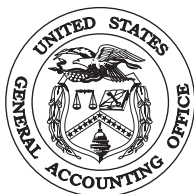


January 2001

Major Management Challenges and Program Risks

Department of Health and
Human Services



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Abstract This report addresses the major performance and accountability challenges facing the Department of Health and Human Services (HHS) as it seeks to enhance the well-being of Americans by providing for effective health and human services and by fostering strong, sustained advances in the sciences underlying medicine, public health, and social services. It includes a summary of actions that HHS has taken and that are under way to address these challenges. It also outlines further actions that GAO believes are needed. This analysis should help the new Congress and administration carry out their responsibilities and improve government for the benefit of the American people.		
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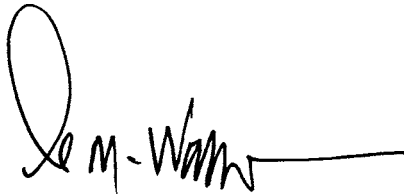
The President of the Senate
The Speaker of the House of Representatives

This report addresses the major performance and accountability challenges facing the Department of Health and Human Services (HHS) as it seeks to “enhance the well-being of Americans by providing for effective health and human services and by fostering strong, sustained advances in the sciences underlying medicine, public health, and social services.” It includes a summary of actions that HHS has taken and that are under way to address these challenges. It also outlines further actions that GAO believes are needed. This analysis should help the new Congress and administration carry out their responsibilities and improve government for the benefit of the American people.

This report is part of a special series, first issued in January 1999, entitled *Performance and Accountability Series: Major Management Challenges and Program Risks*. In that series, GAO advised the Congress that it planned to reassess the methodologies and criteria used to determine which federal government operations and functions should be highlighted and which should be designated as “high risk.” GAO completed the assessment, considered comments provided on a publicly available exposure draft, and published its guidance document, *Determining Performance and Accountability Challenges and High Risks* (GAO-01-159SP), in November 2000.

This 2001 *Performance and Accountability Series* contains separate reports on 21 agencies—covering each cabinet department, most major independent

agencies, and the U.S. Postal Service. The series also includes a governmentwide perspective on performance and management challenges across the federal government. As a companion volume to this series, GAO is issuing an update on those government operations and programs that its work identified as “high risk” because of either their greater vulnerabilities to waste, fraud, abuse, and mismanagement or major challenges associated with their economy, efficiency, or effectiveness.

A handwritten signature in black ink, appearing to read "D. M. Walker", followed by a long horizontal line extending to the right.

David M. Walker
Comptroller General
of the United States

Overview

The Department of Health and Human Services (HHS), with a \$376-billion budget, presents one of the more massive and complex management and program-related challenges in the federal government. The federal health and social programs it oversees tangibly affect the lives and well-being of virtually all Americans and encompass some of the most costly issues facing the nation. According to the mission stated in its fiscal year 2001 performance plan, the Department “seeks to enhance the well-being of Americans by providing for effective health and human services and by fostering strong, sustained advances in the sciences underlying medicine, public health, and social services.” With such a broad mission, HHS’ performance involves many dimensions. This report focuses on the performance of HHS programs and services in certain key mission areas that received heightened congressional attention over the past 2 years.

Performance and Accountability Challenges



- Provide current and future generations with a well-designed and well-administered Medicare program
- Better safeguard the integrity of the Medicare program
- Improve oversight of nursing homes so that residents receive quality care
- Ensure the safety and efficacy of medical products
- Enhance the economic independence and well-being of children and families

Medicare
Governance

One key HHS mission—the effective administration of the \$200-billion-plus Medicare program—has been at the forefront of congressional scrutiny. In HHS, the Health Care Financing Administration (HCFA) administers Medicare, which provides health care to about 40 million individuals 65 years and older and some disabled individuals. At issue is how to make the program operate efficiently now and ultimately become fiscally sustainable when the tidal wave of baby-boom Americans becomes eligible for Medicare. Many experts agree that the program as currently designed and administered will be unable to effectively meet the health care needs of future generations of beneficiaries. While Medicare’s fiscal sustainability and certain inherent difficulties in managing the program are not totally within HCFA’s control, we testified in May 2000 that HCFA faces structural problems that need to be addressed. One problem is that, even though Medicare is a complicated program for the agency to administer through its more than 50 contractors, HCFA cannot devote all its attention to Medicare because it is also responsible for administering Medicaid and other state-centered programs. In addition, frequent changes in HCFA leadership make it difficult for the agency to develop and implement a consistent long-term vision. Finally, constraints on HCFA’s ability to acquire human capital expertise and shortcomings due to its aged information systems limit the agency’s capacity to modernize Medicare’s existing operations and carry out the program’s growing responsibilities. Elements of recent Medicare reform proposals, together with alternatives from existing federal agencies, suggest ways of addressing focus, leadership, and capacity issues.

Medicare Program
Integrity

As policymakers face the challenges of Medicare’s long-term sustainability, HCFA’s day-to-day responsibility for ensuring program integrity also remains a challenge. In 1990, Medicare was designated one of GAO’s “high-risk”

areas and remains so today because of its vulnerability to waste, fraud, abuse, and mismanagement. In recent years, some of the companies that contract with the government to pay physicians, hospitals, and other providers that bill Medicare had defrauded the program or had not rigorously safeguarded the program's payments. Breakdowns in payment safeguards were due partly to HCFA's weak efforts to monitor and evaluate contractors' performance and partly to the lack of information on how providers responded to Medicare's various payment policies. For fiscal year 1999, the HHS Inspector General estimated that about \$14 billion of the nearly \$170 billion in Medicare's fee-for-service payments were improper. We made several recommendations to strengthen HCFA's oversight of Medicare's claims administration contractors, and the agency has taken steps in this direction.¹ Although much attention has been focused on ensuring the accuracy of Medicare's fee-for-service payments, other vulnerabilities exist, suggesting that this estimate understates the program's exposure. New prospective payment methods, along with Medicare's method for paying managed care plans, are designed to dampen providers' incentives to deliver unnecessary care but may result in providers achieving gains by inappropriately reducing patient care. HCFA has not been able to generate data that are timely, accurate, and useful on payment and service use trends essential to effective program monitoring. This will likely remain a problem for some time to come, as HCFA's efforts to modernize its information systems are still largely in the early stages.²

¹*Medicare Contractors: Despite Its Efforts, HCFA Cannot Ensure Their Effectiveness or Integrity* (GAO/HEHS-99-115, July 14, 1999) and *Medicare Contractors: Further Improvement Needed in Headquarters and Regional Office Oversight* (GAO/HEHS-00-46, Mar. 23, 2000).

²*Medicare: HCFA Faces Challenges to Control Improper Payments* (GAO/T-HEHS-00-74, Mar. 9, 2000).

Nursing Home Oversight

Another key HHS mission is to oversee the care provided by the nation's 17,000 nursing homes. In our July 1998 report on the quality of nursing home care in California and subsequent reports on federal and state oversight efforts nationwide, we noted that a significant minority of nursing homes have had serious care problems that harmed residents or put their lives in jeopardy. In these reports, we made a number of recommendations to improve the identification of care problems, secure their correction, and improve HCFA's oversight of state efforts. HCFA generally concurred with our recommendations, and in response the Administration introduced a series of initiatives focused on federal and state efforts to improve nursing home care quality. Certain of the initiatives seek to strengthen the rigor with which states conduct their required annual surveys of nursing homes. Others focus on the timeliness and reporting of complaint investigations and the use of management information to guide federal and state oversight efforts. The states are in a period of transition with regard to the implementation of these initiatives, partly because HCFA is phasing them in and partly because states did not begin their efforts from a common starting point. HCFA's efforts toward improving the oversight of states' quality assurance activities have begun but are unfinished or need refinement.

Drug and Medical Device Safety

HHS is also responsible for ensuring the safety of food, drugs, and other medical products. In HHS, the Food and Drug Administration (FDA) regulates drugs, medical devices, biological products, certain foods, and cosmetics to ensure their safety and efficacy. As part of this effort, FDA inspects facilities that manufacture medical products to ensure their compliance with federal standards for safety, purity, and quality. In recent years, however, the number of inspections completed by FDA has been far fewer than the number required by statute. To target its resources, FDA adopted an

approach to inspect facilities based on their previous record of compliance with federal manufacturing standards. Because of our concern that this strategy may not ensure sufficient follow-up at problem facilities overseas, in 1998 we recommended that FDA revise its strategy for inspecting foreign manufacturers of pharmaceutical products. However, the agency did not agree to adopt the recommendation, citing its preference to wait until its inspection strategy had been fully implemented. With regard to monitoring medical products already on the market, FDA's system has been unable to reliably identify patient deaths or injuries caused by the use of drugs and medical devices. To respond to these shortcomings, FDA has begun to implement targeted approaches intended to maximize its resources.

Child and Family Well-Being

HHS also plays a major role in overseeing the implementation of the landmark 1996 welfare reform legislation. Key features of welfare reform put time limits on cash aid, emphasized the importance of employment for needy adults with children, and gave states increased flexibility to design their own programs. In response to this increased flexibility and other legislative changes, states are making sweeping changes to the nation's safety net programs, including welfare, child support enforcement, child welfare services, and child care subsidies. These changes heighten the importance of having adequate information systems in place to manage programs and provide data to determine the effectiveness and efficiency of program approaches. With the broad range of programs and multiple partners (including states and local public and private agencies) involved, HHS faces the challenge of holding its partners accountable for the use of federal funds to ensure the well-being of children and families.

Major Performance and Accountability Challenges

HHS has an annual budget of \$376 billion—the largest of any federal department—and a direct work force of 59,000 individuals. It is responsible for some 300 programs, which differ in purpose, design, and program delivery. Among the Department’s key missions are to administer Medicare, including anti-fraud-and-abuse activities; oversee nursing homes; monitor the safety and efficacy of medical products; and enhance the economic independence of needy families.

Provide Current and Future Generations With a Well-Designed and Well-Administered Medicare Program

Medicare spending growth has become one of the most pressing and complex issues facing the Congress and the nation. In 1999, Medicare program expenditures were \$213 billion, accounting for about 1 of every 8 federal dollars spent that year. Based on the most recent Medicare Trustees’ 2000 Annual Report, Medicare is expected to double its share of the economy by 2075, crowding out other spending and economic activity of value. Yet the general consensus is that Medicare’s benefit package has become obsolete and should be expanded at least to cover prescription drugs, which will add billions to the program’s cost. Thus, to contain spending while revamping benefits, the Congress is considering proposals to fundamentally reform Medicare. Our work has focused on the issues HCFA faces in administering Medicare today and efforts embodied in proposed reforms or alternative models to ensure the program’s solvency and sustainability for the longer term.

Multiprogram Focus, Leadership Tenure, and Capacity Constraints Weaken Medicare’s Management

Medicare is an inherently difficult program to manage. It ranks second only to Social Security in federal expenditures, covers about 40 million beneficiaries, and has contractors that annually process about 900 million claims submitted by nearly 1 million hospitals, physicians, and other health care providers. Other factors compound this challenge.

First, despite Medicare’s size and complexity, there is no official whose sole responsibility it is to run the program. Among Medicare’s numerous and wide-ranging activities, HCFA must monitor the 50-some claims administration contractors that pay claims and set local medical coverage policies; set hundreds of thousands of payment rates for different providers of Medicare-covered services, including physicians, hospitals, outpatient and nursing facilities, home health agencies, and medical equipment suppliers; and administer consumer information and beneficiary protection activities for the traditional program component, the managed care program component (Medicare+Choice plans), and Medicare supplemental insurance policies (Medigap). In addition to Medicare, the HCFA Administrator and top-level management have oversight, enforcement, and credentialing responsibilities for other major health-related programs and initiatives. These programs require time and attention that would otherwise be spent meeting the demands of the Medicare program (see table 1).

Table 1: HCFA Runs Major Programs and Activities Other Than Medicare

Additional responsibilities	HCFA’s role
50-plus Medicaid programs	Oversight and administration shared with states
50-plus State Children’s Health Insurance Programs	Oversight and administration shared with states
Health Insurance Portability and Accountability Act	Ensures compliance with federal standards in states that have not adopted conforming legislation
Medicare and Medicaid-certified hospitals, nursing homes, home health agencies, hospice providers, and managed care plans; all clinical laboratories.	Credentialing and oversight activities

Frequent changes in HCFA leadership have also inhibited the implementation of long-term Medicare initiatives or the pursuit of a consistent management strategy. The maximum term of a HCFA administrator is,

as a practical matter, only as long as that of the President who appointed him or her. Historically, their terms have been even shorter. In the 24 years since HCFA's inception, there have been 19 administrators or acting administrators, whose tenure has been, on average, little more than 1 year. About 10 percent of the time, HCFA has had an acting administrator. These short tenures have not been conducive to carrying out whatever strategic plans or innovations an individual may have developed for administering Medicare efficiently and effectively.

In addition to leadership constraints, the agency's capacity to manage Medicare is limited relative to its multiple, complex responsibilities. In January 1998 and February 1999, we reported that HCFA was overwhelmed in its efforts to handle the number and complexity of requirements in the Balanced Budget Act of 1997 (BBA). For example, BBA expanded the health plan options in which Medicare beneficiaries could enroll. However, HCFA's staff had no previous experience overseeing these diverse options, such as preferred provider organizations, private fee-for-service plans, and medical savings accounts. According to the HHS Inspector General, many staff lacked experience in dealing with health maintenance organizations—the existing managed care option. Few regional office staff assigned to managed care oversight had training or experience in data analysis, which is key to monitoring internal trends in plan performance over time and assessing plan performance against local and national norms.¹

¹*Medicare's Oversight of Managed Care: Implications for Regional Staffing* (OEL-01-96-00191, Apr.1998).

At the same time, HCFA faces the loss of a significant number of staff with valuable institutional knowledge. In February 2000, the HCFA Administrator testified that more than one-third of the agency's current workforce was eligible to retire within the next 5 years and that HCFA was seeking to increase "its ability to hire the right skill mix for its mission." As we and others have reported, too great a mismatch between the agency's administrative capacity and its designated mandate could leave HCFA unprepared to handle Medicare's future population growth and medical technology advances.² To assess its needs systematically, HCFA is conducting a four-phase workforce planning process that includes identifying current and future competencies needed to carry out the agency's mission and analyzing the gaps between them.³ HCFA initiated this process using outside assistance to develop a comprehensive database documenting the agency's employee positions, skills, and functions. HCFA's human capital problems can be seen as part of a broader pattern of human capital shortcomings that have eroded mission capabilities across the federal government. See our *High-Risk Series Update* (GAO-01-263, January 2001) for a discussion of human capital as a newly designated governmentwide high-risk area.

**Medicare Reform
Proposals Address
Program Governance
Issues**

Elements of recent Medicare reform proposals and alternative models drawn from other federal agencies suggest ways to address focus, leadership, and capacity issues. Options proposed include creating an entity that would administer Medicare without any non-Medicare

²Gail Wilensky et al., "Crisis Facing HCFA and Millions of Americans," *Health Affairs*, Vol. 18 (Jan.-Feb. 1999).

³HCFA's workforce planning efforts to date have been in line with our guidance on this subject, as articulated in *Human Capital: A Self-Assessment Checklist for Agency Leaders* (GAO/GGD-99-179, Sept. 1999).

responsibilities; establishing tenure for the program's administrator that, at a minimum, would overlap presidential terms; and granting the entity administering Medicare greater operational flexibility.

At hearings in February and May 2000, we examined two leading reform proposals,⁴ and while neither fully addressed Medicare's governance shortcomings, each provided potential building blocks of administrative reform. Under the reform proposed by the Administration, HCFA would continue to oversee Medicare+Choice plans and administer the traditional program in addition to its other responsibilities. However, HCFA would be given some new flexibility in personnel, contracting, and purchasing practices. Under reforms proposed by Senators Breaux, Frist, and others, an independent Medicare Board would manage competition among plans; traditional Medicare would exist as one of the competing health plans. The proposal would also divide HCFA into two parts: one division would administer the traditional Medicare plan; the other would carry out HCFA's non-Medicare responsibilities.

Creating a new board to oversee Medicare+Choice would not likely be quick or easy to implement. Prior HCFA experience suggests that a new agency with several hundred staff may be needed to make functional an independent board with the proposed scope of responsibilities. Before HCFA was reorganized in 1997, one of its units—the Office of Managed Care—performed some of the functions envisioned for the

⁴One proposal, The Medicare Modernization Act of 2000, S. 2342, is also known as the President's proposal. The other proposal, popularly known as Breaux-Frist, is the Medicare Preservation and Improvement Act of 1999, S. 1895. Senators John B. Breaux and Bill Frist sponsored the proposal; Senators J. Robert Kerrey, Chuck Hagel, Christopher S. Bond, Judd Gregg, and Mary L. Landrieu are cosponsors.

proposed Medicare board.⁵ The unit was staffed by nearly 150 individuals in a central location and supported by another 120 regional office staff and an unknown number of employees in other HCFA support units such as personnel, training, contracting, finance and budget, and computer systems. Experience also suggests that the period needed to establish a board-run agency and make it fully functional could be 2 years or longer, depending on the number of staff devoted to planning such an enterprise.

In the past, the Congress addressed governance issues for certain programs by separating their administration from a larger body. In 1995, for example, the Social Security Administration (SSA) was reestablished as an independent agency outside HHS,⁶ and in so doing, the Congress strengthened the role of the Commissioner, SSA's agency head. The Commissioner is appointed by the President and confirmed by the Senate, but until the agency became independent, the President could remove the Commissioner for any reason at any time. The independence law provided for a fixed 6-year term and protection from arbitrary removal. The Commissioner can now be removed by the President only for cause—neglect of duty or malfeasance in office.

The Congress has acted in the past to fix the tenure of other agency heads and thus help insulate them from immediate political pressures. In 1976, the term of the Director of the Federal Bureau of Investigation (FBI)

⁵After the reorganization, the functions of the Office of Managed Care were distributed among three new HCFA units: the Center for Health Plans and Providers, the Center for Beneficiary Services, and the Center for Medicaid and State Operations.

⁶The impetus for SSA's independence stemmed from concerns expressed in congressional hearings and reports about a variety of issues, including, among others, the need to improve management and continuity of leadership at SSA and make SSA more accountable to the public and the Congress.

was set at 10 years. Since 1978, there have been five directors and acting directors, serving on average 4.2 years. Within their 10-year terms, however, FBI Directors remain accountable to the President and are not completely insulated from the political environment. The President can remove a director and did so in 1993 when the Director faced allegations of ethics violations.

The Congress has also created advisory boards to help guide an agency's operations. In 1998, for example, the Congress passed legislation that provided for an Internal Revenue Service (IRS) oversight board and introduced other changes in agency governance.⁷ The board is intended to help bring accountability, continuity, and expertise to executive governance and oversight of the agency and to give the Congress more confidence in IRS' day-to-day operations.⁸

Most Medicare reform proposals recognize that—to meet the financing challenges caused by an aging population and increasingly expensive medical technology—the program must be modernized. A fundamental concern is to find a balance between giving the administering entity adequate flexibility to act prudently and ensuring that the entity can be held accountable for its decisions and their implementation. No single approach offers a complete solution, but a combination of elements may be worth considering.

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⁷Internal Revenue Service Restructuring and Reform Act of 1998.

⁸National Commission on Restructuring the Internal Revenue Service, *A Vision for a New IRS*, June 25, 1997.

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Better Safeguard the Integrity of the Medicare Program

Because of the program's vast size and complex structure, we designated Medicare as a high-risk program—that is, at risk of considerable losses to waste, fraud, abuse, and mismanagement—and it remains so today. Each year, we have reported on systemic difficulties in safeguarding Medicare payments. One such difficulty is the production of reliable management information, which has had an impact on paying or denying Medicare claims appropriately, developing new payment methods for post-acute care, paying Medicare's managed care (Medicare+Choice) plans appropriately, and implementing sound financial management practices.

In Medicare's traditional fee-for-service component, HCFA does not have a clear picture of the individual or relative performance of the program's claims administration contractors, which are responsible for safeguarding Medicare's fee-for-service payments. In fiscal year 1999, these payments totaled about \$170 billion. HCFA also lacks sufficient information on newly designed payment systems to determine whether providers are being paid appropriately for the services they deliver. As for Medicare+Choice, HCFA similarly lacks the data needed to monitor the appropriateness of payments made to health plans and the services Medicare enrollees receive. Due to a failed attempt in the 1990s to modernize Medicare's multiple information systems, HCFA's current systems remain seriously outmoded. Without effective systems, the agency is not well positioned for sound financial or programmatic management.

In Traditional
Medicare, Problems
Ensuring Appropriate
Claims Payment
Remain

HCFA contracts with private companies, mostly insurance companies, to review and pay providers' claims for health care delivered to program beneficiaries. These contractors run the day-to-day operations of Medicare's traditional, fee-for-service program component, which accounts for over 80 percent of the program. Although the contractors are the front-line of defense against provider fraud and abuse and erroneous Medicare payments, in the 1990s, several contractors defrauded the government or settled cases alleging fraud for hundreds of millions of dollars.

HCFA rarely uncovered these cases through its own oversight efforts. The reason is, in part, that the agency relied on contractors' self-certifications of management controls and contractors' self-reported data on performance and seldom made independent validations of contractor-provided information. This is inconsistent with federal standards that require the monitoring of internal controls to assess the quality of performance over time and ensure that identified problems are promptly resolved.⁹

Our July 1999 report on HCFA's efforts to monitor Medicare's claims administration contractors identified many weaknesses. For years, HCFA's contractor evaluation process lacked the consistency that agency reviewers need to make comparable assessments of contractor performance. HCFA reviewers had few measurable performance standards and little agencywide direction on monitoring contractor's payment safeguard activities. Under these circumstances, the reviewers in HCFA's 10 regional

⁹The Comptroller General's *Standards for Internal Control in the Federal Government* (GAO/AIMD-00-21.3.1, Nov. 1999) provides a framework for agencies to establish and maintain internal controls and identify and address major performance and management challenges in areas at greatest risk of fraud, waste, abuse, and mismanagement.

offices, who were responsible for conducting contractor evaluations, had broad discretion to decide what and how much to review as well as what disciplinary actions to take against contractors with performance problems. This highly discretionary evaluation process allowed key program safeguards to go unchecked and led to the inconsistent treatment of contractors with similar performance problems. In addition, responsibility for various aspects of contractor activities was splintered across many central office components, while regional staff who conducted day-to-day oversight were not directly accountable to any particular central office unit.

As a result of these findings, we made a number of recommendations to improve HCFA's management and oversight of Medicare claims administration contractors. In summary, we recommended that HCFA enforce contractors' compliance with existing standards while developing better standards for assessing contractor performance; strengthen accountability for evaluating contractor performance and agency oversight; and require verification of contractors' internal controls and contractor-reported data. In response to our recommendations, HCFA

- has begun using national review teams to conduct contractor evaluations. The teams combine the expertise and dual perspective of central and regional office staff.
- established an executive-level position at its central office with ultimate responsibility for contractor oversight and recently established four positions in the field reporting directly to that executive position, reflecting the 4 groupings of its 10 regional offices.

- hired several public accounting firms to review overall internal control design and the effectiveness of financial controls at 26 Medicare contractors and required contractors with control weaknesses to develop plans to correct them.¹⁰

HCFA is also seeking to enhance the usefulness of the Medicare national fee-for-service claims error rate developed by the HHS Office of the Inspector General (OIG). Each year, from reviewing a sample of paid claims, the OIG estimates how many claims were paid in error because they lacked appropriate documentation, were not for Medicare-covered services, or were for services deemed not medically necessary. However, the error rate does not distinguish between benign paperwork mistakes and abusive billing practices, nor does it identify the volume of erroneous payments at each contractor. Thus, to improve the error rate's use as a management tool, HCFA has an initiative to develop a separate error rate for each contractor. It has hired a "validation" contractor that will randomly sample processed claims and recheck the processing and payment decisions made. From the results, HCFA intends not only to measure contractor performance but also to identify which categories of services or provider types are the source of improper billing practices, thus targeting specific areas that need improvement.

**Improved Payment
Methods Can Still Be
Exploited**

In addition to monitoring the contractors' claims review activities to ensure that only appropriate claims are paid, HCFA faces challenges in establishing appropriate prices to pay for covered services. Most recently, it has had the challenge of ensuring the integrity of new payment methods mandated by the Congress. For

¹⁰For fiscal year 2001, HCFA is planning to have effectiveness of information technology, claims processing, financial, and debt collection controls tested at 13 Medicare contractors.

example, the Balanced Budget Act of 1997 introduced several payment reforms, calling for HCFA to develop and implement new methods to pay for post-acute care—the care provided principally by skilled nursing facilities, home health agencies, and outpatient rehabilitation facilities. Under the old payment methods, post-acute care providers were reimbursed their costs (within certain limits) for all the services delivered. The Congress changed this payment approach to control the rapid spending growth for post-acute care that occurred during most of the 1990s.

Under the new approach, known as prospective payment (currently in place for home health providers and skilled nursing facilities), post-acute care providers are paid rates fixed in advance for units of care (such as a day in a skilled nursing facility or an episode of home health care) rather than for the costs of each service. Providers face the risk of loss if their costs exceed their payments, while those that can furnish care for less than the prospective payment rate will retain the difference. However, a new opportunity for providers to boost net revenues inappropriately exists under this approach: providers could skimp on services and compromise the patient's quality of care. HCFA does not have the analytic tools available to identify and document underservice.

Major gaps in information make prospective payment systems vulnerable to manipulation, thus undermining the systems' potential to constrain Medicare costs. To protect taxpayer dollars, HCFA needs the information to ensure that claims payments are accurate and that payment rates are set at the appropriate level. To protect beneficiaries, HCFA needs information on patients' health status and use of services to guard against providers' withholding needed services. Our findings on the prospective payment method for home health services illustrate the problem and support our recommendation, as shown in table 2.

Table 2: Risk-Sharing Could Mitigate Potential Problems in Home Health Payments

Design of home health prospective payment system	<p>Selected design features include the following:</p> <ul style="list-style-type: none">• Home health agencies receive one payment for each 60-day episode of care, regardless of the services provided. There are no limits on the number of episodes a home health agency may provide a patient.• Rates are based on pre-BBA use levels, which are widely regarded as excessive.
Vulnerability to payment abuses	<p>To increase revenues, a provider could</p> <ul style="list-style-type: none">• treat beneficiaries for more episodes than necessary, and• reduce the number of visits provided during an episode.
GAO recommendation	<p>To mitigate beneficiary and financial risk, we recommended that HCFA adopt a risk-sharing provision whereby the government shares in a home health agency's excessive losses but protects the program from an agency's excessive gains.</p>
Agency response	<p>HCFA did not agree to implement our recommendation. It was concerned that any additional change to payment policy would be too confusing for home health agencies at this time. However, we disagree and believe that the absence of any constraint on payments leaves Medicare's new home health payment system open to exploitation.</p>

Medicare+Choice
Has Its Own Set of
Integrity Issues

Medicare's managed care component known as Medicare+Choice is also subject to improper payment problems. In fiscal year 1999, payments to Medicare+Choice plans totaled \$37 billion, or more than 17 percent of all program spending. The fact that Medicare+Choice plan receives a fixed monthly payment for each beneficiary it enrolls rather than for each service delivered raises another set of program integrity challenges involving excessive payments for enrollees and failure to deliver necessary services.

Plans may be overpaid when they attract relatively healthy and low-cost beneficiaries. It becomes a

program integrity issue when plans purposely seek to enroll these individuals. Plans may also be overpaid when their reported data used to establish payment levels are erroneous or misreported. Program integrity is also compromised when plans fail to deliver services that enrolled beneficiaries need. Table 3 provides specific examples of these issues.

Table 3: Program Integrity Issues in Medicare+Choice

Favorable selection of healthier beneficiaries	Through their marketing practices or provider incentive arrangements, some plans may attract healthier beneficiaries and have more of their sick members disenroll. Plans gain financially because healthy beneficiaries cost less to serve than chronically or acutely ill beneficiaries. Whether intentional or accidental, however, favorable selection results in huge excess Medicare costs. In August 2000, we reported that, in 1998, Medicare+Choice plans were paid an estimated \$3.2 billion more than if the plans' enrollees had received care in the traditional Medicare program. In reports and testimony, we have consistently discussed the need to adjust Medicare+Choice payments to reflect enrollees' health status. However, in 1999, the Congress slowed implementation of HCFA's health-status-based payment adjuster and mandated additional studies on HCFA's adjustment methods.
Misreported or erroneous data that increase payments	The HHS OIG found cases in which Medicare paid plans for deceased beneficiaries and beneficiaries receiving services in traditional Medicare. The OIG also found that some plans erroneously reported some of their enrollees as having institutional status, which allowed them to receive inappropriately enhanced payments. In 1998, we reported that some plans took advantage of an overly broad Medicare definition to classify healthy beneficiaries living in retirement communities as living in "institutions," thereby increasing their Medicare payments substantially. HCFA has since adopted our recommendation to tighten the definition of an institution for payment purposes, but the extent to which the new definition is being enforced is uncertain.
Failure to deliver required services	In April 1999, we reported that a large Medicare+Choice plan provided a prescription drug benefit with less coverage than it agreed to in its contract with HCFA. This case was discovered in our review of plan marketing materials, which found that several plans distributed misleading, inaccurate, or incomplete information about covered benefits. In a separate April 1999 report, we noted that several plans failed to adequately inform beneficiaries that they could appeal a plan's decision to deny services or payment for services. We have made several recommendations addressing HCFA's need to develop formatting and content standards for plan marketing and appeals process literature. HCFA has implemented some of our recommendations and has established work groups to consider others.

Reliable information about plan enrollees will become even more critical in the future as Medicare phases in a

new risk adjustment methodology that will pay plans on the basis of their enrollees' expected care costs. Under this new methodology, payment rates will be determined largely by patient utilization data submitted by plans. Any errors in the patient data will thus result in inaccurate plan payments.

**Inadequate
Information Systems
and Financial
Management
Continue to
Undermine Efforts to
Safeguard Medicare**

A major weakness underlying HCFA's efforts to ensure proper payments of Medicare claims is that its information systems are outmoded and many of its financial management procedures are not yet in order. Although HCFA has taken steps to begin modernizing its systems and strengthening its financial management, many challenges remain.

In the early 1990s, HCFA launched a systems acquisition initiative to replace Medicare's multiple, contractor-operated claims processing systems with a single, more technologically advanced system. It was envisioned that such a system would have information for both traditional Medicare and Medicare+Choice, simplify program administration, save on administrative costs, and better ensure proper payment by greatly improving HCFA's ability to spot improper billing practices. Although based on a sound notion, this system acquisition failed due to a series of planning and implementation missteps. Thus, Medicare was left with numerous aging information systems that needed year 2000 renovation. To its credit, HCFA made exceptional efforts to ensure that the agency's systems and those of its business partners were prepared, with the result that HCFA reported few significant year 2000 problems. These system renovations, however, put broader modernization plans on the back burner until recently. To date, initial work on some of its systems has begun, but completion of its systems modernization remains years away.

Similarly, HCFA's first step toward improving its financial management procedures met with success, but much work in this area remains to be done. In an audit of its fiscal year 1999 financial statements, HCFA received for the first time an unqualified, or "clean," opinion. The agency achieved this, in part, because it recognized the need to address long-standing concerns about the accuracy of Medicare accounts receivable—primarily overpayments made to providers that need to be recouped. Assisted by the HHS OIG and auditors from an independent public accounting firm, HCFA conducted an extensive effort to validate reported receivables, which resulted in a one-time write-off of \$3 billion.

However, HCFA has a long way to go to achieve sound financial management—that is, systems, processes, and controls that routinely generate reliable, useful, and timely information for managers and other decisionmakers. Since the audit of the fiscal year 1996 financial statements, subsequent annual audits and other reviews have found numerous weaknesses in internal controls in HCFA's financial activities. At the heart of its problems, the agency does not have a single, integrated financial accounting system that can be used to track and report financial activities, including receivables. Instead, HCFA and its contractors use several fragmented and overlapping systems and do not adequately verify the accuracy of reported activities and balances, which increases the risk of errors and misstatements. For example, Members of Congress were concerned that millions of dollars were owed to Medicare by Texas home health agencies that had been paid too much for services provided to Medicare beneficiaries and were no longer in business. The usefulness of the information HCFA developed in response to this concern was limited, however, since HCFA was not able to determine the correct amounts owed. In part, this was because HCFA's Provider Overpayment Report system, which it uses to track

certain overpayments, had incorrect information. This situation and problems with the adequacy of existing internal controls indicate that extraordinary measures will be needed to maintain a clean opinion on HCFA's annual financial statements until these problems can be remedied.

The fragmentation of accounting systems that overlap without being reconciled makes generating accurate and reliable information a major challenge. For example, even after the \$3 billion write-off of accounts receivable, HCFA was left with significant amounts of delinquent receivables. At the end of fiscal year 1999, HCFA had an accounts receivable balance of \$7.3 billion, of which 45 percent was more than 6 months delinquent. HCFA's efforts under the Debt Collection Improvement Act of 1996 to refer delinquent debt for collection to the Treasury Department in a timely manner have been confounded, in part, because of the work it takes the contractors to validate each debt before it can be referred to Treasury.¹¹ Such validation is problematic because of the unreliability of the agency's systems for tracking and recording overpayments.

We, the OIG, and independent auditors have made numerous recommendations to strengthen HCFA's financial management. Because of the seriousness of the challenge, we recommended that HCFA develop a comprehensive strategy to address financial management and accountability issues. To this end, HCFA has initiated a number of efforts, including working to develop a set of integrated financial management information systems. However, these systems are not expected to be fully operational until 2004 at the earliest. In the meantime, using its current

¹¹The act generally requires that debts delinquent more than 180 days be transferred to Treasury or, in certain cases, a Treasury-designated center for debt collection.

systems, HCFA and its contractors must take interim steps to put adequate controls in place. Without these controls, HCFA is not in a position to generate the consistent and accurate data needed to ensure the integrity of the agency's financial management operations.

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**Improve Oversight
of Nursing Homes
So That Residents
Receive Quality
Care**

Between 1998 and 2000, the Congress held a series of hearings on nursing home care. Our reports and testimony during this period painted a grim picture. In 1999, we estimated that about 15 percent of the nation's 17,000 nursing homes were being cited in consecutive years for serious care problems, which are those classified as causing "actual harm" to residents and those placing residents' health, safety, or lives in "immediate jeopardy." (Serious care problems include malnutrition, dehydration, and pressure sores, among other conditions.) Complaints by residents, family members, or facility staff alleging harm to residents remained uninvestigated for weeks or months. When serious deficiencies were identified, federal and state

enforcement policies did not ensure that the deficiencies were addressed and remained corrected.

The federal government's stake in nursing home care is large, amounting to an estimated \$39 billion in fiscal year 1999. Thus, as the hearings of the Senate Special Committee on Aging focused national attention on the quality of nursing home care, the Administration launched a set of initiatives to address the problems we and others identified.

Quality Initiatives Are Designed to Address Weaknesses in Federal and State Oversight of Nursing Homes

Oversight of nursing homes is a shared federal and state responsibility. On the basis of statutory requirements, HCFA defines standards that nursing homes must meet to participate in the Medicare and Medicaid programs and contracts with states to certify that homes meet these standards through annual inspections and complaint investigations. The "annual" inspection, which states must conduct at each home on average every 12 months, is called a standard survey. The standard survey entails a team of state surveyors spending several days in the home to determine whether care and services meet the assessed needs of the residents. When a home does not meet these needs as embodied in federal standards, it is cited for deficiencies. If the deficiencies are serious enough, state officials refer the home to HCFA for disciplinary measures. The investigation of complaints is largely a state-administered process, with HCFA requiring that serious complaints be investigated within specific time frames.

Our work over the past 2 years showed that federal and state oversight of nursing home care was flawed in the following areas.

- *Annual standard surveys.* State surveyors failed to identify serious care deficiencies or classified them

as less serious than was appropriate. One reason was that the approach surveyors used to spot deficiencies lacked sufficient rigor. Another reason was that homes had time to prepare for surveyors' inspection visits. Because the annual inspections often occurred at roughly the same time each year, homes could anticipate when surveyors were coming.

Accordingly, they could make cosmetic changes and add staff beforehand, thus misrepresenting the home's typical routines and care practices.

- *Lax approach toward sustained compliance.* HCFA's stated goal is to have nursing homes sustain compliance with federal requirements over time. However, the results of several years of annual surveys show that some of the nation's nursing homes during these years are "repeat offenders"—that is, they have been cited in at least two consecutive annual surveys for actual harm or immediate jeopardy deficiencies. Until recently, there was little to deter such poor performance because few referrals for disciplinary actions, such as fines or termination, ever went into effect.
- *Handling of complaints.* Another major problem was that some states did a poor job of handling complaints against facilities. Complainants had difficulty filing complaints, the state survey agency understated the seriousness of complaints, and serious complaints were not investigated promptly.

As a result of our work, we have made a number of recommendations to improve the quality of annual surveys, keep repeat offenders from escaping disciplinary action, and ensure that complaints are promptly investigated. HCFA has generally agreed with our recommendations. Because these problems surfaced dramatically with our 1998 report on California nursing homes, which included several recommendations for action, the Administration began to address the problems cited by introducing the first of a series of initiatives focused on nursing home care.

Some initiatives are being phased in, while others have been added since 1998, concurrent with our reports of additional problems and recommendations made at congressional hearings on nursing home care. The initiatives focus on strengthening the performance of standard surveys, adding more teeth to HCFA's enforcement policies, and improving states' approaches to handling complaints. To implement these initiatives, the states and HCFA are engaged in a range of activities that include, among others, the following:

- States are adopting improved methods to detect and classify deficiencies found during a home's annual inspection; HCFA is developing additional guidance in this area.
- Following a recommendation that we made, HCFA required states to schedule more visits on nights and weekends in an attempt to make the survey visits more of a surprise. However, this measure has still not addressed the problem we identified of the visits occurring close to the same date each year.
- HCFA strengthened the enforcement options available to impose sanctions on nursing homes that are cited for actual harm and immediate jeopardy violations by requiring that states refer for immediate sanction any home found on successive surveys to have a pattern of harming one or more residents.
- To reflect a new emphasis on the more timely investigation of serious complaints, states are hiring additional experienced surveyor staff, developing or upgrading automated tracking systems, and making unit management changes.

**Better Use of
Management
Information Would
Improve Nursing
Home Oversight**

HCFA intends to intensify its use of management information to verify and assess states' oversight activities and view nursing home performance more closely. As one step, it plans to enhance the user-friendliness of the central database—the On-Line Survey, Certification, and Reporting (OSCAR) system—

that compiles, among other types of information, the results of every state survey conducted on Medicare- and Medicaid-certified facilities nationwide. Although OSCAR provides extensive information about state surveys—such as their timing, the deficiencies cited, and the time spent conducting various survey activities—computer programming knowledge is typically needed to obtain these data in a usable form. When analyzed, such information can provide a more complete picture of an individual facility's performance record. Refinements will allow users to access such information with much greater ease.

In addition, HCFA recently directed its regional offices to prepare various tracking reports on indicators of state and regional office oversight performance. Examples of report topics include facilities whose Medicare and Medicaid funding may be terminated because of noncompliance with federal requirements, surveys of facilities under special scrutiny, deadlines met for reporting information through OSCAR, tallies of state surveys that find homes free of deficiencies, and analyses by state of the most frequently cited deficiencies. Preparing these reports using a standard format will enable HCFA to compare performance within and across states and help identify whether federal intervention is needed.

One instance of HCFA's failure to use such information illustrates the potential for the information to serve as a kind of internal control. For a recent cycle of annual surveys in one state, surveyors found no deficiencies at 84 homes inspected. Had HCFA oversight officials checked each deficiency-free home's history of complaint allegations, they would have seen "red flags." When we did such a cross-check during our 2000 review, we found that the state's supposedly deficiency-free homes had received 605 complaints. One of these homes had 39 complaints; 19 homes had 10 or more complaints.

Significant numbers of these complaints were substantiated when investigated.

Overall, many of the new policies and practices to implement the quality initiatives have only recently been instituted and will need time to take hold. For example, better detection and classification of serious deficiencies through the standard survey process will require further methodological developments. New efforts will be required to reduce the opportunities for homes to predict the timing of, and prepare for, these inspections. More time must elapse to know whether strengthened federal enforcement policies in fact create the incentives and environment that discourage poor care and ensure permanent corrections. States' efforts to expedite complaint investigations and systematize the reporting of investigation results are at various stages of completion. Similarly, with respect to improved federal oversight, the effectiveness of HCFA's management information reporting enhancements can only be judged in the months to come.

Vigilance by both state and federal officials must be unrelenting to ensure the safety and well-being of the nation's nursing home residents. The performance of oversight can neither be taken for granted nor relaxed, which means that neither HCFA nor the states can afford to lose their current momentum. The Congress, too, plays an important role in keeping the spotlight on oversight agencies and the nursing home industry to achieve quality improvements.

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Ensure the Safety and Efficacy of Medical Products

FDA regulates products with annual sales of roughly \$1 trillion that touch the lives of virtually every American. FDA seeks to ensure that human and animal drugs, medical devices, and vaccines, among other products, are safe and effective and that the nation's food resources and blood supply are safe. FDA requires manufacturers of drugs and devices to seek its approval before their products are marketed. Once products are marketed, FDA continues to periodically verify the quality of manufacturing processes and continually monitors product safety by collecting and analyzing hundreds of thousands of reports of adverse reactions related to medical product use each year. To carry out this broad mandate, FDA has about 9,000 employees. These include approximately 2,100 scientists who evaluate new product applications and about 1,100 inspectors who ensure that the country's almost 95,000 FDA-regulated businesses comply with minimum safety and quality standards.

The speed of FDA's premarketing review and approval of new drugs has improved in recent years, largely because the Prescription Drug User Fee Act of 1992 allowed FDA to collect fees from the sponsors of new drug applications for the purpose of hiring more medical officers to review the applications. In addition, the FDA Modernization Act of 1997 established clear performance goals and focused attention on medical products with the most risk. However, FDA's efforts to monitor the quality and safety of marketed products have been less successful. The focus on reducing new product review times has slowly shifted resources away from other activities amid a general increase in use of medical products by the American public.

**FDA's Efforts to
Monitor Medical
Product
Manufacturing Need
Improvement**

To ensure that medical products are manufactured in accordance with standards for safety, purity, and quality, FDA periodically inspects facilities that manufacture prescription drugs and medical devices, as well as facilities that process blood and blood products. These inspections ensure that the products are produced in conformance with good manufacturing practices—federal standards for ensuring that products are high in quality and produced under sanitary conditions.

In recent years, FDA has not met its requirement to inspect, every 2 years, domestic pharmaceutical and blood manufacturing facilities, as well as most medical device manufacturing facilities. For example, FDA is required by law to annually inspect 50 percent of the manufacturers of medical devices such as defibrillators, which pose the greatest potential risk to patients. However, it was able to inspect only 26 percent of these facilities in fiscal year 1999.¹² Similarly, we found that FDA was unable to identify and locate all the medical device reprocessing facilities that it was supposed to inspect. FDA maintained that it had to reduce the number of planned inspections of drug and device manufacturers by almost 40 percent because it did not receive a requested increase in funding in fiscal year 2000.

To target its resources, FDA has adopted a risk-based approach to setting medical product inspection priorities. Under this approach, facilities are ranked on the basis of their previous inspections. Facilities that fail to meet good manufacturing practice standards are inspected more frequently than facilities with few deficiencies. Because this approach has been in place

¹²In its fiscal year 2001 budget request, FDA stated that, because of insufficient inspection resources and the growth in high-risk device manufacturing facilities, the agency will not meet its statutory requirement to inspect one-half of these facilities.

only for a short time, it is unclear whether it will provide sufficient inspection coverage to ensure that medical products are being manufactured in a safe and appropriate manner. However, there are already some indications that it may be difficult for FDA to target the facilities that pose the highest risk. For example, we found that FDA was unable to even identify and locate all the medical device reprocessing facilities and foreign pharmaceutical facilities that it was supposed to inspect.

In a March 1998 report, we raised questions about the application of FDA's risk-based strategy for inspecting foreign pharmaceutical facilities. According to FDA, as much as 80 percent of the bulk pharmaceutical chemicals used by U.S. manufacturers to produce prescription drugs are imported, and the number of finished drug products manufactured abroad for the U.S. market is increasing. However, we found that FDA's risk-based inspection strategy would not ensure that timely follow-up inspections were conducted for all foreign manufacturers that had been identified as having serious manufacturing deficiencies and that had promised to take corrective action. Omitting these problem facilities from timely reinspection raises questions about FDA's ability to ensure that American consumers are protected from contaminated or adulterated drug products. We recommended that FDA revise its risk-based strategy for inspecting foreign pharmaceutical manufacturers to ensure that the problem facilities would receive timely follow-up inspections. However, FDA said it would not make any revisions until after the strategy had been fully implemented.

**FDA's Surveillance
Systems for Marketed
Medical Products
Need Strengthening**

FDA attempts to monitor the risks of marketed drugs, medical products, vaccines, and blood products throughout their life cycles. To do this, FDA faces two difficult tasks: (1) establishing the number and rate of illnesses and injuries caused by drugs and medical devices and (2) determining that such adverse events

are caused by the medical product rather than by the patient's underlying illness or some other aspect of their medical treatment. These tasks are complicated by the increasingly high exposure of the American public to medical products; for example, roughly 3 billion prescriptions were filled in the United States in 1999, a number that has increased about 6 percent annually since 1992. The inadequacies of FDA's postmarketing surveillance system can have important regulatory and health consequences. For example, in recent years FDA has been unable to determine the number of deaths due to liver failure in patients taking a drug for diabetes, whether the suicide rate among adolescents taking an acne medication is unusually high, and whether the rate of adverse events caused by reprocessed surgical devices is higher than that for new devices.

FDA's approach to monitoring adverse events has certain flaws. To begin with, FDA estimates that it receives reports for only 1 to 10 percent of serious adverse events. Second, partly because FDA's postmarketing surveillance staff is relatively small, FDA has difficulty sifting through the many adverse event reports it does receive to determine if the reports reflect injuries caused by medical products and if the adverse events present a pattern that requires further investigation. FDA has begun implementing a twofold strategy to address these limitations. First, it is pilot testing a "sentinel" system that uses a small subset of health care institutions and charges them with preparing frequent and detailed reports of adverse events, rather than trying to increase the number of reports from the larger health care community. Second, FDA intends to increase its information processing capabilities by, among other things, encouraging the electronic submission of adverse event reports and acquiring statistical software with improved algorithms for identifying important adverse events from its large report databases.

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Enhance the
Economic
Independence and
Well-Being of
Children and
Families

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 and subsequent legislation made fundamental changes to the nation's safety net for needy families with children. It replaced the 61-year-old welfare entitlement program with block grants to states, called Temporary Assistance for Needy Families (TANF), which has a key goal of ending the dependence of needy parents on government benefits by promoting work. The new welfare law gave states increased flexibility over the design and implementation of their welfare programs and at the same time required them to impose work requirements and enforce a 5-year lifetime limit on the receipt of TANF cash assistance. The Administration for Children and Families (ACF) in HHS oversees state implementation of welfare reform. The law also ended automatic Medicaid eligibility for cash assistance recipients, instead creating a separate Medicaid eligibility category, with states free to apply different criteria for TANF eligibility, including work and preapplication requirements not allowed under Medicaid.

However, concerns that about one-third of the more than 40 million low-income people who had been automatically eligible for Medicaid could lose coverage gave rise to congressionally enacted protections for continued Medicaid coverage. Of particular concern was the possibility that children might unnecessarily lose coverage because, before welfare reform, more children gained access to Medicaid on the basis of family receipt of cash assistance than through other avenues of eligibility, such as low family income, disability, or other special medical needs. In addition to establishing a separate Medicaid eligibility category to protect adults and their older teenaged children, program expansions for children that were mandated by the Medicaid statute were left unchanged. Also, 1 year after the passage of welfare reform, as part of the Balanced Budget Act of 1997, the Congress established the State Children's Health Insurance Program (SCHIP), an optional health insurance program for children in families whose income level is too high to qualify for Medicaid but is at or below 200 percent of the federal poverty level.¹³

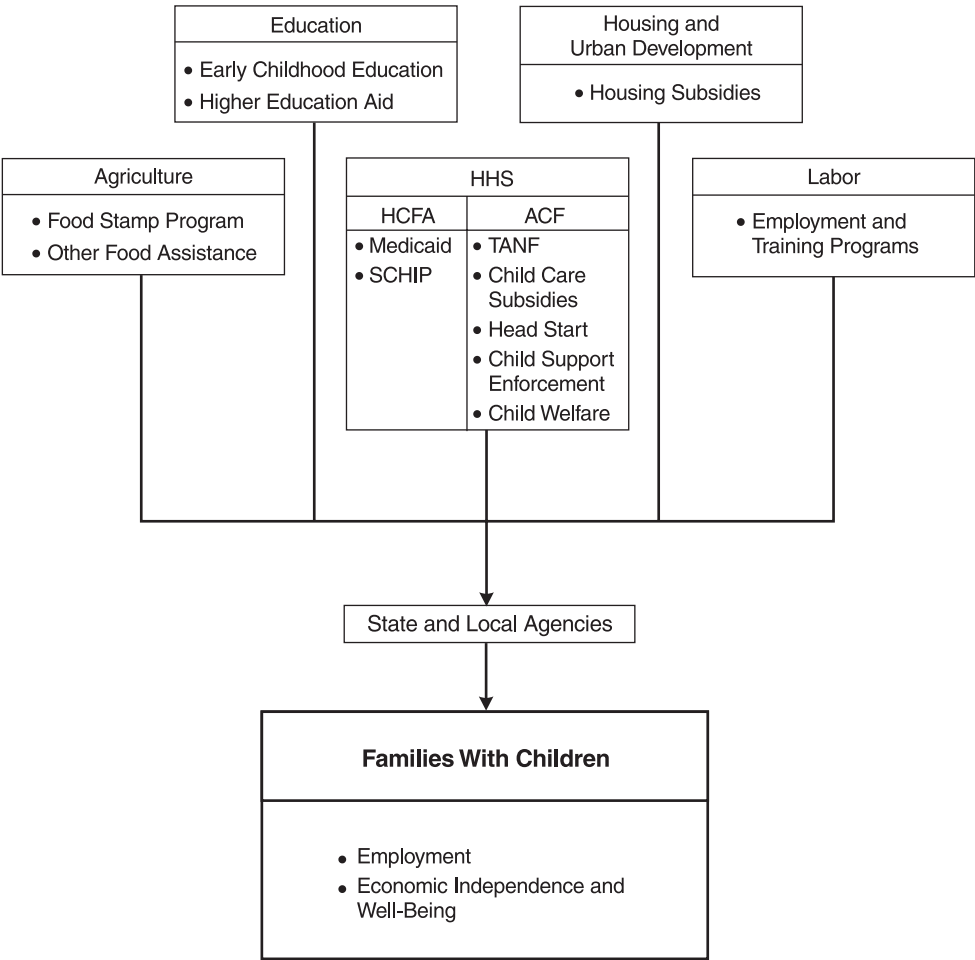
In addition to overseeing the sweeping changes in welfare and health programs for low-income families with children, HHS oversees a number of other programs, such as child support enforcement, child welfare services, Head Start, and child care subsidies. These programs have also undergone changes at the federal, state, and local levels. In the wake of these changes, HHS faces significant challenges in ensuring that states have adequate service delivery systems in place that meet federal objectives efficiently and effectively.

¹³Due to the varying eligibility requirements across state Medicaid programs, the SCHIP legislation allows the state to expand eligibility up to 50 percentage points above its existing Medicaid eligibility standard. Therefore, in Connecticut, children in families with incomes up to 300 percent of the federal poverty level are eligible for SCHIP.

**Better Information
Systems and Data
Collection Needed to
Improve Program
Management**

State and local welfare agencies have made important progress in implementing key aspects of welfare reform, but significant challenges remain. As states have refocused their efforts on moving people into employment rather than qualifying them for monthly cash assistance, they draw on an array of other federal and state programs to support families' work efforts, as shown in figure 1.

Figure 1: Many Programs in Separate Departments Can Enhance Family Independence and Well-Being



One challenge involves having adequate information systems to manage these efforts. In our April 2000 review of states' automated systems, we found that while these systems supported welfare reform in many ways, they also had major limitations. For example, as a

result of separating cash assistance from Medicaid, local officials in five of the six states we reviewed cited automated system glitches that sometimes occur in enrolling families in Medicaid or ensuring their continued enrollment. In addition, a number of state systems do not provide enough information to support enforcement of the 5-year TANF time limit. One of the underlying causes of state systems' limitations is that, with myriad programs involved in supporting welfare reform, automated systems were generally designed to meet the particular needs of each program, rather than the cross-program needs of the clients they serve.

As the federal agency with primary responsibility for welfare reform, HHS is well positioned to lead a coordinated federal effort to facilitate states' efforts to improve their automated systems. State and local welfare officials have many such efforts under way but face a number of obstacles in moving forward. These obstacles include the difficulties inherent in successfully managing large information technology projects and the complexity of obtaining federal approval and funding for systems projects that involve multiple agencies.

Because of the importance of adequate automated systems to the success of welfare reform, we recommended that HHS work with other federal agencies, including the Department of Agriculture, which oversees food stamps, and the Department of Labor, which oversees employment and training services, to facilitate states' efforts by

- disseminating information on best practices for managing information technology generally and best practices specific to automated systems that support welfare reform,
- reviewing, and modifying as needed, the federal process for systems procurement to ensure that it

- meets federal needs for state accountability without unnecessarily hindering state development efforts,
- facilitating links among the automated systems used by different state and local agencies through such means as supporting demonstrations designed to promote better partnerships between state and local agencies and coordinating data reporting requirements for different federal programs, and
 - working with the Congress to ensure that a national system is in place for tracking time limits under TANF, as some families will be reaching these limits this year.

Officials from ACF and HCFA, Agriculture, and Labor have begun meeting regularly to address these issues. Sustained high-level attention will be needed to move forward in this important area.

Improvements in states' automated systems would also help HHS as it attempts to measure the progress its state partners are making to increase the economic independence and well-being of children and families. In our assessment of HHS' fiscal year 1999 performance report and fiscal year 2001 performance plan, we noted that HHS had completed considerable efforts to reach consensus with its state partners on appropriate performance measures and targets in the TANF and child care programs. However, the agency had data on fiscal year 1999 results for only 5 of the 25 measures associated with the outcomes. HHS acknowledged that time lags in obtaining and validating data from the states was, and would continue to be, a problem. HHS noted that there is a concerted effort under way through its departmentwide Data Council to assess data needs for the major programs administered by ACF and to begin to deal more aggressively with data collection and reliability problems.

Although much remains to be accomplished, HHS has made progress in developing new systems and data sources in some areas. In its child support enforcement program, HHS has met the deadline for getting two new national databases—the mandated National Directory of New Hires and the Federal Case Registry—up and running for use by states. These systems provide data to states that can be used to locate noncustodial parents, identify existing child support orders, and send wage withholding notices to employers. In addition, HHS’ enhanced information sharing with IRS has also led to increases in child support collections, which can increase families’ financial well-being and reduce dependence on government support.

In addition to working with its multiple partners to improve automated systems and data, HHS needs to improve its internal systems related to financial management. ACF received a clean opinion on its fiscal year 1999 financial statements. However, a material weakness was reported related to the preparation and analysis of financial statements.¹⁴ The auditors reported that ACF does not have a fully functional, integrated accounting system to produce financial statements in a timely and efficient manner. In addition, reconciliation procedures were not performed consistently during the year, which resulted in delayed reconciliations for several accounts.

**Efforts Needed to
Ensure State
Accountability and
Program
Effectiveness**

With the day-to-day administration of HHS’ major programs for low-income children and families in the hands of so many partners, the agency faces continuing challenges in holding partners accountable for meeting federal goals while allowing them the flexibility they

¹⁴HHS Office of Inspector General, *Report on the Financial Statement Audit of the Administration for Children and Families for Fiscal Year 1999*, Report #A-17-99-00003.

need to meet state and local needs. With the flexibility granted them, program partners implement varied approaches to accomplishing program goals. The great variety in program approaches and service delivery methods can complicate HHS' efforts to determine the effectiveness of its programs. This variety, however, can also create opportunities for HHS to determine the more effective and efficient approach among numerous alternatives and then share that information with program administrators and policymakers.

Our work has shown that HHS needs to do more to ensure accountability. In foster care, states have on occasion claimed reimbursement for juvenile justice placements at facilities that were not eligible for such reimbursement and that may not have met procedural requirements intended to protect the welfare of foster children. While states have primary responsibility for making foster care facility eligibility decisions and meeting procedural requirements in juvenile justice placements, HHS, as the ultimate steward of foster care funds, has to exercise closer oversight of the use of those funds. We also found that HHS had no established method in place to review states' progress in helping youths live on their own—through the federal Independent Living Program—after leaving the foster care system. We recommended that HHS develop a state reporting system and concrete measures of effectiveness to better ensure states' accountability for this program.

We also found inadequate internal controls in place in one component of the Medicaid program. Almost one-third of Medicaid eligible individuals are school-aged children, which makes schools an important service delivery and outreach point for Medicaid. However, to date, there have been poor controls in place on the varied approaches to submitting claims for Medicaid reimbursement for school-based health services and administrative activities. Such controls must achieve an

appropriate balance between the states' needs for flexible, administratively simple systems and assurances that federal funds are being used for their intended purposes. HCFA's current oversight practices have failed to provide that assurance, resulting in confusing and inconsistent guidance across the regions and failure to prevent improper practices and claims in some states.

In addition to ensuring that adequate internal controls are in place, HHS needs to have information on the effectiveness of its programs. In recent years, HHS has made progress in collecting the data needed to assess program outcomes for Head Start, which served over 830,000 children in fiscal year 1999 through public and private nonprofit agencies. As we recommended, and as required by the Congress, HHS is now also taking steps to assess the effectiveness of Head Start by using control groups to ascertain the extent to which positive outcomes can be attributed to Head Start participation. HHS has also continued a long-term research effort that predates welfare reform on the relative effectiveness of different welfare-to-work approaches. HHS has also updated its research efforts, supporting studies in key areas of interest under welfare reform, including how best to help former welfare recipients retain their jobs and advance in the workplace.

The variety of program delivery approaches across states and localities makes it essential that HHS work with state and local agencies to ensure that eligible individuals are made aware of the benefits to which they are entitled. For example, "transitional Medicaid" entitles certain families who are losing Medicaid as a result of employment or increased income to an additional year of coverage. However, as noted in our September 1999 report, in at least one state, only 1 in 25 eligible individuals participated in the transitional program. Moreover, some states did not even track the program's participation rates. As a result, we recommended that HCFA provide states with guidance

or other appropriate technical assistance regarding best approaches for implementing transitional Medicaid such that eligible beneficiaries could benefit from this entitlement. Concurring with our recommendation, HCFA has taken steps to work with each state to review and address states' eligibility and enrollment policies.

States' experience implementing the SCHIP program also illustrates the importance of federal leadership in coordinating the various agencies' efforts to enroll beneficiaries. In working with the states on SCHIP implementation, HCFA used a variety of methods to communicate changes and state program innovations. For example, HCFA helped states develop their SCHIP plans by devising a template that identified the key information required. HCFA also provided frequent guidance to the states in the form of letters to state Medicaid directors and, on an ongoing basis, shared answers to questions frequently raised by the states. Letters, guidance, and questions and answers were all posted on the Internet for easy access. HCFA also worked with the states and other interested groups to develop reporting requirements for key program indicators such as expenditures and enrollment. Despite the short implementation period and the related challenges of establishing programs distinct from Medicaid, the states and the federal government made considerable progress in getting SCHIP up and running, and in just over 1 year, reported enrollment of close to 1 million children in 42 states and territories.

HHS can also work to improve program outcomes and effectiveness by making full use of its strategic planning and annual performance planning process under the Government Performance and Results Act (GPRA). Under GPRA, each federal agency is to identify ways that it will collaborate with other federal agencies on cross-cutting program goals. For example, HHS' fiscal year 2001 performance plan noted the need to coordinate with the Department of Education

concerning Head Start and the goal of increasing the quality of early childhood development and child well-being. This performance plan discussed in much more detail than the 1999 plan Head Start's role in meeting education-related aspects of the early childhood development goals that cut across both HHS and Education. However, HHS' plan did not define how coordination with Education will be accomplished or the means by which performance in meeting cross-cutting goals will be measured. This is in contrast to Education's fiscal year 2001 performance plan that describes its new coordination effort with HHS on early childhood programs. This effort includes forming a joint task force to improve collaboration between the two agencies and develop common program outcome indicators and measures. The absence of this discussion in HHS' performance plan limits its value in improving agency management and assisting the Congress in its oversight role.

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