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STATEMENT OF
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BEFORE THE
SUBCOMMITTEE ON OVERSIGHT
COMMITTEE ON WAYS AND MEANS
UNITED STATES HOUSE OF REPRESENTATIVES

ON

MANAGEMENT OF AND RESULTS OBTAINED FROM THE HEALTH CARE FINANCING ADMINISTRATION'S DEMONSTRATION, EXPERIMENT, AND RELATED EVALUATION ACTIVITIES

Mr. Chairman and Members of the Subcommittee, I am pleased to appear here today to comment on the management of and results obtained from demonstrations and experiments (D&E) and related evaluations conducted by HEW's Health Care Financing Administration (HCFA).

In May 1976, this Subcommittee held hearings on the "Administration of Medicare Cost-Saving Experiments." The Subcommittee found that excessive delays had occurred in implementing experiments and demonstration projects that were intended to provide the Congress with information on specific alternatives to present policies and procedures in the health care system. The Subcommittee concluded that although the Congress had provided HEW with both the money and the authority to carry out a broad range of health care experiments and demonstrations, the development and performance of the experimental projects had seriously fallen short of the expectations and goals of the Congress. According to the Subcommittee, HEW had made no detailed recommendations with respect to implementing specific methods tested.

Mr. Chairman, because you believed that this situation had not improved since 1976, you asked us to review HCFA's D&E activities.

Today I will be discussing (1) the use of social research and development in helping to formulate social policy, (2) the purpose and objectives of and resources for HCFA's D&E activities, (3) the expectations of the cognizant committees of the Congress from such

activities, (4) HCFA's perceptions of the outcomes or impacts of its D&E activities, (5) a description of the processes in carrying out such activities, and (6) our suggestions as to how such processes could be improved.

In summary, we found that:

--HEW D&E activities have fallen short of the expectations and requirements of the cognizant legislative committees of the Congress as expressed in their reports on bills and/or the legislation itself. Specifically, (1) reports to the Congress have not been submitted at the dates specified by law, (2) when reports were submitted they did not meet the specifications contained in the law and/or related committee reports, (3) more recent mandated demonstrations have not been undertaken due to a shortage of staff or money, and (4) demonstrations and experiments or the related evaluations were sometimes completed after the Congress or its committees had already deliberated and acted on the issue involved.

--HCFA's Office of Research, Demonstrations, and Statistics (ORDS) could not readily determine the specific outcomes or "impacts" of its D&E activities. However, a retrospective review of the projects prepared by ORDS, at our request, indicated that these projects had impact on the development of legislative initiatives such as the Administration's Hospital Cost Containment proposals in 1978 and 1979, the development of regulations to implement laws passed in 1977 and 1978, and, in one instance, a regulation change which would

significantly reduce Medicare payments to hospitals. On the other hand, some of the indicated impacts on legislation involved getting additional demonstration authority or requirements in laws passed in 1977 and 1978 which, in one case, ORDS has not used or complied with and thus has had no effect.

--The processes for carrying out the ORDS D&E activities often involve long periods of time which may explain part of the problem in meeting congressional expectations. On the other hand, there is evidence that congressionally mandated D&E activities have not been given priority over non-mandated ORDS research projects.

--With respect to our suggestions for improving the ORDS processes, which should help to improve the utilization of D&E results, we believe (1) there is a need for more involvement of policymakers in the planning process, (2) planning should include identification of the knowledge needed to be responsive to the specific issues of concern to the Congress and other policy-makers, (3) there is a need to arrange priorities to better assure that the expectations of congressional mandates are met timely, (4) ORDS should identify, obtain, and retain raw data from those D&E activities where the data is likely to prove useful in future research, and should verify the data, on a sample basis, to better assure the accuracy and acceptability of project results, (5) there is a need for a control and tracking system which identifies the interim D&E results of ongoing projects by subject matter, (6) ORDS

should take a formal position on the final results reported from each project as to their validity, their policy implications, and how the report should be used, (7) there should be a systematic on-going assessment of the utilization of the results of D&E activities and the outcomes of such utilization, and (8) there is a need for management to more explicitly inform professional staff what is expected of them and to get more information on how they spend their time.

USE OF SOCIAL RESEARCH AND DEVELOPMENT IN HELPING TO FORMULATE SOCIAL POLICY

The use of social research and development, of which demonstrations, experiments, and related evaluations are a part, can help to formulate social policy. Theoretically, the results should help by providing the executive and legislative branches an adequate body of information to use in designing national policies for programs such as Medicare and Medicaid. When it works social research and development can identify cause-effect relationships which are essential for designing rational policy. Thus to measure this cause and effect relationship the essence of any experiment is to allow some factors to vary through intervention while others remain constant. This can be accomplished either by observing changes in an experiment over time or by focusing on the comparison of research results between experimental and control groups, one receiving the intervention while the other does not.

We do not wish to imply that performing successful experiments or demonstrations is an easy task. We recognize that it is extreme-

ly difficult to hold some variables constant while varying others, to plan for and measure the impacts of unintended side-effects, and to find control and experimental groups comparable except for the one variable needed to determine causality.

Nevertheless, there are general characteristics of successful social research which will provide for better and more useful results. To increase the chances of a successful experiment or demonstration care must be taken to

--plan for evaluation in the early stages of the design,

--monitor the on-going progress of the experiment or demonstration through an internal evaluation system, and

--assure that policymakers can use the research results.

Planning for evaluation in the design of research

It is important to establish a viable design for the experiment. Designing an experiment or a demonstration should involve managers and policymakers alike. Specific policymaker needs should be articulated so that the managers can implement demonstrations and experiments which will address these needs. At a minimum the design must be examined for

--statistical accuracy and the relevance of the sample,

--pertinence of the questions or hypotheses being tested,

--flexibility of its framework to handle the many complex interactions among people who are the subjects of the intervention,

--proper utilization of base-line data delineating the character of a situation before the experiment is started, and

--early integration of evaluation into the experiment or demonstration.

Designing evaluation into the experiment is an important aspect to the potential success of the experiment. Evaluation is not an isolated function to be designed after the experiment is underway particularly when, during the research design phase, data systems can be intergrated into the proposed experiment which will allow evaluators access to relevant research results on a timely basis.

The evaluations in particular and the experiment or demonstration in general must meet the following minimum criteria to achieve the high quality necessary to make them useful.

--Relevance--they must provide the information needed by a variety of audiences, especially decisionsmakers, and must answer the right questions at the right time.

--Significance--the information must tell users something new and important; it must go beyond what is already apparent to them.

--Validity--they must provide a reasonably balanced picture of the real effects of the program or activity in question.

--Reliability--they must contain evidence that the conclusions are not based on variations in the data which are due to chance or inconsistent measurement.

--Objectivity--results must be conveyed in a complete and unbiased manner.

Monitoring the demonstration or experiment through an internal evaluation system

We hold the view that program evaluation is an essential part of

program management. Evaluation, like internal audit, accounting systems, and other sources of management information represents an important means by which a manager can find out what is happening in the organization he or she manages and in the program, demonstration, or experiment for which he or she is responsible. At another lever evaluation can also measure the effectiveness of experiments and demonstrations and provide useful information to policymakers. At the operating level, managing or monitoring an experiment or demonstration or an ongoing program requires that an effective evaluation system be established to provide management with information on the health of the activity.

In engineering terms, evaluation systems are feedback mechanisms telling us what the operating system is doing and, perhaps more importantly, when it is deviating from our expectations. These feedback mechanisms might include indicator systems which monitor readily measurable outputs like people served and inputs like dollars spent. They may also include a centralized control and tracking system which identifies research results from a number of ongoing projects, including an ability to identify interim results.

Whichever system or combinations of systems are used they must support the goal of improving Federal program administration by

--demonstrating, to the satisfaction of the oversight officials, the extent to which a project is effectively administered; and

--supporting management in producing an effectively administered project.

Assuring that policymakers can use research results

Unfortunately, there are problems which hinder utilization of social research results. Probably the most succinct expression of our Office's views as to some of the factors which might improve utilization of results were contained in a speech given by the Comptroller General of the United States in June 1979, at the annual meeting of the Council for Applied Social Research, Inc.

At that time he pointed out that recent evidence indicates that policymakers believe social science can help them. A 1977 GAO review of the use of social research (which includes demonstrations and experiments) by national policymakers disclosed high expectations. More than 70 percent of the respondents, consisting of top management officials in Federal agencies, including HEW, thought that social science should have a substantial or very large effect on the formulation of national policy.

Our 1977 review demonstrated, however, that there are proolems in the utilization of social science research. In terms of practice, our study showed that 45 percent of the policymakers indicated that they were not satisfied with the translation of research results into usable products or into techniques for problem solving.

A number of explanations have been offered to account for this gap between the expectations of policymakers and the actual

utilization of social science research. One researcher suggested that a major problem is that little attention is paid by researchers to the nature of knowledge that will be most useful to policymakers, prior to undertaking research projects. Additionally, the researcher said that little attention is given by researchers to applying criteria of policy relevance when they develop priorities for guiding project selection.

Problems in the dissemination of social research information also contribute to low utilization. A major concern is whether or not the results of the research actually reach the appropriate user in an understandable form. Frequently, there are no formal arrangements for this phase of research and dissemination is often haphazard.

The form in which the results of social research reaches policymakers will affect the prospects for utilization. Research reports are often written for academic audiences rather than for use in policymaking. Policy implications associated with project results can only be ascertained by identifying, acquiring, and reviewing project reports on topics relevant to policy issues. It is for this reason that each research design should discuss which groups of users the report is intended to serve.

We do not mean to suggest that utilization can be easily or clearly measured. A study is usually just one input into a very

complex decisionmaking process. The cumulative impact of a series of related studies in an issue area (e.g., hospital cost containment) provides the real utilization value of the research.

Increasing the utilization of social research, such as in the health care financing area, will not be simple and painless. However, we have learned that an interactive process between policymakers and policy researchers is a crucial factor in planning for utilization of research results. Such a process can help assure that policymakers are committed to use research results and that the researchers will produce useful findings.

We have also learned that policy research is more likely to be utilized if planning for utilization is an integral part of the research process from the beginning. We believe that such planning should address and include the following:

--Identification and definition of the policymakers' problems and policy issues needing research and the knowledge needed to be responsive to these problems and issues.

--Information on the extent to which current and completed research is helpful in understanding the problems and issues and contributing to their resolution.

--Identification of priorities to be placed on supporting projects designed to help obtain the additional knowledge needed.

With this overview of the state-of-the-art of Federal social research and development activities, including demonstrations, experiments, and evaluations, and lack of satisfaction with related products, I will proceed with discussing the remaining five matters mentioned at the beginning of my statement.

PURPOSE AND OBJECTIVES OF AND RESOURCES FOR HCFA'S D&E ACTIVITIES

In 1965 the Congress enacted legislation under titles XVIII and XIX of the Social Security Act which established health financing programs for the aged--Medicare--and the poor--Medicaid. Medicare is a nationwide health insurance program which provides a uniform package of medical care benefits to most persons age 65 and over, to certain disabled persons under age 65, and to certain workers and their dependents who need kidney transplantations or dialysis. Medicaid is a grant-in-aid program under which the Federal Government pays part of the costs incurred by States in providing medical services to low-income persons unable to pay for such care.

Responsibility for administering the Medicare and Medicaid programs was initially given to HEW's Social Security Administration and Social and Rehabilitation Service, respectively. Under a March 1977 HEW reorganization, HCFA was established and given responsibility for administering both programs. Ever increasing costs for medical services combined with increasing numbers of Medicare and Medicaid eligibles has rapidly driven up the costs

of the two programs--combined actual Federal costs of $6.3 billion for fiscal year 1967 and estimated combined expenditures of $42.2 billion for fiscal year 1979. These increased costs and how they can be constrained have been a major concern to the Congress and the Nation as a whole.

HCFA's research and demonstration activities have evolved--both organizationally and legislatively--over the past 13 years. Before HEW's March 1977 reorganization, the research and demonstration activities were fragmented among several HEW components--the Social Security Administration, the Social and Rehabilitation Service, and the Public Health Service. Delegation of authority was fuzzy at best. With the formation of what is now called ORDS within HCFA, some of this fragmentation was alleviated. However, there is still some sharing of responsibility in health services research and demonstration activities with respect to HCFA and the Public Health Service, particularly in the area of long term care and quality of care issues.

The purpose of ORDS' research, demonstration, and evaluation activities is as follows:

> "The research, demonstration, and evaluation activities * * * of HCFA are intended to provide an empirical basis for measuring the impact of health care financing programs upon the beneficiaries, providers, and the economy at large. This purpose is carried out through

a wide variety of scientific investigations into the causes of rising health care costs and into methodologies which show potential for decreasing costs without adversely affecting quality of care. The results of * * * studies, experiments, demonstrations, and evaluations provide essential documentation to be used by policy makers in considering the effectiveness of proposed policy and/or legislative changes on HCFA's primary goal: to encourage the most efficient and effective delivery of health care services to program beneficiaries."

More specifically, ORDS describes the objectives of its D&E and evaluation projects as follows:

--"To provide recommendations and/or support for changes in the Medicare and Medicaid authorizing legislation included in Titles XVIII and XIX of the Social Security Act to improve the operation of the programs and to increase the capability of the programs to meet their intended goals and objectives. In the case of Medicaid, the demonstration efforts are also directed towards recommending changes in State authorizing legislation.

--"To provide operational experience on a pilot basis to the administering agencies (HCFA and the States)

as the basis for developing regulations and program procedures and guidelines to implement new legislation or to provide recommendations and support for the revision of ongoing program regulations, policies and operational procedures.

--"To identify areas requiring new policy initiatives at the national, State and sub-state levels due to changes in the state of the art, social and political changes, technologcal innovations, and changing needs of beneficiaries served.

--"To develop new and innovative models to administer and deliver services under the Medicare and Medicaid programs through restructuring existing systems or developing new systems that increasingly incorporate the proven approaches of other disciplines, e.g., engineering, financial management, automation.

--"To develop new data bases that will provide information previously unavailable to policy makers to serve as the basis for program improvement.

--"To develop and test more cost-efficient methods of administering the programs and delivering quality services to eligibles under the programs to maximize available Federal and State resources.

--"To develop and disseminate new knowledge in the field of health care."

To carry out its objectives, ORDS had a total of 291 individuals on board as of mid-October 1979. Thirty-one of these individuals were clerical/administrative personnel. The 260 professional persons were assigned to four organizational components: 52 to the Office of Demonstrations and Evaluations, 103 to the Office of Statistics and Data Management, 38 to the Office of Financial and Actuarial Analysis, and 67 to the Office of Research.

Since October 1967 through September 30, 1978, a total of about 170 health care financing extramural D&E and related evaluation projects had been undertaken by ORDS and its predecessor agencies through contracts and grants. Funding for the 170 projects during this period was about $60 million, which excludes (1) any benefit payments, such as hospital and doctor bills, on behalf of Medicare and Medicaid beneficiaries participating in the D&E projects, and (2) ORDS personnel and other costs to support the D&E and evaluation activities. Because our review focused specifically on D&E and related evaluation projects, the $60 million also excludes the cost of ORDS' and its predecessor agencies' extramural research projects such as looking at the characteristics of Medicaid ineligibles.

HCFA's budgets for fiscal years 1978, 1979, and 1980 included $19.4 million, $31.4 million, and $46.8 million, respectively, for extramural research, demonstration, and evaluation activities. In addition, HCFA allocated for fiscal years 1978-1980 $7.2 million,

$9.9 million, and $8.7 million, respectively, for salaries and other expenses to support all of ORDS' activities. The 1980 amount does not include the increased personnel costs associated with the October 1979 Federal pay raise.

AUTHORIZING LEGISLATION, LEGISLATIVE COMMITTEE EXPECTATIONS, AND HEW RESPONSE

To date, a total of 12 legislative provisions authorize ORDS' health care financing D&E activities, which are carried out in several major subject areas such as hospital cost containment, long-term care, and health systems. A table showing these provisions and a statement of the authorized activities under each is contained in enclosure 1 of our statement. Also, a more detailed analysis of the legislative history and the general congressional intent related to the ORDS demonstration and experimental authorities and of HEW's response thereto, is included as enclosure II.

Overall, we believe that ORDS has fallen short of the expectations or requirements of the cognizant legislative committees of the Congress. For example, reports to the Congress have not been submitted at the dates specified by law and when reports were submitted they did not meet all of the specifications contained in the law and/or committee reports.

The Senate Finance Committee report related to the experiments authorized by section 402 of the Social Security Amendments of 1967 (Public Law 95-248), did include some suggestions

for incentive reimbursement for physicians' services. Otherwise, before the enactment of the Social Security Amendments of 1972 (Public Law 92-603), congressional expectations with respect to HCFA's research, demonstration, and evaluation activities were rather broad. With the enactment of the 1972 amendments, however, congressional expectations became more specific.

Under section 222 and 245 of that law, the statute and/or the legislative committee reports focused on experiments and demonstrations in six areas.

--Prospective reimbursement systems for institutional providers, such as hospitals, with a full report to the Congress on the results, including recommendations, by July 1, 1974.

--Effects of eliminating the 3-day prior hospitalization requirement for Medicare beneficiaries to receive covered care in skilled nursing facilities.

--Utilization of lower level institutional care and homemaker services as an alternative to the more costly post-hospital nursing home benefits provided under Medicare.

--The possible desirability of adding ambulatory surgical centers as providers of service under Medicare with specific demonstrations to determine the best way for paying for care in such facilities.

--The most appropriate and equitable methods of compensating for the services of physicians' assistants.

--Various methods of paying for durable medical equipment (such as wheelchairs, canes, and walkers) under Medicare which would avoid the unreasonable costs resulting from prolonged rental payments for such items which often exceed purchase price.

With respect to prospective reimbursement, the Department's August 1974 report to the Congress was limited to observations based on a descriptive analysis of the Nation's prospective rate experience together with an outline of the Department's plan for further study and testing.

Although no report has been issued to the Congress meeting the specifications of Public Law 92-603, HCFA contends that the Administration's Hospital Cost Containment proposals in 1978 and 1979 represent a strong indication of the direction HEW believes the Congress should go in the area of prospective reimbursement in that such a system should be mandatory, cover all payors, and focus on total hospital expenditures and/or revenues. As mentioned later, ORDS believes that its demonstrations undertaken under Public Law 92-603 had significant impact on these conclusions.

With respect to the other types of experiments discussed in the 1972 amendments and related committee reports, we find even less responsiveness to congressional expectations.

--It was not until April 1977 that ORDS issued a request for proposals for experiments on the effect of eliminating the 3-day prior hospitalization requirement. The three experiments will not be completed until December 1980.

--We know of no experiment undertaken which would meet all the specifications in the Senate Finance Committee report relating to intermediate care and homemaker services, although some have been undertaken involving homemaker services.

--In December 1977 an evaluation report was issued by a HCFA contractor which was generally responsive to congressional concerns relating to the desirability of adding ambulatory surgical centers as providers of services under Medicare. The report, however, did not recommend the best way for Medicare to reimburse for such services as expected by the Congress.

--The results of an evaluation of an experiment to determine the best method for compensating physicians' assistants was issued about five and one-half years after passage of the 1972 amendments and about 3 months after the Congress had already acted on the matter with respect to rural health clinics.

--The problem of unreasonable expenses resulting from prolonged rentals of durable medical equipment--particularly inexpensive items such as walkers, canes, and bedside com-

modes--continues to exist. An experiment was initiated 4 years after the enactment of Public Law 92-603 and a report was issued in March 1980.

In more recent legislation enacted in 1977 and 1978, the Congress has tended to be specific as to its expectations on demonstrations and experiments and has also established specific dates as to when the related reports were to be submitted. For example, the Rural Health Clinic Services Act (Public Law 95-210), approved December 13, 1977, mandated demonstration projects on a cost-reimbursement basis for physician-directed clinics in urban medically underserved areas involving services provided by physician assistants or nurse practitioners. The law requires a report to the Congress no later than January 1, 1981. In September 1978, ORDS awarded a contract to evaluate privately funded demonstrations involving five cities which ORDS believes is partially responsive to the mandate for urban clinic experiments. However, as of March 1980, ORDS has not been able to implement any projects under this demonstration authority which would be fully responsive to the mandate because of staff and funding shortages. As discussed later, we noted that after the enactment of Public Law 95-210, ORDS awarded a number of research contracts and grants that, in our opinion, were unrelated to the mandated issues.

Public Law 95-292, approved June 13, 1978, which was aimed at improving Medicare's End-Stage Renal Disease program, included

requirements for seven experiments and/or studies with a report to the Congress by October 1, 1979. The specific demonstration authority delegated to ORDS under the act pertained to carrying out pilot projects at selected locations in the country involving the purchase of new or used renal dialysis equipment for home dialysis treatment.

In January 1980, HEW did submit a report to the Congress providing information on the status of various experiments and studies required by Public Law 95-292, but it contained few results and conclusions. With respect to the specific demonstration authority delegated to ORDS, the agency believes that one demonstration initiated in September 1977, at only one location, meets the thrust of the 1978 law. In our opinion, however, it falls short of meeting all the specifications in the statute.

HCFA PERCEPTIONS AS TO THE OUTCOMES OR IMPACT OF ITS D&E AND RELATED EVALUATION ACTIVITIES

One basic question raised by the Subcommittee relates to measuring the outcomes or impact of the HCFA demonstrations, experiments, and related evaluations in terms of legislative or policy initiatives or other benefits..

This presented a difficult problem for us because ORDS and its predecessor agencies had not maintained data on a systematic basis which would provide this information. As a result, at our request, ORDS

personnel for the past year have been engaged in retrospectively developing an "impact" statement which is designed to show the extent that the approximately 170 extramural demonstration, experiment, and related evaluation projects had influenced such things as

--proposed legislation either by the Administration or congressional sponsors (Legislative Impact),

--policy changes in such areas as provider reimbursement (Policy Impact),

--developing new projects or broadening the scope of the study (R&D Impact),

--modification to State Medicaid programs or retention of demonstration practices by local service groups after project termination (State or Local Impact),

--adoption by the industry or the professional community of project methodologies (Professional/Industry Impact).

We reviewed ORDS' impact statement which was received on May 2, 1980, and summarized the number of the projects and the amount of their funding for each major issue area such as hospital cost containment and long term care. We then matched the projects and their costs with the indicated outcome or type of impact. Usually ORDS' analysis of a project or group of projects showed an impact of more than one type such as having an influence on both HCFA policy considerations and on specific State programs. In that case, the total value of the project or projects was posted to each of the two

indicated impacts. The results of the analysis and a summary of the indicated impacts is contained in enclosure III.

In terms of level of effort, expressed as the dollar value of the projects, the ORDS statement indicated that about 60 percent of the level of effort had legislative impact and 55 percent had policy impact.

We requested ORDS to provide us supporting documents so that we could verify the described impacts of the demonstration and evaluation projects. However, ORDS did not furnish us the final impact statement or the listing of supporting documents until May 2, 1980. Therefore, we have had insufficient time to independently validate the indicated impacts except in a few cases where (1) the supporting documents provided a clear link between certain projects and agency testimony on proposed legislation or (2) prior or ongoing GAO studies tended to support or cast doubt on the ORDS claims.

In some cases the indicated legislative impacts appeared to have had no effect or a negative effect in terms of congressional expectations. For example, one indicated legislative impact involved withholding any recommendation on a legislative proposal to remove the 3-day prior hospitalization requirement for skilled nursing care coverage under Medicare until an ORDS demonstration project was completed. This particular demonstration, which was specifically requested in the House and Senate Committee reports on the Social Security Amendments of 1972, was initiated 5 years later and is expected to be completed in December 1980.

In another instance, the indicated legislative impact involved getting additional mandated demonstration authority in a law passed in 1978, which ORDS has neither used nor complied with.

In addition to the problem of not being able to validate the indicated impacts because of a lack of supporting data, our review of final reports on 18 of the approximately 70 completed projects as of September 30, 1978, showed that it would be difficult to directly relate most reports to the indicated impacts because:

--At least seven reports highlighted reservations as to the conclusions to be drawn because of the limitations on the geographic areas or populations covered in the experiment or because the intended objective for the project--to be able to apply the results elsewhere--had not been met.

--Four evaluation reports related to certain experiments seemed to focus on weaknesses in the methodology and design of the experiments themselves, instead of on the conclusions that could be drawn from them.

We recognize that the cumulative knowledge gained from a series of related experiments and their evaluations could tend to offset the effect of the reservations and limitations in the individual reports we reviewed. Nevertheless, we believe that the inconclusiveness of individual reports indicates the inherent difficulty of attempting to measure impacts without a systematic ongoing assessment of the actual utilization and outcomes of D&E activities.

DESCRIPTION OF THE PROCESSES IN CARRYING OUT ORDS' D&E ACTIVITIES

ORDS' efforts to support health care financing demonstrations and experiments involve the following processes: budget and project planning, project design and selection, monitoring, evaluation, and dissemination of results. I will now briefly describe each of these processes as they functioned during our review. A more detailed description of the processes is contained in enclosure IV of our statement.

Budget and Project Planning

The planning and budget process starts about 2 years before the contract and grant projects will be awarded. The work-spending plan for ongoing projects to be continued and new-start projects is developed about 10 to 12 months later. The work plan is organized according to major subject matter areas, such as hospital costs, physician reimbursement, and long term care, in which ORDS feels its resource allocations should be distributed.

Project Design and Selection

This function is slightly different for grants than for contracts. The grants cycle is initiated with the publication of a grants brochure describing the priority areas (e.g., long term care) in which research and development grant applications will be considered. The contract cycle begins with publication of a request

for proposal (RFP), which establishes the parameters for the design of the project.

Review panels assess grant and contract proposals received and prepare evaluation reports on competing proposals, including a ranking of acceptable proposals. These reports are used by the ORDS Director in deciding which grant proposals will be funded and by the contracting office to select projects and negotiate contracts according to competitive procurement requirements.

Monitoring

After a D&E contract or grant is awarded, a project officer monitors the project through several means to identify and resolve problems and assess compliance with grant or contract requirements.

Evaluation

The results of demonstrations and experiments are evaluated through (1) an independent contract awarded to evaluate one or more projects or (2) a separate evaluation component built into a D&E grant whereby the grantee may perform the evaluation itself or through a contract with another organization.

ORDS' Office of Demonstration and Evaluation (ODE) administers independent evaluations of contract D&E projects and receives and approves plans and/or RFPs for evaluations conducted by D&E grantees. The ODE project officer administers an evaluation of a contract D&E project the same way as a contract D&E project--i.e., develops and designs the RFP, assesses the proposals received, participates on

the contract review panel, monitors the awarded evaluation contract, and reviews the interim and final reports.

Dissemination

Contractors and grantees are required to furnish ORDS final project reports on the results of the demonstrations and/or evaluations they conduct. After the reports are received, information about them is disseminated by ORDs through formal and/or informal means. Formal means primarily consist of

--sending abstracts of the final reports to the National Technical Information System of the Department of Commerce; and

--including information about the reports in (1) HCFA's annual report on its research and development activities, (2) HCFA and other HEW publications (e.g., Health-United States and the HCFA Review), and (3) presentations and speeches made by HEW and HCFA officials at various forums.

The informal means for disseminating information about final project reports usually consist of

--discussions among ORDS managers and HCFA program managers during meetings not necessarily convened solely for the purpose of discussing these reports,

--discussions among project officers and persons they know to have an interest in the projects and with whom a close working relationship exists, and

--activities initiated by demonstration grantees such as State agencies.

SUGGESTIONS FOR IMPROVING ORDS PROCESSES

We believe that the following modifications to ORDS processes should help to improve the utilization of D&E results.

1. Involvement of policymakers and program officials in planning process

As discussed at the beginning of our statement, an interactive process between policymakers (which includes program officials) and policy researchers is a crucial factor in planning for utilization of research results.

In the early stages of this review, we concluded that there was limited involvement of HCFA program officials in the work planning process on a systematic basis. Because these officials must necessarily be involved in assessing the implications of the results of D&E activities for changes in policy and procedures and would be responsible for putting these changes into effect, we believed their input in the early stages was important.

In December 1979, ORDS sponsored--for the first time--a conference attended by ORDS managers and HCFA program officials in headquarters. This conference provided an opportunity for interaction concerning (1) projects planned for fiscal years 1980 and 1981, (2) what ORDS had learned from projects completed or underway, (3) the issues still to be studied, and (4) the program officials' concerns with ongoing and proposed D&E projects and their perceptions of policy issues needing study.

Hopefully, this type of interaction initiative will facilitate more utilization of ORDS project results by policymakers and could be expanded to bring in Office of the Assistant Secretary for planning and Evaluation officials, the HCFA Administrator, State Medicaid administrators, congressional staff, and health care industry officials.

2. Planning should consider the knowledge needed to be responsive to specific policy issues being examined

Also, we believe long and short term planning should include identification and definition of the policymakers' problems and policy issues needing research and the knowledge needed to be responsive to these problems and issues on a timely basis. We further believe that the plans and related project designs should show how each proposed project will help meet such needs.

The planning documents which we reviewed primarily reflected short term planning and were financially oriented and did not specifically identify and define the types of knowledge that would be most useful to the Congress and other policymakers. For example, these plans did not identify the knowledge needed to be responsive to the specific concerns and policy issues identified in relevant legislative committee reports and did not identify how each proposed project would help to attain the knowledge needed. Nor did they indicate the extent to which current and completed research could be helpful to understanding the problems and issues.

As previously discussed, we believe that designing evaluation into an experiment increases the chance of a successful experiment. This was not done in earlier evaluations of prospective reimbursement systems that had been established without Federal assistance. However, our review of more recent work plans indicated that often the evaluation function has been considered in the planning and design phases.

3. Need to adjust processes to adapt to congressionally mandated demonstrations and experiments

In recent years the Congress has tended to be more specific on spelling out in the law as well as in committee reports its expectations as to the demonstrations it wanted to be done and also established specific dates for HEW to submit reports on the projects. HEW has fallen short in meeting congressional expectations for such mandated demonstrations and we believe that ORDS needs to adjust its processes to adopt to the realities of such mandates. For example, Public Law 95-210, approved in December 1977, required demonstration projects for physician-directed clinics in urban medically underserved areas with a report to the Congress no later than January 1, 1981. We were told that ORDS has not been able to implement projects that meet all congressional specifications because of staff and funding shortages.

Similarly, as previously stated, we believe that none of the ongoing demonstrations meet the specifications of the experiments required by section 1881(f)(1) of the Social Security Act (added by section 2 of Public Law 95-292) which had a reporting date by October 1, 1979. According to HCFA, when Public Law 95-292 became effective, it was too late to request funds for the mandated studies as part of the Department's fiscal year 1979 budget, and additional funds for the 1979 supplemental and the fiscal year 1980 appropriations were denied. Also, HCFA felt that the October 1, 1979, report date in the bill was unrealistic.

While we are not sure at which stage in the ORDS process adjustments should be made to adjust its priorities to recognize such mandated demonstrations or experiments on a timely basis, we noted that after the enactment of Public Law 95-210 in December 1977, ORDS awarded a number of research contracts and grants that, in our opinion, were unrelated to the mandated issues. For example, in January 1978, ORDS awarded a $139,000 research contract to the Blue Shield Association to analyze Medicare and private business claims data.

Similarly, after the enactment of Public Law 95-292, ORDS awarded a $121,000 grant to support (1) the completion of a book, suitable to medical school curriculum committees and to individual faculty members, on the subject of comprehensive quality

assurance and cost-containment in the health field and (2) a $115,000 grant to study the process, effectiveness, and costs of the Medicaid Early and Periodic Screening, Diagnosis and Treatment program in Southeastern Pennsylvania.

Although we are not in a position to make value judgments as to the relative significance or importance of such research as compared with the required demonstrations and experiments, it seems to us that activities specifically mandated by law should receive top priority somewhere in the planning and project design processes.

4. Data Retention and Validation

Of the 18 completed reports we reviewed, 14 were based in whole or in part on raw data developed by the contractor or grantee. ORDS does not ordinarily obtain and retain such raw data--although the Federal Government has helped pay for it. We believe that on a selective basis, data generated by contractors or grantees under one demonstration or evaluation project could prove to be useful in other research.

For example, one report we reviewed involved a pilot project designed to test the feasibility of furnishing out-of-hospital prescription drugs to an elderly population. Although the study was very limited in scope, the data developed by the contractor could be used in any further studies planning a drug benefit for the elderly or for national health insurance. Therefore, we believe that ORDS should review the project results

with the view toward identifying, obtaining, and retaining the raw data from those demonstrations and experiments where the data is likely to prove useful in future research.

We were also told that ORDS generally accepts the analyses of the data developed during a demonstration or experiment without verifying or validating it to better assure the accuracy and reliability of the results. In our review of completed project reports, we noted at least three evaluation reports--including one evaluation of an ORDS experiment--where the contractor or grantee highlighted deficiencies in the data used. In the latter instance, the contractor recommended:

> "Experimental designs should include specified data validation procedures that ensure equity to sponsors and participants. Moreover, data validation activities should be conducted by an independent third party * * *."

We believe that to better assure the utilization and acceptability of project results, some verification of data on a sample basis should be undertaken by ORDS.

5. Need for control and tracking system.

Section 402 of the Social Security Amendments of 1967, as amended, requires that new proposed projects be evaluated by competent specialists with respect to the proposed project's relationships with other completed and ongoing projects. We

believe this concept has applicability to other D&E projects carried out under other authorities as well and ORDS officials told us they often do this. In order to better establish such relationships, we believe ORDS needs a centralized control and tracking system which would monitor the demonstration or experiment through an internal evaluation system and which would identify the interim D&E research results of ongoing projects by subject matter. Such a tracking system, in turn, would require better information from the ORDS monitoring function as to the interim results.

We understand that ORDS is considering an automated centralized tracking system for its contracts and grants; however, this proposed system appears to focus on procurement and financial matters and not on interim results of ongoing projects by subject matter.

We believe that ORDS, in designing such a system, should provide for identification of interim D&E results and should prepare periodically and make available a report showing all ongoing projects and any interim results identified. Such a system should also be used to provide the Congress with current information on HCFA's D&E activities.

6. ORDS assessment or reaction to completed projects.

Our review of a sample of 18 final reports showed that ORDS did not follow the practice of preparing a position paper con-

taining some reaction or advice to management as to the contents or appropriate use to be made of the final report. We believe that to facilitate the utilization and acceptability of ORDS D&E results, ORDS should take a formal position on the results reported from each project. As a minimum, we believe that ORDS should develop a statement as to the validity of the results of every report, what the policy implications are, how the report should be used, and the potential users of the report. In our opinion, such a formal assessment of completed projects would also help to (1) identify on a timely basis project results worthy of disseminating to appropriate and interested congressional parties and (2) identify, over a period of time, those contractors and grantees that tend to produce the most satisfactory results.

7. Systematic assessment of outcomes.

As discussed previously, ORDS has been attempting to retrospectively identify and assess the outcomes or impacts of its D&E activities and has had some difficulty doing so as well as in supporting the indicated impacts. We believe that there should be a systematic ongoing assessment of the utilization and outcomes of D&E activities. In addition to the basic questions of accountability and of justifying the funds requested and spent on such activities, a systematic assessment could also provide important opportunities for

learning why products were used or not used.

For example, if products were not used because

--the results were not obtained from a nationally representative sample,

--quality of care was not considered, or

--the cost of broader implementation was not estimated,

then strategies could be developed to ensure that these problems do not occur in future projects. Such learning could provide opportunities to improve the design and performance of ongoing or future projects.

8. Management of staff resources

ORDS management told us that project officers spend less time on their projects than they should because of other requirements placed on their time--e.g., responding to requests for information from the Congress and others, writing speeches, and general administrative matters. We were unable to verify the amount of time project officers devote to these activities unrelated to their projects because ORDS does not have quantifiable information on how they spend their time.

We believe that ORDS should establish procedures to account for the amount of time its staff, particularly project officers, spend in carrying out their various tasks. Such procedures should benefit management in that it would be better able to assess staff resource needs.

Prior to our review, the Office of Demonstrations and Evaluations requested a contractor to identify and assess its management problems and then develop a training course to address the problems identified. Some of the problems which the contractor identified in his February 1979 report were (1) project officers felt that, while they are given the responsibility for a project, they did not have the necessary authority to manage the project properly and (2) they perceived a lack of uniformity among superiors in standards by which project management is evaluated and thus they were not sure what management expected of them in performing their work.

Likewise, during our interviews with ORDS staff, we were told that project officers had no guidelines which identified ORDS management's expectations of them in terms of their specific technical, non-procurement related responsibilities in carrying out D&E activities. Without a common understanding of project officer responsibilities and supervisors' expectations regarding project management performance, there is no assurance that projects are being managed on a consistent and satisfactory basis. Because nearly all of ORDS' D&E projects are multi-year projects and because of high personnel turnover, no one person has generally been responsible for a project from its beginning to its end.

An ORDS division manager also told us that every ORDS manager does not apply the same performance standards when looking at project management. For example, this manager said she allowed project officers to work independently and correspond with contractors and grantees without the correspondence having to be reviewed and approved by her; whereas, some other managers exercise more control.

According to ORDS, it plans to develop a project officer's handbook to provide guidelines on what management's expectations are regarding their technical and procurement responsibilities in carrying out D&E activities. We believe this would be a good step forward toward improving consistency in management. However, we believe that ORDS should also establish standards of performance by which project officers and managers can be evaluated for project management. In our opinion, the handbook and performance standards would be tools that ORDS could use to better assure control over consistency in project management, to improve communication between managers and project officers, to help assure consistency in feedback to project officers' and managers on their individual performance, and to assist ORDS management in assessing project management problems and staff resource needs.

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Mr. Chairman, this concludes our statement. We will be happy to answer any questions that you or other Members of the Subcommittee might have.

ENCLOSURE I

LEGISLATIVE AUTHORITIES FOR THE OFFICE OF RESEARCH, DEMONSTRATIONS, AND STATISTICS' RESEARCH, DEMONSTRATIONS, AND EVALUATION ACTIVITIES

Legislative authority	Authorized activity
Social Security Act:	
Section 1110	Support research and demonstration projects to promote the objectives of the programs under the act.
Section 1115	Support experimental, pilot, and demonstration projects and waivers to promote the objectives of the programs under the act in the States.
Section 1875	Conduct studies and develop recommendations to increase the efficiency and economy of the Medicare program.
Section 1881(f)(1), added by section 2 of Public Law 95-292	Initiate and carry out pilot projects involving financial assistance for the purchase of new or used durable medical equipment for renal dialysis. Report required October 1, 1979.
Social Security Amendments of 1967 (Public Law 90-248):	
Section 402(a)	Support experiments and demonstration projects dealing with alternative methods of provider reimbursement--specifically, incentive reimbursement.

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Legislative authority	Aurthorized activity
Social Security Amendments of 1967 (Public Law 90-248): (cont.)	
Section 402(a), as amended by section 222(b) of Public Law 92-603	Support a broad range of experiments and demonstration projects encompassing certain complex areas,including negotiated rates and other alternative reimbursement methods for physicians; State ratesetting for institutional providers; fixed-price or performance incentive contracting with intermediaries and/or carriers; and reimbursement for clinical psychologists, physician extenders, intermediate care and homemaker services, and other noncovered services such as ambulatory surgical centers.
Section 402(a), as amended by section 17(d) of Public Law 95-142	Develop or demonstrate improved methods for the investigation of fraud in the provision of care or services under the health programs established by the Social Security Act.
Social Security Amendments of 1972 (Public Law 92-603):	
Section 222(a)	Support experiments and demonstrations to determine the relative advantages and disadvantages of various alternative methods of making payment on a prospective basis to providers of health care services under the Medicare, Medicaid, and Maternal and Child Health and Crippled Children's Services programs authorized under the Social Security Act. Report to the Congress required by July 1, 1974.

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Legislative authority	Authorized activity
Social Security Amendments of 1972 (Public Law 92-603): (cont.)	
Section 245	Conduct research designed to eliminate unreasonable expenses resulting from prolonged rentals of durable medical equipment.
National Health Planning and Resources Development Act of 1974 (Public Law 93-641):	
Section 1526	Make grants to State health planning and development agencies to demonstrate the effectiveness of those agencies in regulating rates for the provision of health services.
Section 1533(d)	Develop uniform systems for classifying and setting rates for health care providers and to establish uniform accounting and reporting systems to facilitate the calculation of volume, costs, and reimbursement rates for services.
Public Law 95-210, Section 3	Conduct demonstration projects to reimburse on a cost basis for services provided by physician-directed clinics in urban medically underserved areas and for services provided by a physician assistant or nurse practitioner employed by such clinics. Report to the Congress required by January 1, 1981.

ENCLOSURE II

AUTHORIZING LEGISLATION, LEGISLATIVE COMMITTEE EXPECTATIONS, AND HEW RESPONSE

To date, a total of 12 legislative provisions authorize ORDS' health care financing D&E activities, which are carried out in several major subject areas such as hospital cost containment, long-term care, and health systems.

Before enactment of the Social Security Amendments of 1972 (Public Law 92-603), congressional guidance with respect to HCFA's research, demonstration, and evaluation activities was rather broad. For example, the original 1965 Medicare law provided authority "to carry on studies and develop recommendations" to increase the efficiency and economy of that program.

Section 402 of the Social Security Amendments of 1967 (Public Law 90-248) authorized HEW to develop and engage in experiments with respect to Medicare and Medicaid under which physicians who would otherwise be paid on the basis of reasonable charges and institutional providers which would otherwise be paid on the basis of reasonable costs could be paid on an incentive basis in any manner agreed upon by HEW and the provider. The objectives of such incentives would be to increase the efficiency and economy of health services without adversely affecting the quality of such services.

The portion of the related Senate Finance Committee report pertaining to section 402 contained some suggestions for experiments

such as

--a combined system of Medicare reimbursement for group practice prepayment plans (the predecessors to Health Maintenance Organizations) to cover both physician and hospital service, and

--payments for physician services under Medicare on the basis of fee schedules.

HEW undertook to carry out the first suggested experiment, but to the the best of our knowledge, not the other.

The 1967 Senate report also called for the development of appropriate and effective measures of the efficiency and quality of health services with which to measure the success of the experiments.

With the enactment of the Social Security Amendments of 1972, congressional expectations in the area of experiments or demonstrations became more specific.

Under section 222 of the law, the legislative Committee reports focused on the following five areas:

1. Prospective reimbursement systems for institutional providers

Although the Committees recognized that the existing retrospective reasonable cost method of reimbursing providers under Medicare provided no incentives for efficiency, they questioned whether any rates set under a prospective reimbursement system would result in Federal reimbursement at levels lower than--or

as low as--that which would result under the existing system.

The Committees also were concerned with possible cutbacks in quality of care and expected that the development of adequate, widely agreed upon measures of quality of care would be needed and should be developed by the Department. The Committees further expected that the prospective reimbursement experiments or demonstrations would be carried out in sufficient scope to give assurance that the results would apply generally.

Under the law, the Department was to submit to the Congress no later than July 1, 1974, a full report of the results of its experiments and demonstration projects as well as an evaluation of other programs with respect to prospective reimbursement. Also, the HEW report was to include detailed recommendations with respect to the specific methods that might be used in the full implementation of a prospective reimbursement system.

The law also authorized experiments, demonstrations, and evaluations involving negotiated rates and various payment arrangements for health services under State laws.

Although the Department's May 1973, implementation plan for the section 222 demonstrations did not anticipate a complete report involving any new experiments by July 1, 1974, it did anticipate issuing a report based on carrying out "a comprehensive evaluation and analysis of existing, pending and past prospective payment systems."

The August 1974, report to the Congress on prospective reimbursement fell short of even the Department's expectations, however,

because it was generally limited to observations based on a descriptive analysis of the Nation's prospective rate experience together with an outline of the Department's plan for further study and testing.

A widely distributed July 1977, HCFA report entitled "Research on Health Care Financing" updated the results of its studies on prospective reimbursement and presented the following elements which HCFA believed to be essential to an efficient system:

1. All hospitals within a given system should submit accounting and reporting data based on uniform systems.
2. Health planning and ratesetting should be closely coordinated.
3. Prospective ratesetting systems should focus on total hospital expenditures including utilization factors.
4. Prospective ratesetting systems should cover all payors.
5. Hospital participation in prospective ratesetting systems should be mandatory.
6. Statistical screens should be established to determine what hospital costs are reasonable.
7. An appeals or exceptions process should be created to allow hospitals the opportunity to rectify what they believe to have been an inappropriate decision.

Similar information was also provided in congressional testimony in June 1977.

Although no report has been issued to the Congress meeting the precise specifications of section 222, HCFA contends

that the Administration's Hospital Cost Containment Proposals in 1978 and 1979 represent a strong indication of the direction HEW believes the Congress should go in the area of prospective reimbursement. For example, prospective ratesetting should be mandatory and cover all payors and should focus on total hospital expenditures and/or revenues. On the other hand, congressional expectations for the development of adequate, widely agreed upon measures of quality of care have not been realized, and we are aware of no specific experiment or demonstration to develop such measures. According to the Director of HCFA's Health Quality and Standards Bureau, the term "quality of care" has not been defined.

2. Effects of eliminating the 3-day prior hospitalization requirement for Medicare skilled nursing facilities

Although not specifically mentioned in section 222 of Public Law 92-603, the related reports of both the House Ways and Means and the Senate Finance Committees expressed concern about the difficulties the 3-day prior hospitalization requirement presented to some beneficiaries needing skilled nursing care. The reports stated that the Committees expected HEW to undertake experiments to determine the effects of eliminating or reducing this requirement. The Department's May 1973, implementation plan included no specific reference to this issue. It was not until April 1977, that HCFA issued a request for proposals on this subject. According to ORDS, the three experiments will not be completed until December 1980. In this regard, we noted that HCFA's indicated legislative impact for this study

was to withhold any recommendation for congressional action on the 3-day prior hospitalization requirement until the study was completed.

3. Intermediate care and homemaker services

Public Law 92-603 and the related Senate Finance Committee report, pertaining to section 222, specifically expressed interest with the use of lower level institutional and homemaker services as an alternative to the more costly post-hospitals benefits then and now provided under Medicare.

Although the Department's May 1973, implementation plan characterized this as a "higher priority" activity and there have been demonstrations involving homemaker services for Medicare patients, as of January 1980, we could identify no project undertaken which would meet all the specifications in the Committee report.

4. Ambulatory surgical centers

Section 222 and the related Senate Finance Committee report specifically discussed the possible desirability of adding ambulatory surgical centers as providers of service under Medicare. According to the report, the Committee expected HEW to conduct a study of various types of facilities providing surgery to ambulatory patients and then enter into a demonstration project to determine the best way of paying for care in such facilities under Medicare.

In December 1977, an evaluation report generally responsive to the Committee's concerns was issued by a HCFA contractor, except

that the report did not recommend the best way for Medicare to reimburse for such services. In any event, bills reported to the Senate on August 11, 1978, (H.R. 5285) and on December 10, 1979, (H.R. 934) contained provisions authorizing Medicare payment for surgical procedures on an ambulatory basis which the findings in the HCFA evaluation report would tend to support. However, since neither Finance Committee report mentioned the study and the congressional sponsor declined to confirm its influence on the proposed legislation, we are unable to comment on its responsiveness.

5. Physicians' assistants

According to the Senate Finance Committee report on section 222, a purpose of this provision was to authorize demonstration projects to determine the most appropriate and equitable methods of compensating for the services of physicians' assistants (sometimes called para-medics or primary care practitioners). The objectives were the development of non-inflationary alternatives which, if accepted, would not impede the continuing efforts to expand the supply of qualified physicians' assistants.

HEW's May 1973, implementation plan gave this project a "higher" priority and a contract was awarded in 1974 to determine under what circumstances payment for physicians' assistants services would be appropriate.

In December 1977, the Congress passed Public Law 95-210 which set forth the methods of compensating physicians' assistants under

Medicare and Medicaid in rural health clinics on a cost-related basis. According to ORDS, the final report on the evaluation of the section 222 project was issued sometime in March 1978--or about 3 months after the Congress had acted on the matter. However, ORDS was able to provide some interim information to the Congress in 1977 on how physicians' assistants were distributed around the country.

Durable Medical Equipment

In addition to the specific areas of interest for demonstrations and experiments expressed in the Committees' reports relating to section 222 of Public Law 92-603, section 245 of the bill authorized HEW to undertake experiments in various methods of paying for durable medical equipment, such as wheel chairs and hospital beds, used in a patient's home under part B of Medicare. According to the Senate Finance Committee report on this section, the specific congressional concern related to a May 1972 GAO study which showed that prolonged rental payments for such items often exceeded the purchase price.

An experiment to implement section 245 was initiated in October 1976, and the final report was issued in March 1980. In the meantime, however, in October 1977 the Congress, apparently dissatisfied with HEW progress in this area, included section 16 in Public Law 95-142--"The Medicare-Medicaid Anti-Fraud and Abuse Amendments." This section modified the method of payment for durable medical equipment effective

October 1, 1977, by requiring HEW to determine on the basis of medical evidence, whether the expected duration of need warrants a presumption that purchase would be less costly or more practical than rental. Where such a presumption can be made, HEW should require the purchase and should provide reimbursement on the basis of a lump-sum payment or a lease-purchase arrangement. According to ORDS, final regulations incorporating the results of the demonstration project have been developed but not yet issued.

Our ongoing survey of the implementation of section 16 of Public Law 95-142, in HEW's Region I (Boston), clearly indicates that congressional expectations with respect to solving the problem of unreasonable expenses to Medicare resulting from prolonged rentals of durable medical equipment have not been met.

Although the reimbursement issues now are more diverse, complex, and controversial than they were at the time of our prior study in 1972, the Medicare carriers, equipment suppliers, and researchers seem to agree that relatively inexpensive items--say less than $75 and $100--should always be purchased rather than rented. Nevertheless, our survey at Medicare carriers serving Rhode Island, Vermont, and New Hampshire showed that, because HEW had not issued regulations implementing section 16, as late as December 1979

--walkers costing $20, with a monthly rental of $4, had accumulated monthly rental charges under Medicare ranging from $36 to $90;

--canes costing $21, with a monthly rental of $4, had accumulated rental charges ranging from $32 to $58; and

--bedside commodes costing $40, with a monthly rental of $6

had accumulated rental charges ranging from $41 to $96.

Since it costs the Medicare carriers on the average about $3 to process and pay a monthly rental claim, we do not believe that the continued rentals of low cost items such as walkers, canes, and commodes makes much sense in light of the congressional intent.

Demonstration and evaluation authorities enacted after the Social Security Amendment of 1972 for which ORDS has been delegated some responsibility are summarized as follows:

The National Health Planning and Resources Development Act of 1974 (Public Law 93-641)

On January 4, 1975, Public Law 93-641 became law. Although the Health Planning Act covered more than the Medicare and Medicaid programs, HCFA's predecessor agencies--and presently ORDS--were given two demonstration authorities under this law.

--Section 1526 gave HEW authority to make grants to six State health planning agencies for the purpose of demonstrating the effectiveness of such agencies in regulating rates for providing health services.

--Section 1533(d) directed HEW to establish within 1 year of enactment uniform systems for classifying and setting rates for health care providers and to establish uniform accounting and reporting systems to facilitate the calculation of volume, costs, and reimbursements for institutional providers. This

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was essentially a technical assistance amendment imposing no specific requirements on the health care industry to use the uniform systems.

According to HCFA, no awards have been made under section 1526 because no State planning agencies have met the requirement that they have the authority to carry out rate regulation functions.

According to HCFA, two contracts have been awarded under section 1533(d). However, because this section did not require the use of uniform systems, the application of the project results was focused on implementation of section 19 of Public Law 95-142 which requires (1) HEW to establish, among other things, uniform cost reporting systems for different types of institutions such as hospitals and (2) Medicare and Medicaid providers to submit cost-related information to HEW in accordance with the uniform reporting system.

In any event, due to circumstances beyond HCFA's control or due to the thrust of subsequent legislation, congressional expectations at the time of the enactment of Public Law 93-641 have not been met.

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In more recent legislation, the Congress has tended to be specific as to its expectations in the area of studies and demonstrations and has also established specific dates or time frames as to when the related reports were to be submitted. The following three laws, enacted between October 1977 and June 1978, contained various demonstration authorities and/or reporting requirements some of which have been delegated to ORDS.

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The Medicare-Medicaid Anti-Fraud and Abuse Amendments (Public Law 95-142)

Section 17 of Public Law 95-142, approved October 25, 1977, provided for the funding of State Medicaid Fraud Control Units. Included as a Senate amendment to the bill was specific authority to arrange for demonstration projects designed to develop improved programs for the detection, investigation, and prosecution of fraud and abuse.

According to the related Senate Finance Committee report, the Committee believed that States, such as New York, which have demonstrated their ability to conduct vigorous and innovative anti-fraud activities with respect to one class of providers (i.e., nursing homes) should be encouraged to develop and implement such programs with respect to other classes of providers. ORDS has been delegated this demonstration authority.

Consistent with the legislative intent, HEW has provided a demonstration grant to the Special Prosecutor in New York to look into possible fraud and abuse in hospitals.

Rural Health Clinic Services (Public Law 95-210)

Public Law 95-210, approved December 13, 1977, contained three provisions involving studies, demonstration projects, or evaluations which were assigned to HCFA--of which only one specifically involved demonstration projects and has been delegated to ORDS. The three requirements pertained to:

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--A study as to the feasibility of imposing a copayment for each visit to a rural health clinic instead of the normal $60 deductible and 20 percent coinsurance imposed under part A of Medicare. A report on this study was due to the appropriate committees of the Congress by December 1978. This study was assigned to HCFA and a report was submitted in November 1979 which discussed several alternatives but made no recommendations concerning substitution of copayments for regular Medicare cost sharing in rural health clinics.

--Demonstration projects on a cost-reimbursement basis for physician-directed clinics in urban medically underserved areas involving services provided by physician assistants or nurse practioners. ORDS was delegated this demonstration authority under section 3 of the law which requires a report to the Congress no later than January 1, 1981.

--Evaluation and related report on the advantages and disadvantages of extending coverage under Medicare to mental health centers and to centers for the treatment of alcoholism or drug abuse. HCFA was assigned this responsibility and a report was due the Congress by June 1978. A report was submitted in October 1978 but contained no recommendations on whether Medicare coverage should or should not be extended.

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With respect to the demonstration authority for urban clinics in medically underserved areas, which was delegated to ORDS, the reports of the House Ways and Means and Senate Finance House Committees indicated concern about the costs of providing for such an untested urban program since the clinics' budgets were several times larger than those of rural clinics. The Committees were also concerned about the potential for uncontrolled proliferation of such clinics in urban areas and the possible abuse of program funds. Therefore, the Committees' reports and the law spelled out in considerable detail what issues the demonstration projects should cover.

In addition, the report of the House Committee on Interstate and Foreign Commerce expressed the intent that the demonstration projects include the various types of providers (private physicians, small clinics with part-time physicians, and public health clinics) that use nurse practioners and physicians' assistants.

In September 1978, ORDS awarded a contract to evaluate privately funded demonstrations involving five cities. The basic purposes of these demonstrations are to (1) assist municipalities in providing health care services to medically underserved areas by expanding existing programs of health departments and hospitals with a limited increase in the city's budget and (2) foster the delivery of preventive health care services.

Our review of project documents indicates that the question of how to pay for the services of physicians' assistants or nurse practioners was only incidental to the basic purposes of the demonstrations.

According to HCFA officials, as of March 1980, ORDS has not been able to implement any projects under the authority of section 3 of Public Law 95-210 which would be fully responsive to the mandate because of staff and funding shortages.

Improving the End-Stage Renal Disease Program (Public Law 95-292)

Public Law 95-292, approved June 13, 1978, included requirements for seven experiments and/or studies with a report to the Congress by October 1, 1979. Of the seven, three involved experiments, with one being delegated to ORDS. This experimental requirement is included in section 1881(f)(1) of the Social Security Act. This section requires HEW to carry our pilot projects at selected locations in the country under which financial assistance in the purchase of new or used durable medical equipment for renal dialysis is provided to individuals suffering from end-stage renal disease at the time home dialysis is begun with the provision for a trial adaptation to home dialysis before the actual purchase of such equipment.

According to the Senate Finance Committee report, there was a need for further study and experimentation relating to more cost-effective measures for providing treatment under this $1 billion program. In January 1980, HEW submitted a status report to the Congress on the experiments and studies which contained relatively

few results or conclusions. The reason stated by HEW was that Public Law 95-292 was not enacted until June 13, 1978, which left slightly over a year to develop the projects. Consequently, the studies had not been ongoing long enough to yield significant results. According to HEW, final study results will be incorporated in future annual reports on the End-Stage Renal Disease program.

With respect to the specific experimental authority delegated ORDS, we were advised of at least three demonstration projects which deal with home dialysis. However, none of these demonstration projects were being done under the authority of section 1881(f)(1) and, in our opinion, none meet all the specifications of that section of the law. However, ORDS believes that one of the demonstrations which was initiated in September 1977, at only one location, meets the thrust of section 1881(f)(1).

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In summary, we believe that the D&E activities undertaken by ORDS have fallen short of the expectations and requirements of the cognizant legislative Committees of the Congress.

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HCFA PERCEPTIONS AS TO THE OUTCOMES OR IMPACT OF ITS D&E AND RELATED EVALUATION ACTIVITIES

One basic question raised by the Subcommittee relates to measuring the outcomes or impact of the HCFA demonstrations, experiments, and related evaluations in terms of legislative or policy initiatives or other benefits. Simply stated, the Subcommittee wanted to know what the Congress and others were getting for the $60 million spent by ORDS and its predecessor agencies for this activity between October 1967 and September 30, 1978.

This presented a difficult problem for us because ORDS and its predecessor agencies had not maintained data on a systematic basis which would provide this information. As a result, at our request, ORDS personnel for the past year have been engaged in retrospectively developing an "impact" statement which is designed to show the extent that the approximately 170 extramural demonstration, experiment, and related evaluation projects had influenced such things as

--proposed legislation either by the Administration or congressional sponsors (Legislative Impact),

--policy changes in such areas as provider reimbursement (Policy Impact),

--developing new projects or broadening the scope of the study (R&D Impact),

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--modification to State Medicaid programs or retention of demonstration practices by local service groups after project termination (State of Local Impact),

--adoption by the industry or the professional community of project methodologies (Professional/Industry Impact).

We reviewed ORDS' impact statement which was received on May 2, 1980, and summarized the number of the projects and the amount of their funding for each major issue area such as hospital cost containment and long term care. We then matched the projects and their costs with the indicated outcome or type of impact. Usually ORDS' analysis of a project or group of projects showed an impact of more than one type such as having an influence on both HCFA policy considerations and on specific State programs. In that case, the total value of the project or projects was posted to each of the two indicated impacts. The results of the analysis are summarized in the following table.

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Major issue area	Projects: Number	Projects: ORDS funding thru FY 1978	Type of impact: Legislative	Type of impact: Policy	Type of impact: R&D	Type of impact: State or local	Type of impact: Professional/ Industry	Type of impact: None shown
		millions						
Hospital cost containment	38	$19.7	$11.3	$ 1.6	$ 5.9	$16.8	$0.1	-
Long term care	33	6.5	2.6	4.7	2.3	2.6	2.3	$1.3
Ambulatory care	22	7.0	5.1	6.1	1.7	2.7	4.3	-
Quality and effectiveness	37	9.0	5.9	7.2	0.5	5.0	1.3	0.4
Health systems organizations	23	9.0	6.4	6.3	7.4	4.1	-	-
Improved management reporting systems	5	4.2	0.2	3.7	-	-	-	-
Improved program administration	8	4.7	3.0	4.2	-	4.4	0.1	-
Total	166	$60.2	$34.5	$33.8	$17.8	$35.6	$8.1	$2.0

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We had requested ORDS to provide us supporting documents so that we could verify the described impacts of the demonstration and evaluation projects. However, ORDS did not furnish us the final impact statement or the listing of supporting documents until May 2, 1980. Therefore, we have had insufficient time to independently validate the indicated impacts except in a few cases where (1) the supporting documents provided a clear link between certain projects and agency testimony on proposed legislation or (2) prior or ongoing GAO studies tended to support or cast doubt on the ORDS claims.

In terms of level of effort expressed as the dollar value of the projects, the ORDS statement did not show any impacts for about 3 percent, or about $2 million, of the total value of the projects. On the other hand, it indicated that about 60 percent of the level of effort had legislative impact, 55 percent had policy impact, about 60 percent had impact on State or local programs, about 30 percent had impact on follow-on research or development activities, and about 15 percent had professional/ industry impact.

For each major issue area the ORDS' perceptions of the major impacts are briefly described as follows.

Hospital Cost Containment

In this issue area, the indicated emphasis was on the impact of the demonstrations and evaluation results on the Administration's legislative cost containment proposals in 1978 and 1979. The projects principally involved those undertaken pursuant to the incentive reimbursement authority contained in section 402 of the Social Secur-

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ity Amendments of 1967 and the prospective reimbursement experiments undertaken pursuant to section 222 of the Social Security Amendments of 1972. The other major indicated outcome of the projects involved benefits to States through the support of State hospital rate setting programs such as have been established in New York, New Jersey, Washington, and Maryland.

Long Term Care

In this issue area, the indicated legislative impact of ORDS experiments pertained to the so-called swing-bed proposals in various pending bills (i.e., using surplus hospital beds for nursing home type patients in areas where there is a need for nursing home beds). The ORDS projects provided support for HCFA testimony on the proposals. Another indicated legislative impact involved withholding any recommendations on a legislative proposal to remove the 3-day prior hospitalization requirement for skilled nursing care coverage under Medicare until an ORDS demonstration project was completed. This demonstration, which was specifically requested in the House and Senate Committee reports on the Social Security Amendments of 1972, was initiated 5 years later and is expected to be completed in December 1980. We believe that such delays in responding to congressional expectations represent a negative impact.

The indicated policy impact involved the incorporation of the results of projects into internal issue papers, the development of new demonstrations, and the dissemination of prospective reimbursement information on nursing homes to Federal and State policymakers.

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Ambulatory Care

In this issue area, the indicated legislative impacts focused on (1) the proposed Senate changes in the Medicare law pertaining to the methods for paying for ambulatory surgery and (2) the physicians' assistant reimbursement provision in Public Law 95-210, enacted in December 1977. As indicated in more detail in enclosure II, we believe these impacts are questionable. The other indicated legislative impact mentioned for this activity involved the inclusion of additional and more specific demonstration authority in the End Stage Renal Disease bill (Public Law 95-292) that passed in June 1978. As previously mentioned, the specific authority delegated to ORDS has not been used and a status report issued to the Congress in January 1980 contained relatively few results and conclusions.

With respect to policy input, the ORDS impact statement indicated that the experience from these demonstrations was used in developing regulations to implement (1) the renal disease bill--regulations were issued in October 1978 and 1979--and (2) section 16 of Public Law 95-142 (durable medical equipment)--regulations have been developed incorporating the results of the demonstrations but they have not been issued.

Quality and Effectiveness

The indicated legislative and policy impacts in this issue area focused on (1) legislative and program policy initiatives

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for obtaining "second opinions" prior to surgery and (2) demonstrations and evaluations of Medicaid's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program which helped formulate the proposed Child Health Assessment Program legislation which passed the House on December 11, 1979, and various policy changes in the EPSDT program. Documentation furnished us by ORDS on May 2, 1980, provided a link between the EPSDT demonstrations and evaluations and the development of this legislation.

Health Systems Organizations

Virtually all of the $9 million effort in this issue area was devoted to demonstratons to stimulate Medicare and Medicaid contracting with Health Maintenance Organizations (HMOs) and to develop improved reimbursement arrangements with such organizations. The indicated legislative and policy impacts were consistent with these purposes.

However, we question the usefulness of some of these projects to the Congress. For example, we noted that in September 1978 HEW announced the award of two demonstration projects featuring the reimbursement of HMOs on the basis of 95 percent of the per capita amount that would be paid by Medicare for services provided to an enrolled beneficiary by other providers in the area. The projects were scheduled to be completed in 1982. In November 1979, the House Ways and Means Committee reported out a bill (H.R. 4000) which would authorize such a reimbursement mechanism to HMOs across the board. Although such demonstration projects

should be useful in implementing the provision of the bill, if enacted, it raised the question in our minds as to how such projects could have assisted the Committee in its decision-making process.

Improved Management Reporting Systems

The level of effort in this issue area involved the development of a uniform cost reporting system for hospitals. The indicated legislation and policy impacts involved (1) HEW support for section 19 of Public Law 95-142, enacted in October 1977, which required the uniform reporting of costs and (2) policy development for implementing such a uniform system.

The System of Hospital Uniform Reporting, called SHUR, was presented as a proposed regulation in January 1979. The proposal ran into difficulty with the hospital industry and the Congress and it has been revised and renamed. A proposed, revised version was published in March 1980.

Improved Program Administration

One of the eight projects in this issue area was a $3 million grant to the New York State Special Prosecutor to develop an improved capability for this investigation and prosecution of fraud and abuse in Medicare-Medicaid payments to hospitals. The other projects related to looking at medical malpractice insurance and State Medicaid quality control systems. The indicated legislative impact was the inclusion of

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additional demonstration authority in the October 1977 Medicare-Medicaid Anti-Fraud and Abuse Amendments.

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As previously discussed, we have been unable to independently verify or validate the indicated impacts except in a few instances where the supporting data provided a clear link between certain projects and such things as agency testimony before congressional committees. On the other hand, based on other ongoing or prior work, we are satisfied that one project in the "Improved Management Reporting Systems" issue area did contribiute to policy developments for the revised version of SHUR. Also, one project in the "Improved Program Administration" area did contribute to a policy change in June 1979 involving how malpractice insurance premiums paid by hospitals will be allocated to Medicare. According to HEW, this new rule could save $310 million per year--$40 million under Medicaid and $270 million under Medicare.

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DESCRIPTION OF THE PROCESSES IN CARRYING OUT THE OFFICE OF RESEARCH, DEMONSTRATIONS, AND STATISTICS DEMONSTRATION, EXPERIMENT, AND RELATED EVALUATION ACTIVITIES

The Office of Research, Demonstration, and Statistics' (ORDS) efforts to support health care financing demonstrations and experiments involve the following processes: budget and project planning, project design and selection, monitoring, evaluation, and dissemination of results. A description of each of these processes as they functioned during our review follows.

Budget and Project Planning

ORDS' budget planning is initiated by HCFA's budget process and is a continuing administrative activity undertaken 2 years in advance of the spending year. This activity estimates the funds required to cover expenditure activity for extramural projects, personnel, and other expenses. The major amounts of requested funds consist of: estimates of the costs of ongoing multi-year projects being performed under grants and contracts, and estimates of the costs of new-start projects selected from an inventory of previously proposed projects which were not started because of a lack of funds or from new project ideas. Each proposed new-start project is identified by title which is descriptive enough to avoid unintentional duplication of effort, but information is not provided on what might be the content of the project.

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ORDS prepares a work-spending plan approximately 10 to 12 months after it has prepared its budget. For example, the 1980 ORDS budget was developed in the second quarter of fiscal year 1978 and the 1980 work plan (which also contains the 1979 spending priorities which were initially conceived during fiscal year 1977) was prepared during the first quarter of fiscal year 1979.

We reviewed ORDS' work plan containing the 1979 and 1980 priorities which generally was developed in accordance with instructions from HCFA's Office of Management and Budget and in accordance with ORDS' internal instructions. The work plan was organized according to 11 major subject matter areas (e.g. hospital costs, physician reimbursement, etc.) which cut across ORDS' functional organizational lines. These areas were also the areas in which ORDS felt its resource allocations should be distributed. The plan contained for each subject matter area about a three-page description about what function the area served for ORDS planning, some aspects of the current knowledge ORDS has in the area, and the objectives of the work planned in terms of its purpose. Additionally, the description contained a brief explanation of the opportunity that the projects will provide for testing alternatives on a small scale and related funding and resource allocation information.

The work plan specifically identified the ongoing projects (by title) to be continued during the budget year and their costs as well as the new specific projects (by title) that ORDS wanted to start

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that year and their estimated costs. The ideas for new-start projects were generated from ORDS project officers and managers--the ideas flowed from project officers up to the managers and from the managers down to the project officers. The ideas were based on the project officers' or managers' understanding of the state-of-the-art knowledge in the subject area and on information received from ad-hoc, informal contacts with researchers, administrators, or providers of services in the subject area.

For the 1979/1980 work plan, ORDS management appointed subject matter managers from one of its four organizational components. Each manager was responsible for coordinating the ideas for the new projects which were included in the budgetary submissions.

At the beginning of the spending year, ORDS compared the work plan with the funds appropriated, examined the need for re-prioritizing projects, and gave organizational components approval for developing a project-specific spending plan in accordance with the approved ORDS work plan. The spending plan was revised throughout the spending year based on actual costs of grant and contract awards for projects contained in the work plan. Continuation decisions for ongoing projects were based on their expiration dates. For new projects, grant decisions were made in March and September and contract decisions were made in the timeframe it was estimated to take to start the procurement process and complete it with the contract award.

award.

To improve its budget and project planning activity, ORDS sponsored, for the first time, a conference in December 1979, which was attended by ORDS managers and HCFA program officials in headquarters. This conference provided an invaluable opportunity for interaction concerning: projects planned for fiscal years 1980 and 1981, what ORDS believed it had learned from completed and ongoing projects in each subject area, and the questions yet to be researched in each subject area during 1980 and 1981. ORDS plans to hold a conference for such a purpose annually. It is also working on a plan to specifically involve HCFA program officials in project planning, budgeting, awarding, and monitoring of performance at specified months throughout the year.

Project Design and Selection

The project design efforts of ORDS' Office of Demonstrations and Evaluations (ODE) fall primarily into two categories: (1) preparation of a grant's brochure and grant solicitation notices and (2) preparation of request for proposals (RFPs) for contracts.

ODE's grants cycle is initiated with the publication of the grants brochure. This brochure contains information on the content of the current priority areas (e.g., long term care) in which research and development grant applications will be considered. The priority areas are established through the ORDS planning process. Solicitation notices for grant applications are published in the Federal Register

usually semi-annually. These notices contain ORDS' general criteria for funding new projects as well as project requirements the application must meet.

The general framework for a demonstration is initially developed at the HEW and/or HCFA management levels. The RFP for the contract project is usually developed at the project officer level and may be initiated during or after the work plan has been developed. The RFP, establishing the parameters for the design of the project, is issued as soon as its development, review, and clearance process is completed and availability of funds is assured. The spending plan and the contract administration requirements provide the guidelines for the RFP.

Although no systematic procedure has been established for seeking input into the design of an RFP, the project officer has a variety of vehicles available to him or her for seeking input when developing the RFP--e.g., discussion meetings that may be held with the ODE project officer's and division manager and other interested parties from ORDS and/or HEW; and solicitation of outside experts, with no interest in bidding on the contract, to review the RFP. Additionally, the design of the RFP represents the project officers' and/or the ODE manager's understanding of the state-of-the-art knowledge which may be acquired through their reading of reports from other projects; occasionally conferences on specific issues sponsored by ORDS/ODE; and informal, ad-hoc, day-to-day contacts with program staff and health and/or health research experts.

Review panels (composed of ORDS staff who for grants are non-voting members; HCFA operating program officials; staff from varying components within HEW such as Public Health Service, Office of the Assistant Secretary for Planning and Evaluation, Office of the Secretary, and Office of Human Development Services; and outside experts) assess contract and grant proposals that are submitted by public and private organizations to determine their individual capabilities for carrying out specific demonstration and evaluation projects in accordance with grant and contract administration requirements. The staff from the other components within HEW on these panels help to prevent unintentional duplication of research efforts. The individual panel members' review of the proposals and the review panel's first meeting initiates the project selection process.

Once the panel has assessed the proposals, it prepares an evaluation report on the competing proposals. The report contains a quantitative and qualitative assessment of each potential proposal and a ranking of the acceptable proposals. For grants, the report is then submitted to the ORDS Director who makes the decision on which proposals will be funded. For contracts, the panel report is submitted to the contracting office and projects are selected according to negotiated competetive procurement requirements.

Monitoring

The implementation of a project is initiated by the award of a D&E contract or grant. The ODE project officer monitors the project

in accordance with grant or contract administration requirements. From our review of a sample of 40 D&E projects, we noted that project officers use several means to monitor work tasks and their timeliness. These means are:

--formal letters between the contractor/grantee and the project officer that indicate specific problems in project performance and ORDS' or HCFA's determinations for overcoming those problems;

--periodic on-site visits to the contractor/grantee and/or the place where the project is being undertaken;

--numerous formal and informal telephone conversations with the contractor/grantee;

--interim status or progress reports submitted by the contractor/grantee, as required;

--interim deliverables such as technical manuals, models, and copies of files from the demonstration (e.g., a State rate setting commision's files on its review of individual hospitals required to participate in the States rate setting agreement); and

--review of drafts of final reports by the project officer.

In addition to the above monitoring activities, we noted that one branch chief, since April 1979, has been periodically sending the ODE director status reports which identify some information on the progress of projects and problems encountered in those projects.

These reports are returned to the branch chief with the director's comments.

With regard to a tracking system for grants and contracts, ORDS has a process for tracking the flow of procurement action on an individual project basis. However, ORDS has no accumulative, consolidated inventory of all D&E projects.

Evaluation

ODE's process for evaluating the results of demonstrations and experiments consist of: (1) a separate evaluation component built into a D&E grant whereby the grantee may perform the evaluation itself or through contract with another organization or (2) an independent contract funded by ODE to evaluate one or more projects.

In the past, ODE's contracted evaluations focused more on D&E contracts than on D&E grants due to ODE's control over work performed and data collected. Most of these evaluation contracts evaluated D&E contracts that originated from one RFP. At the time of the organization and establishment of HCFA, ODE began to move toward cross-cutting evaluations that involved both D&E grants and contracts.

ODE does not support, either through its grants or contracts, an independent evaluation of all demonstrations or experiments. According to ODE, an independent evaluation is made of (1) projects involving Medicare or Medicaid waivers, (2) section 1115 D&E

grants, and (3) D&E projects which ODE management believes might have the largest payoff.

ODE has an Evaluation Studies Staff (ESS). Project officers in ESS administer evaluations contracts. The evaluations that are conducted of grant D&E projects are not directly administered by ESS. However, ESS and D&E project officers are responsible for receiving and approving evaluation plans and RFPs for evaluations conducted by D&E grantees.

A member of the ESS is assigned to be a project officer for each independent evaluation contract funded by ODE. The ESS project officer administers the evaluation project the same way that the ODE project officer administers the D&E project--i.e., develops and designs the RFP, assesses the proposals received, participates on the contract review panel, monitors the awarded evaluation contract, and reviews the interim and final reports.

The implementation of the evaluation may start 6 months or more after the D&E project has been running.

ODE obtains information on the results of its D&E projects from both the D&E final reports and the evaluation final reports. The project officer usually receives one or more drafts of the final report before receiving the final product.

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Dissemination

Contractors and grantees are required to furnish ODE final project reports on the results of the demonstrations and/or evaluations they conduct. When ODE receives final project reports, information is disseminated through formal and informal means. Formal means consist of: (1) participation in HCFA and Department legislative and budgetary planning work groups, (2) sponsorship of conferences on selected projects whereby users are informed of project results, (3) a published annual report on HCFA's D&E activities, and (4) abstracts prepared by the project officer and sent to the National Technical Information System of the Department of Commerce. Information about health care financing demonstrations and experiments has also been reported in the annual Medicare reports issued to the Congress and in other HEW reports (e.g., Health--United States). Information on the projects has further been disseminated, according to project officers, through presentations and speeches made by HEW and HCFA officials at various forums.

HCFA/ORDS has established additional formal means for disseminating information on project results--i.e., the publication of the HCFA Review, HCFA Grants and Contracts Report, HCFA Trends, and HCFA Notes. In June 1979, ORDS began establishing several publications series.

The informal means primarily included: (1) discussions among D&E managers and HCFA program managers during meetings not necessarily

convened solely for the purpose of discussing the final reports on projects and (2) activities initiated by project officers, which may have included the distribution of copies of final reports to or discussions with persons known to have an interest in the projects and with whom a close working relationship exists.

Additionally, an ODE official said that grantees often disseminate the results of their demonstrations. During our audit, we did not try to determine the extent to which this dissemination took place. However, our interviews with five State agencies which had demonstrations indicated that their projects were designed to satisfy specific State needs and, thus, they did not widely disseminate the results from them. Further, the five State agencies were not clear about how the results from their projects had been disseminated by HCFA/ODE or how Medicaid operations had been affected at the Federal level.

Furthermore, regarding ORDS' preparation of abstracts from final project reports for the National Technical Information System, we were told that ORDS had a 5-year backlog. To reduce this backlog, ORDS has hired a consultant to prepare the abstracts because, according to ORDS, it did not have adequate staff resources to devote to this task.