many mothers have used these ambulances?

Mr. YELDELL. We didn't assist any mother with these vehicles because——

Senator CHILES. It would be a lot better if they were being used by the fire department instead of sitting there rotting in the lot and not being used, wouldn't it?

Mr. YELDELL. I don't think you have been told, but the fire department couldn't use them either. They did not have the drivers to maintain the vehicles. Fire Chief Johnson told me they would have been part of their reserve fleet.

I think we ought to make it clear that there are going to be other instances in the city of Washington where this kind of equipment is going to have no use because of shortage of personnel.

HEW'S OFFER TO PROVIDE FUNDS

Senator CHILES. What I hear you saying is when it gets to be the end of the year, everybody looks around and tries to determine if there are any Federal funds that are going to go back. So the reaction is to figure out how you are going to use those Federal funds; and you happened, or somebody happened to pick ambulances.

It is one thing to say we are going to get all the Federal funds that we are entitled to; but it is something else to say we are going to take them whether we have a real need or not. To take the Federal funds and buy ambulances and then have them sit idle is a clear waste of the taxpayers money.

Mr. YELDELL. It is the opposite of what I said. We were asked to take these funds by HEW. We didn't search out the funds. The program was intended to be implemented in the following fiscal year. I am sure you are very aware of the problems we have been having in terms of implementing programs based on decreasing rather than increasing budgets.

I think the pattern is a little bit different. I think the implication has been that we did just as you said, sort out these funds for a purpose not to be implemented. It is not that way.

Senator CHILES. Are you saying that the regional HEW office induced you to use the funds?

Mr. YELDELL. HEW came to us and asked us could we use the funds and for what purpose. We indicated that we were moving to establish this program at District of Columbia. General Hospital. They said it was a valid purpose since they had already talked to us in previous situations.

On that basis, the funds were made available.

Senator CHILES. Did you know when you took the ambulances and when you requested the ambulances whether you were going to have the funds to be able to utilize them or not?

Mr. YELDELL. We fully intended to staff those ambulances in the very next fiscal year. We were not able to do that because we were not able to ask for funds for any new programs.

Senator CHILES. Mr. Yeldell, it doesn't seem like very good management, to me, to take this sum of money, put it in two brand new ambulances, sit those ambulances out in the back lot and allow them to sit there, except to start them up once in awhile and take them down to the motor pool to see whether they are running or not. That doesn't seem like good management.

When this subcommittee heard the problems that you had at Forest Haven we tried to do something about it. We heard of other problems that you were having in bill collection. We tried to do something about it.

I don't think we have ever been told that we had two brand new ambulances that the Federal Government has paid for and that you have got a critical program need to operate those ambulances.

You gave a wonderful example of why mothers would need this program and what the emergency would be, but no mothers have gotten to use those ambulances yet and never will as long as they sit in the back of that lot.

Mr. YELDELL. My problem is this: my program people, not me personally, moved in this venture. They did it with every good intention. They moved to acquire what was an essential item to operate a very good program.

The fact that they were not able to implement that, based on continuing funding shortages, I think, misrepresents the fact that there was any intent to get these vehicles and not put them in use.

Senator CHILES. I talked a long time ago to a fellow when I was running for office in 1970, he said something that just rings so true. He said, "Government don't work." And the people are finding it out.

What you are saying is that Government doesn't work. If that is going on, everywhere, and if it is routine management practice that you take funds like went into those ambulances and say when you did it, that they are needed for a program, but then allowed them to sit there for 17 months, then everyone would agree that Government doesn't work.

QUESTION OF RESOURCES VERSUS MANAGEMENT

Mr. YELDELL. We are dealing with a question of resources rather than management. I think the point that we are trying to make to you here is that program people moved ahead with every intention of implementing a new program.

Senator CHILES. That is management. That is a management decision that somebody made that if we get those vehicles, we are going to be able to use them.

Mr. YELDELL. That is logical. They were talking in June and the next fiscal year started within 30 days. It was very logical. It just didn't happen. I think also the other part of the problem is, again we are zeroing in on one portion of the management of the maternal and child health program, which happens to be distasteful; but on the other hand, that program has done a terrific job in decreasing infant mortality in the city.

It is the same kind of situation I am talking about that always happens in DHR. As long as a program is running fine, nobody talks to our people and certainly nobody gives me any credit. Let one thing go wrong, and you go back to me, management, wanting to know what is wrong.

If the resources are not provided, the job cannot be done.

Senator CHILES. If it was one thing, Mr. Yeldell, I might agree with you; but it is not one thing. It is one thing after another. That is what concerns me.

For the life of me, I just can't understand how you can say that this is no real problem or that we are going to have a few things like this. I don't see how you can say we are going to have a few

ambulances and not use them. If every city in this country has a few ambulances sitting out back that they got with Federal tax dollars and that are not being utilized, that are not doing anything for the people that need the services, that aren't doing anything for anyone else, then we are in bad shape.

Mr. YELDELL. Let me say it this way to you: I think the program has attempted to move through this problem. The movement to staff it now has been completed in the sense that the ambulance company that has been working with Children's Hospital in a similar program has agreed, under contract, to provide the same service for us.

MOVE TO STAFF AMBULANCES

Senator CHILES. Did you take this to the City Council, did you take this up in your budget that you presented to the Mayor? Did you point out that you were sitting with two ambulances that you could not use because you did not have funds available?

Mr. YELDELL. Not in that detail, Mr. Chairman, because we were also operating——

Senator CHILES. Then I don't think you have done your duty.

Mr. YELDELL. I am also under restrictions to not ask for new programs. Where does my duty lie; in response to the Mayor's call for the budget or to over top that? What we attempted to do is solve the problem. We are not saying that we are proud of the fact they were not used.

What we are doing now is trying to get them in use as rapidly as possible. People have been temporarily licensed so that those vehicles can come off that lot and be put to use.

Senator CHILES. The General Accounting Office indicates no one knew they were out there, that you didn't know.

Mr. YELDELL. I personally did not know, sir. That is the whole point, I did not know. That is not surprising in terms of what we are trying to deal with.

Program people knew and program people tried to resolve the issue. To the extent they could, they took every step they could take. To the extent I knew, I have done everything to support them.

What I have assured myself is that the contract will be in place and the ambulances will be utilized.

Senator CHILES. Mr. Yeldell, I would feel much better if you told me, "Yes, I didn't know they were out there. It is such a big department, I can't know every minute every thing that goes on."

Mr. YELDELL. I thought I said that.

Senator CHILES. You said program people knew, but they were doing everything in their power to get them used. If you had run somebody off, if you had come up here and said, "Yes, somebody knew they were out there and didn't do anything about it, and I ran him off or I did something about it," I would feel like you were exercising some management responsibility; but to now say that they were doing everything and that you didn't know——

Mr. YELDELL. Let me just say it bothers me that they weren't used. It bothers me as much as it bothers you. It obviously means services that could have been provided were not provided. It obviously means there is another plight in terms of what is happening in DHR.

It bothers me enough to make sure it doesn't happen again. I have instructed my Assistant Director of Administration, to assume personal control of the procurement of any vehicle and not to approve it unless he is assured that if the vehicles arrive, that they will be immediately put to use for the purpose for which they are bought.

MEDICAL VANS

Senator CHILES. What about your two medical vans that haven't been used since 1975?

Mr. YELDELL. It is a similar problem. Those are buses. The whole intent here was to have people who could not only drive the buses, but assist the patients. This is a screening kind of operation with early perodic screening diagnoses and treatment.

What I have found in attempting to get this together, is that people have been found who can be trained to do the testing and screening, but will not consent to drive the vehicles.

The schools which gave us the grant knew at the time that staffing would be required and they could offer no additional assistance from a resource point of view.

The same situation confronted us on the other end where we could not get the resources in the regular appropriation process because we could not request the funding for new programs.

FREEZE AND REPROGRAMMING OF FUNDS

Senator CHILES. Did you have a freeze back in 1975?

Mr. YELDELL. We have had a freeze every year since early 1973.

Senator CHILES. Under a freeze, can't you reprogram and change your priorities?

Mr. YELDELL. I suspect Mr. Coppie could better answer that. My problem is that a freeze means that you cannot move, if a position becomes vacant, it remains vacant. You can't refill that unless you get a specific exemption to the freeze.

Senator CHILES. But the freeze doesn't mean that you have to continue to do something exactly the way you did it every day, that you can't move people around, that you can't do something in a better way.

Mr. YELDELL. That is correct.

Senator CHILES. You can reprogram within your existing resources.

Mr. YELDELL. You could, to the extent that they would be approved.

Senator CHILES. So you could have reprogramed, in effect, under the ambulances and under the vans, too?

Mr. YELDELL. No; because when you do reprogram, you have to have the resources to do it with.

Senator CHILES. You are saying that everything else that you were doing was more important than providing that kind of care for the mother and taking care of her in that emergency situation that you described to the subcommittee as being the justification for getting the ambulances?

Mr. YELDELL. I didn't say that; but the problem in the Department of Human Resources is that you do run into the problem where you have all of these things competing with equal priorities.

We have District of Columbia General, a life and death situation. We obviously had a situation with Forest Haven, Glen Dale, District of Columbia Village. You run into this kind of problem.

What is very difficult, Mr. Chairman, is for years this Department has had an ever-increasing caseload and an ever-decreasing number of personnel to perform those duties.

It is true that we now have in the combined Department of Human Resources some 1,500 persons less than we had in the pre-existing separate departments. The caseload has increased by a factor of six.

When you start trying to spread those resources out to do the job that has to be done, things are going to suffer. You are not going to be able to do everything you want to do.

What I am trying to say to you is the concern you are exhibiting here, I have the same concerns and we want to try to make every effort we can to make sure those things do not occur. We want to monitor these things and see that there is some other way to solve the problem.

I would as soon have those in use, whether they be by my Department or any other element of the District of Columbia government.

Senator CHILES. Again, just the idea that you are misusing those Federal dollars when we have inflation and when we are operating at a deficit. We have been operating at a deficit at almost every level in the Federal Government.

One of the reasons we appropriate money is because they say there are human needs out there and it is necessary to do something about the human needs. I know there are human needs out there.

IMPLEMENTING PROGRAMS UPON RECEIPT OF FUNDS

But to think that those tax dollars that went into those vans and ambulances are going to sit there and not be used when there is a demand in fire departments as there is in the District, as there is in many other places around the country for Federal funds to be used to help meet human needs.

Mr. YELDELL. Mr. Chairman, it bothers me, too. I don't want my people to ever request a dollar, District or Federal, that they really can't put into use. What I am saying to you is I will make every effort to make sure that no one requests a dollar from the Federal sources or even the District sources that they cannot show me that they are going to use to implement a program and to do it as rapidly as possible.

But under no circumstances, Mr. Chairman, do we intend to let this happen again and under no circumstances will we allow those vehicles to remain unutilized.

Senator CHILES. Do you think that whoever was making the decision not to reprogram and use those vehicles made a proper decision?

Mr. YELDELL. Sir, I think that an effort should have been made in the Department of Human Resources to get those vehicles into use. I had a meeting this morning with my executive staff and made it very clear that as a measure of performance, this kind of incident will be the kind of thing that I will use to indicate that a manager is or is not performing his job properly.

It is that kind of thing, Senator, that I intend to apply across the board. I have scheduled individual meetings with each element of the Department over the next 2 weeks to make it very clear that I do not want to be in a posture where there is this kind of a situation or where there is any other situation where we have acquired funds to implement a program and have failed to do so and we have not taken steps to either get it under operation or to see that the utilization takes place somewhere in the District of Columbia government.

Senator CHILES. What kind of meeting have you held about the results that we now see from the HEW audit team on District of Columbia Village?

ADDRESSING PROBLEMS IN PUBLIC ASSISTANCE AREA

Mr. YELDELL. I think as Mr. Lowe indicated, in addition to working inside the Department, we are working with GAO. Mr. Chairman, the problem in the public assistance area is, as I am sure you know, a national problem.

It has its basis in the fact that HEW required that the District and all other States use what is called a declaration method. We had a situation where people came in and simply declared they were eligible and got on the rolls. Our problem is now trying to weed out those rolls.

We have done several things. In addition to working with the GAO, we have taken some steps on our own. We have worked with HEW to do a pilot project here, first here in the Nation, of exchanging our data tapes on AFDC with Maryland data tapes.

We run against those on a twice a year basis and when we find a problem, we move to deal with those situations of obvious fraud and/or overpayments. We also take our tapes and bump them against the unemployment compensation rolls to make sure people are reporting all their resources. Where we find that is not the case, we move to make the adjustment for overpayments and refer it for prosecution where necessary.

In addition, we, as you have been told by GAO, initiated an extensive review of each one of our AFDC cases. We have not done the 6,000 reported to you, but 16,000 of those cases. The percentage of error has dropped somewhat below 21 percent. It is still at 19 percent.

The fact is that if we can continue doing those at the same pace, over $10 million will have been realized from just this one effort.

Senator CHILES. When were you first asked to move on that, wasn't it 1971?

Mr. YELDELL. No, sir, I was never asked to move on that. I didn't come in until the end of 1971. I have been trying to find ways to deal with this problem ever since I have been there.

Again, the welfare caseload has increased from some 16,000 to 321,000 and rather than get more workers to deal with the caseload, we have had less. You have just given us 50 to try to deal with this problem now. We can't continue to deal with the cases bringing new people in and do the recertification on a timely basis without the staff to do it.

I have taken 85 people from across the Department, from their very needed jobs to move into this area, to eliminate ineligibility and overpayment. I think the results to date are quite satisfactory.

The fact is we now have eliminated many cases from the rolls as purely ineligible. We have reduced the payments in many cases and at the same time, found some that were underpaid; but after making all of those adjustments, the net gain to the city is about $10 million, $10,900,000 in savings that we have been able to bring in meeting increased caseloads without asking for new dollars.

ADDRESSING PROBLEMS IN GENERAL PUBLIC ASSISTANCE AREA

We have done the same thing in the general public assistance area, which is a total local work program. We have found with proper management, we could reduce the time for limited disability from 1 year's duration to an 8-month duration, and as a result, reduce the 1977 budget which was just approved by the Senate, by $6.8 million in 1 year, which is a recurring savings.

I think that, again, it is a critical problem. I have put every resource I have in it to try to solve the problem. I think that here where GAO mentioned a $26 million problem over 5 years, in the space of 2 years, we have got 10.9 million in AFDC plus $5 or $6 million more in other areas.

Senator CHILES. I see what GAO mentioned in their report on this. It reads—

> What concerns us is the gravity of the situation has been known since 1971, 1972, 1973, and 1974, yet no effective corrective action was taken. The Department's eventual corrective action deserves recognition.
>
> I don't think we can be accused of abusing the privilege of hindsight when we expressed the opinion that a more prudent manager would have moved this faster.

Mr. YELDELL. A more prudent manager with resources, yes. I have tried to find ways to get to all of these problems. The bulk of this money occurred from about 1969 to 1973, 2 years before I even came to the Department, almost 3 in fact.

I have tried to deal with the problem. GAO recognizes that our recertification project is having excellent results. Our project in terms of using the unemployment tapes has excellent results. We have closed a great number of cases and saved almost $17 million in 2 years.

PROBLEMS AT DISTRICT OF COLUMBIA VILLAGE

Senator CHILES. The question I started out asking you was about the HEW audit team that found that District of Columbia Village does not meet Federal standards. What is wrong with District of Columbia Village?

Mr. YELDELL. They were dealing with only a portion of District of Columbia Village. The medicare people viewed that portion dealing with skilled care. What they have cited are some problems relating to staffing which is the primary problem and some problems relating to environmental control.

The problem at District of Columbia Village is here is a facility that was built just on the ground about sea level. There are problems with rodents all over the area. There are problems with water coming into the facility. This was a facility built 10 years ago, 1967, I believe.

What we are trying to do there is deal with the physical effort while at the same time trying to deal with the problem of staff. I think the assertion is we have staff for about 450 patients and we currently run a patient load of 550.

Yet there are some 300 people waiting to get in. We have been trying to provide a service to the chronically ill of this city with the best resources we could. Now we have been called to task because we are out of kilter with the staff requirements that the Federal regulations have set up. We intend to appeal the decision. We think we can resolve the problem without loss of medicare or medicaid.

ACCREDITATION AT DISTRICT OF COLUMBIA GENERAL

Senator CHILES. District of Columbia General can't seem to get its accreditation back. It has failed the test twice in 1 year.

Mr. YELDELL. District of Columbia General now has for the first time a professional hospital administrator. The first survey cited some 83 deficiencies. Between the first and second surveys, 43 of those were corrected. The last survey has caused great dismay among the medical staff.

I emphasize "medical staff." They have examined the report. They have decided to appeal that on the basis that the findings are not warranted by the survey that was accomplished. As a matter of fact, some of the deficiencies they listed were not even applicable, not due until October 1976.

In about 2 weeks, they will be going to Chicago. They will begin the appeal process. They feel confident that they can turn it around. I think that they can turn it around. I think that this is the thing, that though they give a report, we have the process of appeal. I think we are going the appeal route as opposed to the previous case where we asked for a resurvey. We feel a great deal was done in that process.

Thirty nine of the deficiencies they cited in the latest survey all deal with the physical plant. This Congress has appropriated as of fiscal 1976, $14 million to correct that. They were given the documentation on that. They were given the actual bill that was passed that indicates that money is now available and the corrections would be done.

The 39th item they list as a deficiency is really a statement that the 38 items above will be corrected when the program is implemented on the remodeling of District of Columbia General. We think we have done a very great deal, Mr. Chairman.

We still have a problem in nursing, but so does every other hospital. We have a problem in medical reports; but it is nowhere near as severe as it was. It is still a problem, but not of the magnitude that would require disaccreditation. We feel strongly that there are many efforts that will move that hospital back where it ought to be.

BILLING SYSTEM FOR HOSPITALS AND CLINICS

Senator CHILES. Last August, in a public hearing, you explained to the subcommittee why the Department has not been able to implement a billing system at the city hospitals and clinics. GAO has asked for that since 1972.

You explained to the subcommittee how it took your Department from April to August to draft a piece of legislation that you said was required to implement the billing system. Then you told us it would only do half of the job and still another piece of legislation would be needed later.

Have you submitted the necessary legislation to the City Council with regard to the billing system that we asked you to implement?

Mr. YELDELL. Yes; the bill has been submitted by the Mayor to the Chairman of the City Council. That bill includes the right of the Mayor to establish the rates which was what we were talking about when we said additional legislation.

That bill was just sent over, I believe, yesterday. We worked from the time we left here with the Corporation Counsel, the Legislative Office, and with the City Administrator, to make sure that we had a bill that would indeed accomplish the things that have been suggested here.

I would also say, Mr. Chairman, that the computer programing necessary to implement the system is in place, that the steps are underway to hire the 86 people as soon as the budget is finally approved for 1977.

Those people will be put onboard as rapidly as possible and put immediately to use, primarily in the inpatient operations to begin with, because that is where the greatest return can occur.

You have reduced the medicaid availability by a million and a half. We feel that with the personnel you have added, we can meet the objective of this committee that we increase medicaid collections. We think we can do it to the tune of the million and a half, which really becomes $3 million when you recognize we lose the Federal match; but evey effort is underway to implement that system.

Once the legislation is approved, as relates to clearly defining what is in the Federal interest, we will move as vigorously in that manner as well.

PURPOSE OF MATERNITY AND INFANT CHILD CARE PROGRAM

Senator CHILES. Would you tell the subcommittee the purpose of the maternity and infant child care program?

Mr. YELDELL. The most basic way I can say it is to deal with the problem across the country of high infant mortality. The program has moved forward to reduce that here in the city of Washington. There is a definition of what they are supposed to do in the manual. But primarily, it is maternal child health and crippled care program, which is geared to the care of mothers, infants, and obviously those children that are crippled.

ACQUISITION OF TWO VEHICLES

Senator CHILES. Would you tell the subcommittee how your Department or how you acquired two vehicles under a grant for the stated purpose of serving the maternity and infant child care program?

Mr. YELDELL. Mr. Chairman, when we originally requested the vehicles, it was for the purpose as we stated. It was to put them in the maternity child health program. We certainly realized long before the vehicles were acquired that we really wanted to use them in

the area of executive direction and support. In my judgment, we erred in not notifying HEW of the change of purpose. We erred in changing the project directly. Each grant carries with it an overhead cost factor called indirect costs. In the case of maternity and child health, it is about 14.2 percent right now. What we should have done was charge those vehicles to the indirect cost provisions and if we had done so then, their utilization would have been proper.

Had we not done that, having them charged to the project caused additional problems.

Senator CHILES. Still would it be proper to have the size vehicle you had?

Mr. YELDELL. Let me say this in relation to size, as far as I understand it, the Department requested that the Department of General Services procure vehicles, as I recall the original request was to do this along with the purchase of police vehicles so that the mass purchasing would obviously give the vehicles proper cost.

That was not done. A single purchase was pursued. As I understand it, there is now the question that there was a limitation on the dollar amount. I am not sure that that limitation applied to leasing the vehicles or that it applied to leasing them using grant funds.

NEWSPAPER QUOTES

Senator CHILES. I notice from the way you are quoted in the paper on the subject, Mr. Yeldell, looking at an article that was in the Washington Post, Friday, September 10, 1976, in which it says, "Yeldell said he disagrees with the GAO claim that Federal money was misused and called it 'ridiculous'."

The following appears as a quote: "'I am running a department of 10,000 people and spending $400 million a year and somebody's going to quibble about my having a car assigned to me,' he protested. 'Anybody of cabinet rank ought to have a car assigned to him.'"

Mr. YELDELL. I did not say that the GAO concern or investigation was ridiculous. My remarks were directed to that reporter in relation to whether or not I needed a car to discharge my duties. I never considered GAO's intervention or its report as ridiculous.

Senator CHILES. "Yeldell said yesterday that if DHR was not entitled to the cars, the Department of General Services should not have arranged to lease them. The procurement officer has the responsibility to see that city government leases are legal, he said."

Mr. YELDELL. That is nothing more than a reference——

Senator CHILES. Colonel Starobin says based on the representations that were made from memos that he received from you as the head of the Department, that it was an emergency to get the vehicles for the project purposes. That after Starobin first said we shouldn't do this, we are exceeding the ceiling price, that he went ahead and OK'd it.

Mr. YELDELL. Mr. Chairman, the period of time we are talking about here covers almost 18 months. Let me preface it again. I certainly regret we are here on this issue.

Senator CHILES. I do, too, Mr. Yeldell.

Mr. YELDELL. I am sure you do. I want you to know that I do, too. From my point of view, I really want to get this resolved. I would like getting your help in moving ahead with this. My comments there again were at the end of a conversation. My statements were directed to the point that my operation led me to request someting of a procurement officer.

I simply said that is the procurement officer's responsibility then to move forward from that point. I don't wish to push anything on Colonel Starobin here. I accept the fact he acted because we asked him to.

Senator CHILES. You accept that now?

Mr. YELDELL. Of course, I do. I accepted it then. My comments then to the reporter dealt with the division of responsibilities. But I am sure that the Colonel, as he has tried to do in the past, has been trying to work with us. Mr. Chairman, I would like to see the issue resolved completely.

I would like to see it dealt with perhaps as rapidly as possible, if it means the termination of the lease. If it means not using the cars, whatever it means to get us back in the business of running the departments, I am prepared to do that.

INTENTED USE OF TWO CARS

Senator CHILES. You still haven't told me how you made a request under the grant funds for the maternity and infant child care program and say it is necessary for you to have two cars under that program and then never use those cars under that program.

Mr. YELDELL. Mr. Chairman, maybe I wasn't clear. When we originally made the request, that was the purpose. As I have said, this has covered a span of some 18 months. Prior to actual acquisition——

Senator CHILES. But before you got the cars, you changed your mind?

Mr. YELDELL. We changed our minds and we could have done that, Mr. Chairman, and used the indirect cost rate funds. Then they could have been used in the area of my use and my executive staff use.

Senator CHILES. How could that have happened?

Mr. YELDELL. Because the indirect costs are not direct project costs and can be used for the overall operation.

Senator CHILES. But did you need to use the funds for that? Didn't you have cars in the Department?

Mr. YELDELL. Here again, Mr. Chairman, there are cars. But I think that what is necessary is understanding the nature of the cars that we have. We have cars that date from 1954 up to 1970. We have them spread out all over the place to try to service all of our locations.

What we are attempting to do is not further fragment program operation. We have social workers, investigators who must go out every day and use these cars to take care of various activities that they are charged with.

MR. YELDELL'S CARS VERSUS CARPOOL VEHICLES

Senator CHILES. But these were heavier cars, they were fancier cars, they were more expensive cars that we are talking about. They weren't the general run-of-the-mill car.

Mr. YELDELL. You were saying we hadn't acquired those yet. You were asking couldn't we use cars that were already available. What I am trying to say is we are very much disadvantaged in the area of cars in the Department of Human Resources. We did a report in July that we forwarded to the City Budget Office that brought out part of this problem.

At that time, we had 310 vehicles and as I said, they dated in age from 1954 to 1970. The criteria says that they ought to be replaced each 6 years or if the mileage exceeds 72,000 miles. Of the 310 vehicles we had at that time, over 80 percent exceeded this criteria. We did an analysis of what it cost to maintain the vehicles. In most of the areas of passenger carrying vehicles, we were spending more in maintenance than the acquisition cost of the vehicle. We laid all of this out and tried to go through the formal process of procuring additional cars. We showed where we could buy 43 new cars, adding them to the fleet, and end up spending less money than for the maintenance.

Senator CHILES. These two cars weren't bought under a fleet arrangement. They had to be bought specially. They had to be bought where you didn't get a fleet price.

In fact, the price was then so high, you decided to lease them on an annual basis because the price exceeded the limitation.

Mr. YELDELL. I am mixing two of your questions together. I was trying to deal with the issue of why we couldn't use what was already available. As it relates to this, I am taking a note of what has been stated here. My intent is to get this problem corrected.

Senator CHILES. In its annual report to the Department of Human Resources on motor fleet operations, the Department of General Services intends to point out that 12 sedans and station wagons were by District standards underutilized during fiscal year 1976. One of these vehicles accumulated only 627 miles compared to a 12,000 mile standard over the 12-month period.

Mr. YELDELL. What it doesn't show is why they weren't utilized. If you look at the state of some of our vehicles, I think you will find out. They are tied up in repairs. They can't be run. We have situations of vehicles being out on the parkway with wheels running off.

The problem is there has been no movement for new vehicles to be acquired. We are running vehicles almost 20 years old. The fact, Mr. Chairman, is that you can't do that. That is the problem we are running into. You can't just look at it from utilization alone. You have to go behind that vehicle to find out why it is not being used.

Senator CHILES. You have two brand new medical vans and two brand new ambulances you aren't running wheels off of.

Mr. YELDELL. No problem, Mr. Chairman. I told you, my intent is to make sure that doesn't happen again. That is a little bit different than the regular fleet we have been operating.

USE OF GRANT OVERHEAD FUNDS

Senator CHILES. Mr. Yeldell, the concern I have is again a statement that I keep hearing you say that we have got the money that we could utilize under our overhead funds, we have got some money we can utilize under grant funds to overhead funds. As I recall this is part of the money that was used for a $30,000 office renovation in your office. Those are some of the funds that were going to be used to do the kitchen.

Mr. YELDELL. Which we didn't do, Mr. Chairman.

HISTORY OF CONGRESSIONAL CONCERN

Senator CHILES. Now you are saying even though you misrepresented, or your Department misrepresented the purpose for which these cars were going to be used, you could have used your overhead funds anyway and you could have gotten a car that way. The reason I am stressing this is that the Congress has been concerned and this subcommittee has been concerned years before this Senator came to the subcommittee about the use of cars in the government generally, and more specifically in the city government.

When Senator Inouye was chairman of this subcommittee, how many cars did he find at the time, Mr. Mayor?

Mayor WASHINGTON. I don't recall exactly.

Senator CHILES. It seems like there were around 11 of them, that people that had cars and chauffeurs at that time. That is just a figure off the top. I can't really remember the exact figure. But as I recall, he specifically pared that down to where it was left in which the Mayor had a car and had a specific driver.

Mayor WASHINGTON. What they did was also give me the authority at that same time to make the determination of those who would have essential use of cars.

Senator CHILES. But then this particular subcommittee has taken issue with the request made by the chairman of the City Council, approved by the City Council, for a car and driver for the Chairman of the City Council.

Later, the Chairman withdrew that request as I recall, at the time we went to conference because the House had made a provision for that. Yet, we find that you have a car, bigger, better than the fleet that the city is buying. The Department of General Services questions the use of a car with that kind of an engine, that kind of cost. They are told you need it anyway, it is necessary for the program.

You told me before you obtained the car, you knew it wasn't going to be used for that program. Yet, Mr. Starobin says that he got the request in December, just before the car was purchased in the first week of January and he was still told at that time that it was for the project purpose.

That is why it had to be obtained right away. Why was that statement made?

Mr. YELDELL. The cars weren't really acquired until March.

Senator CHILES. When?

Mr. YELDELL. In March.

Senator CHILES. I thought he said he got them off the lot in January.

Mr. YELDELL. No, sir, the cars could have been available at that time. The color of the cars was green. I didn't really want to get in any situation where we were using anything other than what were government cars at that time, either black or tan. Mr. Chairman, let me say further, that the responsibilities of the Chairman of the Council, though they may be vast in the legislative area do not really correlate with the kinds of responsibility I have nor does it require his movement among the number of vocations that I happen to have. I would like to put it in that light, rather than ranking it in importance. I am talking about utility, in terms of moving around to discharge my responsibilities. What we are really trying to do here, Mr. Chairman, is just get a job done.

If we have erred in terms of how we went about the process, I would like to correct it.

CAVALIER ATTITUDE REGARDING GRANT FUNDS

Senator CHILES. What concerns me is in the brief time I have been on the subcommittee, I have looked at situations like Forest Haven where we are dealing with people that can't help themselves. We are dealing with the people that are at the bottom end of the spectrum as far as what they can do for themselves because of their afflictions.

We witnessed a kind of continuing neglect on the part of the city. Where there were plans that were not implemented. Even the plans weren't forthcoming or were delayed. Finally, the subcommittee, not at the request of your Department or the request of the city, said, here are the funds, go do it. We are dealing with the General Hospital failing accreditation. We are dealing with tremendous problems there. Then I look and see a $30,000 office and I see a renovation started on a kitchen and I see a fancy car that has gone with grant funds or comes out of grant funds which it wasn't used to support. This all shows a cavalier sort of attitude regarding Federal funds just as if because it's part of the overhead for the grants we can use it any way we want to.

I wish I had you on the carpet up here for taking some Federal funds, wrongfully maybe, and putting them in Forest Haven or taking some grant funds wrongfully and doing something for District of Columbia General Hospital. But every time I have you up here or every time I begin to question you, it is for taking those Federal funds and doing something to fix up an office or doing something to get a fancy car.

Mr. YELDELL. I think it is a little imbalanced there. Really, in relation to the issues raised, it wasn't an office. There were six offices that were dealt with. The cost, I think was reasonable. My concern in relation to the use of the funds is not cavalier. I am trying to assure you now that even with that process, I have made it very clear to our people that we will not request the Federal or District funds that are not going to be used in direct relationship to providing services to the people.

The situation at Forest Haven is not fair. We have moved ahead within the resources that have been made available. I would call your attention to the very time that you moved to deal with Forest

Haven in 1976, we had made every effort in our budget before the City Council to do the same thing. The City Council did not approve it. The Mayor vetoed it. They overrode the veto.

I am in a situation where I have tried to do exactly what you have wanted to do, but, of course, my movement as a department head limits me on that level.

RESOURCEFUL MISMANAGEMENT

Senator CHILES. Mr. Yeldell, you find a way to get funds when it is doing something to fix up the office or purchase fancy automobiles. In that you are a little more resourceful. You seem to always find a way.

Mr. YELDELL. I found a way with you in making the problem known to you when we never did that before.

Department heads did not come up here and ask anything out of the line of what was approved in the city. I made it very clear to you, and I resented the action of the Council and we did need the help and you responded. I tried to be resourceful in every area. I pushed money to District of Columbia General over and above what it had by taking it from everywhere in the Department. District of Columbia General was stuck with a budget of $24, $25 million for years. I got in there and got things for them through every means I have.

Now we have a budget that is approaching $40 million. We have tried to do all these things. What the problem is is the appearance we are trying to do things for ourselves. When I looked at that office redecoration, the plans called for two wash basins and a shower. We were in our office last night until midnight. A shower might very well be helpful.

But I knocked it out. It wasn't for any personal use. It was for the entire office use. But the point was after having reduced the project, I got a price estimate back from the Department of General Services that doubled the cost and I immediately terminated the project. I don't want to waste the money and I don't try to do things just for myself. The cars we are talking about were not used exclusively by me.

Senator CHILES. Do you keep a log on that car?

Mr. YELDELL. We do not. We will from now on. We have never kept a log on that car, but we will, if we keep the car.

Senator CHILES. Do you believe it is good management to pay $8,000 for cars that should have sold for $5,300?

Mr. YELDELL. I don't think it is good management to pay any dollars more——

Senator CHILES. But it is the Federal Government's money. So you go on and do it on a lease and you don't worry about whether the purchase price is too high, you just work it out.

Mr. YELDELL. But we can't discount the fact they were used during the period of a lease. When one leases and gets a service, you have to differentiate that from the cost of purchasing it. What has happened is simply adding up what the factor was. Sometimes you buy, sometimes you lease. When you lease, you do it for utilization and not for ownership. I don't want to go any higher than we have to pay

for it. That is why we tried to get them with the police cars. That is why we asked DGS. Let me assure you that will never happen again because we won't move to get any cars this way.

COMMENTS OF MAYOR WASHINGTON

Senator CHILES. Mr. Mayor, do you have any comments on this situation?

Mayor WASHINGTON. Which ones, Mr. Chairman? We have discussed a lot of them here today.

Senator CHILES. You can pick anything you like, ambulances, cars, vans, offices, rest rooms, District of Columbia General.

Mayor WASHINGTON. Let me just say first of all, Mr. Chairman, I think that this has served us all well. I have submitted to Mr. Lowe, a document that I believe deals with what their recommendations asked for. One of the elements that is important is that the leasing which we have been talking about is authorized in writing by the Federal grantor but what I have done is advise that all the vehicles, whether they are purchased or leased with grant funds or otherwise, should fall under the same general plan for acquisition and use. I think, Mr. Chairman, we have worked it out.

I think it is very important that Mr. Yeldell pointed out what he did. I think he has tried to be candid and he has indicated areas where he has erred. I have talked to him about these. We have had a long discussion about these matters and about what you regard as perhaps at some point, an appearance of being cavalier.

I don't think he is in that framework at all. I think there is much to be said about the fact that his Department is big. It touches about one out of every five citizens in this city in some form or another, either through health, social services or some other program. It is frank to say that the problems get far more consideration than the job he is trying to do.

The fact is as I said to him, the need for the cars is based on his responsibilities and his functions to move all over the city at all times of the day and night to handle emergencies, to handle human frailties as they develop and that should be the determination.

He has indicated that he erred. I think the error that I have discussed with him, not only with the buses, but others should be immediately corrected and not happen again. We have discussed this. My reason for going into the car situation was to see if it did not run over one Department. I simply wanted to find out. I have had our own internal auditor, Mr. David Legge, take a look at this as it comes along with his work of GAO. Mr. Coppie took the immediate initiative.

I was away when it developed. The City Administrator and the Corporation Counsel all looked at it. But it ran over three or four Departments, including the Department of General Services. The response I then made to Mr. Lowe. But I think there is something that has been said, Mr. Chairman, that gives me a feeling that perhaps all of the attitudes in context may be reconciled by the hearings themselves. You have been helpful.

You have recognized a number of the problems. It is my belief you will continue to be helpful. I am going to demand that these

departments, along with the material that I have already dealt with here, appropriately assign whatever requisitions and procurements that they have. But I think there is something bigger than that in this whole picture. That is the extent to which Mr. Yeldell indicates he has erred. The fact that he wants to take proper action, indicates that he wants to work with you, the committee, and the Congress.

PARTNERSHIP OF CONGRESS AND THE CITY

I am distressed from time to time these days as we seem to be pulling away from our partnership, in some sense. I don't know whether it is attitude or commitment. Certainly it isn't politics because nobody is intervening in that area. But there are suggestions. My comments are that I think that our partnership has got to be nurtured even to a greater extent so that we understand our respective roles and we discourage those because delivery of services is our important ingredient.

I have been pleased by your cooperation in this area of putting your finger on some of the problems that went beyond what our city position was. Quite frankly, the City Council overrode my recommendations and I was left to come forward to the Congress with a solid position, which I did.

You said you weren't bound by that. I wanted, at that point to have it understood, that I felt that my responsibility was to justify the city budget whether I agreed with all the elements or not. We are now in some serious fiscal crises just like in all the other cities and we want to make sure that the dollars go to the places where they should go.

I don't start with Joe, I start and end with him because he has got a big piece of the operation. But I make that clear to all of my Department heads. I have in cabinet meetings and personal visits. I think that we have got it together now. I am just hoping that the corrective action takes place immediately.

I have already taken some steps in reply to the GAO so we can get on with the business of running the city. It is a very substantive job. It is not an easy job in these cities. I am just saying to you that I want your continued cooperation. We need your continued cooperation in order to get the bigger job done.

Sure, as I talk to you, these little problems people understand and they have a tendency to grow out of. They could be attitudinal, whatever they are we have to get them out of our system and get on with the big job. That is why I am saying to you the kind of sensitive cooperation that we need to do the work, do the bigger job, I am hopeful that we are able to achieve and leave the room with some feeling that we have reconciled and resolved our position and partnership to a point where it can move the city forward as it must.

Thank you, Mr. Chairman.

Senator CHILES. Thank you, Mr. Mayor. I think to have a partnership, you have to have confidence. That works both ways.

Mayor WASHINGTON. Absolutely.

CONFIDENCE IN THE CITY GOVERNMENT

Senator CHILES. I think that we are talking about an issue between not just the city government and the Federal Government in this instance on grant funds. We are talking about confidence in the Home Rule project. We are talking about confidence in the revenue sharing program and the whole grant program that the Federal Government administers.

We are talking about the confidence and reliability that we can place in a request for funds for a particular program under a grant as to whether they are going to be used for that purpose. And when we get to a situation like the ambulances it becomes a question of confidence as to whether they are going to be utilized at all and not sit there for 17 months.

That really again comes back to a management situation.

Mayor WASHINGTON. I agree with you, Mr. Chairman, in terms of what we are talking about in management. But I think when we talk about the Home Rule process as I have said, I have had some serious problems that have faced me with respect to where the priorities are in the bigger picture. But I have got to work within a partnership.

It is a two-way street, as you say. I think that building of confidence depends upon sharing with each other. I can't say that too much because you have had that experience. I have too, in trying to manage this city over the years.

I have a priority in one group and Congress has another one. We are dealing with all of these problems. One is in the police area. Another one is with a settlement house. I haven't any problem with that, except I thought that in accordance with the process it ought to come and be presented within the Home Rule Charter concept.

Senator CHILES. I happen to concur with you on that. I just didn't happen to win.

Mayor WASHINGTON. But I am left with the problem, Mr. Chairman. I don't want to get into those things because I know you have been helpful. I know you raise these questions seriously.

WORKING WITH THE CONGRESS

Senator CHILES. What I want to point out, Mr. Mayor, is I might not be on this subcommittee long. Who knows? I might not face my test of accountability that I have to face. But if you are going to try to get somebody that will put in some funds for Forest Haven, that will put in some positions to try to collect tax dollars, that will try to put in additional personnel so that you can get some of the cheaters out of welfare, you are not going to have that person putting that time in if you are going to have ambulances that are sitting back there that are never used, if you are going to have advances that are never used and if you are going to have people putting in for grant funds and giving false information to get those grant funds. It is not going to happen, Mr. Mayor.

Mayor WASHINGTON. Mr. Chairman, I think we can dialog on this. I think what we want to do is move in the corrective area. Whatever the problem is, Mr. Yeldell said convincingly that that is the first

order of business, to get those matters resolved so we can get on with the bigger ones.

I have had the problem, Mr. Chairman, you mentioned regarding how long you are here. I have been through a number of chairmen. I know what that is, from Senator Byrd, Senator Proxmire, Senator Bayh, and Senator Inouye.

I have lived through them all. I lived through a situation where a subcommittee chairman told me that we didn't need the jail or we didn't need one as large as we had anticipated. I am now looking at the fact that I need a jail a third as large.

Nobody is going to go back into the history and tell me what my priorities are as against somebody else's. I lived within the priorities of the chairman, who at the same time was helping and assisting us in so many areas.

We just didn't come to an agreement on the jail, which I perceive from what I was seeing, needed to be a third larger. Then they cut it back from 1,440 to 960. Mr. Chairman, what I am trying to say to you is that your priorities and your comments here today, are not going to fall on deaf ears. They are going to be heard and listened to. I think Mr. Yeldell has come in all candor to try to give you this explanation, not only of the situation as it exists, but whatever corrective action is necessary. I am going to see to it. There we are.

I again ask for your continued cooperation and your confidence in this process because you just went to the floor for a billion dollars and more. We are going to be certainly in a position to say to you that that confidence is well placed.

CONCLUSION OF HEARINGS

Senator CHILES. That concludes the hearings. The subcommittee will recess and reconvene at the call of the Chair.

[Whereupon, at 5:45 p.m., Wednesday, September 22, the hearings were concluded and the subcommittee was recessed to reconvene at the call of the Chair.]

LIST OF WITNESSES, COMMUNICATIONS, AND PREPARED STATEMENTS

SUBJECT INDEX

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