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STATEMENT OF
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BEFORE THE
SUBCOMMITTEE ON AGING, FAMILY AND HUMAN SERVICES
COMMITTEE ON LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

ON

RESULTS OF GAO REVIEWS OF
FAMILY PLANNING ACTIVITIES UNDER
TITLE X OF ~~THE~~ PUBLIC HEALTH SERVICE ACT

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Mr. Chairman and members of the Subcommittee, we are pleased to be here today to summarize the results of our reviews of the family planning program authorized under title X of the Public Health Service Act. Since enactment of title X in 1970, we have evaluated several aspects of the program and have issued eight reports on our findings to the Congress, congressional committees, or members of the Congress. Another report was issued to the District of Columbia's Department of Human Resources. Appendix I lists these reports.

BACKGROUND

Through the Department of Health and Human Services (HHS), the Federal Government provides funds for family planning services through several programs, the largest of which is title X. Since passage of the Family Planning Services and Population Research Act of 1970, over $1 billion has been provided for family planning service grants under title X. In fiscal year 1980, title X provided about $156 million to serve about 3.8 million people in over 5,000 clinics. It also provided about $6.1 million for training, information and education, and program implementation research.

Also in fiscal year 1980, an estimated $219 million was provided for family planning services through other Federal programs authorized under the Social Security

Act--$122 million under title XIX (Medicaid), $72 million under title XX (Social Services), and $25 million under title V (Maternal and Child Health). To a lesser extent, family planning services are provided under Federal health service programs, such as Community Health Centers and Migrant Health.

Today, we would like to summarize our major findings on the title X program. These findings relate to problems which have impeded the accomplishment of program objectives and have demonstrated the need for improvements in program management.

PROBLEMS IN ACCOMPLISHING PROGRAM OBJECTIVES

One major purpose of title X is to make comprehensive voluntary family planning services readily available to all persons desiring them so they can choose their family size and space their children as they want. The original legislation gave priority to low-income persons because the consequences of unplanned and/or unwanted births were most prevalent among poor families. These consequences included higher infant mortality and greater risk of maternal mortality and premature births.

In 1978, title X was amended to specifically recognize adolescents as a target group. Adolescents were targeted because of growing concern over the large number of teenage pregnancies and the adverse social, economic

and health consequences--including higher infant mortality and prematurity rates--associated with births to teenage mothers.

The title X program has increased the availability and accessibility of family planning services to low-income persons and adolescents throughout the Nation and has provided medical, social, and educational services to many persons. Also, the program has helped to prevent unwanted and/or unplanned pregnancies by making contraceptive services available to persons desiring them. However, although we have not made a comprehensive evaluation of the effectiveness of the title X program, our work has shown that the program has not reached or effectively served many individuals in its target population.

In April 1975, we reported that a number of welfare recipients interviewed in Chicago, Philadelphia, and Dallas had desired to use family planning services but were not enrolled in a program and were not aware of clinic locations. We found that (1) projects in these cities generally had not established procedures aimed at reaching low-income persons, (2) welfare caseworkers had not complied with Social Security Act requirements to

offer family planning services to appropriate welfare recipients, and (3) inadequate coordination existed between local welfare offices and family planning clinics.

Client dropout was another problem discussed in our April 1975 report, and again in our June 1981 report. In April 1975, we reported that 62 percent of the clients in our sample at three projects had not been seen by clinic personnel in 15 months. Our June 1981 report shows that client dropout continues to be a problem. We sampled clients making initial visits in 1978 to seven clinics in five States. From 25 to 48 percent of these new clients made only one visit to the clinics.

We recognize that some client turnover is to be expected as clients move, change health care providers, or choose to become pregnant or sterilized. Also, we recognize that high client dropout rates do not necessarily mean clinics are inefficient or ineffective. On the other hand, we believe that to some extent, high dropout rates could be indicative of program ineffectiveness.

Our January 1980 report on Federal efforts to improve pregnancy outcome discussed several other indicators of how well the family planning program is reaching its target population and how effective the program has been in preventing unwanted or unplanned

pregnancies--particularly for women who are a high risk for poor pregnancy outcome. Such women include those who (1) are under 17 or over 35 years old, (2) are low-income or unmarried, or (3) have had several previous pregnancies, a very recent pregnancy, or a history of obstetrical complications.

Our report noted that although title X grantees had helped prevent pregnancy for many low-income and adolescent mothers, many other women were not being served, were served too late to prevent pregnancy, or were served ineffectively. We pointed out that large numbers of adolescents were continuing to have unwanted and/or unplanned pregnancies, many births to unwed mothers were continuing to occur, and a significant number of women--over one million annually--were continuing to have abortions to prevent births. Contributing factors included (1) the lack of resources in some areas, (2) the lack of coordination among all programs funding family planning services, (3) the lack of focus on high-risk groups, other than adolescents, and (4) the lack of client motivation to seek or effectively use family planning services because of attitudinal barriers or incorrect information on pregnancy.

Our January 1980 report also discussed the wide range of public views on how to best deal with adolescent pregnancy. Considerable controversy exists over such

issues as providing contraceptives to adolescents without parental consent and providing sex education in the schools. We suggested there was a need for a clear Federal policy on Government's role relative to these issues.

IMPROVEMENTS NEEDED IN PROGRAM MANAGEMENT

Our reviews of the title X program have identified several areas in which improvements in program management could reduce cost or enhance program effectiveness and efficiency by

- --Streamlining the required level of services for oral contraceptive clients and increasing grantee revenues through more aggressive fee collections;
- --Consolidating and better coordinating the several Federal programs that fund family planning services;
- --Improving data collection efforts and grantee monitoring;
- --Improving weaknesses in grant and contract award and, in some cases, management procedures; and
- --Assuring that funds authorized for program implementation research are appropriately used.

Streamlining services and increasing revenues

Two of our reports discussed the potential for operating title X clinics more efficiently, providing services at less cost, and improving fee collections from clients able to pay or from third party insurers.

In our April 1975 report we noted extreme variances--from $16 to $219--in the average cost per patient visit among projects in three HHS regions. We observed several factors contributing to these variances including patient volume, physician utilization, population density of the area served, and procurement practices, such as the extent to which projects maximized efforts to purchase supplies as economically as possible. We reported that HHS had not (1) established criteria for measuring the reasonableness of clinic costs, (2) performed sufficient audits of family planning projects to evaluate efficiency, or (3) established a reporting system for monitoring project costs and performance.

Our 1975 report also discussed the need to make more extensive efforts to collect revenues from third party sources, such as Medicaid and Social Services programs, and from clients able to pay. Problems we identified concerning clinics' ability to obtain reimbursements under the Medicaid or Social Services

programs included (1) noncoverage of many nonmedical services under Medicaid, (2) inadequate clinic accounting and billing systems, and (3) difficulties in becoming approved as a provider or obtaining sufficient reimbursement under Medicaid. Also, most of the projects we visited had not instituted fee schedules to collect fees from clients able to pay according to HHS' requirements.

In our most recent review of the title X program, we noted that progress had been made in fee collections since 1975--particularly from the Social Services program. However, further improvements are needed because family planning clinics have lost revenue and treated clients inequitably because they have not uniformily applied sliding fee scales based on clients' ability to pay. The varying fee practices have occurred because HHS did not keep regulations current and had not emphasized fee collections. Also, State title XX fee policies have often conflicted with title X, and clinic officials and clients in some areas perceive that services are free. HHS resolved some of the problems by issuing new regulations in June 1980 which required charging clients whose incomes are above the poverty level. However, problems remain in the areas of inconsistent application of sliding fee scales and conflict with title XX policies.

In June 1981, we also reported that family planning clinics could operate more efficiently and make services more attractive to clients without compromising quality by eliminating unnecessary medical procedures. Although family planning clinics were generally providing services required by HHS, the clinics were not operating as efficiently as possible because HHS guidelines recommended or required that (1) clients using oral contraceptives visit the clinic too frequently and (2) clients be provided education and certain medical tests that did not appear necessary. In addition, some clinics were providing more services than required by HHS, such as routine venereal disease tests and semi-annual physical examinations. These procedures reduced the clinics' operational efficiency and also contributed to long waits for appointments and long office visits at some clinics. These conditions may have deterred initial or continued participation in family planning programs.

Program consolidation and coordination

Several of our reports have discussed problems resulting from or accentuated by the multiplicity of Federal programs funding family planning services and the need to consolidate and/or better coordinate these programs.

In April 1975, we reported on problems that resulted, at least in part, from having four different HHS organizations administer different family planning programs. These programs were authorized under different laws and had different (1) Federal-State cost sharing arrangements, (2) eligibility requirements, and (3) degrees of direct Federal administration. These differences had a substantial impact on a variety of activities at clinics including fee collections.

The administrative problems associated with overseeing activities of grantees receiving funding from several sources was perhaps best illustrated in our July 1976 report on a large Louisiana title X grantee that had received over $50 million from 10 Federal programs between 1967 and 1974. Our study revealed that lax administrative controls and practices allowed the grantee to circumvent limitations on the use of Federal funds and to improperly obtain Federal funds. Contributing to the problems were the diverse and inconsistent administrative requirements among programs which precluded coordinated management of Federal funds, the weak requirements for managing grants and contracts, and inadequate monitoring.

Our January 1980 report showed that the lack of coordination among the several Federal programs that

fund family planning services hindered the effectiveness of efforts to prevent unplanned and/or unwanted pregnancies among women who are at high risk of poor pregnancy outcome. For example, in several States or local areas, no one was coordinating efforts by federally funded grantees to ensure that needs were adequately assessed and addressed efficiently and effectively.

Our June 1981 report discusses the conflicts between fee policies in the titles X and XX programs. It also discusses the inability of HHS' Deputy Assistant Secretary for Population Affairs to effectively carry out his responsibilities as set forth in title X. Those responsibilities include administering, coordinating, and evaluating HHS' family planning activities.

Monitoring and data collection

One of the most common deficiencies identified in our reviews has been the lack of adequate program monitoring. The lack of sufficient monitoring by HHS has contributed to the program's inability to fully accomplish intended objectives and ensure that program funds were always used appropriately, and to the failure of several grantees to develop and implement fee schedules in accordance with HHS' regulations.

One of the factors inhibiting adequate program monitoring has been the lack of adequate management information systems. In April 1975, we reported that HHS' National Reporting System for Family Planning Services was of questionable usefulness because a number of projects failed to submit reports, submit reports regularly, or submit accurate and complete data. We also reported that HHS lacked a reporting system and criteria for monitoring project cost and performance and had not adequately monitored State compliance with requirements in the Social Security Act to offer and provide family planning services to certain welfare recipients.

In our June 1981 report we show that HHS had made several changes to its national reporting system, including making it a sample system instead of requiring reports from every project. However, the system was still plagued with problems and in June 1980, HHS decided to discontinue it. The system's termination leaves program officials with little national data about clients served and contraceptive methods used.

Our June 1981 report also noted that HHS had established criteria and a reporting system (in addition to the National Reporting System for Family Planning Services) for evaluating project performance and the reasonableness of project costs. However, the

new system produces data which have a number of limitations on their usefulness and lacks credibility among grantees and HHS regional officials. Several were skeptical of the data's accuracy and the appropriateness of the system's indicators for measuring efficiency of family planning clinic operations.

Our December 1977 report on activities of one grantee noted that HHS had not established guidelines for managing or an adequate system for monitoring consolidated family planning program grants. A consolidated grantee is one that receives title X funds from HHS and redistributes part of these funds to other organizations which provide family planning services. The lack of guidelines specifying the functions and responsibilities of consolidated grantees contributed to a breakdown in cooperation and coordination between the grantee and the organizations it funded. For example, the grantee provided certain services viewed as unnecessary by the organizations. This problem would probably have been identified, and corrective action possibly taken, through better monitoring by HHS.

Grant and contract procedures

Our reviews have indicated a need to improve grant and contract award procedures and, to some extent, management procedures. In April 1975, we reported that although HHS required projects to ensure costs were reasonable and

necessary whenever they contracted with other providers, the guidelines were silent on the monitoring and administration of grantee subcontractors. Weaknesses in administration of subcontracts by some grantees failed to protect the Government's interests. For example, we noted that a grantee's subcontractor had purchased equipment that was unused and apparently unneeded.

In our February 1977 report on problems in administering the title X program in one region, we identified several management weaknesses in grant review and grantee selection procedures and in procedures for awarding contracts. For example, the region awarded two grants even though the grantees' applications did not comply with regulations governing the content of grant applications. The region's procedures were not adequate for an orderly review and selection process and did not provide for an objective and fair selection of grantees. In addition, the region's contracting procedures for family planning training services violated procurement regulations and requirements relative to fair and objective review of proposals.

Use of funds for program implementation research

HHS has used funds authorized each year under section 1004 of title X for "program implementation

research" for a variety of activities. These activities included studies on how to serve various target groups, technical assistance to grantees, preparation of 5-year plans required by title X, data collection, and training. In our June 1981 report, we questioned whether all such uses of these funds were (1) appropriately classified as research or (2) within the range of activities envisioned by the Congress when it enacted section 1004. We noted that HHS had not formally defined the parameters of program implementation research.

CORRECTIVE ACTIONS AND REMAINING PROBLEMS

Since 1975, we have made several recommendations to the Congress, the Office of Management and Budget, and HHS to help resolve the problems identified. Corrective actions have been taken on many of our recommendations. However, some recommendations have not been acted upon and some problems persist.

In our July 1976 and January 1980 reports, we recommended that the Congress consolidate Federal programs funding family planning services. We reaffirmed the need for such a consolidation in our testimony during the March 31, 1981, hearing on title X before the full Senate Committee on Labor and Human Resources. Enactment of some form of program consolidation could alleviate the problems caused by the multiplicity of

Federal programs funding family planning services. At the same time, such action could make it more difficult to implement other recommendations. For example, in our 1980 report, we recommended that the Congress amend title X to require that some priority be given to providing family planning services to low-income women who have a high risk of poor pregnancy outcome.

The Office of Management and Budget has taken action on our recommendations to strengthen administrative requirements for Federal grants to public and private institutions and to improve fiscal accountability and audits of grantees, particularly those receiving funds from several different Federal sources.

Our recommendations to HHS involved several program areas, including enhancing program effectiveness, reducing program costs, coordinating activities, and improving monitoring and data collection. In general HHS has been responsive to our recommendations. However, in our view, HHS has not taken sufficient action to

--establish procedures for enrolling low-income persons, particularly welfare recipients, desiring family planning services;

--ensure that grantees collect fees from persons able to pay;

--help resolve conflicts in fee policies between titles X and XX;

--facilitate the coordination and evaluation roles of the Deputy Assistant Secretary for Population Affairs;

--increase program audits of title X grantees; or

--guide programmatic and administrative activities of consolidated grantees.

We will be following up on these matters and working with HHS to bring about the needed improvements.

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This concludes our statement. Mr. Chairman, we would be pleased to answer any questions you or other members of the Subcommittee may have.

GAO REPORTS ON FAMILY PLANNING ACTIVITIES UNDER TITLE X OF THE PUBLIC HEALTH SERVICE ACT

"Family Planning Clinics Can Provide Services At Less Cost But Clearer Federal Policies Are Needed" (HRD-81-68, June 19,1981).

"Should Full Funding Be Applied To The Rental Assistance And Family Planning Programs?" (PAD-80-16, Feb. 12, 1980).

"Better Management and More Resources Needed to Strengthen Federal Efforts to Improve Pregnancy Outcome" (HRD-80-24, Jan. 21, 1980).

Letter Report to the Director, Department of Human Resources, Government of the District of Columbia, on infant mortality problems in the District (Oct. 31, 1978).

Letter Report to Congressmen Barber B. Conable and Frank Horton on the administration of a family planning services grant by the Genesee Region Family Planning Program, Inc. of Rochester, New York (HRD-78-24, Dec. 13, 1977).

"Problems in Administration of Family Planning Programs in Region VIII" (HRD-77-42, Feb. 28, 1977).

Letter Report to Congressman Timothy E. Wirth on the administration of family planning programs in Region VIII (HRD-76-155, Aug. 2, 1976).

"Administration Of Federal Assistance Programs--A Case Study Showing Need For Additional Improvements" (HRD-76-91, July 28, 1976).

"Improving Federally Assisted Family Planning Programs" (MWD-75-25, April 15, 1975).