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SUMMARY OF GAO TESTIMONY BEFORE THE
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
HOUSE COMMITTEE ON ENERGY AND COMMERCE

The Hill-Burton Program--the Nation's major health facility construction program--has provided about $5.9 billion in construction grants, direct loans, and loan guarantees since 1946. Certain conditions had to be met when facilities received Hill-Burton funds, including (1) providing a reasonable volume of uncompensated medical care and (2) making medical services available to all persons residing in the service area.

Regulations implemented in 1979 substantially altered how facilities established compliance levels, determined eligibility, maintained records, and reported on levels of uncompensated care. Many problems followed, and the Department of Health and Human Services continues to have difficulty monitoring compliance, obtaining accurate compliance data from facilities, and investigating and resolving complaints in a timely manner.

The large number of facilities, the limited staff resources, and the enormous workload generated by the 1979 regulations raise questions as to whether the Department can conduct the number of compliance assessments required to release facilities from their 20-year obligations or obtain up-to-date compliance information as required by the regulations.

HHS had satisfactorily implemented most of GAO's 1979 recommendations to improve the administration of the Hill-Burton loan assistance program. GAO pointed out certain additional actions that HHS should take to further improve the program.

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UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C.

FOR RELEASE ON DELIVERY
EXPECTED AT 2:00 P.M.
APRIL 30, 1982

STATEMENT OF

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BEFORE THE

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

HOUSE COMMITTEE ON ENERGY AND COMMERCE

ON

ADMINISTRATION OF THE HILL-BURTON PROGRAM

Mr. Chairman, we are pleased to be here today to discuss the results of our review of the Hill-Burton program--the Nation's major health facility construction program. Between 1946, when enacted by the Congress, and September 1981, Hill-Burton provided about $5.9 billion in construction grants, direct loans, and loan guarantees.

Today, I will present our overall observations on the three major areas the Subcommittee asked us to assess:

--The administration of the Hill-Burton uncompensated care and community service assurances.

--The administration of the recovery provisions relating to Hill-Burton grants and loans.

--Actions taken to improve the administration of the Hill-Burton loan assistance program.

ADMINISTRATION OF THE UNCOMPENSATED CARE AND COMMUNITY SERVICE ASSURANCES

The 1946 legislation required that certain conditions be met when facilities received Hill-Burton funds. Two of these were that the facilities (1) provide a reasonable volume of medical services, generally for a 20-year period, to persons unable to pay (commonly known as the uncompensated care assurances) and (2) make medical services available to all persons residing in the area during the life of the facility (commonly known as the community service assurance).

The first regulations containing specific requirements for the uncompensated care assurances were issued in 1972. The first specific regulations for the community service assurance were issued in 1974. Before January 1975, the States were responsible for administering and enforcing both assurances. At that time, Public Law 93-641 transferred these responsibilities to the Federal Government and required that more stringent investigation, monitoring, and compliance standards be developed. Regulations for these

requirements were not finalized until May 1979, and little Federal administration or enforcement of the Hill-Burton assurances occurred between 1975 and 1979.

When the regulations were issued in May 1979, about 7,000 facilities had a community service assurance obligation, and about 5,400 of these also had an uncompensated care assurance obligation. The new regulations included many specific provisions that substantially altered how facilities established compliance levels, determined eligibility, maintained records, and reported on levels of uncompensated care. With so many changes being made at one time to a program over 30 years old, it was not surprising that many facilities were unaware of all the changes, and many complaints were received.

Before 1980, the Bureau of Health Facilities (BHF) within the Public Health Service was responsible for administering both assurances. In January 1980, the Public Health Service and the Office of Civil Rights (OCR) entered into a formal memorandum of understanding, which provided that, at BHF's direction, OCR would conduct complaint investigations and compliance reviews relating to the community service assurance. In December 1980, the Secretary of Health and Human Services (HHS) delegated full monitoring and enforcement responsibility for the community service assurance to OCR,

while BHF retained responsibility for the uncompensated care assurances.

Uncompensated Care Assurances

BHF activities relating to the uncompensated care assurances have primarily involved providing technical assistance to facilities, processing and investigating complaints, conducting compliance assessments, and implementing an assurances reporting system.

Initially, BHF expended much effort to inform facilities of the requirements of the 1979 regulations and has operated a toll free hotline to answer inquiries from both facilities and the public. Nonetheless, BHF's complaint files indicate that some hospital officials remained unaware of the 1979 regulations or did not understand them.

Most complaints received by BHF involved allegations that facilities had not adequately informed people of the availability of free medical care or had billed people who believed they were eligible for free care. Many complaints centered on technical violations of the regulations, such as the lack of Hill-Burton signs or notices concerning the availability of free care. Only a few alleged denial of medical services.

Although BHF developed procedures for processing complaints, it had not implemented them effectively. Specifically,

--the complaint system has not been timely or responsive,

--decisions to investigate complaints were not based on BHF's priority ranking system, and

--systematic followup seldom took place to ensure that facilities corrected violations.

Other priorities and a lack of travel funds limited the number of compliance assessments BHF made during fiscal years 1980 and 1981. Most assessments made during 1981 were 20-year closeout assessments to determine whether facilities had provided sufficient free care to satisfy their uncompensated care obligations. Only about 29 percent of the assessments were done for general compliance monitoring. BHF officials indicated that, during fiscal year 1982, all compliance assessments scheduled will be closeouts.

BHF has made closeout assessments its top priority; however, in view of the number of facilities that will reach the end of their 20-year uncompensated care obligation in the near future, it will be difficult for BHF to keep pace with the workload.

BHF implemented a reporting system in September 1980 to obtain compliance information from Hill-Burton facilities, but it experienced problems in obtaining correct and complete data during the first reporting cycle. Consequently, much

time and effort have been expended helping facilities complete the reports and correcting submitted reports. Because of this and the large number of facilities BHF must deal with, we doubt whether it will obtain compliance information from all Hill-Burton facilities within 3 years, as required by the 1979 regulations.

Community Service Assurance

Since December 1980, OCR's efforts relating to the community service assurance have concentrated on investigating complaints and conducting compliance reviews.

Ninety-two of the community service complaints filed with OCR have alleged denial of service. Of these complaints, 51 had been investigated, and the OCR investigation reports showed that 16 of the complaints were substantiated. In processing and investigating complaints, OCR has generally been timely and responsive, and it has usually ensured that facilities took action to correct violations.

Completing compliance review reports in a timely manner appeared to be a problem for OCR. As of September 30, 1981, final investigation reports or letters of findings had been prepared on only 7 of 55 compliance reviews undertaken in fiscal years 1980 and 1981. In addition, although a reporting form was developed by BHF to obtain information from facilities

on the community service assurance, OCR has not yet used the information to plan its work or to monitor facilities' compliance.

OCR and BHF have not coordinated complaint investigations and compliance reviews or shared pertinent reports and data. Such coordination would be beneficial because complaints often involve both community service and uncompensated care issues. About 31 percent of OCR's complaints had also been recorded by BHF.

State Agreements

The 1979 regulations provided that both kinds of assurances would be federally administered, but allowed HHS to enter into formal agreements with States for administrative assistance.

The Public Health Service contacted all the States to determine if they wanted to help administer the assurances. As of February 1982, only six States (California, South Dakota, Minnesota, Ohio, Vermont, and Montana) had entered into formal agreements to administer the uncompensated care assurances.

Since assuming responsibility in December 1980, OCR has not solicited States to enter into agreements to help administer the community service assurance. As of February 1982, only California had entered into such an agreement.

We included California and Minnesota in our review, but could not determine how well they were administering the assurances because of the recency of the agreements.

The issues and problems identified during our review suggest a number of actions that could improve the administration of the uncompensated care and community service assurances. We are reluctant, however, to suggest actions that would require substantial additional resources when:

--The number of complaints filed against facilities and the number of serious violations found were relatively small when compared to the total number of Hill-Burton facilities.

--The number of facilities with uncompensated care obligations is rapidly decreasing. By 1985, about one-third of the facilities may have satisfied their obligations.

--Hill-Burton annual uncompensated care obligations at several facilities we visited were relatively low compared to the total amounts of charity care provided.

ADMINISTRATION OF THE HILL-BURTON RECOVERY PROVISIONS

Under titles VI and XVI of the Public Health Service Act, HHS is entitled to recover, within 20 years of construction, a portion of the value of Hill-Burton facilities

which are converted, sold, transferred, or otherwise no longer public or nonprofit health facilities. The right to recovery may be waived for good cause.

Through October 30, 1981, 61 recovery transactions had been completed and about $4.1 million recovered. Sixty-five other recovery actions were in process. As of the same date, BHF had granted 84 waivers of recovery, and 58 requests for waivers were being processed. All of these actions involved facilities funded under title VI.

To identify facilities that have changed their status, BHF relies on several sources of information--State health agencies, Health Care Financing Administration (HCFA) reports on Medicare facilities, the uncompensated service assurances reports, and national medical journals.

HHS' Office of Inspector General has completed a detailed audit of the recovery and waiver process and is now completing its report which may have suggestions for improvements. Although our work was limited we identified certain actions that could improve the recovery process.

Regional staff are instructed to periodically request information on ownership changes from HCFA regional officials. To assure that complete information is received in a timely manner, BHF should arrange to have HCFA automatically provide such information on a regular basis.

Also, BHF continues to use a draft manual, issued in October 1980, to communicate to regional office personnel the procedures for waivers and recoveries under title VI. For waivers and recoveries under title XVI, HHS had not developed regulations as of February 1982, although the legislation was enacted in 1975.

HHS should finalize the title VI waiver/recovery manual and develop regulations for title XVI waivers and recoveries.

ACTIONS TAKEN TO IMPROVE THE ADMINISTRATION OF THE HOSPITAL LOAN ASSISTANCE PROGRAMS

Our June 1979 report "Hospital Loan Assistance Programs: Actions Needed To Reduce Anticipated Defaults" (HRD-79-64) showed that HHS' monitoring of Hill-Burton loans was inadequate and that efforts to improve loan monitoring were unsuccessful. In that report, we recommended that the Secretary of HHS

--make comprehensive assessments to identify the risk of default on all loans,

--issue additional loan monitoring guidance and implement a viable loan monitoring program,

--closely monitor the financial status of loans secured with inadequate collateral,

--determine and monitor the status of hospital sinking funds, and

--advise the Congress of the potential losses and the adequacy of the loan default fund.

In response to our recommendation on comprehensive risk assessments, BHF developed the Loan Early Warning System (LEWS). This system screens all borrowers in BHF's loan portfolio and assesses the probability that they will default. We believe that LEWS is conceptually sound and should help detect problem borrowers.

Since initiating the LEWS pilot phase in 1978, however, BHF has experienced data base development problems, and as a result, the system's planned nationwide implementation has been delayed. BHF should focus attention on correcting the deficiencies in the LEWS data base.

Once completed, the LEWS data base will include 5 years' financial data from audited financial statements, which the system will use to analyze financial ratios, compare the financial performance of individual hospitals with the industry average, and develop an overall ranking of risk for the hospitals.

BHF has acted to implement a loan monitoring program by defining loan monitoring responsibilities and requiring regional loan officers to routinely analyze loans in their portfolio. Each quarter, BHF obtains a LEWS-generated list of potential problem facilities and regional office summaries of problem facilities. Once identified, problem facilities can be provided technical assistance. The number of facilities

experiencing serious financial problems decreased from 99 to 38 during fiscal year 1981.

Although BHF has identified loans secured with inadequate collateral, BHF cannot unilaterally improve the Government's position. However, when a borrower requests approval for new financing, BHF will approve the new financing only if the borrower agrees to provide additional collateral.

Several steps have also been taken to improve the Government's position in regard to facilities with sinking fund accounts. First, the BHF loan manual now requires applicants to formally agree to establish sinking fund accounts as part of the loan conditions. Regional loan officers must report whenever sinking fund requirements are not met.

BHF cannot, however, require facilities without sinking fund account agreements to establish such accounts unless a facility later requests approval for new financing. When this happens, BHF will modify the loan terms to require that a sinking fund be established.

Finally, our June 1979 report showed that many hospitals were experiencing financial problems serious enough to lead to defaults on guaranteed loans. Although the Congress established a $50 million default fund, in 1979 HHS was not certain whether this amount was adequate. Therefore, we recommended that the Department

advise the Congress of the potential losses on guaranteed loans and the adequacy of the fund. HHS did not concur with our recommendation, but agreed to notify the Congress if the fund required replenishment.

Because of HHS' improvements in monitoring Hill-Burton loans, HHS' position appears reasonable. Of the $50 million appropriated by the Congress in 1972 for the fund, about $45.8 million remained available as of September 1981.

Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions that you or other members of the Subcommittee have.