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REPORT TO THE CONGRESS 095029

Improving Federally Assisted Family Planning Programs

Department of Health, Education, and Welfare

BY THE COMPTROLLER GENERAL OF THE UNITED STATES

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

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

This report describes the operation of family planning programs assisted and monitored by the Department of Health, Education, and Welfare and suggests ways to improve the efficiency and economy of such programs.

We made our review pursuant to the Budget and Accounting Act, 1921 (31 U.S.C. 53), and the Accounting and Auditing Act of 1950 (31 U.S.C. 67).

We are sending copies of this report to the Director, Office of Management and Budget, and to the Secretary of Health, Education, and Welfare.

Comptroller General
of the United States

Contents

ABBREVIATIONS

AFDC	Aid to families with dependent children
GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare
HSA	Health Services Administration
NCHS	National Center for Health Statistics
SRS	Social and Rehabilitation Service
OEO	Office of Economic Opportunity

COMPTROLLER GENERAL'S REPORT TO THE CONGRESS

IMPROVING FEDERALLY ASSISTED FAMILY PLANNING PROGRAMS
Department of Health, Education, and Welfare

D I G E S T

WHY THE REVIEW WAS MADE

Federal expenditures for family planning have increased from about $84 million in fiscal year 1971 to about $217 million in fiscal year 1974.

Because of Federal funding and the Congress' interest in family planning as a necessary service, GAO examined administration and management of family planning programs in Illinois, Pennsylvania, and Texas. GAO's work was supplemented through additional observations in Kansas and Missouri.

FINDINGS AND CONCLUSIONS

Family planning programs have provided medical, social, and educational services to patients. In some instances, the medical care has resulted in the early detection and treatment of diseases.

However, family planning services could be improved and the efficiency and economy of family planning projects could be enhanced.

Delivery of family planning services to welfare recipients needs improvement

Welfare caseworkers have not adequately complied with the requirement to offer family planning services to appropriate welfare recipients and the Department of Health, Education, and Welfare (HEW) has not adequately monitored State implementation of the requirement.

Although HEW regulations require projects to give priority in providing family planning services to low-income persons, projects generally have not established procedures for enrolling such persons, especially welfare recipients. Coordination between local welfare offices and family planning projects has not been adequate.

Of 837 welfare recipients of childbearing age (ages 15 to 44) sampled in 3 metropolitan poverty areas:

--About 21 percent indicated they had discussed benefits and availability of family planning services with a caseworker. (See p. 14.)

--About 38 percent were using family planning services, but most obtained the services without assistance from welfare caseworkers or project personnel. (See p. 20.)

Of the 517 women in the sample who were not enrolled in a family planning program, 21 percent were interested in using family planning services. (See pp. 22 and 23.)

Of the 411 women in the sample not desiring to enroll in a family planning program, 34 percent did not give a reason and 13 percent cited such reasons as religion, planned pregnancy, threat to health,

etc., possibly without knowing the benefits of family planning. (See p. 23.)

Another sample of 524 patients enrolled in family planning clinics serving poverty areas in the same metropolitan areas showed that 222 patients had incomes in excess of HEW's low-income criteria.

However, 224 patients, or 43 percent, of the 524 patients were welfare recipients. The local welfare offices did not refer the majority of the recipients to the projects, but they learned of the projects from another patient, a friend, or a relative. (See p. 25.)

Such factors as lack of HEW guidance and monitoring and insufficient staff at the State and local level contributed to the failure to fully implement the requirement--set forth in 1967 amendments to the Social Security Act--that family planning services be offered to welfare recipients.

This situation still exists despite the 1972 amendments, which increased the Federal matching rate for family planning services to 90 percent.

The amendments also added a 1-percent penalty reduction in a State's funds for aid to families with dependent children for failure to offer and provide family planning services to welfare recipients desiring such services.

Until State welfare agencies emphasize to caseworkers the importance of complying with the requirement to offer and, on request, arrange for family planning services and until HEW's Social and Rehabilitation Service has a system and adequate staff to effectively monitor State implementation of the requirement, the 1972 amendments will do little to achieve the aims of the Congress. (See pp. 27 and 28.)

Improved program management needed

Family planning projects reviewed were providing an acceptable range of medical, social, and educational services to their patients.

But the projects' economy and efficiency could be enhanced by:

--Making greater use of third-party reimbursement programs, such as Medicaid, and collecting fees from persons able to pay. (See p. 31.)

--Performing adequate and prompt followup to reschedule patients who have missed appointments and reinstate patients who have dropped out of projects.

  Broken appointment rates ranged from 30 to 70 percent of scheduled appointments. Patient dropouts were also very high. GAO estimated that about 62 percent of the patients in the sample dropped out of some projects. (See p. 39.)

--Establishing criteria for monitoring and evaluating costs and performance of family planning programs, including more HEW audits.

  Great variations in average cost-per-patient visit were noted which, in GAO's opinion, seemed extreme. Within the three HEW regions, average per-visit cost ranged from $16 to $219. HEW audit effort needs to be increased and grantee responsibility for subcontractor operations needs to

be clarified. (See p. 43.)

Federal funding sources

Within HEW, four separate organizational units administer family planning programs under different legislative authorities.

The programs, as a result of legislative requirements, have different Federal-State sharing arrangements, eligibility requirements, and degrees of direct administration of the various funds.

The programs operate autonomously with little coordination among the organizational units. The Office of Population Affairs under the Secretary of HEW is the primary focus within the Federal Government for family planning services. (See ch. 2.)

Questionable usefulness of the national reporting system

Although HEW requires all family planning projects receiving Federal financial support to participate in a national reporting system, a number of projects do not report and others do not report regularly.

The HEW regional offices, States, and projects GAO visited concluded that reports generated by the national system were of little value. Also, the reports have been incomplete, inaccurate, and tardy.

RECOMMENDATIONS

GAO recommends that the Secretary of HEW direct the Administrator, Social and Rehabilitation Service, to:

--Establish a system and provide adequate staffing to (1) determine compliance and permit enforcement of the 1-percent penalty provision and (2) require States to report information needed for determining compliance. (See p. 28.)

--Require States to adopt policies emphasizing to caseworkers the importance of offering family planning services to welfare recipients and to closely monitor caseworker efforts. (See p. 28.)

--Encourage States to establish coordination between local welfare offices and federally assisted projects so that recipients interested in family planning can be identified and enrolled to assure that they receive services. (See p. 28.)

GAO also recommends that the Secretary direct the Administrator, Health Services Administration, to:

--Require family planning projects to establish procedures aimed at enrolling low-income persons, especially welfare recipients who desire such services. (See p. 28.)

--Provide technical guidance and assistance to projects to maximize use of third-party reimbursement programs and collection of fees from patients able to pay. The Administration should identify and help resolve problems that hamper projects from attaining State approval as providers of services eligible for reimbursement under such federally assisted programs as Medicaid. (See p. 50.)

--Direct projects to perform adequate and prompt followup on missed appointments and patient dropouts to assist in retaining patients. (See p. 50.)

--Establish criteria for monitoring and evaluating costs and performance of family planning programs. HEW audit effort should be increased and grantee responsibility for subcontractor operations should be clarified. (See p. 50.)

GAO further recommends that the Secretary have the information needs at various management levels (headquarters, regional office, State, project, and clinic) determined and have a reporting system or systems to meet these needs developed. (See p. 62.)

AGENCY ACTIONS AND UNRESOLVED ISSUES

HEW agreed with most of GAO's recommendations and reported actions taken or planned. HEW indicated that that some of its corrective actions would require a gradual process. (See pp. 10, 28, 50, and 63.)

Actions taken or planned, in most cases, should improve administration and management of federally assisted family planning programs. However, followup action will be necessary to determine effectiveness of or need for additional actions.

MATTERS FOR CONSIDERATION BY THE CONGRESS

This report describes the extent to which national goals have been met as prescribed by the legislative and executive branches since Federal family planning programs began.

CHAPTER 1

INTRODUCTION

In a July 1969 message to the Congress, former President Richard Nixon emphasized that no American woman should be denied access to family planning because of her economic condition. He set as a national goal the provision of adequate family planning services within the next 5 years to all those who wanted but could not afford them.

Family planning is a voluntary action by individuals to plan the number and spacing of their children--usually by preventing unwanted pregnancies but, in some instances, by enhancing fertility of persons desiring children. Family planning services provide the medical, social, and educational services necessary to enable individuals to meet their family planning objectives.

Medical services include gynecological examinations, urinalysis, blood pressure tests, venereal disease screening, pap smears, pregnancy testing, sickle cell anemia testing, services to overcome infertility, and provision of a variety of contraceptive methods.

Social services include assistance to patients needing transportation and/or child care in order to attend a clinic and referral and followup for patients having other medical problems.

Educational services include informing the community of the availability of services, counseling potential patients on the benefits of family planning, and advising patients on the advantages and disadvantages of the various contraceptive methods.

Until about 60 years ago, there were no organized family planning programs in the United States. The evolution of public support for family planning was slow due to legal, medical, and social constraints.

Before 1960, family planning services were generally limited to those who could afford them. Studies indicate, however, that the poor tend to have larger families because

they have less access to family planning information and cannot afford the services. Only a few States (all in the South) used Federal funds to help finance family planning services in the 1940s and 1950s. Since the 1960s, there has been a rapid rise in Government support for family planning services as a result of the concern for equal opportunity for the poor.

FEDERAL LEGISLATION

Legislation representing the principal sources of Federal funds for family planning services includes the Social Security Amendments of 1965 (Public Law 89-97), 1967 (Public Law 90-248), and 1972 (Public Law 92-603); the Economic Opportunity Amendments of 1967 (Public Law 90-221); and the Family Planning Services and Population Research Act of 1970 (Public Law 91-572). The provisions of these laws and funding information are discussed in chapter 2.

Several other federally supported health programs also provide family planning services but on a smaller scale. These programs include the Department of Health, Education, and Welfare (HEW) comprehensive health service programs, the HEW Indian Health Service, and the Department of Housing and Urban Development Model Cities Program.

CHAPTER 2

ADMINISTRATION AND FUNDING OF FAMILY PLANNING PROGRAMS

Family planning programs administered at the Federal level by the Social and Rehabilitation Service (SRS) and the Health Services Administration (HSA) under HEW are discussed below.

SOCIAL SECURITY ACT

Title XIX

Federal involvement in supporting family planning services expanded with the Social Security Amendments of 1965, which added title XIX--the Medicaid program--to the Social Security Act. Medicaid is a grant-in-aid program in which the States and the Federal Government share the cost of health care provided to persons entitled to public assistance under the Social Security Act (categorically needy). States have the option of including other persons whose income or other financial resources exceed State qualifications for public assistance but are insufficient to pay for necessary medical care (medically needy). Family planning was not a specific service identified within the program but could be a reimbursable service, depending on State administrative decisions.

The Social Security Amendments of 1972 added family planning services as a required Medicaid service for public assistance recipients and increased the Federal matching rate to 90 percent from various rates ranging from 50 to 83 percent. Family planning services paid by Medicaid may include appropriate medical examinations, diagnoses, medical counseling and treatment, laboratory services, surgical procedures, drugs, supplies, and devices provided in doctors' offices, clinics, hospitals, family planning centers, or other suitable settings. Services may be furnished or prescribed for both men and women, including minors considered sexually active. On December 9, 1974, HEW published proposed regulations in the Federal Register to implement the 1972 provisions; however, the increased Federal matching rate for title XIX had become effective on October 30, 1972.

The Medical Services Administration, SRS, administers title XIX funds. Title XIX funds are usually provided to the State welfare agencies but may also be administered by State health agencies or agencies created solely for this purpose.

Medicaid eligibles include the categorically needy and, at the State's option, the medically needy. The categorically needy, as defined by the States at the time of this review, were low-income people who qualified for one of several Federal-State public assistance programs--programs for the aged; the blind; the disabled; and families who had been deprived parental support due to death, disability, or absence. The categorically needy included most of the family planning patients also eligible under title IV-A of the Social Security Act. At the State's option, Medicaid services can be made available to low-income families with an unemployed father living with the family. The District of Columbia and 24 States have elected to take this option.

The medically needy are persons who meet the above categorical requirements and have income or resources that exceed State qualifications for public assistance but are not sufficient to pay for necessary medical care. Again, the District of Columbia and 24 States have elected to make Medicaid services available to medically needy persons. Family planning services are not, however, a required Medicaid service for the medically needy.

Title IV-A

The Social Security Amendments of 1967 authorized Federal funds for family planning services to be provided to eligible persons under part A of title IV, known as the Aid to Families with Dependent Children (AFDC) program. The AFDC program provides direct financial assistance to needy families as well as supportive social services, such as family planning, to assist them in moving from dependency to economic self-sufficiency. Other goals of the social services are to prevent or reduce illegitimate births, strengthen family life, and protect children. The amendments included a mandatory requirement for States to offer family planning services to present welfare recipients and, at the State's option, to certain former or potential

welfare recipients. State plans and periodic progress reports must be submitted to HEW to insure that steps are being taken to provide the services.

The Social Security Amendments of 1972 included new incentives for States to provide family planning services. Under title IV-A the mandate (i.e., offer of services) of the 1967 amendments was strengthened by requiring family planning services to be offered and, when requested, provided promptly to all current and to certain former or potential welfare recipients. The Federal matching rate for family planning services was increased from 75 percent to 90 percent as an incentive to the States to implement the 1972 amendments. Any State failing to offer and provide services to current recipients desiring them is subject to a 1-percent penalty reduction in its AFDC funds for the year.

Implementing regulations issued by HEW extended the coverage for family planning services to include all women--married or single, childless or pregnant, or mothers who meet financial eligibility requirements--however, the regulations' effective date has been postponed by law until October 1, 1975. However, the 1-percent penalty provision became effective July 1, 1972, and the increased Federal matching rate became effective on January 1, 1973.

The Assistance Payments Administration and the Community Services Administration, SRS, administer title IV-A funds at the Federal level, and the funds are usually provided to State welfare agencies for program administration at the State level. Each State determines eligibility requirements, which must include current welfare recipients. Family planning services may be provided, at the State's option, to former and potential welfare recipients--46 States provide some form of family planning services to potential welfare recipients, and 40 States provide some form of services to former welfare recipients.

Title V

The Social Security Amendments of 1967 authorized Federal funds under title V for family planning services as part of an overall program for promoting the health of mothers and children, particularly in rural areas and in

areas having a concentration of low-income families. Title V funding was provided through formula and project grants. Formula grants are apportioned among the States and administered under a State plan approved by HEW. Project grants are direct awards to public and nonprofit private organizations for family planning services exclusively or for a range of services, including family planning. Project funding under title V was scheduled to lapse on June 30, 1973, but a 1-year extension was authorized. Authority for direct project funding by HEW under title V lapsed on June 30, 1974, and the funded projects were to be merged into the States' formula grant program.

Title V requires each State to satisfactorily show that it plans to extend family planning services statewide by July 1, 1975. We sought information about the current status of State planning mechanisms for implementing the title V requirement. At our request, HEW obtained answers to certain questions that are summarized below for the 50 States.

Questions	Response		
	Yes	No	Unknown
Does State have a planning mechanism to extend family planning services statewide by July 1, 1975?	42	6	2
Does planning mechanism identify the following throughout the State:			
-Extent of need for family planning services through the title V program?	36	7	7
-Extent to which need is being met through the:			
title V program?	39	4	7
other programs?	40	4	6
-Resources required to provide services in areas not currently served?	34	9	7
-Plans for extending services through the title V program?	27	13	10

The Associate Bureau Director, Family Planning, and Associate Bureau Director, Maternal and Child Health, Bureau of Community Health Services, HSA, administered title V family planning funds. The Associate Bureau Director, Maternal and Child Health, administers formula grants provided directly to State health agencies. The Associate Bureau Director, Family Planning, administered project grants provided directly to State agencies or to other public or private organizations. The project grants were provided on a fund-sharing basis of 75 percent Federal funds and 25 percent State funds. These funds were intended for low-income areas, with the formula funds especially targeted for low-income rural areas. Persons served did not have to meet specific eligibility requirements.

PUBLIC HEALTH SERVICE ACT

Title X

Federal involvement in family planning services received increased emphasis when the Congress passed the Family Planning Services and Population Research Act of 1970. The act established, under title X of the Public Health Service Act, an Office of Population Affairs under the Secretary of HEW to serve as the primary focus within the Federal Government for family planning services. It also required the Secretary to develop and to report annually to the Congress the results of a 5-year plan for expanding family planning services.

Under the act, grants and contracts are placed with public and nonprofit private organizations to provide comprehensive voluntary family planning services to all persons desiring them. Formula grants to State health departments were also authorized but have never been funded. The authority for formula grants was eliminated by the Health Programs Extension Act of 1974 (Public Law 93-45). There are no eligibility restrictions under title X; however, the law requires that services be given to low-income persons as defined by Federal regulations. Nevertheless, projects are required to seek payment from third-party reimbursement sources, such as title XIX and title IV-A of the Social Security Act and private insurance.

The Associate Bureau Director, Family Planning, HSA, administers title X funds. The Federal share of title X project costs may vary but must be less than the total cost. The non-Federal share may be derived from (1) State or local funds; (2) identifiable in-kind expenses; (3) income from private sources, including health insurance; and (4) contributions.

ECONOMIC OPPORTUNITY ACT

Title II

The Economic Opportunity Amendments of 1967 designated family planning as a "special emphasis" component of the antipoverty program under title II. Family planning became one of eight national Office of Economic Opportunity (OEO) programs, such as Head Start, legal services, and neighborhood health centers, funded directly by OEO to assist eligible low-income persons to control fertility and improve their economic status. The President's fiscal year 1974 budget request included no direct appropriations for OEO but provided for the transfer of remaining family planning projects to HEW for continuing support or consolidation. This transfer was complete as of June 7, 1973.

FUNDING

The amount of Federal funds expended for family planning services by each of the above programs in fiscal years 1971, 1972, 1973, and 1974 is shown in the following table.

Legislative authority	Fiscal year 1971 Million	1971 Percent	1972 Million	1972 Percent	1973 Million	1973 Percent	1974 Million	1974 Percent
Title XIX of the Social Security Act (note a)	$ 6.5	7.7	$ 8.7	6.7	$ 18.2	9.3	$ 30.6	14.1
Title IV-A of the Social Security Act (note a)	12.3	14.6	28.2	21.7	53.4	27.2	56.0	25.8
Title V of the Social Security Act-formula grants (note a)	11.7	13.9	11.7	9.0	11.7	6.0	11.7	5.4
Titles V of the Social Security Act and X of the Public Health Service Act-project grants	30.0	35.6	57.3	44.1	98.0	49.9	118.8	54.7
Title II of the Economic Opportunity Act (note b)	23.8	28.2	24.0	18.5	15.0	7.6	(b)	(b)
Total	$84.3	100.0	$129.9	100.0	$196.3	100.0	$217.1	100.0

[a]Figures are estimates since exact amount applicable to family planning services was commingled with cost of other medical and social services.

[b]Administrative responsibility for OEO-funded projects was delegated to HSA on June 7, 1973.

As discussed above, federally assisted family planning programs are administered by four separate organizational units within HEW. The various programs involve different Federal-State sharing arrangements, different eligibility requirements, and different degrees of direct Federal administration of the funds made available for the programs. Such a situation could impede the delivery of family planning services in an efficient and economical manner. Its impact on the delivery of family planning services is discussed in chapter 4.

AGENCY COMMENTS

HEW has stated that some of the problems discussed in the report are caused by the fact that HEW's family planning programs are authorized by several separate legislative authorities. (See app. I.)

HEW noted the similarities between the authorizations under title X of the Public Health Service Act and the family planning project grants previously authorized under title V of the Social Security Act--both of which were administered by HSA. HEW stated that the formula grant program authorized under title V is administered by the States and that the individual State programs are not under direct Federal supervision.

According to HEW, the other two major family planning activities, authorized under titles IV-A and XIX of the Social Security Act, are incorporated in programs administered by SRS, not HSA, and are part of a social welfare program, not a health program. HEW stated further that the objectives of these programs differ from those of the HSA programs because the programs have been authorized to meet different objectives.

CHAPTER 3

DELIVERY OF FAMILY PLANNING SERVICES TO WELFARE RECIPIENTS NEEDS IMPROVEMENT

Improvement is needed in the delivery of family planning services to welfare recipients. HEW has not adequately monitored State implementation of the title IV-A requirement to offer services to recipients, nor has it required title X projects to establish procedures aimed at reaching low-income persons, especially welfare recipients. Consequently, federally supported family planning services for such persons have been hampered because:

--Welfare caseworkers have not adequately complied with requirements to offer family planning services to appropriate welfare recipients. (See p. 12.)

--Projects generally have not established procedures aimed at reaching low-income persons, the priority group established by HEW regulations. (See p. 24.)

--Coordination between local welfare offices and family planning projects has not been adequate. (See p. 26.)

Because of the above problems, we found the following conditions:

--Some welfare recipients who desired to use family planning services were not enrolled in a program and some were not aware of clinic locations.

--Many welfare recipients indicated no interest in using family planning services, but some recipients may have made this decision without knowledge of the social and economic benefits resulting from family planning.

--Some welfare recipients obtained family planning services without assistance from caseworkers or project personnel. In some instances, welfare recipients used services other than title X-funded projects.

--Title X projects were serving a number of patients with household incomes above the HEW "low-income" criteria. In some instances, projects were not aware of their patients' priority status because they did not require patients to provide income data.

A study issued in 1973 by a national private organization estimated that there were 5.7 million women of childbearing age in the United States living in households with insufficient incomes to pay for medical care (medically needy), and it was projected that there would be about 5.9 million such women by 1975. These women, between the ages of 15 and 44, are the primary target group for federally subsidized family planning services. Women who are welfare recipients are considered the "neediest" of the medically needy group.

To review local welfare department effectiveness in offering family planning services to welfare recipients and the effectiveness of projects in enrolling welfare recipients as patients, we selected metropolitan poverty areas in Chicago, Philadelphia, and Dallas. A local welfare office served each poverty area and it also had a title X-funded family planning clinic within its boundaries. The results of our review are discussed below.

COMPLIANCE WITH REQUIREMENT TO OFFER FAMILY PLANNING SERVICES TO WELFARE RECIPIENTS

SRS has not provided sufficient guidance to States for implementing the family planning requirement under the 1967 amendments to title IV-A. Also, SRS has not established reporting requirements and monitoring procedures to determine the degree to which States have implemented the amendments. SRS merely makes sure that the State plan includes a provision that the State will offer family planning services to appropriate recipients. SRS regional officials indicated that, because of a lack of staff, they did not monitor or evaluate the effectiveness of State implementation of the requirement.

Impediments to implementation cited by State and local welfare officials included insufficient caseworkers to handle the workload and the priority given to using available staff

resources to determine eligibility for welfare payments. Also, two States had implemented policies that did not permit full compliance with the title IV-A requirement. (See pp. 15 to 16.)

Certain factors, therefore, interfered with the full implementation of the 1967 amendments (i.e., offer of services) and they still exist, despite the provisions of the 1972 amendments. Until State welfare agencies emphasize to caseworkers the importance of complying with the title IV-A family planning requirement and until SRS has a system and adequate staff to effectively monitor State implementation of the requirement, the 1972 amendments will do little to insure that these services are offered and provided.

To determine whether States are complying with the requirement to offer, and when requested, promptly provide family planning services to appropriate welfare recipients, SRS must establish reporting requirements and monitoring procedures which, as a minimum, should include review of records or contacts with welfare recipients. We believe the procedures should provide for statistical sampling techniques, such as those already employed under a quality control system developed by HEW to maintain integrity in welfare programs. This existing system is a coordinated effort by HEW and the States to provide management with information indicating whether statewide rates of ineligibility and incorrect payments are within tolerance levels established by HEW. Such a system could be used in determining compliance with the title IV-A family planning requirement and in enforcing the 1-percent penalty provision.

For their part, States should define more clearly the caseworker's role in offering family planning services to appropriate recipients. This effort should not pose much additional work for the caseworker and could be accomplished routinely in processing new applicants and in redetermining eligibility for recipients.

Interviews conducted with a random sample of welfare recipients of childbearing age in Chicago, Philadelphia, and Dallas showed a need for improvement in welfare department emphasis on offering family planning services. The sample welfare recipients were selected from the welfare roles

between January and June 1973. The extent of caseworker effort in this area is indicated in the table below.

Question	Chicago		Philadelphia		Dallas		Total	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Has the caseworker ever initiated a discussion concerning family planning?								
Yes	87	28	14	5	78	29	179	21
No	225	72	246	95	187	71	658	79
Total responses	312	100	260	100	265	100	837	100

Caseworker efforts

Overall, only 179 recipients, or 21 percent of our sample, indicated that the caseworker had initiated discussion of the benefits and availability of family planning services. Conditions noted in the three areas in which the sample was taken and supplemented by observations in Kansas and Missouri are discussed below.

Illinois

The Illinois Department of Public Aid is responsible for administering the title IV-A requirement. The department is required by State law to provide family planning services to all welfare recipients of childbearing age who desire them, and public aid caseworkers are responsible for informing all recipients of the availability of such services.

Each new recipient is provided with an information sheet explaining family planning and how to obtain the services free. Recipients are instructed to contact their caseworkers for information on family planning.

Although new recipients are provided with some data (i.e., services and information sheets), we found that caseworkers did not verbally offer family planning to recipients. The major causes cited for the lack of caseworker effort were (1) priority given to determining financial eligibility for welfare rather than family planning needs and (2) insufficient caseworker staff to handle the workload.

Pennsylvania

The Pennsylvania Department of Public Welfare is responsible for administering the title IV-A requirement. The department has not issued adequate guidance to the local welfare departments to implement the title IV-A requirement, although it did issue various statements on family planning between December 1965 and March 1968. A State official advised us that these general statements continually changed the procedures to be followed by the caseworkers. Local welfare officials advised us that from 1968 to 1971 local welfare offices discussed family planning services only at the recipient's request. According to these officials, this policy was followed because of the substantial workload requirements in determining eligibility for welfare payments.

At a training session held in May 1972, caseworker comments concerning problems in discussing family planning included the following:

--Discussions about family planning are not recorded in the recipient's file because supervisors disapprove.

--Supervisors approve only of female caseworkers discussing family planning with recipients.

--Supervisors do not approve of family planning discussions with unmarried recipients.

--Supervisors have indicated to the caseworkers that the training sessions are a waste of time--that nothing will come of them.

A draft revision of the department manual in May 1972 provided additional guidance for caseworkers in discussing and offering family planning services. However, the draft was not issued or formalized.

Consequently, local welfare offices have continued the practice that recipients must initiate a request for family planning services. For the welfare office reviewed, we estimate that only 7 percent of the 6,400 case folders contain documentation that family planning services were discussed with the recipient. However, this estimate may be low to the extent that family planning discussions did occur but were never recorded in the case folders, because (1) workload requirements may have precluded caseworkers from documenting offers of family planning services and (2) offers of family planning services may not have been recorded in anticipation of disapproval by the caseworkers' supervisors. State officials planned to take action to insure that family planning services were offered to welfare recipients.

Texas

The Texas Welfare Department is responsible for implementing title IV-A within the State. When an applicant is determined to be eligible for AFDC benefits, she is given a pamphlet explaining the various social services available, including family planning. A card is also enclosed and, if the applicant desires a service, she must return the card indicating her interest. She will then be contacted by a social worker.

The welfare department procedures manual requires that welfare workers initiate discussions of contraception with those AFDC family members who have had children out of wedlock in the past 2 years and refer them to a medical family planning resource if the recipient indicates an interest. In our opinion, the above directive is too restrictive in that it does not require caseworker discussion with many other AFDC recipients who may be interested in family planning.

Missouri

The Division of Welfare of the Missouri State Department of Public Health and Welfare administers title IV-A. The social services and the public assistance manuals require that caseworkers inform recipients about the availability of family planning services in their community. However, 28 of the 32 eligibility caseworkers and 7 of the 12 social services caseworkers interviewed in 1 county stated they knew of no requirements to mention family planning to applicants or recipients.

The following observations or comments resulted from our visit to a county welfare office in Missouri:

--Because of the separation of the assistance payments and social services functions, some eligibility caseworkers are reluctant to discuss services, including family planning; their supervisors have told them to stay out of the services area.

--No family planning literature is available for distribution by the eligibility caseworkers.

--The application for AFDC contains no reference to the availability of family planning.

--Most of the eligibility caseworkers were young. Some expressed reluctance to discuss family planning with people older than themselves.

--Some of the eligibility caseworkers may not have time to discuss family planning with applicants because the intake section is understaffed.

--Many caseworkers are inexperienced due to a high turnover of personnel.

--Some caseworkers said they did not know where to refer applicants for family planning; therefore, they do not bring up the subject.

--Because of understaffing only about 12 percent of AFDC recipients in the county are receiving social services.

--Because home visits are not required to approve an application for AFDC in the county, the initial contact applicants have with welfare personnel is during a short interview with the intake worker while filling out an application. If the application is approved, the recipients may never see any other welfare personnel until their eligibility is redetermined, some 6 to 12 months later.

--Because about 50 percent of AFDC applications are rejected, intake workers are reluctant to discuss services with applicants.

--Some of the caseworkers indicated they would not bring up family planning unless the applicant had at least two illegitimate children.

Kansas

The Kansas State Department of Social and Rehabilitation Services administers title IV-A. State personnel said all caseworkers are required to inform recipients that family planning services are available.

We interviewed eligibility and social service caseworkers in two county welfare offices. In both counties

--a new application form, effective January 1974, asks whether the applicant understands that family planning services are available under the State's plan for medical assistance;

--intake workers said they discuss family planning if the applicants ask questions; and

--service workers generally agreed they are required to discuss family planning.

The social service workers in one county said they frequently do not have an opportunity to discuss family

planning because the size of their caseloads and the nature of their clients' problems demand that they give priority to emergency situations. As one service worker explained, it is inappropriate to discuss family planning with someone who has been evicted from her home, has problems with drugs or legal authorities, or has emotional disorders. They also complained that an increasing amount of their time is taken by the administrative chore of filling out forms and reports.

Our interviews with 13 service workers and review of 16 case files in the other county indicated that family planning is usually discussed with clients. Some of the service workers complained about not having received any special training or guidance to better enable them to discuss family planning with a minimum of embarrassment to themselves and the client.

In both counties, applicants talk to a service worker only when they wish to request services. Although officials in one county could not provide an estimate, officials in the other county estimated no more than 40 percent of their applicants see a service worker.

Use of family planning services

Responses by randomly sampled welfare recipients showed that they were using a number of different sources of family planning services and methods of payment. Responses by patients using title X projects showed that many patients had income in excess of the HEW low-income criteria. The projects were serving a number of welfare recipients but not as a result of welfare office or project assistance. Usually recipients learned about the services from another patient, a friend, or a relative.

A total of 837 welfare recipients of childbearing age in Chicago, Philadelphia, and Dallas were interviewed to determine the extent to which family planning services were being used, the sources of services, and the methods of payment. The table on the following page indicates the results of the interviews.

Questions	Chicago Number	Chicago Percent	Philadelphia Number	Philadelphia Percent	Dallas Number	Dallas Percent	Total Number	Total Percent
Is the recipient using a family planning method?								
Yes	147	47	101	39	72	27	320	38
No	165	53	159	61	193	73	517	62
Total responses	312	100	260	100	265	100	837	100
Who is providing the services?								
-Title V or X facility	52	35	21	21	54	75	127	40
-Private physician	50	34	19	19	13	18	82	25
-Other (hospital, planned parenthood, etc.)	45	31	61	60	5	7	111	35
Total responses	147	100	101	100	72	100	320	100
Who pays for the services?								
-Free	77	52	23	23	57	79	157	49
-Medicaid	63	43	77	76	10	14	150	47
-Recipient	7	5	1	1	5	7	13	4
Total responses	147	100	101	100	72	100	320	100

Although only 21 percent of those in our sample indicated that the caseworker had initiated a discussion of family planning services (see p. 14), 320 recipients, or about 38 percent of our sample, were currently receiving family planning services.

Only 127 recipients, or about 40 percent of our sample of those using a family planning method, used a title V- or X-funded project. An additional 82 recipients, or 25 percent of those using a family planning method, used the services of private physicians; the remaining 111 recipients, or 35 percent, used family planning clinics associated with hospitals, private organizations, or comprehensive health centers, which generally were located in poverty areas.

Of the 320 welfare recipients currently receiving family planning services, 150 recipients, or 47 percent, indicated that the services were paid for by Medicaid. An additional 13, or less than 5 percent, indicated that they paid for the services themselves. In our opinion, the lack of adequate caseworker counseling contributed, in part, to recipients using their own assistance resources to pay for services although they were eligible under Medicaid.

Potential for increased use of family planning services by welfare recipients

There is potential for a substantial increase in the use of family planning services by welfare recipients. On the basis of our sample of 837 welfare recipients, we estimate that about 1,610 of the 14,000 women of childbearing age receiving welfare in the poverty areas sampled were not using family planning but were interested in enrolling in a family planning program.[1] We also estimate that about 3,280 women would indicate no interest in using family planning but could be women who did not receive adequate counseling.[2]

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[1]On the basis of the 95-percent confidence level, plus or minus 320 welfare recipients.

[2]On the basis of the 95-percent confidence level, plus or minus 490 welfare recipients.

Welfare recipients in our sample who were not using family planning services were interviewed to determine (1) how many were interested in using family planning and (2) the reasons they were not interested. Interviews with the 837 randomly sampled welfare recipients showed that 517, or 62 percent, indicated that they were not currently receiving family planning services. (See p. 20.) The table on the following page summarizes responses by these welfare recipients.

As shown by the responses, 106 recipients, or about 21 percent, were interested in enrolling in a program. Many of these recipients were not aware of service sources or clinic locations. It is evident that their family planning needs were not being fulfilled. Proper counseling by their welfare caseworkers probably would have motivated these women and some of the disinterested recipients to enroll in a family planning program. There was potential for additional enrollments from the 138 recipients (34 percent) who indicated no interest in family planning without further explanation and the 55 recipients (13 percent) not interested for other reasons. Effective discussion by caseworkers could have helped these recipients in determining whether family planning would be helpful in meeting their families' social and economic goals.

An official from the Chicago clinic informed us that the clinic was operating at about 75-percent capacity. In Dallas and Philadelphia, project officials said the clinics do not have waiting lists or backlogs of patients awaiting service. In Dallas any woman is served, including those who come to the clinic without a prior appointment. The Dallas clinic is obtaining additional space for two examining rooms to increase its capacity by about 40 percent.

Because it appears that clinics in the same poverty areas as the welfare offices sampled were not operating at capacity, and in view of the significant potential for increased use of family planning services by welfare recipients, increased emphasis by both welfare caseworkers and project personnel is required to identify and enroll recipients who desire the services.

Questions	Chicago Number	Chicago Percent	Philadelphia Number	Philadelphia Percent	Dallas Number	Dallas Percent	Total Number	Total Percent
Does the recipient wish to enroll in a family planning program?								
Yes	40	24	25	16	41	21	106	21
No	125	76	134	84	152	79	411	79
Total responses	165	100	159	100	193	100	517	100
If no, why not?								
-Tubal ligation	21	17	31	23	72	47	124	30
-Hysterectomy or other surgery	18	15	29	22	26	17	73	18
-Pregnant	5	4	5	4	10	6	21	5
-Not interested (no further explanation)	64	51	39	29	35	23	138	34
-Other (religious, not living with husband, planned pregnancy, threat to health, etc.)	16	13	30	22	9	6	55	13
Total responses	124	100	134	100	152	99	411	100

PROCEDURES FOR ENROLLING LOW-INCOME PERSONS

Title X provides for comprehensive voluntary family planning services to all persons desiring them. HEW regulations require that projects receiving title X funding give priority in providing family planning services to low-income persons.

Most of the title X projects visited had not established procedures directed toward enrolling the priority population of low-income persons, especially welfare recipients.

In order to evaluate the effectiveness of projects in delivering family planning services to the priority group, we selected a random sample of 524 patients served at specific locations. Our sample clinics served the same general areas as the local welfare offices in the sample discussed previously.

In evaluating whether a family planning patient was a member of a "low-income family" we applied the following criteria set forth in the Code of Federal Regulations (42 CFR 59).

Low-income family means a social unit composed of one or more individuals living together as a household and whose total annual income, less certain expenses such as childcare, union dues, and carfare, is not in excess of:

--$2,500 in the case of one such individual;

--$3,400 in the case of two such individuals;

--$4,200 in the case of three such individuals;

--$5,000 in the case of four such individuals;

--$5,800 in the case of five such individuals;

--$6,400 in the case of six such individuals; and

--$7,000 in the case of seven or more such individuals.

The results of our random sample are shown below.

	Chicago		Philadelphia		Dallas		Total	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Patients interviewed	260	100	149	100	115	100	524	100
Results of interview:								
-Number of patients below low-income	162	62	66	44	74	64	302	58
-Number of patients above low-income	98	38	83	56	41	36	222	42
Total responses	260	100	149	100	115	100	524	100
Patients with income above HEW criteria range:								
-Up to 10 percent	4	4	5	6	8	19	17	8
-11 to 30 percent	17	17	12	14	13	32	42	19
-31 to 50 percent	26	27	15	18	8	20	49	22
-Over 50 percent	51	52	51	62	12	29	114	51
Total responses	98	100	83	100	41	100	222	100

Our sample showed that of the 524 patients interviewed, 222, or 42 percent, had incomes more than the HEW low-income criteria. However, 224 patients, or 43 percent, of the sample were welfare recipients and ranged from a low of 35 (30 percent) in the Dallas sample to a high of 133 (51 percent) in the Chicago sample.

The projects we visited in each State indicated that most new family planning patients knew of the program from another patient, a friend, or a relative. Although a substantial number of the project enrollees were welfare recipients, these recipients were not enrolled as a result of project efforts. Projects had not established procedures aimed at enrolling low-income persons and generally did not coordinate with the local welfare offices to identify and enroll welfare recipients interested in family planning. Also, since patients were not required to provide income data, some projects were not aware of their patients' priority status.

COORDINATION BETWEEN LOCAL WELFARE OFFICES AND PROJECTS

We inquired about the coordination between local welfare offices and projects for enrolling recipients interested in family planning. In most instances, the offices and projects did not coordinate their activities to identify and enroll recipients who desired service. Conditions noted in each State are presented below.

Illinois

Representatives for one project speak periodically at staff meetings held by the local welfare office. Statistics maintained on this project showed that 114 recipients were referred by the welfare office during fiscal year 1973. At another project, representatives discussed the clinic facilities with the local welfare office when the program began in January 1972. They also provided family planning brochures to the welfare office for distribution to recipients. There has been little or no further coordination, and a report for fiscal year 1973 showed that only six patients were referred to the project by the local welfare office. This project was operating at about 75 percent of capacity.

A representative of a third project was unaware of any coordination with the local welfare office or referrals of welfare recipients for family planning services. Additional workload has not been solicited by this project because it is operating at full capacity. A report for fiscal year

1973 showed that only eight patients were referred to the project by the local welfare office.

Pennsylvania

The three projects visited in Pennsylvania did not effectively coordinate with local welfare offices to identify recipients interested in family planning services. Projects generally advised the welfare offices of clinic locations and, in some instances, provided program literature. According to project records, welfare offices ranked very low as a referral source for new family planning patients. Two of the projects have not taken any action to establish ongoing coordination so that recipients interested in family planning can be identified, referred, and followed up to assure services. The third project has taken action to increase welfare referrals.

Texas

An official at one project agreed that coordination with the local welfare office needed strengthening. The project provided a tour of the family planning facility for welfare caseworkers several years ago but no systematic referral mechanism has been established. Consequently, referrals from the welfare office are minimal.

At two other projects we were advised there is little or no coordination with the local welfare office.

CONCLUSIONS

The provision of family planning services to low-income persons, especially welfare recipients, needs to be improved. Offering of family planning services by welfare caseworkers, better coordination between local welfare offices and federally assisted projects, and improved procedures should help to identify and enroll recipients desiring services.

Improvement is needed in HEW monitoring of State and project efforts for providing services to low-income persons. The conditions noted in our review still exist despite the provisions of the 1972 amendments. Until HEW has a system

and adequate staff to determine compliance and to enforce the 1-percent penalty provision, the 1972 amendments will do little to insure that these services are offered.

RECOMMENDATIONS TO THE SECRETARY OF HEW

We recommend that the Secretary of HEW direct the Administrator, SRS, to:

--Establish a system and provide adequate staffing to (1) determine compliance and permit enforcement of the 1-percent penalty provision and (2) require States to report information needed for determining compliance.

--Require States to adopt policies emphasizing to caseworkers the importance of offering family planning services to welfare recipients and to closely monitor caseworker efforts.

--Encourage States to establish coordination between local welfare offices and federally assisted projects so that recipients interested in family planning can be identified, enrolled, and followed up to insure that they receive desired services.

We also recommend that the Secretary direct the Administrator, HSA, to require family planning projects to establish procedures aimed at enrolling low-income persons, especially welfare recipients.

AGENCY COMMENTS AND OUR EVALUATION

HEW generally concurred with our recommendations. (See app. I.)

HEW stated that:

--Certain actions have already been taken to establish a system to determine compliance and permit enforcement of the penalty provision.

--Guidelines have been issued to the States on the major actions they will be held accountable for in delivering family planning services.

--Most States have issued instructions to local jurisdictions on implementing monitoring systems to insure compliance with the penalty provision.

--A monitoring system will be developed gradually due to the differing degrees of development among the various State systems and the varying methods and sources of family planning services provided under different titles of the Social Security Act.

--Instructions have been issued to States emphasizing the importance of offering family planning services to welfare recipients.

--HEW is developing monitoring instruments for use by HEW regional offices to monitor State activities and for use by State agencies to monitor local agency performance.

--The importance of coordination between the States' welfare departments and federally assisted family planning projects is being emphasized by regulations and program instructions. Clients do have the right, however, to select the medical service providers, which may be private physicians, federally assisted family planning projects, county health department clinics, or private clinics.

Regarding our recommendation that family planning projects be required to establish procedures aimed at enrolling low-income persons, especially welfare recipients, HEW:

--Told us regional family planning officials have been working with Federal and State officials to coordinate the provision of family planning services to welfare recipients and low-income individuals.

--Provided information on the extent to which family planning projects used title IV-A and title XIX funds as a reimbursement source during fiscal year 1974.

--Told us that priority has been given to low-income persons in that over 70 percent of the persons served by organized family planning programs in fiscal year 1974 were low-income individuals and over 15 percent were from families on welfare.

--Told us efforts are continuing to inform priority persons and provide services to all who want but cannot afford them.

After we received HEW's comments, an HEW official told us that the above 70-percent figure represents the number of persons served by organized family planning programs who had incomes below $6,810. This income level, used in a special study made for HEW, was arrived at by assuming that the poverty level for a nonfarm family of four was $4,540 and that low income was 150 percent of that poverty level. The study showed that about 49 percent of persons served were below the poverty level.

CHAPTER 4

NEED FOR IMPROVED PROGRAM MANAGEMENT

Family planning programs examined in Illinois, Pennsylvania, and Texas were providing an acceptable range of medical, social, and educational services to the patients enrolled. In some instances, the medical care resulted in the early detection and treatment of disease. However, improvement in title X program management could enhance economy and efficiency by:

--Making greater use of third-party reimbursement programs and collecting fees from persons able to pay so that Federal grant funds are used most productively. (See p. 31.)

--Following up, in appropriate cases, to reschedule patients who have missed appointments and to reinstate patients who have dropped out of projects. (See p. 39.)

--Establishing criteria for monitoring and evaluating family planning programs, including more HEW audits. (See p. 43.)

--Strengthening procurement practices. (See p. 48.)

EXTENT OF THIRD-PARTY REIMBURSEMENT

HEW regulations require that title X family planning projects seek third-party reimbursement for services whenever appropriate. Program funds for title XIX (Medicaid), title IV-A (AFDC), and patient fees constitute the most likely revenue sources available to family planning projects.

Effective January 1, 1974, HEW modified its funding policy for health service delivery projects, including family planning projects, to require that such projects recover third-party reimbursements and other revenue to the maximum extent possible so that Federal grants will be used most productively. More intensive effort on the part of health service delivery projects is required to (1) maximize

the amount of project services paid through third-party reimbursement mechanisms; (2) use fully all other Federal, State, local, and private sources of funding; and (3) charge individuals according to their ability to pay for services provided. The policy that no person should be denied services solely because of an inability to pay and that priority should be given to persons from low-income families remained unchanged.

Factors limiting third-party reimbursement

Some of the barriers to effective use of reimbursement mechanisms are described below:

--Many clinics provide a comprehensive set of services, including outreach, counseling, referral, education, social services, and medical services. Many of the nonmedical services are not reimbursable under Medicaid.

--Many clinics have inadequate accounting and billing systems. Few clinic personnel are well trained in eligibility screening, benefit structures, accounting procedures, claims preparation, and related procedures.

--Some payment programs are not obligated to pay the full cost of covered services. Even when a clinic can identify the cost of the specific services the reimbursement rate may not be adequate. This gap could be quite large, particularly under Medicaid in some States.

--Many clinics are not recognized as eligible for medical reimbursement, partly because they have not pursued this status diligently and partly because State agencies have delayed recognition through uncertainty about the application of regulations to specific cases.

Our review showed that family planning projects must improve their use of Federal third-party reimbursement programs (titles XIX and IV-A) and establish fee schedules for persons able to pay for their services. HEW needs to

provide technical assistance and guidelines for the accomplishment of these goals.

Title XIX--Medicaid

Under the 1965 amendments to the Social Security Act establishing title XIX, family planning services could be provided to cash assistance recipients at the State's option. Although most States elected to provide family planning services, the services and conditions under which they are provided vary widely among States. Some States do not reimburse the cost of services provided by free-standing clinics (not affiliated with a hospital). Also, some States discourage the use of the Medicaid program (supported by Federal and State funds) to reimburse title X projects for services to eligible Medicaid patients because such reimbursement would increase expenditures of State funds under Medicaid for title X project services already supported by Federal and local funds.

The 1972 amendments to title XIX of the Social Security Act made family planning a required Medicaid service for cash assistance recipients and increased the Federal matching rate to 90 percent from a variable range of 50 to 83 percent. The State matching share was reduced to 10 percent.

Implementing regulations for the Medicaid portion of the 1972 amendments had not been issued as of February 1974. It is unlikely that a significant increase in reimbursements from Medicaid for family planning services will occur unless States recognize free-standing clinics as approved Medicaid providers and unless States are willing to contribute 10 percent of the cost under the more liberal Federal-State (90-10) sharing arrangement.

Few third-party payments had been received by the projects we visited even though an average of 20 percent of the patients were eligible for Medicaid.

Conditions noted in the three States reviewed are discussed below.

Illinois

The Illinois Family Planning Council is responsible for statewide services in Illinois. Of the 80,000 patients served by 45 council provider agencies, about 20 percent are identified as eligible for Medicaid. At the time of our review, we were advised by a council official that a third-party reimbursement took as long as 4 months. Because eligibility status can change, it was difficult to prove that a patient was eligible for Medicaid services at the time service was provided. Effective September 1973, however, the council negotiated a contract with the Illinois Department of Public Assistance providing for Medicaid third-party reimbursements for all council provider agencies. The contract is expected to alleviate the above problems.

We visited three agencies of the council to obtain information on the use of third-party reimbursement programs. Two of the agencies said they had not sought third-party reimbursement because it was not required as part of the funding agreement with the council. An official of the third agency said it sought third-party reimbursements whenever possible but had collected only about $18,000 from Medicaid during calendar years 1971 and 1972. At the time of our review, the provider was reimbursed on the basis of $9.61 per patient visit for Medicaid patients.

Pennsylvania

Under the Medicaid program the State reimburses all family planning services furnished by State-approved providers. However, if a clinic provides free services, the State does not recognize the clinic as an eligible provider for Medicaid reimbursements. A State Medicaid official said it is not logical to provide State funds under Medicaid to a clinic that is already federally funded and providing free services to all participants. The maximum reimbursement rate for family planning services in Pennsylvania is $6 per visit, which is considerably less than project costs. Since most title X projects provided free services, they obtained very little third-party reimbursement from Medicaid. Some projects, unable to establish reimbursement agreement with the State, required Medicaid patients

to obtain contraceptive pills from local pharmacies which, in turn, received Medicaid reimbursement. In our opinion, this practice makes uneconomical use of both Federal and State funds because the pills could have been supplied by the project at a much lower cost.

We visited three projects in Pennsylvania to obtain information on the use of third-party reimbursement programs.

An official at one project advised us that no Medicaid reimbursements were obtained from the State even though about 20 percent of the project's estimated 8,600 patients were eligible for Medicaid. This project attempted to obtain approval to participate in the Medicaid program in July 1972; however, the State disapproved the application because the project provided free services and had no fee schedule.

At another project, about 35 percent of the 11,000 patients served were eligible for Medicaid. Again, the project was unable to obtain State approval for Medicaid because the State was reluctant to provide funds under Medicaid to a project already federally funded under title X. Lack of guidance from the State Medicaid agency was also cited as a factor impeding third-party reimbursements.

Officials at a third project indicated that Medicaid reimbursements were obtained at a rate of $6 per visit. The project had received Medicaid funds of about $282 as third-party reimbursements for 47 eligible patients during January, February, and March 1973, even though 15 percent of the 1,700 patients were eligible. Records indicate that the project had been an approved provider under the Medicaid program since 1966 because it is a delegate agency of a national family planning program approved by the State.

Texas

The Texas Department of Public Welfare has contracted with a private organization to administer its Medicaid program. All Medicaid recipients receive a monthly card certifying their eligibility and only persons with current Medicaid cards can receive family planning services under the program.

Providers of family planning services bill the private organization which, in turn, is reimbursed by the welfare department on a monthly basis. Officials informed us that reimbursements are made on an individual basis at standard rates for services provided.

The three projects we reviewed were not obtaining third-party reimbursements. Only hospitals and private physicians were reimbursed for family planning services to Medicaid patients because the necessary State matching funds to extend the program to other providers, such as title X projects, was not expected to become available until sometime in fiscal year 1974. We did not obtain data on the percentage of Medicaid eligibles served by 2 of the projects, but about 10 percent of the 8,700 patients served by the third project were eligible for Medicaid. All three projects anticipated third-party reimbursements from Medicaid when State matching funds became available and procedures were established for reimbursement.

Supplemental information on Missouri and Kansas follows.

Missouri

The Division of Welfare administers the Medicaid program and reimburses providers who have signed agreements with the State. Family planning clinics are not recognized as eligible Medicaid providers. State officials said the legality of using State funds to reimburse a federally funded clinic is being studied by the division's legal staff. Payments are, however, made to physicians for services provided, whether in their offices or at clinics.

Payments for contraceptives under Medicaid are presently limited to oral contraceptives and intrauterine devices. Physicians' services for fitting a diaphragm are reimbursable but the cost of the diaphragm is not. Nonprescription contraceptive devices or supplies are not covered, according to State officials, because of the problems involved in setting reasonable reimbursable costs for products that have a wide disparity in wholesale costs. They also stated the quantities obtainable would be difficult to set.

Missouri is claiming 90-percent matching under Medicaid for only a limited number of family planning services, such as vasectomy, tubal ligation, insertion of intrauterine devices, and office visits specifically for contraception. Payments allowed for these services are limited; for example, a visit to a doctor's office is limited to $6 and a maximum payment for a vasectomy is $60. The State does not claim 90-percent matching for other family planning services, such as Pap smears and laboratory tests, because of the lack of HEW regulations and difficulties in determining whether these services were rendered as part of a family planning program.

Officials at the two family planning projects visited advised us that the State would not recognize their clinics as Medicaid providers.

Kansas

In Kansas the State Department of Social and Rehabilitation Services administers the Medicaid program, which is designed to provide medical care for all people in the public assistance categories as well as in an additional group classified as medically needy. A State official said a relatively small number of people meet the medically needy criteria.

Family planning clinics have not been authorized as Medicaid providers because they do not meet all the requirements for participation, such as (1) establishing a fee schedule, (2) asking every individual served if she has third-party benefits, and (3) billing all third-party payers for reimbursable services.

Kansas has not claimed any 90-percent Federal matching for Medicaid expenditures. The matching formula for family planning services has been the same as for other Medicaid services (52 percent Federal) because family planning services have not been segregated. An official said the major problem in making such a segregation is in differentiating between medical procedures performed for family planning and the same procedures performed for other purposes. In January 1974 the State officials were considering alternative methods for identifying family planning services.

Officials of the family planning clinics in one county said it is impractical to seek third-party reimbursement agreement from Medicaid because the cost of setting up and operating accounting and billing systems would exceed the expected benefit; few of their patients are eligible for Medicaid.

Title IV-A--AFDC

There is little monitoring by the SRS regional staffs of family planning contracts or third-party reimbursement agreements between State welfare agencies and federally funded projects. SRS generally does not review or approve the contracts, nor does it require States to submit detailed expenditure reports showing the extent to which title IV-A funds are used as third-party reimbursement sources by family planning projects.

Title IV-A funds were not used as a third-party reimbursement source by the projects we visited. Project officials cited the inability to obtain State or local matching funds as one reason. Also, the 25-percent matching required under the 1967 amendments and, more recently, the 10-percent matching required under the 1972 amendments must be in cash. Project officials advised us that it is very difficult to obtain funds from local sources.

In addition, project officials indicated that title IV-A was not used as a revenue source because of the fiscal complexities in establishing contracts with the State agency. Most projects do not serve welfare recipients exclusively and therefore must account separately for services provided to recipients.

There is confusion as to the intended use of title IV-A funds as a third-party reimbursement source for title X projects. Project officials are uncertain whether title IV-A funds may be used to reduce direct project funding or must be used to expand the overall project program.

In June 1971 HEW issued a memorandum to its regional offices to clarify policies on the use of title IV-A funds to purchase services, including family planning. HEW informed the regional offices that the 1967 amendments to the

act require States to use title IV-A funds to supplement rather than supplant other public support so that Federal financial assistance under title IV-A can expand the total amount of services provided to poor people.

HEW officials advised us that the June 1971 memorandum was still in effect and that its policy contradicted, to some degree, title X requirements for projects to obtain third-party reimbursement as a means of reducing the need for direct Federal financial support. HEW needs to provide further clarification to State welfare agencies and to title X family planning projects of the conditions under which title IV-A funds may become a third-party revenue source.

Fee schedules

A potential source of revenue to the projects is the charging of fees to patients who may be able to pay part or all of the cost of family planning services. On the basis of our random sample of patients at the three projects (see p. 25), it appears that about 42 percent of the patients served had income in excess of the HEW low-income criteria but received services free of charge. The projects we sampled were in metropolitan poverty areas. It is possible, therefore, that projects in areas with less poverty are serving an even higher percentage of patients with income above the low-income criteria.

Most of the projects visited had not instituted fee schedules, although some projects were considering such a practice. In our opinion, HEW should emphasize the need for projects to establish and collect fees to maximize revenues and reduce reliance on direct Federal financial support. In addition, the establishment of fee schedules could help projects to obtain approval as Medicaid providers.

FOLLOWUP ON MISSED APPOINTMENTS AND PATIENT DROPOUTS

Followup efforts of some projects were limited because procedures were not established. Other projects had, however, implemented followup procedures which appeared to be prompt and effective. Still others maintained reports on followup statistics that did not identify clinics separately,

making it impossible to evaluate patient followup performance for individual clinics.

We recognize that some project dropouts--patients who have not been seen by clinic personnel in 15 months--may continue using a contraceptive method, but it appears reasonable that retention of patients within the program assures better contraceptive control and provides continuing medical supervision. Since the prevention of unwanted pregnancies is a continuous process, prompt followup of missed appointments is important to determine if the person desires to continue in the program or, if not, to obtain data on the reasons. Such information could be useful in patient retention. Some patient turnover is to be expected as a result of menopause, tubal ligations, or hysterectomies.

Our random sample of patients for two projects in Philadelphia and one project in Dallas showed that patient dropouts were very high. Of 906 patients sampled, 562 patients, or 62 percent, had dropped out of these projects since their inception. Details are shown below.

Project location	Number of patients	Patient dropouts	
		Number	Percent
Philadelphia	649	428	66
Dallas	257	134	52
Total	906	562	62

Dropout statistics for the project selected in Illinois for sampling purposes were not readily available. The project did not consider a patient a dropout until after 18 months of inactivity and the project had been in operation less than 18 months at the time of our review.

Many of the projects we visited experienced high broken appointment rates ranging from 30 to 70 percent. We inquired into the extent of followup performed on missed appointments. Conditions noted in each State are discussed on the following pages.

Illinois

At one project, there are no followup procedures for missed contraceptive pill resupply appointments. After a missed annual appointment, the patient is contacted by telephone and, if that is unsuccessful, by letter to arrange a new appointment. If the patient decides to drop out of the program, the project requests the patient to complete a questionnaire furnishing comments about the project's operation. The annual dropout rate for the clinic is about 25 percent.

At another project, an outreach worker contacts the patient either by telephone, letter, or field visit if the patient has missed an appointment. Pill resupply visits are coordinated with medical visits scheduled at 6-month intervals. No dropout statistics were available for this project because it had been operating less than 18 months at the time of our review, and a patient was not considered a dropout until after 18 months of inactivity.

The third project we visited had no followup system for patients who failed to keep appointments or dropped out of the program. However, project officials said procedures would be implemented to reach these patients by letter or telephone. Pill resupply visits were coordinated with medical visits scheduled at 6-month intervals.

The Illinois Family Planning Council operates an automated patient-tracking system which is capable of producing missed appointment listings for its provider agencies. However, council officials said they did not use the system for this purpose because the data would be 30 days old and of limited value to the provider agencies for followup. Further, officials indicated that the provider agencies preferred manual followup since it was more prompt. In view of the variations in followup practices noted at the three provider agencies visited and because the council has a total of 45 provider agencies, we believe consideration should be given to using the automated system on a prompt basis to assist providers in their followup efforts and to improve patient retention.

Pennsylvania

At one project, a clinic performs followup on missed appointments only once a year, although patients using contraceptive pills are scheduled for resupply visits every 3 to 6 months. Clinic personnel said followup efforts have been hindered by a lack of staff. At another clinic under the same project, missed appointments are followed up the same day or the next and contact is made by telephone or mail to schedule a new appointment.

A second project uses a card file system to identify patients who missed appointments during the previous month. Contact is made by telephone or letter to reschedule appointments. Outreach workers contact patients personally when they miss more than one appointment.

One clinic under a third project follows up broken appointments immediately by letter or telephone. At another clinic, followup by telephone or letter is performed only after a patient misses a semiannual or annual examination visit. This clinic provides pill patients a 3-month supply of pills. Clinic personnel advised us that pill resupply visits are not scheduled and the clinic does not know if a patient failed to receive the next 3-month supply until the patient misses the scheduled semiannual examination.

At a third clinic, all missed appointments are followed up by telephone, letter, and a home visit, if necessary. However, patients using contraceptive pills who are scheduled for annual examination visits are provided with a 7-month supply of pills. If the patient does not make a resupply visit after 7 months, the clinic does not know until the patient misses her annual examination visit.

A fourth clinic under the same project performs no followup. Patients are considered inactive if they do not return to the clinic within 6 months after the last visit.

Officials at two of the three projects said they planned to use automated patient-tracking systems to identify patients who missed resupply visits or regularly

scheduled visits. The system, if implemented effectively, should help clinics to improve followup efforts and patient retention.

Texas

Each of the three projects we visited contacted patients who did not keep clinic appointments either for a physical examination or for a resupply of pills by telephone, letter, or in person by an outreach worker.

Only one of the three projects used a computerized system for followup. The computer is programed to print out reminder notices, which are mailed to all patients scheduled for appointments during the next week. The computer also prints out a listing of patients who have missed scheduled visits during the past week. The listing is provided to clinic outreach workers for immediate followup. A project official advised us that the computerized system is instrumental in retaining patients in the program.

VARIANCES IN PROJECT COSTS

HEW has not established criteria for title X projects to measure the reasonableness of costs for services provided, nor has HEW performed sufficient audits of family planning projects to evaluate program efficiency. In addition, HEW has not established a reporting system for monitoring project costs and performance. We noted extreme variances in the average cost per patient visit. The average visit cost for projects with available cost information is shown below.

HEW region	Number of projects	Average cost per visit	
		Low	High
III	10	$20	$133
V	[a]52	16	219
VI	23	20	93

[a]Cost data for region V includes 39 provider agencies of the Illinois Family Planning Council in addition to projects in other States in the region.

The HEW region V project Director advised us that, as a result of our inquiry, a management review would be performed for those projects averaging more than $75 per patient visit. This review was expected to provide guidelines for use by HEW personnel in evaluating the reasonableness of costs when funding projects. We believe the $75 criterion should be lowered since HEW headquarters estimates the national average cost per patient visit to be $55 to $65. Low-cost projects should also be studied to identify and promote cost-efficiency measures.

Although we did not perform a detailed analysis of project costs, we observed some factors which contributed to the cost variation among projects. Our observations are discussed below.

Patient volume

Patient volume is a major factor affecting average costs. Generally, a higher patient volume results in a lower average cost per patient visit. For example, in HEW region III, 1 project with over 7,000 enrolled patients who made 11,000 visits in fiscal year 1972 averaged about $37 per patient visit, whereas a smaller program with only about 1,000 enrolled patients who made about 2,000 visits averaged about $133.

Some projects experienced a low average cost per patient visit because the projects had been in operation for a number of years and were operating at or near capacity. For example, 1 project in operation for 7 years had about 2,000 patients enrolled who made about 2,700 visits during the project year. The average cost per patient visit was about $23 for the project.

Area served

Projects serving metropolitan areas usually experience a lower average cost per patient visit than projects serving rural areas. For example, a project in Texas served Dallas primarily through six clinics in various parts of the city. The average cost per patient visit was about $49 and the project served over 16,000 patients who made over 21,000 visits for the 12 months ending December 31, 1972. In

contrast, another project in Texas served a 10-county rural area and had no clinic facilities. This project averaged about $93 per visit but had only about 2,100 visits for the 12 months ending July 31, 1973. Services were provided by private physicians who were paid $20 for each initial visit and $5 for each revisit. The project also incurred high travel costs for outreach services and patient transportation.

Procurement of contraceptive pills

Payments for contraceptive pills affect project costs. Because most family planning patients use such pills, the economical purchase of such supplies can reduce project costs. The following chart shows the range of payments for contraceptive pills for a 20-, 21-, or 28-day cycle.

HEW region	Number of projects	Range of prices
III	3	$.28 to $1.86 per cycle
V	3	.28 to .99 per cycle
VI	3	.15 to .70 per cycle

Generally, projects that purchased pills under nationwide contracts with manufacturers experienced lower costs. For example, in Illinois, one project paid as much as $.99 per cycle while another project under a national contract paid $.28 per cycle for the same product. The cost difference for using this contraceptive pill amounted to over $9 per patient year and contributed to lower costs for the project using a national contract source.

We were advised by project officials that some of the variations in pill prices were due to the purchase of more expensive pills because of physician preference. The more expensive pills usually involved differences in brands or in packaging.

Physician utilization

Most of the projects we visited did not actively monitor physician utilization. For the projects examined, the average number of family planning patients seen by physicians varied from a low of 1 an hour to a high of 15 an hour. Since most projects pay for physician services by the hour, such variation affects project costs. For example, in Illinois, one project with an average cost of $38 per patient visit paid its physicians $25 an hour and the physicians served about 8.9 patients an hour. Another project with an average cost of $76 per patient visit paid its physicians $18 an hour but the physicians served only about 4.6 patients an hour.

Project officials cited such factors as adequacy of facilities, appointment techniques, and extent to which nurses performed medical duties as possible reasons for variations in the number of patients served by physicians.

Adequacy of facilities

The number of examining rooms per physician had some bearing on the number of family planning patients a physician could serve per hour. For example, one project in Illinois had a number of examining rooms, which enabled one physician to examine patients without any loss of time due to preparatory and preexamination procedures. The average physician utilization for this project was 8.9 patients an hour. Another project in Illinois operated with three examining rooms; however, a different physician was assigned to each room. The average utilization for this project was 6.6 patients an hour. One clinic under a project in Pennsylvania operated in a converted row home and had only one examining room to serve all patients scheduled for a clinic session. The average utilization for this clinic was only two patients an hour.

Appointment techniques

Some projects had instituted various appointment techniques to increase physician utilization. For example, one project in Texas followed the procedure of sending a reminder notice to the patient before a scheduled appointment.

We were advised that this resulted in a reduction in the number of broken appointments. Other projects purposely overappointed in order to improve clinic attendance even when broken appointment rates remained high. Some project officials indicated that they served walk-in patients in order to increase physician utilization, although the number of walk-ins appeared minimal and had little impact on physician efficiency.

Use of nurses for some medical duties

Some projects experienced higher physician utilization because they had instituted programs whereby nurses were assigned increased duties under the supervision of an attending physician. The nurses were given training in preparing cervical smears for lab analysis and performing certain examinations (breasts, abdomen, and pelvic) which are usually performed by the physician. For example, officials for a project in Texas averaging over eight patients an hour advised us that its physicians are assisted by a highly trained staff performing many of the services which would normally be performed by physicians.

Other reasons for variation in physician utilization

The type of patient served can affect physician utilization. For example, one project reviewed generally served only "high-risk" patients who were identified by the project as

--women whose lives may be threatened by pregnancy,

--women who have never been pregnant but are sexually active and desire to avoid pregnancy, and

--soon-to-be-married women for whom family planning "before the fact" is always desirable.

The project director indicated that it is preferable for the physician to spend extra time with such high-risk patients. The number of patients seen by the project's physicians in an hour's time was about five.

Clinic location also has a bearing on physician efficiency. For example, physicians at one clinic were seeing an average of one patient an hour. The clinic was in an area with a concentration of senior citizens. In addition, the clinic was in an area with the highest median income in the city. Because of the low utilization the clinic was moving to an area with a greater need for services.

Lack of audit

HEW has not audited family planning programs in Pennsylvania, Illinois, Kansas, Missouri, and Texas. A memorandum issued by HEW on May 1, 1972, stated that the HEW audit agency has been unable to provide either routine or special audits with the degree of promptness or coverage desired. The memorandum required project grantees to obtain independent audits as a means of strengthening their management capability. The independent audits performed at the projects we visited were generally financial in nature and did not provide information on program management.

CONTRACT WEAKNESSES

HEW regulations require that projects which contract with other providers of services should insure that the costs of contracted services are reasonable and necessary. However, such regulations are silent as to the extent of monitoring and administration required by the projects over the subcontractors. We noted weaknesses in the administration of a few subcontracts by project grantees.

For example, a project in Texas subcontracting with a private organization specified, in the contract terms, that the subcontractor would function autonomously with no monitoring performed by the project grantee. The project's main function was to act as a fiscal conduit for providing Federal funds to the subcontractor without assuming any responsibility for subcontractor performance. The project administrator advised us that project personnel believed they had no control over the subcontractor's operations. This arrangement does not insure that the funds are spent in an efficient or economical manner for authorized purposes.

Another project in Texas had one subcontract for about $80,300 solely for outreach services and another subcontract for about $96,000 for complete family planning services, including outreach. Under the subcontract for outreach services, outreach workers received annual compensation of about $7,500 in comparison to about $4,600 for outreach workers under the other subcontract, although the duties and qualifications were similar. The project administrator said he considered the $7,500 annual compensation too high and believed the outreach functions could be performed at less cost by project staff rather than by a subcontractor.

One subcontractor purchased about $8,700 of equipment that was unused and apparently unneeded. This same subcontractor established the satellite clinic that experienced the low physician utilization described on page 48. The project administrator believed he had no management responsibility for the subcontractor's operations.

Although corrective action appeared warranted for the above situations, project officials believed that they had no authority to rectify the conditions.

The contracting situations described above do not adequately protect the Government's interest. Subcontracts should include monitoring requirements imposed upon the project to insure that services are provided in an economical and efficient manner.

CONCLUSIONS

Improvement in the management of family planning projects is needed to enhance efficiency and economy. HEW has not performed sufficient audits and does not have information necessary to measure project cost and performance. Criteria are needed for evaluating the reasonableness of costs. Projects need to perform adequate and prompt follow-up on missed appointments and patient dropouts to assist in patient retention. Technical assistance and guidance by HEW is needed so projects can increase the use of third-party reimbursement resources and fees so that Federal grant funds can be used most productively.

Free-standing clinics must be recognized as family planning providers by State Medicaid agencies if a significant increase in the use of third-party reimbursements is to be achieved.

RECOMMENDATIONS TO THE SECRETARY OF HEW

We recommend that the Secretary require HSA to:

--Provide technical guidance and assistance to projects to maximize the use of third-party reimbursement programs and the collection of fees from persons able to pay. HSA should identify and help resolve problems that hamper projects from attaining State approval as providers of services eligible for reimbursement under such federally assisted programs as Medicaid.

--Direct projects to perform adequate and prompt followup on missed appointments and patient dropouts to assist in patient retention.

--Establish criteria for monitoring and evaluating costs and performance of family planning programs. HEW audit effort should be increased and grantee responsibility for subcontractor operations should be clarified.

AGENCY COMMENTS AND OUR EVALUATION

HEW informed us that it was aware of problems in obtaining third-party reimbursements and collecting fees from patients. HEW stated that it:

--Had provided technical assistance in fiscal year 1974 to enable family planning projects to obtain provider status under Medicaid and to obtain title IV-A contracts with States.

--Had provided technical assistance to help improve reimbursement rates and to increase the comprehensiveness of services that will be reimbursed.

--Aided projects in setting up financial records required to qualify as providers.

--Issued instructions to regional family planning officials to see that all family planning projects establish fee schedules by June 1975 to obtain payment from patients able to pay for part or all of the services provided.

The technical assistance undertaken by HEW is definitely needed, and we encourage HEW to take followup action at an appropriate time to determine the effectiveness of the technical assistance and the need for additional assistance.

HEW informed us that its studies of program dropouts produced statistics indicating that extensive action is not needed in all programs; however, program officials do encourage establishment of followup procedures to retain individuals who have dropped out casually and require only a followup contact to return to the program. We believe it is important for a program to know why a patient has dropped out in order to help retain the type of individuals referred to by HEW and to identify the need for possible program improvements.

HEW also said that:

--A number of activities, including the establishment of performance criteria and a cost-reporting system, are underway to improve the monitoring and evaluation of family planning projects.

--Consideration will be given to increasing its audit agency's attention to family planning programs, along with other priority areas requiring new or increased audit attention.

--Steps are being taken to broaden the scope of the work being performed by public accounting firms to include assessments of project effectiveness and economy.

--Application of performance criteria, reporting requirements, and management audit procedures will aid regional project officers to more quickly assess and rectify weaknesses in the administration of subcontracts by project grantees.

CHAPTER 5

FAMILY PLANNING SERVICES REPORTING SYSTEM

The National Center for Health Statistics (NCHS) is responsible for developing and operating a coordinated reporting system for all federally funded and, to the extent possible, private family planning programs in the United States. The purpose of this reporting system is to provide national and area statistics on the status of family planning services and to provide basic program planning and evaluation data for the efficient and effective development, operation, and evaluation of family planning programs.

DEVELOPMENT OF THE SYSTEM

The rapid growth of family planning services programs in the mid-sixties brought attention to the need for--and the lack of--current, accurate information on the extent to which Federal and private programs were fulfilling the need for subsidized family planning services.

Although some Federal agencies operated or were planning to operate a reporting system for the family planning projects they funded, statistics from these systems could not provide data on a national basis for use in expanding family planning service programs or for evaluating their effectiveness. Some family planning projects are funded by more than one Federal agency and, because each agency's reporting system would include all patients served, an unduplicated count using these figures would be impossible.

In order to consolidate and coordinate the various Federal family planning statistical reporting systems, the Bureau of the Budget (now the Office of Management and Budget) in May of 1968 designated HEW's Office of the Assistant Secretary for Health and Scientific Affairs (now the Office of the Assistant Secretary of Health) as the focal point for family planning reports and statistics

throughout the Federal Government. Among other things, HEW was expected to:

--Exercise leadership in developing a coordinated program on family planning statistics, including standard classifications and terminology.

--Secure, to the extent possible, the cooperation of private organizations and State and local governments.

--Insure the assembly, analysis, and publication of statistical information on all aspects of family planning programs in the United States.

In November 1968, NCHS was delegated the responsibility for developing and operating a national family planning statistical reporting system.

The interim system

Because of delay in NCHS' implementation of a national reporting system, representatives from HEW's Maternal and Child Health Service, the Office of Economic Opportunity, and a national private organization met to determine what data should be collected and how the data should be processed. As a result, an interim reporting system was developed which could be put into operation early in 1969 through an existing Maternal and Child Health Service contract for a reporting system.

NCHS adopted this interim system and received approval of it from the Bureau of the Budget in February 1969. NCHS planned to receive family planning data through this interim system until it could develop and operate a national system.

Because the Maternal and Child Health Service contract was to expire on December 31, 1969, NCHS decided to award a contract, through competitive bidding, for taking over the system on January 1, 1970, and operating it as it then existed through July 1970, when NCHS expected to receive the personnel and funds necessary to develop and operate a national reporting system. A cost-plus-fixed-fee contract was awarded to the low bidder. Subsequently, the contract

was modified and extended several times, so that the cost increased from the original $107,500 to $405,043. The contract remained in effect through July 1971 and NCHS still had not developed a national reporting system.

The national system

On February 3, 1971, 176 firms were invited to submit technical proposals for a 3-phase effort to continue operation of the interim system and develop and operate a national reporting system. Cost proposals were to be submitted for only the first phase, which was expected to require a year's effort to (1) continue operation of the interim system; (2) develop, test, and begin total operation of a national system; (3) make modifications to the reporting format; and (4) train users on the new system. The second phase was expected to simply require continued operation of the national system, but the third phase would require operating the system and processing the data collected on the basis of a selected specified sample of projects or clinics. The contract was to be awarded for only the first phase with options on the two succeeding phases.

After contract negotiations with 3 of 14 firms submitting proposals, the interim system contractor was awarded a $349,826 cost-plus-fixed-fee contract, effective June 25, 1971, for the project's first phase period of about 12 months. The contract contained options on the two succeeding phases, which would last about 12 months each.

The National Reporting System for Family Planning Services was implemented in January 1972 and in May the contract was modified, as requested by the contractor, to reflect increased costs and volume of work and additional duties not anticipated in its original cost estimates. The total estimated contract cost increased by $79,023 to $428,849.

On June 28, 1972, and June 29, 1973, the contract was modified when the contractor exercised the options to continue with the second and third phases, respectively, of the contract through June 30, 1974. As a result of these and

two other modifications, the total estimated cost of the national reporting system for the period June 25, 1971, through June 30, 1974, was $1,799,876.

PARTICIPATION

Only private physicians who provide family planning services to private patients are ineligible to participate in the reporting system.

Prospective participants are primarily identified through the Federal grant mechanism in that funding agencies notify NCHS when they award a grant to a family planning project. All other eligible providers of family planning services (such as those affiliated with private organizations and those funded by State and/or local government) desiring to participate in the reporting system must take the initiative and contact NCHS. In both instances, NCHS provides the prospective participants with enrollment forms and, after the forms have been returned, material related to reporting. This material consists of such items as instructional manuals, control sheets, and patient visit forms. The patient visit form comprises 18 items which can be divided into 3 major information categories: identification; social and demographic; and family planning service rendered.

Projects are expected to begin participating in the system when they receive the patient visit forms and other material. This participation involves the completion of a patient visit form for each family planning services recipient willing to provide the information necessary to complete the form. Patients are not required to provide the information as a prerequisite to receiving services. Completed forms are supposed to be sent to the NCHS contractor on a periodic basis. Projects with their own automated reporting systems may submit individual patient data on magnetic tapes or punched cards in lieu of the standard forms if their definitions, data collection, processing, and record formats are in accordance with the system's standards and requirements.

All projects and clinics enrolled in the national reporting system are supposed to be submitting their family planning services data on a regular basis. However, as of August 28, 1973, only 3,693 of the 4,959 clinics enrolled in the national system had reported any data during the calendar year.

The regional program Director for family planning services at HEW region V headquarters said it was impossible to identify clinics that were not reporting to the system because the reports received at the headquarters level did not list each of the clinics separately but, rather, grouped them on some geographic basis. We were also informed that only about one-fifth of the title V Maternal and Child Health Service-supported projects within HEW region V were reporting statistical data to the system and that some of these projects had been identified as submitting incomplete data.

USE OF INFORMATION

From data supplied by projects or clinics, the national reporting system produces monthly, quarterly, and annual statistical tables which include such information as number of services provided, patient characteristics, funding sources, number of patient visits, and number of sterilized and infertility patients. The tables are not uniformly distributed to clinics, projects, States, funding agency regional offices, funding agency headquarters, or NCHS personnel.

HEW's sixth annual report, dated February 1973, to the House Committee on Appropriations stated that the tables are used for the efficient and effective development, operation, and evaluation of family planning programs. An NCHS official stated that the system was never intended to provide evaluation reports to clinics or projects and that the system's primary purpose is to produce an annual statistical report to the Congress and for Federal agency headquarters' use.

To determine how the statistical tables were being used, we contacted officials at HEW headquarters, three HEW regional offices, three States, and several family planning projects. Only an official at HEW headquarters and a project official in Pennsylvania indicated that the reports were used. According to the HEW official, the reports are used for planning purposes and answering congressional inquiries. The project official advised us that the reports are only useful in preparing the project's annual report. Another HEW official, however, advised us that information from the reporting system is rarely used because it is not considered complete or reliable.

Officials from three HEW regional offices (III, V, and VI), three States (Illinois, Pennsylvania, and Texas), and all of the clinics and projects--except for the one in Pennsylvania--that we contacted indicated that the reports received from the national system are not used. The major reasons cited for not using the reports are that they are generally inaccurate, incomplete, and tardy. In addition, we were advised at several of the projects we visited that a considerable amount of staff time is spent filling out the required forms. Conditions noted in the three States reviewed are discussed below.

Illinois

Our discussion with selected officials at HEW region V headquarters, the Illinois Department of Public Health, the Illinois Family Planning Council, and the three family planning clinics selected for detailed review revealed that the family planning reporting system has not been a useful source of management information for evaluating and monitoring family planning programs.

The council, which serves as an agent for the Illinois Department of Public Health, has the responsibility for submitting patient record data on its projects to NCHS.

The council has developed its own reporting system and patient record form for use in managing its family planning projects and submits a monthly computer tape to

NCHS to provide the data deemed necessary for the national system. Clinics collect patient data for transmittal to the council, which consolidates and returns the information to the clinics in the form of monthly printouts. It does not use the national reports.

Pennsylvania

The reports generated by the national reporting system are not being used for management purposes by HEW regional, State, or project officials. The family planning Director for region III advised us that the reports are of little value in monitoring and assessing the various family planning programs. The Director said not all family planning projects are participating in the reporting system; for those that are, the data reflected in the reports is inaccurate.

Two of the three projects visited in Pennsylvania have found no use for the reports generated by the national reporting system. An official at the third project said that the reports are helpful in preparing its annual report but for nothing else.

The most frequent objections to the national reporting system were that the reports were inaccurate and tardy. Some project officials added that the reports do not meet the projects' needs and only add an additional administrative burden on the projects. Officials at one project said that they knew of no one in the family planning business who either liked or used the reports of the national reporting system.

At the time of our review, two of the projects were in the process of developing their own reporting systems.

Texas

The reports generated by the national reporting system are not used for any purpose by HEW region VI officials. The family planning program Director for region VI said the reports are not accurate, complete, or on time. The reports are often up to 3 months late getting to the regional office and the regional totals are always incorrect because they do

not include any data from Louisiana, which does not participate in the national reporting system.

The Director informed us that even if the reports were accurate, complete, and on time they are not, for the most part, an effective management tool. He did state that patient-load data showing the number of new patients, continuing patients, and patients served who are not using a contraceptive would be useful if the information were accurate and on time.

The State of Texas is involved only in the national reporting system for the three project grants funded through the State Department of Health. The director of the Maternal and Child Health Division of the State Department of Health informed us that it has found the reports too inaccurate to use. The director stated that she had received many complaints from the projects concerning the time required to provide data for the national reporting system.

None of the projects we reviewed used the reports generated by the national reporting system for any management purpose. At one project we were informed that the only reason the project filled out the forms was because it was a requirement for getting Federal funds. The reports are not received on time, nor do the figures agree with the project's local records.

At another project we were informed that it considers the reports to be useless. It stated that the system did not show patient dropouts until 15 months after the patient's last visit. Since the reports are generally about 3 months late, the project would not receive this information until about 18 months after the patient dropped out.

At the third project we reviewed, the officials said the reports are not accurate, complete, or on time. For the period January 1, 1973, through March 31, 1973, the national system reported that the project had over 8,500 patient visits; however, the project's records showed that for the same period, plus one additional month, the project had only 7,320 patient visits.

OBSERVATIONS BY OTHERS

An HEW contractor developing a family planning evaluation process stated, in an analysis of the reporting system, that it is of limited value for HEW regional office project-monitoring use. The contractor's analysis included the following as general overall problems with the reporting system.

--The system receives no data input on project resources (dollars, hours, etc.) that would give some efficiency indicators.

--Definitions of some categories of input information prevent either regional or project monitoring of levels of patient service and project adherence to program standards. For example, limiting the definition of "patient visits" to "new" or "continuing" prevents regional offices and projects from determining the number of visits for checkups, supplies, and problems and annual revisits which could serve as monitoring indicators of adherence to minimal medical standards and problems with service delivery.

--Reports are for the reporting period only; they are not cumulative and they cannot be manually totaled from period to period by region (or by project) to obtain cumulative service levels for a project grant period.

--HEW regional offices receive too little information from the system to permit them to monitor adherence to minimal medical standards, the range of services being provided, whether patients are actually being provided free choice of contraceptive methods, or whether outreach methods are reaching the intended target population. Regional offices do not, unless they make special arrangements, receive information on types or levels of medical services provided; referral or counseling services provided; the contraceptive methods prescribed; income levels, welfare status, or education of patients; or the referral source of patients.

In addition to the general overall problems, the analysis also mentioned that, as a program management tool, the reporting system lacks some specific data inputs and outputs considered essential for a determination that projects are providing quality family planning and supportive services to those women who could not otherwise obtain them.

CONCLUSIONS

The national reporting system, as it now exists, is not a useful source of management information essential for efficient and effective development, operation, and evaluation of family planning programs nationwide. Reports generated by the system are generally considered by the intended users to be inaccurate, incomplete, and tardy. They do not contain information that can be used for day-by-day project management. In addition, statistical reports generated by the system cannot be relied upon for measuring project and program effectiveness at the State, regional, or national level because not all federally funded family planning projects and clinics are enrolled in the system and many that are either do not consistently submit data or do not report at all, even though participation is mandatory.

RECOMMENDATION TO THE SECRETARY OF HEW

We recommend that the Secretary have the information needs at the various management levels (headquarters, regional office, State, project, and clinic) determined and have a reporting system or systems developed to meet these needs.

AGENCY COMMENTS

Recognizing that the national reporting system has not been a useful source of management information, HEW concurred with our recommendation. It informed us that it has already started to identify information needs specific to different management levels and will develop specific methods for data collection and analysis appropriate to each.

CHAPTER 6

SCOPE OF REVIEW

Because family planning programs are relatively new and involve substantial Federal funds, and in view of the congressional interest in the programs, we reviewed the administration and management of the programs in Illinois, Pennsylvania, and Texas. Our review dealt with determining State compliance with an HEW requirement to offer and provide family planning services to welfare recipients who desire such services and an HEW requirement to expand family planning services statewide by July 1, 1975.

Our review, which began in March 1973, applied in part to all States within three Federal regions--III, V, and VI--but particular attention was directed to the family planning activities in Illinois, Pennsylvania, and Texas. At the selected family planning projects, we reviewed data on range of services, costs and funding, purchasing procedures, efficiency of physician utilization, extent of third-party reimbursement, and project effectiveness in enrolling low-income persons.

We discussed program activities, grant award procedures, and the national reporting system with personnel at the project, State, and HEW regional and headquarters offices.

Through additional observations in Kansas and Missouri, we supplemented our work in the area of State compliance by checking into (1) implementation of the HEW requirement to offer and provide services to welfare recipients and (2) the use of third-party reimbursements

In metropolitan areas in Chicago, Dallas, and Philadelphia, we randomly sampled (1) welfare recipients to determine State compliance with the HEW requirement to offer family planning services and (2) family planning patients to evaluate the effectiveness of projects in delivering services to the priority group.

APPENDIX I

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
WASHINGTON, D.C. 20201

OFFICE OF THE SECRETARY

FEB 3 1975

Mr. Gregory J. Ahart
Director, Manpower and
Welfare Division
U.S. General Accounting Office
441 G Street Street, N.W.
Washington, D.C. 20548

Dear Mr. Ahart:

The Secretary has asked that I respond to your request for our comments on your draft report entitled, "Opportunity for Improving Federally-Assisted Family Planning Programs". They are enclosed.

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

Sincerely yours,

John D. Young
Assistant Secretary, Comptroller

Enclosure

APPENDIX I

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE COMMENTS ON THE GAO DRAFT REPORT "OPPORTUNITY FOR IMPROVING FEDERALLY ASSISTED FAMILY PLANNING PROGRAMS"

Overview

The Department is in agreement with most of the GAO recommendations in this report.

The purpose of family planning programs is to aid individuals who desire services but who have financial or other difficulties in obtaining them. The Department strives to see that the target groups of low income persons and persons receiving welfare are given priority in receiving services.

Some of the problems cited in the report are caused by the fact that the Department's family planning programs are authorized by many separate legislative authorities:

> ... The basic family planning services legislation PL 91-572, "The Family Planning Services and Population Research Act of 1970," (Title X of the Public Health Service Act) was enacted to provide family planning services to individuals who had either financial or other difficulty in obtaining services.
>
> ... Other health program financing for family planning services is authorized under Title V of the Social Security Act. The family planning services grants program under Title V, which was the precedent program for PL 91-572., and the maternity and infant care project grant program were similar to family planning programs now funded by PL 91-572. All Title V family planning services funds are now merged into formula grants to States. The formula grant program is administered by the States and the individual State programs are not under direct Federal administration.

The two other major DHEW family planning activities are authorized under the Aid for Families with Dependent Children program and the Medicaid program, Titles IVA and XIX of the Social Security Act. These programs are under the Administrator of the Social and Rehabilitation Service rather than the Health Services Administration and are part of the social welfare program rather than the health program. The Title IVA program provides social services as well as preventive medical family planning services. The rules for those programs are based on different program objectives than the Health Services programs since they have been authorized to meet different objectives.

GAO Recommendation

> Establish a system and provide adequate staffing to determine compliance and permit enforcement of the one percent penalty provision and require States to report information needed for determining compliance.

Department Comment

The Department concurs in the intent of this recommendation and has in fact already taken a number of actions to carry it out using existing staff:

> ...In January 1974 representatives from fifteen States met to discuss whether their various reporting systems could meet the requirements for reporting under the penalty provision of family planning.
>
> ...The Department has issued guidance (in the form of Program Instructions) to the States on the major actions they would be held accountable for in the delivery of family planning services. One dated February 12, 1974, concerns the penalty provision; another dated March 21, 1974, requests and provides instructions for narrative reports; and a third dated May 15, 1974, discusses the format of these statistical reports. Most States have issued instructions to their local jurisdictions on implementing monitoring systems to insure compliance with the penalty provision. To date narrative reports have been received from over 40 States and four jurisdictions.

Developing this system will be a gradual process due to (1) the differing degrees of development among the various States in their systems, and (ii) the varying methods and sources of providing family planning services under different titles of the Social Security Act (VI and I, X, XIV, XVI) -- which make monitoring a complex problem. We will continue to work with the States to assist them in refining their reporting systems. These initial actions toward determining compliance--which will permit enforcement of the penalty provision--have thus been accomplished.

GAO Recommendation

> Require States to adopt policies emphasizing to caseworkers the importance of offering family planning services to welfare recipients. Caseworker efforts should also be closely monitored by the States.

APPENDIX I

Department Comment

We concur. Program Instructions have been issued which emphasize the importance of offering family planning services to welfare recipients. Regional office guidelines on applying the penalty provision are currently being developed by SRS; they include instructions to regional office staff to assist State agencies with respect to all aspects of family planning requirements.

Although caseworker involvement is recognized as an effective tool, it is just one of a number of means by which the recipient can be informed of availability of services. In accordance with Program Instruction (AO-PI-74-1), an offer of family planning services must be made in writing at stated time periods to current recipients and former and potential applicants and recipients according to the State plan. Where a written offer is not appropriate, a substitute method shall be utilized. State reports received indicate that instructions regarding "offer" and "request for services" are being met. A requirement for a written offer was established in order to assure that there was some tangible evidence that informing had occurred.

Although the system now being utilized to offer family planning services does not mandate the GAO approach which is to have caseworkers actively engaged with the majority of clients, caseworkers will undoubtedly be offering family planning services, where appropriate, as part of the service provided to clients.

This case-finding will assist clients to make family planning decisions. There will be follow-up at the regional office and, where indicated, at headquarters to determine whether there is compliance.

States have been reporting considerable activities in informing and making family planning services available under all titles of the Social Security Act mentioned above.

With respect to the second part of the recommendation, the Department is developing monitoring instruments which can be utilized by regional offices to monitor State activity -- and by the State agencies to review local agency performance in all social services, including family planning.

GAO Recommendation

> Encourage States to establish coordination between local welfare offices and Federally-assisted projects so that recipients interested in family planning can be identified, enrolled, and followed-up to ensure that they receive desired services.

APPENDIX I

Department Comment

We concur. State agencies were advised by regulation and by two program instructions of the Federal requirements and penalty provisions pertaining to family planning services. The importance of coordination between the States' Welfare Departments and Federally assisted family planning services is being emphasized.

State reports indicate clients are referred to Federally-assisted projects. Clients do have the right to select the medical service provider. These may be private physicians, Federally-assisted family planning projects, county health department clinics, and clinics conducted under private auspices.

We are in agreement with the statement on page 33, GAO Report, that welfare clients should not have to pay for family planning services. In instances where clients do pay rather than accept free service, it may be that the client elected to secure this service from a private physician who does not accept Medicaid payments.

GAO Recommendation

> Require family planning projects to establish procedures aimed at enrolling low income persons, especially welfare recipients.

Department Comment

We concur. Department regional family planning officials have been working with Federal and State welfare officials to coordinate the provision of family planning services to welfare recipients and low income individuals.

By July 1974 nineteen States had contracts to use Title IVA and Title XIX funds to reimburse Title X family planning service providers for services to eligible individuals. Negotiations are also being conducted in other States to strengthen current efforts to obtain SSA Titles IVA and XIX payments. Applicants for grants will be required to indicate efforts they plan to make to enroll welfare recipients and low income persons. (Organized family planning programs reported that in FY 1974 they received $15.5 million from SSA Title IVA and $15.5 million from SSA Title XIX to provide services to individuals eligible for IVA and XIX services. This is about 15% of the total funds available for the fiscal year 1974).

The Department has given priority to low income persons--over 70 percent of the persons served by organized family planning programs in FY 1974 were low income individuals and over 15 percent were from families on welfare. Efforts are continuing to inform priority persons and provide services to all who want but cannot afford them.

APPENDIX I

GAO Recommendation

Provide technical guidance and assistance to projects to maximize the use of third party reimbursement programs including the collection of fees from patients able to pay for services. HSA should identify and help resolve problems which hamper projects from attaining State approval as providers of services eligible for reimbursement under Federally-assisted programs such as Medicaid.

Department Comment

The Department has been aware that there are some problems in obtaining third party reimbursements and in collecting fees from patients and undertook a study under HEW contract OS 72-169 to develop strategies for maximizing legitimate third party collections by health programs. This study indicated that although third party reimbursements were restricted by several factors it would be possible to increase such reimbursement collections.

Regulations for Health Services Funding were published in the Federal Register January 9, 1974, which required each project to develop the capability to recover third party reimbursements and other revenue to the maximum extent possible so that Federal grant dollars will be used most productively.

The regulations require each project to establish a plan to (1) institute sound fiscal management procedures so that it can recover to the maximum extent feasible third party revenues to which it is entitled as a result of services provided; (2) garner all other available Federal, State, local, and private funds, and (3) charge beneficiaries according to their ability to pay for services provided, without creating a barrier to those services. Instructions have been issued to Regional family planning officials to see that all family planning projects establish fee schedules by June 1975 to obtain payment from patients who are able to pay for part or all of the services provided.

During FY 1974 technical assistance was provided to States and grantees by Regional program consultants and Boone Young Associates through a contract for technical assistance. This technical assistance was to help States obtain provider status under Medicaid (Title XIX) and to help grantees negotiate with States to set up IVA contracts. Other technical assistance was provided to work toward improving rates of reimbursement and to increase the comprehensive of services that will be reimbursed. Projects were aided in setting up financial records required by Title XIX to become providers.

GAO Recommendation

Direct projects to perform adequate and timely follow-up on missed appointments and patient dropouts to assure patient retention.

Department Comment

Studies conducted for HEW on patient dropouts indicated that over 50 percent who dropped out of a specific clinic had moved or had transferred to another clinic or a private physician, another 18 percent were pregnant or desired pregnancy, and 16 percent cited personal or other reasons. Data from another study indicated that over 65 percent of the women who dropped out of the program and who were not pregnant or desiring pregnancy, sterile, or sexually inactive were using some method of contraception. Therefore we do not believe that dropout statistics indicate the need for extensive program actions in all programs. Program officials do encourage establishment of follow-up procedures to retain individuals who have dropped out casually and require only a follow-up contact to return to the program.

The report (p. 54) recommends that projects follow-up on patients who are no longer at risk of unwanted pregnancy in order to provide periodic medical exams. [See GAO note.]

The Title X program was set up to provide family planning services. The other services provided are directly related to family planning services. Women who do not desire or need family planning services are encouraged to obtain periodic health maintenance care from private physicians, community health centers, or through referral services provided by family planning, but not through the family planning service project.

GAO Recommendation

Establish criteria for use in monitoring and evaluating the costs and performance of family planning programs; HEW audit effort should be increased and grantee responsibility for subcontractor operations clarified.

Department Comment

A number of activities are already underway to improve the monitoring and evaluation of family planning project costs and performance.

Uniform criteria have been drafted for use in assessing project performance with respect to National program goals and objectives (performance criteria).

A cost reporting system is being developed and is planned for installation in all projects by FY 1976.

GAO note: Page references in this appendix may not refer to the final report.

We will consider increasing Audit Agency attention to the Family Planning Program -- together with other priority areas requiring new or increased audit attention. As noted by the report, public accounting firms are performing some audit work at project sites. We are taking steps to offset a condition noted in this connection by GAO (that the audits are generally financial in nature) which will result in the scope of such audits being increased to cover assessments of project effectiveness and economy.

With regard to criteria to measure the reasonableness of costs for services provided, the report notes (pp. 55 ff) the many variables that affect costs of providing services--patient volume, area served, personnel utilization, etc. Consequently, there will be a wide range of per patient costs. While variation in project costs is inherent, we are establishing criteria with which to assess cost efficiency.

The report notes "...a few instances (of) weaknesses in the administration of subcontracts by project grantees" (p. 65). Where these problems exist, application of the performance criteria, reporting requirements and management audit procedures described above will aid Regional project officers to more quickly assess and rectify them.

GAO Recommendation

Determine the information needs at the various management levels (headquarters, Regional Office, State, project and clinic) and develop a reporting system to meet these needs.

Department Comment

We concur. The Department recognizes that the National Reporting System is not a useful source of management information. The system does provide some demographic and service data for use at the National program level; however, it does not provide utilization and cost information. Our three-year experience with the National System has proven that no one system can serve the multiple and varied needs of the different management levels (headquarters, Regional Office, State, project and clinic). We have already started to identify information needs specific to different management levels and will develop specific methods for data collection and analysis appropriate to each.

General Comment [See GAO note.]

5. Page 34 - The table on this page indicates that only 106 of the 517 welfare recipients who were not currently receiving family planning services were interested in enrolling in a family planning program. Of the 411 not interested in enrolling, 48% were sterile and 5 percent were pregnant. These statistics indicate that most of welfare recipients interested in family planning services were receiving services.

[See GAO note.]

GAO note: Deleted comments pertain to material presented in the draft report which has been revised or which has not been included in the final report.

APPENDIX II

PRINCIPAL HEW OFFICIALS

RESPONSIBLE FOR ACTIVITIES

DISCUSSED IN THIS REPORT

	Tenure of office			
	From		To	
SECRETARY OF HEW:				
Caspar W. Weinberger	Feb.	1973	Present	
Frank C. Carlucci (acting)	Jan.	1973	Feb.	1973
Elliot L. Richardson	June	1970	Jan.	1973
Robert H. Finch	Jan.	1969	June	1970
Wilbur J. Cohen	Mar.	1968	Jan.	1969
John W. Gardner	Aug.	1965	Mar.	1968
ASSISTANT SECRETARY FOR HEALTH:				
Theodore Cooper (acting)	Feb.	1975	Present	
Charles C. Edwards	Mar.	1973	Feb.	1975
Richard L. Seggel (acting)	Dec.	1972	Mar.	1973
Merlin K. DuVal, Jr.	July	1971	Dec.	1972
Roger O. Egeberg	July	1969	July	1971
Philip R. Lee	Nov.	1965	Jan.	1969
DEPUTY ASSISTANT SECRETARY FOR POPULATION AFFAIRS:				
Louis M. Hellman	May	1970	Present	
Katherine B. Oettinger (note a)	Aug.	1967	May	1969
Milo D Leavitt, Jr. (note b)	July	1966	Aug.	1967
ADMINISTRATOR, HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION (note c):				
Harold O. Buzzell	May	1973	June	1973
David J. Sencer (acting)	Jan.	1973	May	1973
Vernon E. Wilson	May	1970	Dec.	1972
Joseph T. English	Jan.	1969	May	1970
Irving Lewis (acting)	Sept.	1968	Jan.	1969
Robert Q. Marston	Apr.	1968	Sept.	1968
ADMINISTRATOR, HSA:				
Robert van Hoek	Feb.	1975	Present	
Harold O. Buzzell	July	1973	Jan.	1975
ADMINISTRATOR, SRS:				
James S. Dwight	June	1973	Present	
Francis D. DeGeorge (acting)	May	1973	June	1973
Philip J. Rutledge (acting)	Feb.	1973	May	1973
John D Twiname	Mar.	1970	Feb.	1973
Mary E. Switzer	Aug.	1967	Mar.	1970

[a]Served under the title "Deputy Assistant Secretary for Population and Family Planning."

[b]Served under the title "Deputy Assistant Secretary for Science and Population."

[c]Effective July 1, 1973, this Administration was abolished and the Public Health Service was reorganized into six health agencies under the direction and control of the Assistant Secretary for Health.

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