115448

BY THE COMPTROLLER GENERAL

Report To The Congress

OF THE UNITED STATES

Cost Cutting Measures Possible If Public Health Service Hospital System Is Continued

GAO had completed its review of ways Public Health Service medical care costs could be reduced before the President proposed legislative action to discontinue eligibility of seamen to receive free medical care and terminate the Service's hospital system.

The weaknesses GAO found in the Service's hospital management system and its difficulties with verification of seamen eligibility for care should be of interest to the Congress in deliberating the President's proposal. Prompt enactment of the proposal would eliminate the need for the actions GAO recommends for reducing Service medical care costs.

If the hospital system is continued, the Congress should amend the Federal Medical Care Recovery Act to authorize recovery of health care costs of beneficiaries from third-party resources, such as insurance companies, under circumstances not involving tort claims. The Secretary of Health and Human Services should also require the Service to initiate actions to improve eligibility determinations, recovery of costs from liable parties, and controls over contract providers.

115448

HRD-81-62
JUNE 10, 1981

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

B-203221

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

This report discusses potential opportunities for cost savings at Public Health Service hospitals and is part of our effort to explore how health care costs can be contained.

We completed our review before the President proposed legislative action to discontinue eligibility of seamen as Public Health Service beneficiaries and to terminate the hospital system. The difficulties associated with the Service's verification of seamen eligibility and the weaknesses we found in the Service's hospital management system should be of interest to the Congress in deliberating the President's proposal.

Copies of this report are being sent to the Director, Office of Management and Budget, and the Secretary of Health and Human Services.

Milton J. Socolar

Acting Comptroller General
of the United States

COMPTROLLER GENERAL'S
REPORT TO THE CONGRESS

COST CUTTING MEASURES POSSIBLE IF PUBLIC HEALTH SERVICE HOSPITAL SYSTEM IS CONTINUED

D I G E S T

GAO reviewed Public Health Services' (PHS') policies and procedures in

--determining the eligibility of seamen for free health care as PHS beneficiaries,

--obtaining reimbursement for care provided to beneficiaries for injuries due to negligence of third parties and for care provided in community facilities to individuals who are not beneficiaries, and

--managing a program under which PHS contracts with private health care providers.

In February 1981, after completion of the GAO review, the President proposed that the Congress discontinue the PHS hospital system which was originally established in 1798 to provide care for sick and disabled seamen. PHS' difficulties with verification of seamen eligibility and the weaknesses GAO found in hospital management should be of interest to the Congress as it deliberates the President's proposal. GAO makes recommendations to the Congress and the Department of Health and Human Services (HHS), but prompt enactment of the President's proposal would eliminate the need for these changes to the hospital system.

MANY PATIENTS NOT ELIGIBLE FOR FREE HEALTH CARE BENEFITS

Individuals claiming to be seamen and seeking health care as PHS beneficiaries must present evidence of eligibility, but GAO noted that PHS hospital and clinic staffs did not require all persons to furnish documented evidence of eligibility, were lenient in reviewing evidence submitted, and rarely verified the accuracy of evidence given. As a result, some patients who were not eligible beneficiaries were provided

health care. GAO believes that if PHS had required eligibility data for all claimants seeking care as seamen and reviewed the data, it would have precluded some ineligibles from receiving free care. PHS officials said that training of hospital admissions personnel is needed to correct this management weakness. (See p. 4.)

PHS officials stated, and GAO concurs, that no practical means exist to verify the accuracy of documented evidence of seamen eligibility based on the current eligibility criteria. (See p. 8.)

RECOVERY OF HEALTH CARE COSTS FROM LIABLE THIRD PARTIES COULD BE IMPROVED

The Federal Medical Care Recovery Act of 1963 establishes the Government's right to recover costs of medical care provided to persons as a result of negligence of third parties (tort liability circumstances). GAO's examination of four PHS hospitals showed that the hospitals generally were not attempting to identify patients who were treated in PHS facilities or by private health providers for injuries incurred under tort conditions. Cases which were identified and referred to the HHS' Office of General Counsel for collection resulted in little action in pursuing collections. The statute of limitations had expired on many of these cases, closing out PHS' opportunities to recover costs from liable third parties. (See pp. 11 to 16.)

GAO noted that the Federal Government could also recover millions of dollars for health care provided to beneficiaries for conditions not involving tort claims. Although the hospitals did not routinely attempt to screen patients for other insurance coverage, GAO surveyed inpatients at two hospitals and found that many had some form of health insurance. National health reports show that 87 percent of the population has some health insurance coverage from employer, employee, public, or private health plans. Although in some other Federal health care programs legislation requires States and

Federal agencies to obtain available third-party resources to pay for health care costs, no specific legislation or regulations authorize or require PHS to recover health care costs from third-party resources in nontort circumstances. (See p. 17.)

GAO also found that the hospitals were providing care to community residents who were not entitled to free care, but were expected to reimburse the hospitals based on their ability to pay. Contrary to established procedures, the hospitals were not verifying patients' ability to pay, were not billing many patients who said they could pay, and were lenient in following up on delinquent accounts. (See p. 19.)

LACK OF MANAGEMENT CONTROL OVER CONTRACT HEALTH CARE PROGRAM

PHS provides medical, dental, and pharmaceutical services to eligible seamen, members of the Coast Guard, National Oceanographic and Atmospheric Administration personnel, and PHS-commissioned corps officers. When its hospitals or clinics are unavailable or cannot provide certain health care services, PHS contracts with private providers to render services to eligible recipients. Contract care program costs have escalated from about $3.2 million in fiscal year 1970 to an estimated $32.5 million for fiscal year 1981.

GAO found that PHS has little control over the volume, cost, or quality of services provided under the contract care program. PHS hospitals were not using uniform criteria for determining (1) locations and numbers of beneficiaries which justified a contract provider, (2) numbers of contract providers needed, and (3) procedures for selecting contract providers. The amounts paid to contract providers for similar types of services varied considerably. (See pp. 24 to 26.)

The contract care program permits contract physicians whose incomes are directly affected by each decision to determine eligibility and authorize treatment. Thus, a physician can guarantee payment from PHS and then establish the amount of payments by the volume of medical care he or

she authorizes or provides. GAO believes this represents a potential conflict of interest for contract providers and found evidence that some physicians may have taken advantage of their circumstances. Further, PHS hospitals do not adequately audit or monitor the activities of most contract providers. (See pp. 27 to 33.)

RECOMMENDATION TO THE CONGRESS

If the Congress decides not to legislate the discontinuance of seamen as PHS beneficiaries and the closure of the hospital system, GAO recommends that the Congress amend the Federal Medical Care Recovery Act to authorize recovery of health care costs from third-party resources, such as insurance companies, when providing care under circumstances not involving tort claims. (See p. 20.)

RECOMMENDATIONS TO THE SECRETARY OF HEALTH AND HUMAN SERVICES

GAO recommends that the Secretary:

--Direct PHS to comply with established procedures for reviewing data submitted by individuals claiming to be seamen and seeking health care from PHS. If hospitals and clinics lack trained admissions staff, PHS should be directed to provide such training. (See p. 9.)

--Direct PHS to designate a unit in each hospital specifically responsible for

  (1) obtaining third-party resource data from all patients treated by or at PHS' expense,

  (2) referring all cases in which care is provided for injuries incurred under tort conditions to regional attorneys for collection under the terms of the Federal Medical Care Recovery Act, and

  (3) verifying ability to pay and obtaining payment from persons treated at PHS facilities but not entitled to free PHS care. (See p. 21.)

--Direct the Office of General Counsel to review its procedures for processing potential third-party liability cases and initiate action to resolve each case before the statute of limitations expires. (See p. 21.)

--Require PHS to better manage the provision of health care to its beneficiaries by private providers by

(1) developing criteria for the location, number, selection, and payment of contract providers;

(2) establishing controls over hospital admissions and consultations that contract physicians order at PHS' expense;

(3) implementing an improved information system to assist program managers in managing the contract health care program;

(4) monitoring contract physician practices through regular site visits and medical audits and terminate contracts with providers who abuse the program; and

(5) requiring the hospitals to effectively monitor and transfer their beneficiaries from private hospitals to PHS hospitals when medically feasible. (See pp. 33 and 34.)

AGENCY COMMENTS

HHS generally agreed with GAO's recommendations and has taken or plans to take corrective action to improve (1) verification of eligibility for individuals seeking health care as PHS beneficiaries, (2) recovery of health care costs from third-party resources, and (3) management controls over the PHS contract care program.

HHS disagreed with GAO's recommendation that the Office of General Counsel review its procedures for processing potential third-party liability cases and initiate action to resolve each case before the statute of limitations expires. HHS believes that problems as serious as those GAO noted in region X do not exist at other regional offices. Although HHS agreed that third-party

recoveries under the Federal Medical Care Recovery Act could be improved, it lacked personnel and funds to implement GAO's recommendation. GAO believes that the problems identified in region X are significant and HHS should seek the resources necessary to implement the recommendation. (See pp. 21 and 22.)

Contents

ABBREVIATIONS

FMCRA	Federal Medical Care Recovery Act
GAO	General Accounting Office
HHS	Department of Health and Human Services
PHS	Public Health Service

CHAPTER 1

INTRODUCTION

Public Health Service (PHS) hospitals had their origin in the 1798 "Act for the Relief of Sick and Disabled Seamen," which mandated Federal responsibility for the continuing medical care of seamen on active duty. Through subsequent legislation, much of it enacted since 1940, the Congress added other groups as beneficiaries who are eligible to receive care in these hospitals. Seamen and uniformed members of PHS Commissioned Corps, the Coast Guard, and the National Oceanographic and Atmospheric Administration are primary beneficiaries and have first claim to PHS medical care. Active and retired members of the military and their dependents have secondary claim to PHS health care. In addition, to carry out research and training programs and other special studies, the hospitals may provide care to certain groups or individuals.

The Congress established PHS to provide health care to seamen when the Nation depended heavily on maritime transportation. Although conditions have changed radically since that time, seamen are still eligible for free health care in accordance with the original legislation.

Over the past 182 years, the health care delivery system operated by PHS has changed significantly. For instance, what in 1960 was a group of 15 hospitals and 25 outpatient clinics is now a regionalized system of inpatient and outpatient care provided by 8 general medical and surgical hospitals, 1 special care hospital, 27 outpatient clinics supervised by the hospitals, and a network of about 400 private contract providers.

While each hospital serves a different case mix, the hospital system's original mission to provide medical services to American seamen has remained its core function and its basic reason for existence. Some PHS hospitals serve primarily seamen, while Department of Defense or community patients predominate in others. Overall, health care services for primary beneficiaries constitute less than 50 percent of the PHS hospital system's workload. In fiscal year 1980, PHS spent about $143.3 million in operating its hospitals and clinics and about $29.7 million in reimbursing private providers under contract with PHS for services rendered to PHS beneficiaries.

Because of the declining workload at PHS hospitals, in January 1978 an ad hoc committee was formed to study the hospitals and plan their future use. This committee recommended that PHS use the hospitals increasingly as a community health resource and add to the beneficiary classes persons lacking access to the health care system. Responding to this recommendation, some PHS hospitals have served many patients by extending health care services to community groups.

OBJECTIVES, SCOPE, AND METHODOLOGY

The objective of our review was to identify opportunities where PHS could reduce its costs of operation. We limited our review to assessments of the (1) management of the contract care program, (2) adequacy of PHS' efforts to obtain payment for patient services from third-party resources, and (3) procedures used to determine and verify eligibility of beneficiaries receiving health care at PHS facilities or from PHS contract providers.

At the PHS Bureau of Medical Services, Division of Hospitals and Clinics, headquartered in Hyattsville, Maryland, we obtained background information on the PHS hospital system and reviewed legislation, regulations, policies, and procedures governing the eligibility of PHS beneficiaries and the contract care and third-party recovery programs.

We decided to assess the management and operation of the contract care program because of the significant increase in the amount of funds expended in the program during the past decade. We performed our audit work at four PHS hospitals which reported the largest expenditures for contract care (Baltimore, Maryland; Nassau Bay, Texas; New Orleans, Louisiana; and Seattle, Washington) and at four PHS outpatient clinics in the New Orleans region. At each hospital and clinic, we discussed management responsibilities for implementing and overseeing the program with PHS officials and reviewed private physician and hospital contract files maintained at each PHS facility.

PHS is authorized by the Federal Medical Care Recovery Act (FMCRA) (Public Law 87-693) to recover the costs of medical care provided to individuals who receive care under tort circumstances. To assess the effectiveness of PHS' cost recovery efforts, we examined the procedures followed by the above-mentioned hospitals and clinics in identifying potential third-party tort cases and collecting funds from individuals treated, but who were not PHS beneficiaries. We reviewed the emergency room log books from November 1978 through February 1979 at three hospitals, and at the fourth hospital, which did not have such a log, we reviewed the files of patients admitted for emergency treatment during June 1979 to determine the adequacy of compliance with the procedures. In addition, we interviewed program officials from the Department of Health and Human Services' (HHS') Office of General Counsel and reviewed a random sample of cases which had been referred for potential collection action in one region. The number and selection of cases was not intended for statistical projection, but for the corroboration of officials' statements that limited effort was made to collect from potentially liable third parties.

We were interested in determining whether seamen being treated in PHS hospitals had personal health insurance that could be used to pay for hospital care. At two PHS hospitals, we asked nearly all seamen who were inpatients during our visit if they had coverage under personal health insurance. A few patients were not available for questioning because of their health status.

We also observed admission and screening procedures which the four selected hospitals and clinics followed to determine eligibility of PHS beneficiaries. Because PHS personnel told us they rarely verified eligibility data submitted by seamen seeking care, we reviewed the medical files of 77 seamen admitted to these hospitals for a week in July 1979 and the files of 106 seamen treated as outpatients for a week in November 1979. The actual weeks varied dependent upon the date we visited each hospital and clinic.

PROPOSED LEGISLATIVE ACTION SUBSEQUENT TO OUR REVIEW

On February 18, 1981, the President proposed that the Congress eliminate seamen from eligibility as PHS beneficiaries and terminate the PHS hospital system. The President's proposals are premised, in part, on the declining primary care patient load, the availability of health services for beneficiaries in cities where PHS hospitals are located, and the change in conditions that originally justified providing health services to seamen.

We previously reported to the Chairman, Subcommittee on Labor, Health, Education, and Welfare, Senate Committee on Appropriations (MWD-76-3, July 7, 1975), that the number of primary beneficiaries being treated in the hospitals was declining. We repeated this message in a report to the Chairman, Senate Committee on Appropriations (HRD-77-111, May 26, 1977), and added that the declining patient load impaired the hospitals' ability to maintain service capabilities at each hospital.

The difficulties associated with PHS' verification of seamen eligibility and the weaknesses we found in PHS' hospital management system should be of interest to the Congress as it deliberates the President's proposal. Prompt enactment of the presidentially proposed action would eliminate the need for congressional and departmental actions recommended by us.

CHAPTER 2

MANY PATIENTS MAY NOT BE ELIGIBLE FOR FREE HEALTH CARE BENEFITS

PHS is providing health care to individuals claiming to be seamen 1/ without assuring that they are eligible PHS beneficiaries. We found that PHS (1) has not required all claimants seeking care to furnish evidence of eligibility, (2) was lenient in reviewing documented evidence of eligibility submitted, and (3) rarely verified the validity of information given. As a result, PHS is providing care in its facilities and reimbursing private providers for care given to individuals who are not or may not be eligible PHS beneficiaries.

Compliance with established procedures would have resulted in the submission and review of eligibility evidence and the identification of some ineligibles who have been treated. Controls over documentation used in the eligibility process would also have better assured that other ineligibles were not treated. However, we believe that some individuals who are ineligible for PHS care as seamen will continue to receive care because no practical means exist to verify that individuals meet the existing PHS eligibility criteria for seamen.

PROCEDURES FOR DETERMINING ELIGIBILITY NOT BEING FOLLOWED

PHS is providing free health care to ineligible or potentially ineligible individuals claiming to be seamen because it is not following established procedures intended to assure that such individuals are eligible PHS beneficiaries.

Legislation authorizing health care for seamen does not define what constitutes a seaman. Therefore, through its regulations PHS defines a seaman as a person who

--was employed on a licensed, registered, or documented U.S. vessel;

--performed seamen duties at sea; and

--had 60 days continuous service on such vessel during the 180 days immediately preceding the application for benefits or shorter periods of service totaling 60 days as long as the time between jobs does not exceed 60 days. Exceptions

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1/Includes fishermen, fishing boatowner-operators, deep sea mariners, inland waterways boatmen, and offshore oil rig workers.

to this requirement are made if the seaman becomes ill or is injured on board ship while actually employed.

When a seaman requires medical, surgical, or dental treatment or hospitalization, he or she must provide satisfactory evidence of eligibility for such benefits. As evidence of eligibility, a seaman must present a properly executed master's certificate, 1/ a continuous discharge book, 2/ or a certificate of discharge 3/ which shows that the above criteria are met. Although applicable regulations and guidelines do not specify the primary document to be used as evidence of eligibility, the availability of the master's certificate to individuals seeking health care has resulted in it being the primary document used in the eligibility process.

Owner-operators and employees of commercial fishing boats which are registered under U.S. maritime laws are eligible for free care at PHS facilities to the same extent as seamen. They must accompany the vessel on fishing trips, and a substantial part of their duties must be comparable to duties seamen perform on that vessel or other vessels engaged in similar fishing operations. PHS directives state that PHS cannot require any person alleging to be a commercial fishing boatowner-operator or employee to provide more information than that required on the master's certificate.

Specifically excluded from eligibility for PHS benefits by the regulations are owner-operators of sport fishing vessels, pleasure boats, and similar vessels not engaged in commercial fishing operations.

Current PHS estimates indicate that there are about 398,000 seamen eligible for PHS health care services. Of these, 40,000 are deep-sea mariners, 225,000 are inland waterways boatmen, 101,000 are commercial fishermen or fishing boatowner-operators, and 32,000 are employees in the offshore oil industry.

According to PHS data, seamen receive most care provided to primary beneficiaries in PHS facilities and under contract with private providers. For example, during fiscal year 1979, seamen received 207,026 (90.7 percent) of the 228,225 days of inpatient

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1/A master's certificate of service is a PHS form to be completed by the master or agent of a registered vessel as certification that the seaman meets eligibility requirements.

2/A discharge book is a history of employment maintained by a merchant seaman and signed by a vessel's master or agent at the completion of each employment.

3/A certificate of discharge is a certificate-of-employment form given by a vessel's master or agent to a merchant seaman. The form is evidence of extended employment on a merchant vessel.

care provided to primary beneficiaries in PHS facilities and 45,395 (97.7 percent) of the 46,460 days of inpatient care provided by contract providers. Similarly, of the 648,820 outpatient visits in PHS facilities and 200,657 visits to contract providers, seamen accounted for 82.1 and 98.2 percent, respectively.

PHS procedures require that hospital and outpatient admission personnel obtain and review the master's certificate (or other documentation) to establish an applicant's eligibility as a PHS beneficiary. When an individual cannot provide documentation of eligibility, the admissions personnel may conditionally accept self-certification of eligibility. They are to then verify the individual's asserted employment and service dates on a registered vessel. PHS hospital and clinic admissions personnel are also to verify suspected fraudulent master's certificates. If the certificates are fraudulent, the admissions personnel are to forward them to the HHS regional attorney. The United States Code provides for severe penalties--$10,000 fine and/or 5 years in prison--for individuals who knowingly provide false information on the master's certificate of service.

To determine the effectiveness of PHS procedures for determining the eligibility of seamen applicants for health care, we reviewed the files of the 77 seamen inpatients at the four PHS hospitals during a week in July 1979 and randomly selected the files of 106 patients treated as outpatients during a week in November 1979. (The week varied at each hospital depending on when we visited each hospital.) Nearly 50 percent of the 183 patient medical files we examined failed to show that the applicant was eligible for medical care at PHS' expense. Master's certificates were often incomplete or contained data which indicated the applicant was not eligible, as shown below.

Adequacy of Eligibility Documentation in Applicant's Medical Files

	Number of files
Deficient documentation:	
No eligibility documentation in file	12
Incomplete master's certificates	37
Ships apparently not registered (not listed in Coast Guard Registry)	12
Master's certificates show insufficient sea time	4
Master's certificates signed only by applicant (not signed by master or agent)	23
Complete documentation:	
Documents properly completed	95
Total	183

We also noted cases in which PHS provided health care to individuals who lacked eligibility based on the evidence submitted or who submitted suspicious data. For example:

--A person who had received free medical care from PHS since 1975 owned and operated a charter fishing service. The individual's first master's certificate, dated October 20, 1976, specified that he used the vessel for charter fishing. A PHS directive specifically prohibits charter boatowner-operators from being eligible for PHS medical care. The department chief told us that the hospital had given medical care to this ineligible applicant because of the (1) lack of emphasis on verifying eligibility due to the hospital's open door policy and (2) difficulty of getting and keeping qualified admitting clerks.

--One PHS facility we visited provided free medical care to a 63-year-old woman based on a self-prepared master's certificate, which described her boat as a pleasure craft. Data in the medical file stated that she "lives on a 43-foot sailboat * * * up on blocks * * *. She has been touring the world with her husband for the last 10 years since they retired." The 1964 legislation, which extended PHS benefits to fishing boatowner-operators, excluded pleasure boatowners and crew from PHS medical benefits. The assistant chief of the department said she was embarrassed to learn they were providing medical care to this apparently ineligible applicant.

--A 14-year-old seawoman whose master's certificate showed she was employed on her father's commercial fishing boat received free medical care from PHS. Although regulations require PHS facilities to obtain assurance that a bona fide employment relationship exits, PHS accepted her master's certificate without question as evidence of eligibility even though her father had signed it. PHS paid a private physician's bill for this patient.

In discussing the reasons for the lack of adequate review of documentation presented by seamen applicants, PHS officials stated that obtaining and retaining qualified persons as admitting clerks was difficult. They also stated that admitting clerks may not have had enough training to recognize when they should question the eligibility of persons seeking health care as PHS beneficiaries.

PHS NOT VERIFYING DATA ON MASTER'S CERTIFICATES

As stated earlier, seamen eligibility for free PHS health care is based on documented evidence--usually a master's certificate--that an individual (1) served on a licensed, documented, or registered vessel, (2) performed specified types of duties, and (3) met certain length-of-service requirements.

PHS officials told us that they rarely verify data presented as evidence of eligibility. They said that no reasonable means exist to make such verification and that verifying the eligibility of commercial fishing boatowner-operators was impossible. They added that the only way to be assured that the claimants actually meet PHS' eligibility criteria would be to occupy the vessels and boats at all times.

Some of the factors which virtually preclude verification are as follows:

1. Although eligibility is to be based on employment on a registered vessel, an up-to-date list of such vessels is not available. PHS hospital and clinic personnel use a list of registered vessels which is annually published by the Coast Guard. However, PHS officials told us that, because of the time lag between vessel registration and distribution of the Coast Guard list, no means exist to determine that unlisted vessels named on certificates or asserted by individuals seeking care are, in fact, registered vessels.

2. PHS has no current list of the masters of registered vessels. Accordingly, PHS has no reasonable means to assure that either the master of the ship or the applicant is the individual listed on the master's certificate.

3. Without observing vessels in operation, PHS has no means to verify that an applicant performed seamen duties on a registered vessel.

4. The mobility of merchant and fishing vessels preclude verification of actual service dates of seamen. Of particular difficulty is the verification of the requirement for 60 days of consecutive service or 60 days of short services without 60 days lapse between the short services.

For the reasons discussed above, we agree with PHS officials that verification of eligibility is not reasonably possible based on the current eligibility criteria.

CONCLUSIONS

PHS has provided free health care to individuals claiming to be seamen without assuring their eligibility for such care. It has not followed established procedures requiring all claimants to provide evidence of eligibility and has been lenient in reviewing the documentation provided by seamen applicants. We believe that compliance with these established procedures would have precluded some ineligibles from receiving free care at PHS' expense. PHS officials asserted that the lack of trained admissions staff was the

reason for the hospitals' noncompliance. We believe that, if training of staff is needed, such training should be provided.

PHS rarely verifies the validity of data presented as evidence of eligibility for individuals seeking health care as PHS beneficiaries. PHS officials stated that verification of eligibility under the existing criteria is not feasible. Based on our review, we concur that verification of data submitted to prove eligibility as a seaman is not always possible. As a result, PHS cannot assure that only eligible beneficiaries receive health care at PHS' expense.

RECOMMENDATIONS TO THE SECRETARY OF HHS

In the event the Congress decides not to legislate the discontinuance of seamen as PHS beneficiaries and the closure of the hospital system, we recommend that the Secretary direct PHS to comply with established procedures for reviewing data submitted by individuals claiming to be seamen and seeking health care from PHS. We also recommend that, if PHS hospitals and clinics lack trained admissions staff, PHS be directed to provide such training.

AGENCY COMMENTS

In commenting on our recommendations (see app. I), HHS agreed on the need to improve (1) PHS' compliance with established procedures for reviewing admissions data for individuals seeking health care from PHS and (2) the effectiveness of eligibility determinations. HHS said that the Bureau of Medical Services within PHS will take the following corrective actions:

--Issue a directive to all hospital directors calling for strict enforcement of the established procedures for reviewing admissions data.

--Assess the training needs of PHS hospital admissions staff and provide appropriate training in the eligibility determination area.

HHS disagreed with a proposal in our draft report on the need to establish controls over master's certificate forms by prenumbering and distributing them to only eligible owner-operators of vessels or their masters. HHS said that the master's certificate is one of several acceptable forms of eligibility documentation and cited others. As stated on page 5, we observed that the master's certificate was the primary document used in the eligibility determination process even though other forms of eligibility documentation are permitted. HHS said that a computerized enrollment system for seafarers to be developed by the Bureau of Medical Services, which includes a recipient module routine for use for eligibility screening, is a better alternative.

Our overall objective is to improve procedures in order to minimize free PHS health care to ineligible applicants. Because of HHS' plans to improve controls over the eligibility determination process, including computerized eligibility screening, we have deleted our proposal for prenumbering and controlling the distribution of master's certificate forms from the final report.

CHAPTER 3

RECOVERY OF HEALTH CARE COSTS FROM LIABLE THIRD PARTIES COULD BE IMPROVED

HHS has not recovered millions of dollars for health care services provided each year to PHS beneficiaries because (1) PHS facilities generally have not attempted to recover costs from liable third parties in accordance with the intent of the Federal Medical Care Recovery Act and (2) HHS regional attorneys have not vigorously pursued third-party collections. In addition, PHS is inadequately screening, billing, and collecting funds for treatment provided to persons who are not eligible beneficiaries.

The Government's right to recover the cost of medical care and treatment it provides to persons as a result of the negligence (tort liability) of a third party is clearly established by FMCRA. The Congress has not, however, established the Government's right to recover its costs in nontort instances, when care is provided to Federal program beneficiaries who have other health care resources. Legislating such authority could save significant sums of money.

During our review, we noted that many seamen beneficiaries have other health care coverage, such as private health insurance. Because FMCRA does not apply to the entitlement of the Government to recover costs incurred in treating patients with such insurance, the nonrecovery of such costs results is a "windfall" profit to insurance companies. This was one of the concerns that prompted the Congress to enact FMCRA. We believe that the Congress should amend the act to include nontort recovery from third parties.

PHS FACILITIES HAVE NOT EXERCISED AUTHORITY GRANTED BY FMCRA

For PHS patients injured by another person's negligence, the Government has the right to recover medical expenses from the liable third party (tort-feasor) under FMCRA. Our examination of cost recovery programs at the four PHS hospitals we reviewed showed they generally were not trying to identify potential third-party tort cases or recover health care costs from negligent parties.

FMCRA authorizes PHS to recover the cost of medical care and treatment provided to patients if (1) PHS has furnished medical

care at Government expense to the injured person and (2) circumstances have created a tort liability 1/ upon some third person.

Under FMCRA the PHS cost recovery program involves two basic parts: (1) PHS facilities will identify and forward potential third-party cases to HHS regional attorneys and (2) HHS regional attorneys will press claims against third parties.

PHS facilities do not screen for potential third-party cases

The screening process involves identifying cases which have potential merit as liable third-party cases. This is a basic part of the third-party recovery program. HHS guidelines state that the ultimate success of this program depends largely on the degree of attention devoted to the screening process. The Department's policy is to screen for third-party recovery of all patients needing more than minimal care 2/ that involve the potential tort liability of third persons. Our review showed, however, that PHS facilities do not adequately screen for potential third-party liability cases.

HHS guidelines state that the treating physician is responsible for identifying potential third-party liability cases and that the physician will obtain the facts from the patient and decide whether such facts suggest seeking recovery from a third party based on tort liability. If warranted, the physician may report these facts to the person that administers and processes third-party cases at the particular PHS facility. The guidelines require that physicians report all cases in which the patient's injury apparently resulted from a negligent act or omission by another person. Cases to be reported include instances in which the patient

--was injured in a motor vehicle accident as a driver, passenger, or pedestrian;

1/One commits a "tort" and becomes liable therefore in damages when his commission of an act causes harm to another and, even though not intended to cause harm, constitutes the violation of a legal duty owed to the injured person.

2/Minimal care has been defined by HHS as (1) less than 2 days of hospitalization, (2) less than 10 outpatient visits, or (3) less than 2 days of hospitalization and 8 outpatient visits combined.

--was injured in a fall which was due to an obstruction or an unguarded opening or to snow and ice in the street or on private property;

--was injured as the result of a railroad accident;

--was injured in a fall due to defective stairs, scaffolds, ladders, or other supporting equipment;

--suffered an electric shock caused by his or her contact with exposed powerlines, electrical wire, poorly grounded electrical equipment, or other sources of electric shock;

--was injured due to defective operation of an elevator or escalator in a non-Government building;

--suffered food poisoning after eating at a public eating place;

--was injured as a result of faulty equipment or machinery; and

--was injured due to exposure to noxious fumes or gases or to adverse reactions to drugs, cosmetics, or other commercial products.

We examined the procedures used to identify potential third-party liability cases at four PHS hospitals and four PHS outpatient clinics. We found that physicians and other PHS personnel performed almost no third-party screening. Generally, PHS reported potential third-party cases only when a facility received correspondence from a private attorney or insurance company requesting a patient's medical record and the correspondence suggested a possible negligent third party or a lawsuit.

Officials at each hospital we visited said PHS has not emphasized the third-party recovery program. The PHS physician who administers the contract care program in 11 Eastern States was not aware of FMCRA and the screening and reporting responsibility it imposes. The directors of five PHS outpatient clinics under his jurisdiction told us that those clinics and their contract physicians were not conducting third-party screening. Most outpatient clinic directors could not estimate the volume of potential third-party cases because they had not been looking for such cases.

Other comments from PHS officials responsible for the third-party recovery program at the hospitals we visited are summarized on the following page.

--Baltimore - "We have no systematic procedure to identify negligent third parties for either outpatients or inpatients. Physicians do not identify or report these cases."

--New Orleans - "PHS is concerned primarily with providing health care and has not allocated a position for third party identification or reporting. As a result, many potential third party liability cases are not caught."

--Nassau Bay - "We have never emphasized the third party recovery program. We're short-handed and too busy carrying out other responsibilities which PHS has emphasized. The only time a third party case may be identified is through legal and insurance company correspondence."

--Seattle - "Third party cases would be identified only through legal or insurance company correspondence. Obviously the procedures are not followed since PHS physicians do not screen patients."

We identified many unreported potential third-party liability cases at each facility visited. Examples of unreported potential third-party liability cases included:

--A seaman who was seriously injured when hit by a car. A partial billing for emergency care at a private hospital (patient was not yet discharged) was $81,599.77.

--A seaman who was involved in an accident in which his motorcycle was rear ended by an automobile. PHS hospitalized this person for 4 days.

--A seaman who was seriously injured when hit by a car while he was standing in a telephone booth. Expenses for emergency hospitalization at a private hospital exceeded $10,000. This patient also required 29 days of care at a PHS hospital, which at the 1980 billing rate amounted to an additional $5,684.

--Two seamen who were riding in an automobile that was struck by a truck owned by a major oil company. Both seamen suffered injuries and were hospitalized at a PHS hospital. One of these individuals first received care at a private hospital, for which PHS paid more than $11,000.

PHS headquarters officials told us that it is unrealistic to expect the attending PHS physician to identify and report potential third-party cases because their prime concern is to minister to the medical needs of the patient. They stated that identification of such cases is more realistically a function of admissions or

medical records personnel. PHS facilities generally do not report third-party cases to HHS. However, HHS takes little, if any, action when PHS does report cases.

Regional attorneys do not pursue collections

PHS procedures provide that, after hospital and clinic personnel identify cases in which health services are required for PHS beneficiaries as a result of a tort condition, the cases are to be forwarded to the HHS regional attorney for collection, including any litigation required.

Our review of 1978 third-party collection reports submitted by regional attorneys from all 10 HHS regions showed that only about $323,000 had been recovered from third parties in hospital division cases. PHS headquarters officials stated that the hospitals generally received no feedback from the regional attorneys on the status of referred cases and had not initiated followup procedures to indicate the effectiveness or results of their referrals.

In reviewing HHS' efforts to press claims against negligent third parties in region X, we found that the regional attorney had taken little, if any, action on cases that agencies had referred to his office. The statute of limitations had expired for many of these cases. The regional attorney stated that third-party recoveries are not emphasized in region X. Responsibility for processing third-party claims was delegated to a nonattorney administrative assistant, who had many other duties and said she had not worked on a large percentage of the third-party claims. Recoveries and closed cases in 1978 and 1979 were significantly less than in 1973 and 1974. In 1979 the regional attorney closed only nine cases and recovered $15,421. In contrast, during 1973 the regional attorney closed 63 cases and recovered $51,039.

We randomly selected 51 of 586 open cases referred to the region X attorney's office. Our analysis confirmed statements made by program officials that limited action was taken in pursuing collections. More specifically, the regional attorney's office had taken no action on 38 of the 51 cases. Also, the statute of limitations had expired for at least 9 of the 38 cases. For example:

--The regional attorney was notified in December 1975 of a potential third-party case in which a car hit a coastguardsman riding his motorcycle. A Coast Guard investigation report stated that the injured person would be hospitalized for about 5 to 7 months, with 2 months more for recuperation. The report concluded that the driver of the car was negligent and that the motorcycle operator did

not contribute to the cause of this accident. Although the office of the regional attorney received detailed information about this accident in 1975 (including the name of the negligent third party), no action was taken. The statute of limitations expired in 1978.

--The regional attorney was notified in 1977 of a potential third-party case in which a seaman was seriously injured in an automobile accident. This accident occurred on November 23, 1976, and required hospitalization until January 4, 1977. The cost of care at a private hospital was $15,126. This patient was later transferred to a PHS hospital for further care and treatment. Although the regional attorney received medical information concerning the circumstances of this patient's injury and the cost of emergency care, he took no action on this case. The statute of limitations expired in 1979.

--The regional attorney was notified in March 1977 that a coastguard person sustained injuries when pinned between two vehicles. Although the name of the negligent person was provided to the regional attorney, he took no action. The statute of limitations expired in September 1979.

--The regional attorney was notified on July 27, 1977, that an automobile struck a PHS beneficiary while he was walking. Medical expenses reported were about $2,000. The regional attorney sent a letter to the patient requesting information about the cause of the accident and the name of the person driving the automobile. This letter was returned because of an incorrect address. The regional attorney took no further action even though the desired information had been provided to him in the police accident report. The statute of limitations expired in December 1979.

--The regional attorney was notified by PHS of a potential third-party case in which a seaman was injured in a fall in June 1975. PHS paid medical expenses exceeding $25,000 for emergency hospitalization and medical consultants. Because it appeared that the accident may have been due to negligence on the part of someone else, the regional attorney wrote a letter to the injured person asking for further details. The attorney received no response and took no further action. The statute of limitations expired in June 1978.

MANY PHS PATIENTS HAVE ALTERNATIVE HEALTH CARE COVERAGE

Although the PHS facilities we visited did not generally screen patients for other insurance coverage, our review showed many American seamen were covered under various other health care plans. Several unions, such as the National Maritime and the Seafarer's International Unions, provide health and welfare plans to cover their members. Other seamen had health care coverage through Medicare and Medicaid or through private health insurance plans. Responses to a questionnaire that we submitted to seamen inpatients at two PHS hospitals indicated that 57 percent at one hospital and 42 percent at the other had coverage through their union or other health plans. According to a PHS official, 22 percent of all seamen admitted to PHS facilities during 1979 were eligible for Medicare. A 1980 PHS health statistical report showed that 87 percent of the population were covered by some form of health insurance.

In commenting on our draft report (see app. I), HHS stated that in a February 1981 survey the Health Services Administration estimated that all eligible deep sea mariners and nearly all offshore industry sea mariners have group health insurance. Although complete and reliable data are not available at this time, HHS estimated that, excluding Medicare coverage, 23 percent of all eligible seamen have some form of group health insurance coverage.

We noted that many seamen with alternative health plan coverage had been hospitalized for a considerable time at public expense. For example, at the Nassau Bay PHS hospital, one seaman had been hospitalized for 155 days. The 1980 PHS billing rate charges for this patient's care totaled $30,380. This patient said he had health coverage through his employer--a large oil company. At the New Orleans PHS hospital, a seaman who had other health insurance had been hospitalized 229 days and was still in the hospital during our visit. This patient had received medical care for which charges totaled $44,884. In line with its existing cost recovery policy, PHS will not bill the available third-party resources for these types of cases.

PHS DOES NOT BILL NONTORT THIRD-PARTY RESOURCES

The Federal Government is paying millions of dollars for the health care of persons who have health and/or accident insurance or other resources that could be used to pay for such care. Legislation requires States and Federal agencies to obtain available third-party resources to pay the health care costs of the beneficiaries of some other Federal health care programs (for example, Medicaid and the Civilian Health and Medical Program for the Uniformed Services); however, no specific legislation or regulations

have been enacted to authorize or require PHS hospitals to recover health care costs from other resources under circumstances not involving tort claims. In the absence of such authority or requirement, PHS has a policy not to seek nontort third-party payments. A September 1979 circular stated:

> "All PHS facilities are herewith advised that any effort to collect the cost of authorized care, either in-house, contract, or other, for primary beneficiaries from Medicare, Medicaid, private insurance companies, or any other third party payor is unauthorized. 1/ * * * contract physicians must never be advised to bill any source other than the contracting PHS or Coast Guard facility for non-emergency or authorized emergency care rendered to an eligible primary beneficiary. We are always 'first payor' in such cases. * * *
>
> "* * * An annual appropriation is available to us to provide care to statutory beneficiaries. To seek payments from other Government agencies or the private sector for this care is inappropriate."
>
> "1/Claims against negligent third parties may be forwarded to DHHS regional attorneys in accordance with procedures involving the Federal Medical Recovery Act."

Many patients have insurance under which some courts have deemed the Government has contractual rights to recover costs of medical care that it has provided to beneficiaries. This includes health insurance, workmen's compensation, automobile insurance coverage for medical expenses (including no-fault insurance), and uninsured motorist coverage. However, not all courts have agreed on the right for governmental recovery in nontort situations. In our opinion, PHS could recover a significant amount of money from third parties if such authority were granted.

An associate director for ambulatory care at one PHS hospital responded to the September 1979 circular by stating that:

--The instruction, if followed, would cost the hospital at least $500,000 yearly. 1/

--Medicare, a State worker compensation fund, and employee health benefit plans are third-party programs that are paid for by a beneficiary or his or her employer. Failure

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1/Contrary to PHS instructions, this PHS hospital was instructing contract care providers to bill third-party resources before billing PHS.

to use those programs means that the beneficiary has lost the use of some of his personal resources.

--It is never inappropriate for a manager of Federal funds to use such basic management principles as avoiding unnecessary cost or using other prepaid benefits on a patient's behalf.

PERSONS NOT ELIGIBLE AS PHS BENEFICIARIES OFTEN RECEIVE FREE CARE

Federal regulations state that anyone may receive PHS treatment in an emergency. In such cases, they require patients who are not PHS beneficiaries to pay for care at rates established by the Office of Management and Budget. PHS also provides free care to patients who are unable to pay. PHS did not, however, bill many of these persons who were treated at PHS facilities even though they stated they could pay for their treatment.

At the hospitals reviewed, admissions staffs generally asked emergency nonbeneficiaries whether they could pay for their care and treatment. If a patient stated he or she could not afford to pay, the hospitals absorbed all expenses without attempting to verify the patient's ability to pay. For nonbeneficiaries who said they could pay, the hospital often did not bill them, and those billed generally did not pay. PHS headquarters officials said an overriding cause of weaknesses in PHS' billing and collection activities is the longstanding provision of services to beneficiaries without charge. They said that PHS hospitals are simply not accustomed to bill or collect for services.

The following examples show that health care expenses for nonbeneficiaries generally are not recovered.

--Baltimore - During fiscal year 1979, billings to inpatients who stated they could pay for PHS services totaled $362,178. The hospital expected to collect only $10,800 (3 percent). During fiscal year 1979, PHS billed only 10 of the 996 outpatient nonbeneficiaries even though many of these outpatients stated they had private health insurance or other resources to pay. A Baltimore PHS hospital official stated that, because the hospital does not routinely bill for outpatient visits, it loses up to $225,000 yearly.

--New Orleans - During fiscal year 1979, the PHS hospital billed emergency inpatients for $35,910. It had collected only $4,003 (11 percent) as of April 1, 1980, and the responsible official doubted that more funds would be received. For 371 emergency outpatient visits by nonbeneficiaries during fiscal year 1979, the hospital submitted only 67 bills totaling $2,104, and collected only $680.

--Nassau Bay - A hospital finance official said that generally about 70 percent of the nonbeneficiaries receiving emergency care did not pay their bills. During fiscal year 1979, bills for 78 percent of the inpatient charges and 71 percent of the outpatient charges were not paid.

--Seattle - Finance personnel stated that only about 10 percent of the nonbeneficiaries who claim ability to pay actually paid their bills.

None of the PHS hospitals reviewed adequately followed up on delinquent accounts. According to hospital officials, they generally did not send followup collection letters to debtors because of insufficient staff.

CONCLUSIONS

PHS facilities do not routinely screen patients to determine whether negligent third parties had caused the injuries. Thus, many potential third-party cases are not identified and brought to the attention of HHS attorneys responsible for pressing claims under tort conditions.

HHS' Office of General Counsel does not vigorously pursue third-party collections cases submitted by PHS. At the region X attorney's office, no action had been taken to press claims on 75 percent of the cases we analyzed. In several of these cases, the statute of limitations had expired.

In the absence of specific legislative authority, PHS policy prohibits PHS facilities from seeking payments from third-party resources in nontort instances. As a result, PHS has not attempted to recover substantial health care expenses. We believe the Government's right to recover medical costs from third parties in nontort instances needs to be legally established. Enactment of such a legislative provision would result in the recovery of significant funds from third-party resources. Our review was not designed to project specific amounts. However, considering the number of beneficiaries with other health insurance and the lack of effort to collect from third parties in tort circumstances, we believe that PHS could recover millions in tort and nontort instances.

Patients not entitled to free care at PHS facilities do not generally pay for services because PHS was not (1) verifying their ability to pay, (2) billing many of them, and (3) adequately following up on delinquent accounts.

RECOMMENDATION TO THE CONGRESS

Pending other congressional action discussed in chapter 1, we recommend that the Congress amend FMCRA to authorize recovery

of health care costs from third-party resources when providing care to beneficiaries for conditions not involving tort claims.

RECOMMENDATIONS TO THE SECRETARY OF HHS

In the event the Congress decides not to legislate the discontinuance of seamen as PHS beneficiaries and the closure of the hospital system, we recommend that the Secretary direct PHS to designate a unit in each hospital specifically responsible for:

--Obtaining third-party resource data from all patients treated by or at the expense of PHS.

--Referring all cases in which care is provided to beneficiaries for injuries incurred under tort conditions to regional attorneys for collection under the terms of FMCRA.

--Verifying ability to pay and obtaining payment from persons treated at PHS facilities but not entitled to free care as PHS beneficiaries.

We also recommend that the Secretary direct the Office of General Counsel to review its procedures for processing potential third-party liability cases and initiate action to resolve each case before the statute of limitations expires.

AGENCY COMMENTS AND OUR EVALUATION

In commenting on a draft of this report (see app. I), HHS concurred with our recommendation calling for the establishment of a unit in each hospital specifically responsible for carrying out PHS' third-party recovery program. However, HHS disagreed with our report's recommendation on the need for the Office of General Counsel to review its procedures for processing potential third-party liability cases and initiate action to resolve each case before the statute of limitations expires.

HHS stated that it did not believe that problems as serious as those we noted in region X exist in other regional offices. Although HHS agreed that FMCRA recoveries could be improved, it stated that implementation of our recommendation would require additional resources or the redirection of other resources assigned to higher priority matters by the Department. According to HHS, the Office of General Counsel does not have the personnel and funds necessary to write for police reports and trace down beneficiaries, tort-feasors, or their insurers in all cases in which there is at least the possibility of an FMCRA claim.

Consequently, HHS said that the regions must rely on the beneficiaries' cooperation to inform the Office of General Counsel whether they have retained private counsel or on contacts made by the counsel or by the tort-feasor's representative indicating that settlement or litigation is imminent. At that point, HHS said that the Office of General Counsel can determine whether pursuit of the claim is worthwhile. HHS added that the Office of General Counsel obtains, in many instances, a recovery in very old cases after late contact is made and before funds are distributed. HHS said in no event had the Office of General Counsel knowingly allowed a statute of limitations to expire.

We recognize that our report focuses on the third-party recovery activities in region X. However, as noted on page 2, the number and selection of cases we reviewed was not intended for statistical projection but for collaboration of statements made by program officials from the Department's Office of General Counsel that efforts to collect from potentially liable third parties was limited. Our review of selected cases confirmed these statements and that, in several cases, the statute of limitations had expired. We believe that the problems identified in region X are significant and support our recommendation. In view of the potential for recovery of a significant amount in health care costs from third-party resources, we believe that HHS' Office of General Counsel should seek the personnel and funds necessary to improve FMCRA recoveries.

CHAPTER 4

LACK OF MANAGEMENT CONTROL OVER CONTRACT HEALTH CARE PROGRAM

PHS pays private health care providers (physicians and hospitals) for emergency care, services not available at its facilities, and routine ambulatory care for primary beneficiaries not located near PHS facilities. PHS has given private contract physicians broad authority for providing and authorizing health care at PHS expense. Over the past few years contract care costs have risen dramatically and continue to increase at a substantial rate. We found that PHS has little control over the volume, cost, or quality of services provided under the contract care program.

DESCRIPTION OF CONTRACT CARE PROGRAM

Primary beneficiaries are entitled to medical, surgical, and dental treatment and hospitalization without charge at PHS hospitals and clinics and at PHS' expense from other public or private medical or hospital facilities. Care provided by private sources is referred to as contract care; however, not all of the care provided by private sources is supplied under contract.

According to the authorizing legislation, PHS may pay physicians and facilities to provide the following types of care:

--Specialized diagnosis or treatment which a PHS hospital or outpatient clinic cannot provide, upon referral from that facility.

--Emergency hospitalization.

In practice PHS also pays for routine ambulatory medical care provided to beneficiaries in many locations where a PHS hospital or outpatient clinic is not accessible. Neither the law nor the regulations specifically mandate PHS to provide routine ambulatory medical care at non-PHS facilities. However, PHS has elected to do so under the authority of the Secretary and established a network of contract physicians to provide this care.

Under this program, contract providers include private physicians and community hospitals. PHS has contracts with about 280 physicians and 82 hospitals nationwide. While PHS' general policy is to contract with only one physician per community, many communities have alternates or more than one principal contract physician. If a seaman requires emergency medical treatment, PHS will pay for such care by health care providers and facilities

not under contract, but requires such care to be authorized by a PHS official.

The following table shows the dramatic increase in the cost of PHS' contract care program over the past several fiscal years. The cost is projected at $32.5 million for fiscal year 1981.

Private Contract Patient Care

Fiscal year	Amount	Percent increase over previous year
1970	$ 3,170,626	
1971	4,718,907	49
1972	5,557,668	18
1973	6,095,207	10
1974	7,419,201	22
1975	8,879,855	20
1976	11,535,386	30
1977	14,062,044	22
1978	18,550,000	32
1979	24,664,000	33
1980 (estimated)	29,700,000	20
1981 (estimated)	32,500,000	9

According to a PHS official, PHS hospitals do not have budgets for contract care, but are given allocations which can be increased to the extent of the appropriation if expenditures exceed projected costs. One program manager told us that, as more medical technology becomes available (usually at much higher cost) and PHS has no exclusions on the type of medical care it will provide, contract care costs will continue to increase rapidly.

PHS LACKS MANAGEMENT CONTROL OVER ITS CONTRACT CARE PROGRAM

PHS lacks management control over its contract care program because it

--has no criteria for the location, number, selection, or allowable reimbursement of contract providers;

--has created the potential for conflicts of interest in the current program, because it allows contract physicians to determine eligibility, provide treatment, and authorize hospitalizations and consultations at PHS' expense; and

--has not adequately monitored the contract providers, including the cost and volume of their services.

Lack of criteria for the location, number, selection, or allowable reimbursement of contract providers

At all four hospitals reviewed, the program managers told us that PHS has no formal criteria to establish where contract physicians should be located, how many physicians should be under contract, or on what basis contract physicians should be selected. In May 1980, the Division of Hospitals and Clinics issued a policy stating that no contract physician will be established within 40 miles of a PHS facility.

Program managers said that PHS contracted with physicians in areas where significant populations of primary beneficiaries lived, but where no PHS hospital or outpatient clinic was available. They also said that PHS has continued operating outpatient clinics when closing hospitals and sometimes arranged for a contract physician when closing an outpatient clinic. PHS hospital and headquarters officials said that PHS has often contracted with physicians in response to requests from beneficiary groups or individual Congressmen.

Program managers had their own informal criteria for locating and selecting contract physicians as well as using alternates. For example, one program director told us that he preferred to establish more than one primary contract physician in a community even though this conflicted with PHS guidelines. He preferred to give beneficiaries a choice of physicians and estimated that 50 percent of his contract locations had more than one primary contractor. Another program director's policy was to have an alternate contract physician if one was available and the primary contract was with one physician. A third program manager's policy was to contract with an alternate in areas where service demand was large enough to warrant having an alternate available when the primary contract physician was unavailable.

Using arbitrary or inconsistent criteria to determine where PHS will provide services to beneficiaries through the use of contracts results in inequity to beneficiaries who do not have access to a PHS facility or contract provided routine medical care at PHS' expense. These beneficiaries must either bear the cost of treatment themselves or travel to the nearest PHS facility.

PHS has no fee schedules, such as those used in other Federal health programs (Medicare or Medicaid), to govern the amounts it pays to contract physicians and hospitals. Program managers negotiated contracts with physicians and hospitals that included varying methods of payment. For example, PHS paid some contract physicians on a fee-for-service basis and paid others a monthly amount regardless of the number of patients treated. The annual amounts paid to 137 contract physicians under the jurisdiction of the

four PHS hospitals reviewed ranged from less than $100 to more than $200,000, as shown below:

Range of amounts paid by PHS to contract physicians in 1979	Number of contract physicians
$ - to $ 10,000	80
10,001 to 50,000	44
50,001 to 100,000	11
100,001 to 200,000	1
Over $200,000	1
Total	137

The fee schedules of physicians under fee-for-service contracts varied greatly. Some contract fee schedules specified the charges for only a few items, such as an office visit, a hospital emergency room visit, a hospital visit, and a hospital admission, while other contract fee schedules were detailed and listed charges for dozens of procedures and surgeries. As the following table shows within one PHS hospital's jurisdiction, four contract physicians in the same State were allowed substantially different fees for the same procedures or type of visit.

	Physician			
	1	2	3	4
Office visit	$18	$10 to $15	$15	$10
Hospital emergency room visit	35	35	(a)	10
Hospital visit	20	15	(a)	10
Hospital admission	45	35	(a)	25

a/Not itemized.

PHS uses several different methods to pay contract hospitals. Some hospitals submit itemized bills of their usual charges. Negotiated contracts with other hospitals provide for paying the hospitals' usual charges, less a percentage discount. Other PHS contracts provide for a per diem payment. Our review of one hospital's itemized bills showed that sometimes the negotiated per diem payment greatly exceeded the itemized (usual) charges. For example, the itemized bill for one patient who was hospitalized for 23 days was $3,958. Under a negotiated $272 per diem rate, PHS paid the hospital $6,256.

PHS hospital officials told us that contracting with hospitals is no longer beneficial because PHS is unable to negotiate advantageous per diem rates. Furthermore, most hospitals prefer

to bill PHS for its patients the same way they bill other patients. PHS officials also said that beneficiaries may get emergency medical care at the nearest medical facility, regardless of whether it has a PHS contract.

Potential conflicts of interest in the contract care program

PHS has little control over the cost of contract care, because contract physicians determine the volume and cost of services they will provide to PHS beneficiaries. They dictate the amount of hospitalization and number of consultations that PHS will provide under the program, determine the eligibility of persons they treat, prescribe the treatment, and dictate the treatment needed and the number of visits required. Thus, contract physicians have a financial interest in determining that persons are eligible and in providing a generous amount of treatment.

Medical audits and invoices show that some contract physicians have taken advantage of these circumstances. A PHS audit of one contract physician's practice showed that 52 percent of the medical records lacked documentation to prove the patient was eligible for PHS medical care benefits. In addition, the audit showed that the physician ordered excessive laboratory tests, often ordering a complete battery of tests when most physicians would not have done so. Over 50 percent of the charges for outpatient services were related to laboratory tests and X-rays, and the average cost per outpatient visit (including laboratory and X-ray) was 178 percent of the average outpatient visit cost in six other communities in the State.

The contract physician with the largest volume of bills in one region had several patients who visited him repeatedly in 1979. According to the program manager, PHS reviewed this physician's practice and advised him that his use of injections was excessive. The program manager also said that, while the physician later reduced his injection rate, he increased other therapy for many patients, thus maintaining the same level of income from PHS. In fiscal year 1979, PHS paid this physician about $93,000.

Contract physicians have the authority to admit beneficiaries requiring immediate hospitalization to the local contract hospital or any private hospital. They generally are not required to notify PHS program managers of such admissions. Contract physicians are responsible for monitoring patients they have admitted to determine when the patients can be transferred to a PHS hospital. However, these physicians have no incentive to transfer the patients to PHS hospitals if they are the attending physicians. As long as the patients remain in the private hospital, PHS will continue to pay the contract physicians for daily hospital visits and other services.

PHS officials could not readily identify the number of hospital admissions by individual contract physicians; however, we found that some contract physicians admitted many patients. For example, one contract physician admitted 35 people in 7 months for conditions, such as bronchitis, hypertension, gastric ulcer, and hemorrhoids. PHS paid $108,753 for hospitalization in this community in fiscal year 1978. Another physician admitted 95 beneficiaries in calendar year 1979. A PHS outpatient clinic director reviewed and approved this physician's bills for payment. The clinic director told us that, in his opinion, although not all of the admissions were necessary, he had no choice but to approve the bills for payment.

PHS guidelines state that beneficiaries are entitled to X-ray services, medications, prescriptions, consultant and specialist services, and other adjunct medical services the contract physician finds necessary. However, PHS has no mechanism for controlling the use of these services by contract physicians. A PHS outpatient clinic director stated that contract physicians have unlimited use of consultants, while his clinic has only a $1,600 annual budget for consultants.

Hospital officials expressed concern over the conflicts of interest in the contract care program and PHS' inability to control program costs. The following comments were typical:

--A program manager said that conflict-of-interest loopholes in the contract care program allow contract physicians to determine the amount of their paycheck. To keep patients at private hospitals rather than move them to PHS hospitals is financially advantageous to contract physicians. If the contract physician is the attending physician, PHS is bound by his or her judgment on when and if the patient can be transferred. According to the program manager, short of having medical investigators willing to testify against their colleagues, PHS cannot control the contract care program.

--A PHS hospital finance chief said that the contract care program is out of control and impossible to manage from a cost-containment standpoint. He said that a conflict of interest exists when a physician decides eligibility, prescribes the necessary treatment, and establishes the number of visits and consultations required. In his view, problems exist not only with excessive visits, treatments, and charges, but also with treating ineligibles. Furthermore, the potential for abuse and collusion is greatly increased when contract physicians have free rein to use any private physician as a consultant. In his opinion, essentially any physician or hospital could provide "contract care" and receive payment from PHS.

--One hospital director expressed his concern about the potential for collusion among contract physicians, consultants, and private hospitals. He estimated that, nationwide, millions of dollars were probably wasted by physicians adding a couple of days to an inpatient stay or ordering extra consultations or laboratory tests.

--A program manager said that PHS cannot adequately control the contract care program until it removes the conflict-of-interest loophole that allows a contract physician to both determine eligibility and provide treatment.

Lack of monitoring of private providers and the cost and volume of their services

PHS does not adequately monitor the private providers and the cost and volume of their services. Program managers had little data available to them for monitoring these providers' activities. Sometimes, program officials did not review bills that providers had submitted for payment. PHS visited few of the contract providers annually and audited even fewer. One method of reducing the cost of private hospitalization would be to transfer patients from private hospitals to PHS hospitals as soon as medically feasible. However, we found that PHS did little monitoring of its inpatients in private hospitals. Thus, PHS had no assurance that contract physicians had transferred patients to PHS hospitals as soon as medically possible.

Lack of data available on the contract care program

According to program officials at the hospitals visited, a lack of information hampered them in managing the program. PHS contract care program managers had no reports that showed amounts paid to individual contract physicians, contract hospitals, or noncontract providers. They also had no information available that showed the cost of care by patient. We had difficulty determining the amount spent on an individual beneficiary for an episode of care because physicians, hospitals, consultants, and others submitted bills separately and PHS filed paid bills by provider, not by patient.

One program manager told us that he would spend several million dollars during fiscal year 1980 for contract care without knowing the leading causes of hospitalization, emergency room treatment, or primary care. He stated that he had no information that would help him do more than pay bills. Headquarters officials told us that PHS is developing an information system which will conform to the Medicaid management information system format and will give contract care program managers more useful program data.

Information, such as diagnosis, demographic data, treatments, charges, injections, diagnostic tests, and medications, was available to some extent from invoices. However, no system existed to gather the data and prepare analyses to help the program managers identify problem areas.

PHS paid some bills from private providers without review by program managers

The hospitals we visited had different policies for reviewing and approving bills submitted by private providers. None of the policies assured cost containment, and review practices often allowed any submitted bill to be paid. The contract care program managers at three hospitals did not routinely review contract physician bills before making payment, and each hospital had a different policy for reviewing contract hospital bills.

PHS policies did not assure an independent review of private providers' bills. For example, one PHS hospital program manager did not review contract physicians' bills or bills for hospitalizations they ordered. Another hospital reviewed noncontract hospital bills for care authorized by an outpatient clinic or contract physician only when a question arose about the bill being processed for payment. One program manager generally reviewed contract provider bills, but did not review bills from consultants whose services the contract physicians requested. Thus, PHS has allowed contract physicians to use consultants and approve their bills for payment without any PHS program official monitoring the bills. At one hospital, only the contract physician, who had a financial interest in approving the bills, was reviewing and certifying a large portion of the bills for payment.

Even when hospital policy required the program manager to review all non-Federal provider cases, the approval process was essentially a rubber-stamp operation. One program manager said he lacked time to review case summaries to determine whether a person treated was eligible, the services were needed, or the charges were reasonable. He said he did not evaluate whether contract physicians authorized hospitalization only in emergencies. We observed this program manager approving emergency hospitalization bills for payment after merely glancing at them and without attempting to verify that the PHS hospital had been properly notified, eligibility had been established, or a true emergency existed. This resulted in essentially any submitted bill being approved and negated any attempt to contain costs.

We identified many cases in which PHS paid hospital and physician bills without adequate evidence of PHS responsibility. For example:

--A paid private physician bill showed charges for an office visit, a hospital admission, a cataract extraction 2 days later, and a contact lens and sterilizer. The program manager told us PHS could pay for such care only if it were an emergency and PHS had authorized the care. He said, however, that cataract operations were not usually emergencies, that his hospital could do this surgery, and that it generally required a beneficiary to come to the PHS hospital for the surgery. When we asked why he had approved this bill for payment, he said that he was unfamiliar with the circumstances of this case; however, he had approved the bill for payment just 2 days before.

--One contract physician billed PHS for two patients that he examined and then admitted (in one case, 2 days later) them for hysterectomies. These did not appear to be emergencies and, according to the program manager, the operations probably could have been done at the PHS hospital. The first patient was in a private hospital for 8 days at a cost of $2,214. The second patient was hospitalized for 7 days at a cost of $1,730. The contract physician's charges for the initial office call, surgery, and hospital visits, excluding followup care, were $1,860 for the two patients. If the contract physician had followed PHS regulations, requiring these beneficiaries to go to the PHS hospital for nonemergency care, most of these charges would have been avoided.

PHS regularly inspected few contract providers

PHS policy guidelines recommend annual inspections of all contract physician practices; however, none of the program managers were carrying out this policy. They made medical audits of only a few contract practices. They did not increase the number of site visits and medical audits even though the few reviews that were conducted revealed abuses by some contract physicians. In one region, PHS inspected only 1 contract physician in fiscal year 1978 and only 8 of about 40 contract physicians in fiscal year 1979. The program manager said he conducted a site visit only in response to complaints or problems. In another region, the program manager seldom made site visit reports. In fiscal year 1979, he had prepared written reports covering site visits to only 9 of 48 contract locations.

PHS generally audited contract physicians only if a site visit revealed inconsistencies or problems that warranted further review. Failure to inspect all sites may allow some problem practices warranting a medical audit to go undetected. Although PHS performed few medical audits, generally these audits revealed serious problems. For example, a medical audit of one contract physician revealed that

--in 52 percent of the cases reviewed, documentation was inadequate to prove the patient was eligible when receiving medical care,

--the physician ordered too many laboratory tests and X-rays, and

--the physician consistently overcharged PHS for certain medical procedures.

The program manager said that, as a result of the medical audit, this physician's contract was modified to exclude payment for X-ray and laboratory procedures performed in his office and to require him to submit eligibility documentation to PHS for each beneficiary treated. The program manager stated that this physician's billings to PHS dropped from $100,000 to about $20,000 a year after the contract was modified.

Another medical audit revealed serious problems with administrative and billing practices of a contract physician. This physician had at least five different fee schedules whose use depended on the patient's third-party coverage. The auditor found no financial records in the physician's office covering PHS patients. According to the program manager, further investigation by PHS' and HHS' Office of Investigations disclosed that the physician had billed both PHS and a State workmen's compensation program for the same treatment. The case was eventually referred to the Department of Justice and the physician was prosecuted under criminal proceedings.

Lack of monitoring of beneficiaries in non-PHS hospitals

In an emergency, when a patient's condition does not permit applying for care at a PHS hospital, the beneficiary may seek care at the nearest hospital. According to PHS policy, liability will not extend beyond the time the patient could have been transferred to a PHS facility unless authorized by PHS. To implement this policy, each PHS hospital must establish a program to monitor the status of patients in non-PHS hospitals and to transfer them to PHS hospitals as soon as medically possible. Program officials told us that the transfer program cannot effectively control costs at private facilities, because PHS is bound by the attending physician's judgment on when and if a patient is suitable for transfer.

Three of the four PHS hospitals we reviewed were devoting little effort to monitoring patients for transfer. The program manager at one hospital said that the PHS staff generally waited for the non-PHS hospital to notify them that a patient had been discharged. If they did not receive such notification by the

estimated date of discharge, they followed up to find out whether the patient was still there and when he or she would be discharged. The program manager at another hospital did not monitor patients in non-PHS hospitals and did not know how many PHS patients were in private hospitals, where they were hospitalized, their status, or the disposition of the cases.

Only one hospital was making a concerted effort to monitor patients and get them transferred to PHS hospitals. Although data on the number of patients transferred were not readily available, PHS staff at this hospital were monitoring the status of patients admitted to non-PHS hospitals; consequently, several had been transferred to PHS hospitals. If the attending physician indicated the patient could be transferred but the patient refused, PHS denied financial responsibility for care rendered after the date the patient could have been transferred.

CONCLUSIONS

PHS lacks management control over the cost, quality, and extent of medical care that private sources provide to its beneficiaries, because it

- --has not established criteria for the location, number, selection, or payment of contract providers;
- --allows contract physicians to determine eligibility, provide medical services, and authorize hospitalizations and consultations at PHS' expense; and
- --does not adequately monitor the cost and volume of medical services given to PHS beneficiaries by private providers even though medical audits identified serious problems in some contract practices.

The amounts PHS paid to private providers have risen dramatically over the past few years. Improved program management should result in controlling the growth and costs of this program.

RECOMMENDATIONS TO THE SECRETARY OF HHS

In the event the Congress decides not to legislate the discontinuance of seamen as PHS beneficiaries and the closure of the hospital system, we recommend that the Secretary require PHS to:

- --Develop criteria for the location, number, selection, and payment of contract providers.
- --Establish controls over hospital admissions and consultations that contract physicians order at PHS' expense.

--Implement an improved information system to assist program managers in managing the contract health care program.

--Monitor contract physician practices through regular site visits and medical audits and terminate contracts with providers who abuse the program.

--Require the hospitals to effectively monitor and transfer PHS beneficiaries from private hospitals to PHS facilities when medically feasible.

AGENCY COMMENTS

In commenting on our draft report (see app. I), HHS agreed with our recommendations to better manage the provision of health care to PHS beneficiaries by private providers. HHS' comments are summarized below.

Criteria for contract providers

HHS said that PHS Circular 80-10, issued in May 1980, defines the PHS policies and criteria for the location, number, selection, and payment of contract providers. The circular authorizes only one principal PHS contract physician to be designated per community, specifies that no contract physician office may be established within 40 miles of a PHS facility, and requires that U.S. Coast Guard contracts be coordinated to eliminate duplicate appointments of a PHS contract physician and a U.S. Coast Guard contract physician in the same community.

To better manage and control payments to contract providers, HHS stated that PHS hospitals will be instructed to modify each contract in force as follows:

--A maximum limit will be set on the amount which can be charged to the contracts.

--Definitive objectives and level of activity expected from providers will be established, such as types of treatments and number of patients.

--Providers' contracts will include a clause stating the Government's right to question and to disallow unreasonable or unwarranted services or costs.

Also, HHS said that PHS is considering other measures to improve management controls at PHS hospitals, such as:

--Restricting items that do not affect provider services but do affect costs, such as prohibiting the use of private rooms except when medically necessary, not paying for over-the-counter drugs, and restricting medical services to those absolutely medically necessary.

--Establishing guidelines for fees for contract services.

--Establishing guidelines for payments for such items as catastrophic illness, accidents, and long-term care.

--Defining the nature and type of medical treatment allowed.

Controls over hospital admissions and consultations

HHS said that the rules and guidelines contained in the "Contract Physician's Guide," and reiterated in a June 1, 1980, memorandum, are now being enforced. Also, HHS said that the authority and responsibility of contract physicians, as outlined in the guide, are incorporated as contractual terms and conditions in all contracts let with physician contractors. According to HHS, proof of eligibility must be appended to all bills for patients examined or treated by a contract physician.

HHS stated that each PHS hospital will be required to establish controls over hospital admissions and consultations ordered by a contract physician. According to HHS, one mechanism being considered is to include a clause in every provider contract stating that all fees charged by noncontract providers, to whom patients are referred by the provider, will be viewed as subcontract costs to be applied against the ceiling established in the providers' contracts.

In addition, HHS said that all PHS hospitals will be required to negotiate immediately contracts setting forth maximum ceilings to PHS upon notification that an eligible individual is receiving treatment from a noncontract hospital.

Improved information system

HHS believes that only the development of an effective management review system will permit an acceptable review of contract patient care costs. Accordingly, HHS said that a request for contract is being developed for a 12-month consultant's services to develop a management information system for contract patient care. According to HHS, the system includes computer-assisted and manual procedures to assure better management of the contract health care program.

Monitoring of contract physician practices

HHS stated that PHS will consider making at least one onsite visit a year to each provider. Within available travel ceilings, HHS said that it will schedule site visits and medical audits to examine the providers' documentation for establishing patient eligibility and basis for fee establishment. Also, HHS will require providers to detail documentation used to determine patient eligibility.

Additionally, to better monitor contract physician practices, HHS said that PHS will instruct PHS hospitals to:

--Communicate with providers that the quality of service should be provided in the most economical manner and that all provider claims be carefully scrutinized for reasonableness of care and fees and require providers to submit more detailed description of diagnosis and treatment so that quality and appropriateness of medical services can be evaluated.

--Identify providers exhibiting patterns of apparent abuse and immediately communicate to them that abuses must be corrected or contracts will be terminated.

Monitoring of PHS beneficiary transfers from private to PHS hospitals

HHS said that PHS has always pursued its policy to monitor and transfer PHS beneficiaries from private hospitals to PHS facilities when medically feasible. However, in most cases, HHS said that the PHS facility resources are best served by arrangements made on original admission to a PHS or other Federal health care facility, or to a private hospital.

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Washington, D.C. 20201

3 APR 1981

Mr. Gregory J. Ahart
Director, Human Resources
Division
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

The Secretary asked that I respond to your request for our comments on your draft report entitled, "Opportunities Exist to Significantly Reduce Public Health Service Hospital Costs." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

Bryan B. Mitchell
Acting Inspector General

Enclosure

GAO note: The page references in this appendix may not correspond to the page numbers in the final report.

APPENDIX I

COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES ON THE GENERAL ACCOUNTING OFFICE DRAFT REPORT ENTITLED "OPPORTUNITIES EXIST TO SIGNIFICANTLY REDUCE PUBLIC HEALTH SERVICE HOSPITAL COSTS"

General Comments

In the cover summary of the General Accounting Office (GAO) report, it states that:

> "In February 1981, after completion of GAO's review, the President proposed legislative action to discontinue eligibility of seamen as Service beneficiaries and to terminate the hospital system. The difficulties associated with the Service's verification of seamen eligibility and the weaknesses GAO found in the Service's hospital management system should be of interest to the Congress in deliberating the President's proposal. Prompt enactment of Presidentially proposed action would eliminate the need for the congressional and departmental actions recommended by GAO."

Accordingly, if the Congress decides not to legislate the discontinuance of seamen as Public Health Service (PHS) beneficiaries and the closure of the hospital system, the Department will proceed with the implementation of the proposed actions as outlined in the comments to the GAO recommendations cited below.

GAO Recommendation

We recommend that the Secretary direct PHS to comply with established procedures for reviewing data submitted by individuals seeking health care from PHS. If the PHS hospitals and clinics lack trained admission staff, PHS should be directed to provide such training.

Department Comment

We concur. The Bureau of Medical Services within PHS has and will take action concerning compliance with established procedures for reviewing admissions data for individuals seeking health care from PHS. For example, in January 1981, the Bureau Director issued a directive to all hospital directors calling for strict enforcement of the established procedures contained in the Bureau's Contract Physician's Guide. The Bureau will also issue another directive calling for strict enforcement of the established procedures published in the Bureau's Operations Manual - PHS Hospitals and Clinics.

The effectiveness of eligibility determinations can be improved by a better trained and more productive PHS admissions staff. In this regard, the Bureau of Medical Services will assess the training needs of the PHS hospital's admissions staff, and will provide appropriate training in the area of eligibility determination. The Chief, Medical Records Department, will be held accountable for conducting and supervising this on-the-job training requirement.

Two activities are already underway to upgrade the performance of PHS hospital admissions staff:

(1) Computer terminals will be installed during FY 1981 to implement the patient registration and eligibility verification function as part of the installation of the Public Health Automated Medical Information System (PHAMIS). Questionable beneficiary eligibility cases will thereby be subjected to a more thorough follow-up.

(2) Five PHS hospitals have newly installed staff scheduling and performance procedures. Reassignments resulting in workload equalization are being realized in this process. If funding permits, the new procedures will be instituted in the remaining three PHS hospitals during FY 1982.

GAO Recommendation

We further recommend that the Secretary require PHS to establish controls over master's certificate forms by prenumbering them and distributing them to only eligible owner/operators of vessels or their masters.

Department Comment

We do not concur. A properly completed Master's Certificate of Service is an optional form of documentation. Other acceptable eligibility documentation includes a continuous discharge book, certificate of discharge, payroll records, letter from the ship's master, and other evidence that the seafarer has been employed on a registered, enrolled, or licensed vessel.

The Department believes that a computerized enrollment system for seafarers is a better alternative. The Bureau of Medical Services will develop a Request for Contract (RFC) for the installation of a Contract Patient Care Management Information System (CPC/MIS). A part of this sytem would include a Recipient Module routine to be used for eligibility screening.

GAO Recommendation

We recommend that the Secretary direct the PHS to designate a unit in each hospital specifically responsible for (1) obtaining third-party resource data from all patients treated by or at the expense of the PHS, (2) referring all cases in which care is provided to beneficiaries for injuries incurred under tort conditions to regional attorneys for collection under the terms of the Federal Medical Care Recovery Act, and (3) verifying ability to pay and obtaining payment from persons treated at PHS facilities but not entitled to free care as PHS beneficiaries.

Department Comment

We concur. The Bureau of Medical Services has published a PHS Hospital and Clinics Operations Manual and a Contract Physician's Guide. Each hospital is responsible for the implementation of the procedures in these publications which encompass the three areas cited in the recommendation.

The Director, Bureau of Medical Services will request each hospital director to designate in writing: (1) who will be responsible for obtaining third party resource data; (2) who will be responsible for referring to regional attorneys' PHS health care costs collectible from third parties in tort liability circumstances under the terms of the Federal Medical Recovery Act (FMRA); and (3) who will be responsible for verifying the person's ability to pay, and obtaining payment from persons treated at PHS hospitals and clinics, but not eligible for free care as PHS beneficiaries.

GAO Recommendation

To better manage the provision of health care to PHS beneficiaries by private providers, we recommend that the Secretary require the PHS to develop criteria for the location, number, selection, and payment of contract providers.

Department Comment

We concur. PHS Circular 80-10, issued in May 1980, defines the PHS policies and criteria for the location, number, selection, and payment of CPC providers. The circular authorizes only one principal PHS contract physician to be designated per community, specifies that no contract physician office may be established within 40 miles of a PHS facility, and requires that U.S. Coast Guard contracts be coordinated to eliminate duplicate appointments, that is, the appointment of a PHS contract physician and a U.S. Coast Guard contract physician in the same community. The Bureau of Medical Services Director will reemphasize to PHS hospital and clinic directors the essential nature of the circular, and will hold them accountable for carrying out its explicit provisions.

In addition, to better manage and control payments to contract providers, PHS hospitals will be instructed to modify each CPC contract in force as follows:

--A maximum limit will be set on the amount which can be charged to the contracts.

--Definitive objectives and level of activity expected from providers will be established, such as types of treatments and number of patients.

--Providers' contracts will include a clause stating the Government's right to question and to disallow unreasonable or unwarranted services or costs.

APPENDIX I

Also, PHS is considering measures such as the following to improve management controls at the PHS hospitals.

(1) Restricting those items that do not impact provider services but do impact costs, such as prohibiting the use of private rooms except when medically necessary, not paying for over-the-counter drugs, restricting medical services to those absolutely medically necessary, etc.

(2) Establishing guidelines for fees for CPC services.

(3) Establishing guidelines for payments for such items as catastrophic illness, accidents, and long-term care.

(4) Defining the nature and type of medical treatment allowed.

GAO Recommendation

To better manage the provision of health care to PHS beneficiaries by private providers, we recommend that the Secretary require the PHS to establish controls over hospital admissions and consultations that contract physicians order at PHS expense, and to implement an improved information system to assist program managers in managing the contract health care program.

Department Comment

We concur. The rules and guidelines contained in the Contract Physician's Guide, and reiterated in June 1, 1980 memorandum, are now being enforced. The authority and responsibility of contract physicians, as outlined in the guide, are considered mandatory, and are incorporated as contractual terms and conditions in all contracts let with physician contractors. Proof of eligibility, as described in the guide, must be appended to all bills for patients examined or treated by a contract physician. Non-emergency care treatment requires a preauthorization from PHS (form HSA-159) to qualify for payment.

We believe that only the development of an effective management review system will permit an acceptable review of CPC costs. Accordingly, a request for contract is under development for a 12-month consultant's services to develop a MIS for CPC. The MIS/CPC includes computer-assisted and manual procedures to assure better management of the contract health care program.

Additionally, each PHS hospital will be required to establish controls over hospital admissions and consultations ordered by a contract physician. One mechanism being considered is to include a clause in every provider contract stating that all fees charged by non-contract providers to whom patients are referred by the provider, will be viewed as subcontract costs and will be applied against the ceiling established in the providers' contracts.

Further, all PHS hospitals will be required to negotiate immediately contracts setting forth maximum ceilings to PHS upon notification that an eligible individual is receiving treatment from a non-contract hospital.

Also, to assist in the management of the CPC program, PHS is considering the allocation of contract health care budgets to each PHS hospital and clinic. The hospitals and clinics would then be expected to operate within these budgetary limits.

GAO Recommendation

To better manage the provision of health care to PHS beneficiaries by private providers, we recommend that the Secretary require the PHS to monitor contract physician practices through regular site visits and medical audits and terminate contracts with providers who abuse the program.

Department Comment

We concur. With respect to site visits, PHS will consider making at least one on-site visit a year to each provider. Within available travel ceilings, we will schedule site visits and medical audits to examine among some of the areas, the providers' documentation for establishing patient eligibility and basis for fee establishment. Also we will require providers to detail documentation they use to determine patient eligibility. The proposed CPC/MIS application will provide a solid base for selective audits, particularly as high costs or questionable medical practices may surface in the planned computer-generated reports and various output triggers.

Additionally, to better monitor contract physician practices, PHS will instruct PHS hospitals to:

(1) Communicate with providers that the quality of service should be provided in the most economical manner and that all provider claims be carefully scrutinized for reasonableness of care and fees. Also require providers to submit more detailed description of diagnosis and treatment so that quality and appropriateness of medical services can be evaluated.

(2) Identify those providers exhibiting patterns of apparent abuse and immediately communicate to them that abuses must be corrected or contracts will be terminated.

GAO Recommendation

To better manage the provision of health care to PHS beneficiaries by private providers, we recommend that the Secretary require the PHS to require the hospitals to effectively monitor and transfer PHS beneficiaries from private hospitals to PHS facilities when medically feasible.

APPENDIX I

Department Comment

We concur. PHS has always actively pursued its policy to monitor and transfer PHS beneficiaries from private hospitals to PHS facilities when medically feasible. However, in most cases, the PHS facility resources are best served by the arrangements made upon original admission to a PHS or other Federal health care facility, or to a private hospital.

GAO Recommendation

We also recommend that the Secretary direct the Office of the General Counsel (OGC) to review its procedures for processing potential third-party liability cases and initiate action to resolve each case before the statute of limitations expires.

Department Comment

We do not concur. The GAO report singles out Region X for what we believe to be unjustified criticism. We do not believe that problems as serious as those contained in the report exist as alleged in the other regional offices. OGC does not have the personnel and funds necessary to write for police reports and trace down beneficiaries, tortfeasors, or their insurers in all cases in which there is at least the possibility of a Federal Medical Care Recovery Act (FMCRA) claim. Consequently, the regions must rely either on the beneficiaries' cooperation to inform OGC whether they have retained private counsel or upon contacts made by counsel or by the tortfeasor's representative indicating that settlement or litigation is imminent. Then OGC can determine whether pursuit of the claim is worthwhile.

OGC, in many instances, obtains a recovery in very old cases after a late contact is made and before any funds are distributed. However, in no event OGC has knowingly allowed a statute of limitations to run.

While we agree that FMCRA recoveries could be improved, the implementation of the GAO recommendation would require additional resources or the redirection of other resources which the Department has assigned to higher priority matters.

Technical Comments

For a better perspective of some of the issues brought out on page 10 in the GAO report, some quantitative data is introduced. In a revised survey, dated February 19, 1981, the Health Services Administration estimated that total workforce employed on American flag vessels to be 537,000 and not 300,000 as stated in the report. Of this total, the seafarers eligible for PHS health care services was estimated to be 398,000 or 74 percent. The health insurance coverage was estimated to be 91,000 or 23 percent of the PHS-eligible beneficiaries as shown in the following table.

APPENDIX I

ESTIMATED SEAFARER WORKFORCE

Seafarers Employed on U.S. Documented or State Registered Vessels		Eligible for Free PHS Health Care	%	Covered by Group Health Insurance	%
Deep Sea	40,000	40,000	100	40,000	100
Fishing	196,000	101,000	52	3,000	3
Inland Waterways	267,000	225,000	84	16,000	7
Offshore Industry	34,000	32,000	94	32,000	100
TOTAL	537,000	398,000	74	91,000	23

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