Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

THE PERINATAL SERVICE CAPACITY OF THE FEDERALLY FUNDED COMMUNITY HEALTH CENTERS:

AN OVERVIEW

DECEMBER 1992

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REGION

Dana L. Miller, *Project Leader*
Timothy J. Corbett
Madelaine T. Tully
Deborah Skahan

HEADQUARTERS

Maruta Zitans
Barbara Tedesco

For additional copies of this report, please contact the Boston regional office at 617/565-1050.

Department of Health and Human Services

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AN OVERVIEW

DECEMBER 1992 OEI-01-90-02332

EXECUTIVE SUMMARY

PURPOSE

This report describes recent trends in the perinatal service capacity of the community health centers funded under Section 330 of the Public Health Service Act.

BACKGROUND

Community health centers (CHCs) play an important role in reducing infant mortality by delivering comprehensive perinatal care to high-risk women in medically underserved areas across the nation. Many of these women are difficult to reach and do not appreciate the importance of prenatal care. In 1991, the Federal government supported services at 514 CHCs through Public Health Service (PHS) Section-330 grants, PHS Section-329 and -340 grants for migrant workers and the homeless, Medicare and Medicaid reimbursements, Maternal and Child Health grants, and the National Health Service Corps.

In recent years the Federal government has made an increasing investment in the centers. Little information is available, however, on the extent to which the centers are able to meet the perinatal care needs of the women they serve. To examine the capacity of the centers to provide perinatal care, we conducted a mail survey of all CHCs; interviewed center staff and management; held discussions with PHS administrators, State officials, and infant health care experts; and reviewed relevant literature and data. Our survey was completed in June 1991. Our findings are based primarily on information reported by the centers to us and to PHS.

FINDINGS

Increased Capacity: The capacity of the community health centers to provide perinatal care increased in several respects between 1988 and 1990:

- Prenatal caseloads increased an average of 22 percent.
- The range of medical and health promotional services increased at 68 percent of the centers. The services added at the largest number of centers were HIV testing and counseling, smoking-cessation programs, and classes in parenting and childbirth.
- The range of ancillary services--such as home visiting and transportation--increased at 32 percent of the centers.
- Total center revenues increased 27 percent.

Increased Demand: Despite these increases in capacity, demand for perinatal services has continued to grow, and many center clients still do not receive the optimal coordinated package of care in a timely fashion.

- Fourteen percent of the centers reported that they provided no perinatal services on site between 1988 and 1991. Our study did not examine the extent to which these centers made alternative perinatal care arrangements for their clients.

- Demand for services increased at 82 percent of the centers; 39 percent of these centers reported their capacity to meet this growing demand either decreased or remained the same.

- Many centers reported that they do not coordinate, as part of their perinatal case-management efforts, all of the health and social services recommended by the Public Health Service. This may, in part, reflect variations in the definition of "case management" among centers.

- On average, 55 percent of each center's prenatal clients entered care during the first trimester in 1990. Nationally, 76 percent of all women, 62 percent of minority women, and 58 percent of women in Healthy Start project areas entered care during the first trimester.

- On average, 21 percent of each center's first-trimester enrollees received fewer than 9 prenatal visits. Our study did not examine the extent to which these patients may have received care elsewhere.

Limitations to Care: Centers identified several major constraints that seriously limit their capacity to provide perinatal care. Among these are:

Staffing. Medical staff shortages, in part as a result of cuts in the National Health Service Corps in the 1980's, present serious problems at 63 percent of centers. Although the number of prenatal clients increased an average of 22 percent at the centers, the number of obstetricians, family physicians, and certified nurse midwives increased an average of 5 percent.

Medical Malpractice Insurance. The high cost of medical malpractice insurance has been a serious problem at 56 percent of centers. In late 1992, Congress took initial steps to address this problem by passing legislation (P.L. 102-501) that extends medical malpractice liability protection under the Federal Tort Claims Act (FTCA) to health care providers at the centers.

Community-Provider Relations. Seventy-six percent of the centers report serious problems stemming from inadequate coordination of perinatal services in the community, a lack of other local providers willing to treat uninsured and

publicly insured women, difficulty arranging obstetric backup for center staff and for consultation for high-risk clients, or difficulty obtaining hospital privileges for center staff.

Health Insurance. On average, 19 percent of each center's perinatal clients were uninsured in 1990. At 9 percent of centers, more than half of the perinatal clients were uninsured.

Medicaid Funding: Medicaid is an important source of revenue for the centers' perinatal services.

- On average, 67 percent of each center's perinatal clients were enrolled in Medicaid in 1990.
- Medicaid reimbursements to centers increased, as a percentage of total revenues, from approximately 17 percent in 1988 to 21 percent in 1990.
- Nonetheless, 73 percent of the centers reported serious problems with Medicaid--burdensome application procedures, inadequate and/or slow reimbursement, restrictive eligibility criteria, or a limited range of covered services.
- Only 56 percent of centers reported that they offered on-site assistance with enrollment in Medicaid, even though recent Federal law required that the States outstation workers to do so.
- Only 27 States and the District of Columbia had begun to implement cost-based reimbursement to the CHCs by May 1991, as called for in the Federally Qualified Health Centers mandate.

Comprehensive Perinatal Care Program (CPCP): The CPCP provided supplemental funds for enhanced perinatal services to approximately two-thirds of the centers for at least one year between 1988 and 1991.

- Eighty percent of centers that received CPCP funds expanded their range of perinatal services between 1988 and 1990, compared with 50 percent of other centers.
- A larger percentage of CPCP grant recipients than of other centers coordinate all of the PHS-recommended health and social services through their perinatal case-management efforts.
- Responses to our survey indicated no significant differences between CPCP grant recipients and other centers in the percentage of clients who entered care in the first trimester in 1990. We did not gather information on changes over time in first-trimester enrollment.

- Responses to our survey indicated no significant differences between CPCP grant recipients and other centers in the percentage of first-trimester enrollees who received at least nine prenatal visits in 1988 or 1990.

Urban-Rural Comparisons: Between 1988 and 1990, the capacity of urban and rural centers to provide perinatal care increased in terms of prenatal caseload size, the range of services offered, and overall revenues. The increases were greater for urban centers than for rural centers.

- A greater percentage of rural centers (20 percent) than urban centers (6 percent) offered no perinatal services on site between 1988 and 1991. Our study did not examine the extent to which these centers made alternative perinatal care arrangements for their clients. Rural centers with perinatal programs offered more timely care than urban centers.

- Urban and rural centers identified the same factors as serious limitations to their ability to provide perinatal care. Limited space was a problem for a greater percentage of urban centers, and staff shortages were a problem for a greater percentage of rural centers.

KEY AREAS FOR ACTION

In recent years, government at all levels has looked to the CHCs to play a more prominent role in providing perinatal care to poor, high-risk women. As the data in this report suggest, the capacity of centers to provide perinatal services has increased in several important respects since 1988. More women are being served and a wider range of services is being offered. Many centers, however, are burdened by major problems that limit their ability to meet the heightened expectations they face. The problems are pervasive and suggest vulnerabilities that cannot be effectively addressed by the centers alone.

In part, the difficulties facing centers reflect problems of access and cost in the nation's health care system and are dependent for resolution on broad reforms in that system. Nonetheless, there are important actions policy makers can take now to strengthen the capacity of centers to provide care. The data in this report suggest four critical areas that warrant immediate attention. Policy makers at all levels of government--Federal, State, and local--need to:

- **Address the staffing needs of the centers.** If community health centers are to meet the increasing demand for services, they need to be better able to attract, retain, and utilize clinicians. Thus, it is vital to identify cost-effective steps to (1) ensure an adequate supply of clinicians, (2) develop more effective incentives for clinicians trained with public funds to locate in underserved areas, and (3) ease undue restrictions on the credentialing of certified nurse midwives, nurse practitioners, and physician assistants.

- **Assure that recent legislation effectively relieves the centers of the high cost of medical malpractice insurance.** The high cost of malpractice insurance, particularly for clinicians providing perinatal care, has limited the centers' ability to offer services. In late 1992, Congress took initial steps to address this problem by extending medical malpractice liability protection under the Federal Tort Claims Act (FTCA) to health care providers at the centers. It is necessary to monitor this new arrangement to ensure that it effectively addresses the centers' concerns.

- **Continue to improve ties between the centers and the Medicaid program.** An effective link between centers and the Medicaid program is vital given the high proportion of Medicaid-insured women served by the centers and the expanded Medicaid coverage now available for their prenatal care. It is particularly crucial to ensure that the law requiring outstationing of Medicaid eligibility workers at CHCs and the law ensuring cost-based reimbursement to centers as Federally Qualified Health Centers (FQHC) are both fully implemented and working optimally.

- **Continue to strengthen relationships with other health and social service providers.** To be more comprehensive and efficient, the perinatal services offered by centers must be more effectively linked with those of other providers in the community. It is particularly important to increase the number of providers willing to serve Medicaid patients, to simplify enrollment, to facilitate referrals among programs, and to ensure that center clinicians have staff privileges at hospitals in their communities.

RECOMMENDATION

The Assistant Secretary for Health, the Administrator of the Health Care Financing Administration, and the Assistant Secretary for Planning and Evaluation should develop a plan of action to address the key areas outlined above.

The PHS and HCFA should, individually and collaboratively, develop plans of action that incorporate specific targets and concrete steps to ensure that the key areas for action are addressed. The ASPE should review these plans and assure that they are compatible and adequate to meet the nation's health goals for the year 2000 to reduce infant mortality rates and increase access to perinatal care. The ASPE should coordinate activities and monitor implementation of the plans.

The PHS cannot effectively address these problems alone. Other Departmental components, State and local government agencies, and nongovernmental organizations must be involved in planning and implementation. Of particular importance is cooperation between public health and health care financing agencies at both the Federal and State levels.

Only through concerted action to address the key problem areas identified above can the potential for the community health centers be more fully realized. Strategies for improving perinatal care, such as expanded insurance coverage and aggressive

outreach programs, will be successful only to the extent that centers can provide sufficient clinical services linked effectively with other health and social services. Unless the serious problems affecting the community health center system are addressed, the centers' capacity to meet increased demand and heightened government expectations will continue to be strained and the system will remain vulnerable.

COMMENTS ON THE DRAFT REPORT

We received formal comments on our draft report from the Public Health Service (PHS), the Office of the Assistant Secretary for Planning and Evaluation (ASPE), and the Health Care Financing Administration (HCFA). These comments are reproduced in appendix C.

The PHS and ASPE concurred with our recommendation and proposed steps to implement it. The HCFA did not concur with our recommendation. The HCFA suggested that the key areas for action we identified are being addressed by current efforts in the Department and that the implementation of our recommendation could result in a duplication or delay of these ongoing efforts.

We continue to believe that the development and implementation of an interagency action plan by PHS, ASPE, and HCFA is critical to the strengthening of the community health centers' perinatal care capacity. The participation of HCFA, which plays a vital role in support of the community health centers' provision of perinatal care, is important to this effort.

We recognize that PHS, ASPE, and HCFA are involved in ongoing initiatives that address concerns about infant mortality and perinatal care. We urge PHS, ASPE, and HCFA to consider these current activities as resources upon which to draw in developing a comprehensive plan that incorporates both specific targets and concrete steps to ensure that the key areas for action are addressed. We hope the interagency effort will provide an opportunity to further involve State and local policy makers in a concerted plan to support the centers' provision of perinatal care.

We have revised our draft reports to reflect additional comments we received from PHS, ASPE, and HCFA.

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INTRODUCTION

PURPOSE

This report describes recent trends in the perinatal service capacity of the community health centers funded under Section 330 of the Public Health Service Act.

BACKGROUND

Birth Outcomes in the United States: The high rate of infant mortality in the United States continues to be a cause for concern. Each year, approximately 40,000 infants die before their first birthday--about 1 percent of all live births in the nation. In the 1950's, the U.S. ranked 5th among the world's nations in lowest infant mortality; in 1991, it ranked 23rd. The rate for black infants continues to be double that for white infants.[1]

Perinatal Care: A pregnant woman with no prenatal care is three times more likely to have a baby born at low birthweight--a key indicator of the risk of infant death--than a woman with adequate care. The Public Health Service (PHS) recommends timely, high-quality care before, during, and after birth as an effective way to lower the infant mortality rate and ensure healthier infants. Such perinatal care should include early and continuing risk assessment; health promotion; and medical, nutritional, and psychosocial interventions and follow-up.[2]

Several factors, however--including financial, geographic, and cultural barriers--prevent many women from obtaining timely perinatal care.[3] Rising medical malpractice insurance costs, inadequate health insurance coverage, a decreasing supply of obstetric providers, and a lack of physicians willing to treat low-income women are among the factors that have further limited the accessibility of perinatal care.[4] In 1989, almost 170,000 American women received no prenatal care until the third trimester, and another 86,000 received no care at all during pregnancy. Thirteen percent of whites received inadequate care; the proportion of blacks and Hispanics is twice that.[5]

Community Health Centers: Community health centers (CHCs) play an important role in reducing infant mortality by delivering comprehensive perinatal care to high-risk women in medically underserved areas across the nation. Many of these women are difficult to reach and do not appreciate the importance of prenatal care.

The CHC program was established in 1965 to meet the health care needs of the nation's medically underserved. Federal administration of the program was consolidated in 1975 under Section 330 of the Public Health Service Act. The total number of centers, however, has not been maintained at the level originally envisioned.[6] The number of grantees was cut substantially in the early 1980's--from 867 in 1981 to 530 in 1983, a 39 percent decrease.[7] At the time of our survey, in

1991, PHS funded 514 centers; 60 percent of these served predominantly rural populations, and 40 percent served predominantly urban populations.[8] As of December 1992, PHS funded 549 centers.

The Federal government supports the services provided by community health centers through PHS Section-330 grants as well as through Medicare and Medicaid reimbursements, Maternal and Child Health grants, PHS Section 329 and 340 grants for migrant workers and the homeless, the National Health Service Corps,[9] the Supplemental Food Program for Women, Infants, and Children (WIC),[10] and the Rural Health Clinic Program[11]. In recent years, funding for the centers has increased,[12] and several initiatives have been implemented to expand center services and improve access to care. These include:

Medicaid Expansions: Since 1982, Congress has enacted several changes in the Medicaid program, including mandated and optional changes in eligibility requirements and other measures, intended to improve the availability of perinatal care.[13]

Federally Qualified Health Centers Legislation: The Omnibus Budget Reconciliation Acts of 1989 and 1990 require State Medicaid programs to cover a core set of services provided by community health centers and to reimburse centers for the reasonable cost of covered services.

The Comprehensive Perinatal Care Program (CPCP): The CPCP provides supplemental funding to some CHCs for enhanced perinatal services, including improved outreach and case management. Funds were first awarded in 1989.[14]

Healthy Start: In September 1991, HHS awarded competitive grants to 15 communities in support of coordinated programs to reduce infant mortality rates.

Although there has been increasing Federal interest in perinatal care and the community health centers, little information is available on the extent to which the centers are able to address the perinatal care needs of the women they serve. A clear understanding of the centers' current capacity to provide perinatal care is vital to further planning and program design.

This report presents an overview of recent trends in the perinatal service capacity of the Section-330-funded centers, and summarizes and compares data on urban and rural centers. It also presents information on two areas of special policy interest: Medicaid reimbursements to the centers, and CPCP funding of the centers.

COMPANION REPORTS

This is one of three reports on the capacity of the community health centers to provide perinatal care. Two companion reports address the provision of perinatal services at urban and rural centers: *The Perinatal Service Capacity of the Federally Funded Community Health Centers: Urban Centers*, OEI-01-90-02330, and *The Perinatal Service Capacity of the Federally Funded Community Health Centers: Rural Centers*, OEI-01-90-02331.[15]

METHODOLOGY

To examine the capacity of the community health centers to provide perinatal care, we conducted a mail survey of Section-330-funded centers, interviewed staff and management at 10 centers; held discussions with PHS administrators, State officials, and infant health care experts; and reviewed relevant literature and data.

We sent the mail survey to all 514 community health centers receiving Section-330 funds in June 1991; of these, 431 (84 percent) responded. Our findings are based primarily on the responses of those 369 centers (72 percent of all centers) that reported that they offered perinatal services on site during the 1988-91 period. (See appendix A for a detailed methodology.)

Our review was conducted in accordance with the *Interim Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

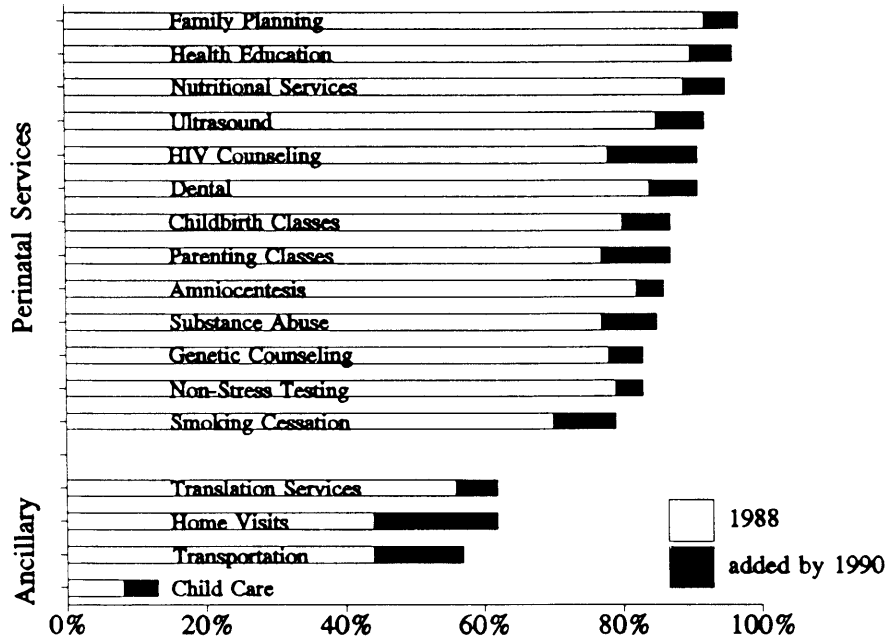
FINDINGS

INCREASED CAPACITY: ***The capacity of the community health centers to provide perinatal care increased between 1988 and 1990 in terms of prenatal caseload size, the range of services offered, and funding.***

▸ **Caseloads:** The number of prenatal clients served by the centers rose 22 percent between 1988 and 1990, from an average of 359 per center to 436. The number of births to center clients rose 19 percent during the same period, from an average of 253 per center to 300. Centers reported a total of 140,157 prenatal clients and 88,142 births in 1990.

▸ **Services:** The range of perinatal services increased at 68 percent of the centers. The services added at the largest number of centers were HIV counseling and testing, smoking-cessation programs, and classes in parenting and childbirth.[16] The range of ancillary services increased at 32 percent of the centers. Home-visiting services were added at the largest percentage of the centers and child care during appointments was added at the smallest percentage (see figure 1).

Figure 1
Percentage of Centers that Provided Each Perinatal Service, Including Ancillary Services Either On Site or Off Site, 1988 and 1990



Source: OIG Survey of Community Health Centers, June 1991.
N=369

Sixty-five percent of the centers offered on-site assistance with enrollment in the Supplemental Food Program for Women, Infants, and Children (WIC) in 1990, an increase from 57 percent in 1988.[17]

► **Revenues:** Total revenues for all center services increased 27 percent between 1988 and 1990; this includes an 18 percent increase in Section-330-grant funding.[18] Fifty percent of the centers reported that the amount of funding available for perinatal services had increased since 1988.

INCREASED DEMAND: ***Despite these increases in capacity, demand for perinatal services has continued to grow, and many center clients still do not receive the optimal coordinated package of care in a timely fashion.***

► **Availability of services:** Sixty-two (14 percent) of the centers that responded to our survey provided no perinatal services on site from 1988 to 1991.[19] While these centers are required to ensure that clients receive services elsewhere, our study did not examine the extent to which centers did so. Twenty-nine (47 percent) of the centers that did not provide on-site perinatal services indicated that they would have liked to, but noted that budgetary constraints, a lack of obstetric providers, and an inability to obtain hospital privileges prevented them from doing so.

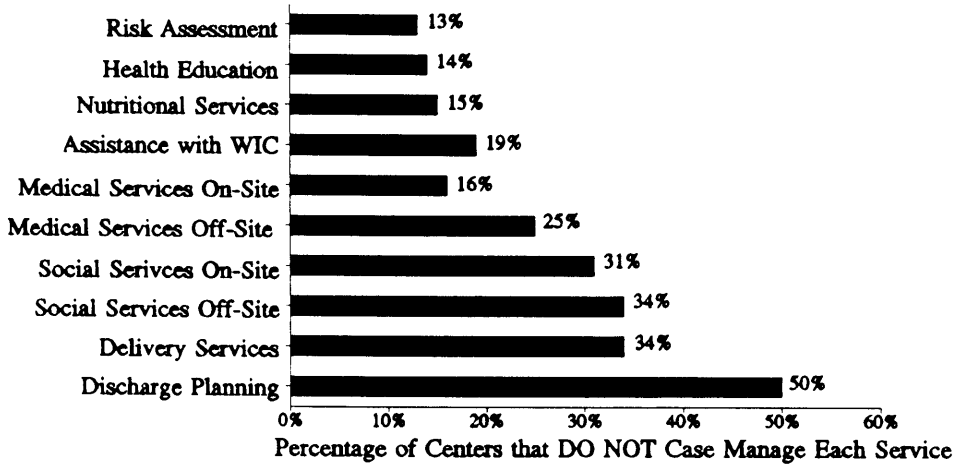
► **Demand for services:** Eighty-two percent of the centers that offered perinatal care reported an increase in the demand for services since 1988. Of these, 39 percent reported that their capacity to address this demand had either decreased or remained the same. An additional 12 percent of the centers reported that demand for perinatal services had not changed since 1988. Of these, 17 percent reported that capacity to meet demand had decreased.

Several centers reported that they were overwhelmed by demand and have been periodically forced to turn away new perinatal clients because they lack the capacity to serve them. Centers attributed increased demand for services to several factors, including: Medicaid eligibility expansions, and presumptive and continuous eligibility provisions; a diminishing number of community providers willing to treat low-income and Medicaid patients; and increasing unemployment rates among center clients. Many unemployed women have neither the income nor the health insurance to afford private medical care, and therefore seek subsidized care at the centers.

► **Case management:** According to PHS, perinatal care should include risk assessment; health promotion; and medical, nutritional, and psychosocial services and follow-up.[20] To maximize the accessibility, quality, and comprehensiveness of services, PHS requires centers to provide case-management services.[21]

Although centers may provide some of the services recommended by PHS, 63 percent of the centers reported that they do not provide case management for all of these services (see figure 2).

Figure 2
Percentage of Centers that DO NOT Case Manage Each Perinatal Service



Source: OIG Survey of Community Health Centers, June 1991.
N=369

There is no commonly accepted definition of case management, and the process has been implemented differently at different centers. Centers might coordinate the delivery of services and not refer to such coordination as case management.

Centers reported several problems, however, that indicate inadequate coordination of care:

- Missed appointments are not rescheduled for an average of 35 percent of each center's perinatal clients.
- The timely transfer of medical records to and from facilities for delivery and other services is a problem at 27 percent of the centers.
- Follow-up care within the first 8 weeks after birth was not provided for an average of 27 percent of each center's prenatal clients in 1990.

▸ **Timing of care:** On average, 55 percent of each center's prenatal clients entered care during the first trimester of pregnancy in 1990. Nationally, 76 percent of all women, 62 percent of minority women, and 58 percent of women in federally designated Healthy Start project areas entered care during the first trimester.[22] These rates compare with a PHS goal of 90 percent of all women by the year 2000.[23]

▸ **Number of visits:** The American College of Obstetricians and Gynecologists recommends that women entering care in the first trimester receive a minimum of 9 prenatal visits.[24] On average, however, 21 percent of each center's first-trimester enrollees received fewer than 9 prenatal visits at the center. Our study did not examine the extent to which these patients may have received care elsewhere.

► **Availability of appointments:** Thirty-seven percent of the centers did not offer prenatal appointments at times convenient for working women in 1990. Restricted appointment hours may force working women to choose between work and prenatal care.

► **Waiting times:** At 27 percent of the centers, waits for initial prenatal visits are 2 to 4 weeks; at 4 percent, waits are more than 1 month. Long waits for initial appointments can have adverse effects. If a woman tests positive for pregnancy in her second month and then must wait 4 weeks for her first prenatal appointment, she may enter care in her second trimester. The implications of such waits are even more problematic when pregnancy is detected later and when the mother is at high risk, as many center clients are.

Sixteen percent of the centers reported that office waiting times grew longer between 1988 and 1990. Centers reported that long office waits may discourage women from making and keeping appointments.

LIMITATIONS TO CARE: ***The centers identified several major constraints that seriously limit their capacity to provide perinatal care. These include medical staff shortages, medical malpractice insurance costs, unsatisfactory community support, limited space, and inadequate health insurance of center clients.***

► **Medical staff shortages:** Medical staff shortages are so severe that they seriously[25] hinder the provision of perinatal services at 63 percent of the centers. While the number of perinatal clients served by the centers increased an average of 22 percent between 1988 and 1990, the number of full-time equivalent (FTE) obstetricians, family physicians, and certified nurse midwives increased an average of 5 percent. Twenty-six percent of the centers reported that at least 1 obstetrician, family-physician, or nurse-midwife position had been vacant for longer than 1 year (see table 1).

Table 1
Percentage of Centers Reporting at Least One Clinical Provider Position Vacant[26]

Staff Position	Currently Vacant	Vacant more than Six Months	Vacant more than one year
Obstetrician-Gynecologist	26%	22%	13%
Family Physician	31%	26%	15%
Nurse Midwife	13%	11%	6%

Source: OIG Survey of Community Health Centers, June 1991
N=369

Centers face serious problems recruiting and retaining medical staff. The work is demanding, and wages and benefits are generally not comparable to those in the private sector. Although the National Health Service Corps used to supply a large

percentage of center providers, funding for the corps was seriously cut in the 1980's. In recent years the corps has produced a decreasing number of providers.[27]

Obstetricians are in short supply, and many are unwilling to work in community health centers. They are also the most expensive providers to support: Their salaries and medical malpractice insurance premiums are substantially higher than those of other providers. Family-physician and certified-nurse-midwife models of care also pose problems: The supply of family physicians and nurse midwives is limited; many obstetricians are reluctant to provide supervision and backup services for them; and many hospitals will not extend delivery privileges to them. Thus, these more affordable staffing models are impractical for many centers.

► **Malpractice insurance costs:** The cost of medical malpractice insurance has been a serious drain on resources at 56 percent of the centers. The cost of medical malpractice insurance has become a more serious limitation since 1988 at 27 percent of the centers.[28]

These costs have made it difficult for centers to expand their staffs, since scarce funds must be spent on insurance instead of salaries. Centers that contract for care have had difficulty paying the rising wages necessary to meet the insurance costs of private physicians. One center reported that it has been unable to obtain coverage at any cost.

In late 1992, Congress took initial steps to address this problem by passing legislation that extends medical malpractice liability protection under the Federal Tort Claims Act (FTCA) to health care providers at the centers.[29]

► **Unsatisfactory community support:** The PHS expects that centers be "active participants in their community's health care system. . . . This typically means fostering partnerships and participating in consortia and task forces addressing the area's health care issues."[30] These consortia should include local health departments, social services departments, hospitals, and other public and private health care providers. Thirty-five percent of the centers, however, do not participate in perinatal care consortia.

Inadequate coordination of perinatal services in the community, insufficient support from the local medical establishment, or limited hospital privileges[31] seriously restrict the provision of services at 76 percent of the centers. Unsatisfactory community support is indicated by several problems cited as serious impediments to the delivery of care:

- a lack of other local providers willing to treat uninsured and publicly-insured women (59 percent);
- difficulty arranging obstetric backup for family physicians, certified nurse midwives, or nurse practitioners (35 percent);
- difficulty arranging medical consultation for high-risk clients (29 percent);

- o difficulties obtaining admitting or delivery privileges for staff obstetricians, family physicians, or nurse midwives (35 percent); and
- o a decrease between 1988 and 1990 in the percentage of staff providers with hospital admitting privileges (19 percent).

► **Limited space:** Limited space seriously hinders the provision of services at 55 percent of the centers. This problem has become more serious since 1988 at 31 percent of the centers. In addition, limited collocation of services on site seriously restricts the comprehensiveness of care at 26 percent of the centers. Centers that cited limited space as a serious problem more frequently cited limited collocation of services as a serious limitation.

► **Inadequate health insurance:** An average of 19 percent of each center's perinatal clients were uninsured in 1990. At 29 percent of the centers, 25 percent or more of the perinatal clients were uninsured. At 9 percent of the centers, more than 50 percent were uninsured. These clients received services free of charge or at reduced rates, according to a sliding scale.

MEDICAID FUNDING: ***Medicaid funding for perinatal care at the centers has increased in recent years, but centers reported that Medicaid policies and procedures--including a burdensome application process, inadequate reimbursement rates, a restricted range of covered services, and limited eligibility--are among the factors that seriously inhibit the provision of care at most centers.***

► **Medicaid reimbursements:** Medicaid reimbursements to the centers increased approximately 56 percent between 1988 and 1990.[32] As a percentage of total center revenues, they increased from approximately 17 to 21 percent.

► **Medicaid-enrolled clients as a portion of perinatal caseload:** An average of 67 percent of each center's perinatal clients were Medicaid-enrolled in 1990. At 50 percent of the centers, at least 71 percent of these clients were Medicaid-insured.

► **Medicaid limitations:** Medicaid eligibility expansions or presumptive and continuous eligibility provisions resulted in an increase in demand for perinatal services at 57 percent of the centers, but difficulties with Medicaid policies and procedures--including burdensome application procedures, inadequate and/or slow reimbursement, restrictive eligibility criteria, or a limited range of covered services--seriously limit the provision of perinatal care at 73 percent of the centers (see table 2).

Table 2 Percentage of Centers Citing Each of the Following Medicaid Factors as a Serious Limitation	
Burdensome application procedures	54%
Inadequate reimbursement rates	49%
Restrictive eligibility criteria	42%
Slow reimbursement process	41%
Limited range of covered services	40%

Source: OIG Survey of Community Health Centers, June 1991
N=369

Several recent Medicaid reforms have been designed to increase access to perinatal care. These had not yet been fully implemented at the time of our survey:

- Only 56 percent of centers offered assistance with Medicaid enrollment on site, even though Federal law required that the States outstation workers to do so.[33]

- Only 27 States and the District of Columbia had begun to implement cost-based reimbursement to CHCs as of May 1991, even though the Federally Qualified Health Center provisions of the Omnibus Budget Reconciliation Acts of 1989 and 1990 called on the States to do so by April 1, 1990.[34]

COMPREHENSIVE PERINATAL CARE PROGRAM (CPCP): ***The CPCP provided supplemental funds for enhanced perinatal services to approximately two-thirds of the centers for at least one year between 1988 and 1991. A larger percentage of centers that received CPCP funds than of those that did not expanded their range of services between 1988 and 1990. CPCP grant recipients conduct more extensive case management than other centers. There were no significant differences, however, between grant recipients and other centers in either the percentage of clients who entered care in the first trimester in 1990 or the percentage of these who received at least nine prenatal visits.***

► **Caseload size:** In 1988, before CPCP funds were awarded, those centers that eventually received CPCP funds served an average of 454 prenatal clients, compared with an average of 156 served by other centers. In 1990, CPCP-funded centers served an average of 547 prenatal clients; other centers served an average of 201.[35] Thus, CPCP-funded centers served considerably more clients than other centers, but there is no significant difference between CPCP-funded centers and other centers in the rate at which caseload size grew between 1988 and 1990.[36]

► **Services:** CPCP funds were intended, in part, to support increased perinatal services at the centers,[37] and 80 percent of the CPCP-funded centers reported that

the range of perinatal services increased between 1988 and 1990. Half of the other centers reported that the range of services increased.

- **Case management:** CPCP funds were also intended to support better coordination of care for perinatal clients,[38] and 46 percent of the CPCP-funded centers provide case management for all of the services recommended by PHS. Twenty-two percent of the other centers provide case management for all of these services.

In addition, 70 percent of the funded centers participated in perinatal care consortia; 58 percent of the other centers did so.[39]

- **Timing of care:** The CPCP was further intended to support early entry into care and more prenatal visits.[40] Responses to our survey, however, indicate that CPCP-funded centers and other centers did not differ significantly in terms of either the percentage of center clients that entered care in the first trimester in 1990, or the percentage of first-trimester enrollees that received nine or more prenatal visits in 1988 or 1990. Our study does not allow a comparison of CPCP grant recipients and other centers with regard to trends over time in first-trimester entry into care.

URBAN-RURAL COMPARISONS: ***Urban centers exhibited greater perinatal care capacity in terms of prenatal caseload size, the range of services offered, and revenues. Rural centers provided more timely perinatal care. Urban and rural centers identified the same factors as serious limitations to the provision of perinatal care.***

- **Caseloads:** Urban centers served more prenatal clients and experienced greater caseload growth than rural centers. Prenatal caseloads at urban centers increased an average of 23 percent between 1988 and 1990, from 477 to 586. Prenatal caseloads at rural centers grew an average of 20 percent, from 261 to 312.

- **Services:** Only 6 percent of the urban centers that responded to our survey did not offer any perinatal services on site between 1988 and 1990; 20 percent of the rural centers did not do so. Of those that did offer services, a greater percentage of urban (78 percent) than rural (63 percent) centers reported that the range of perinatal services they provided, either on or off site, increased between 1988 and 1990.

A higher proportion of urban centers offered on-site assistance with enrollment in both Medicaid and WIC in 1990. Sixty-six percent of urban centers offered on-site assistance with enrollment in Medicaid and 81 percent offered on-site assistance with enrollment in WIC; 49 percent of rural centers offered on-site assistance with enrollment in Medicaid and 54 percent offered on-site assistance with enrollment in WIC.

- **Case management:** A greater percentage of urban (44 percent) than rural (32 percent) centers provide case management for all the services recommended by PHS.

A greater percentage of urban (34 percent) than rural (18 percent) centers, however, also often encounter problems with the timely transfer of medical records to and from referral facilities for services other than delivery.

- **Revenues:** Total revenues for all services at urban centers increased 31 percent between 1988 and 1990; total revenues for all services at rural centers increased 20 percent. Section-330 funding increased approximately 18 percent at urban and rural centers alike. This funding represented 35 percent of total 1990 revenues for urban centers and 44 percent for rural centers. Medicaid reimbursements increased 59 percent at urban centers and 42 percent at rural centers. These reimbursements represented 25 percent of total 1990 revenues for urban centers, and 13 percent for rural centers.[41]

- **Timing of care:** Rural centers, on average, provided more timely prenatal care than urban centers. Seventy-six percent of the rural centers conducted initial prenatal visits for their clients within 2 weeks of a positive pregnancy test, compared with 60 percent of the urban centers. On average, 59 percent of each rural center's clients, and 51 percent of each urban center's clients, entered care in the first trimester in 1990. In addition, an average of 82 percent of the first-trimester enrollees at rural centers and 74 percent at urban centers received at least 9 prenatal visits in 1990.

- **Limitations:** Urban and rural centers alike reported that their provision of perinatal care is seriously inhibited by several factors, including medical staff shortages, medical malpractice insurance costs, unsatisfactory community support, limited space, and inadequate health insurance. There were significant differences between urban and rural centers involving space and staffing.

Limited space seriously restricts the provision of perinatal care at a greater percentage of urban (64 percent) than rural (48 percent) centers, and has become a more serious problem since 1988 at a greater percentage of urban (38 percent) than rural (24 percent) centers.

Staff shortages present serious limitations to care at a larger percentage of rural than of urban centers.[42] At rural centers there was a 1 percent decrease in the number of FTE obstetricians, family physicians, and certified nurse midwives between 1988 and 1990; at the same time there was a 20 percent increase in the size of the prenatal client caseload. At urban centers there was a 12 percent increase in the number of FTE providers and a 23 percent increase in the size of the prenatal caseload. Difficulty arranging backup for obstetric supervision of family physicians is a serious limitation to the provision of care at a greater percentage of rural (34 percent) than urban (22 percent) centers. Consultation for high-risk patients is also a serious problem at a greater percentage of rural (36 percent) than urban (21 percent) centers. In addition, high medical staff turnover has become a more serious limitation to the provision of perinatal care since 1988 at a greater percentage of rural (18 percent) than urban centers (11 percent) (see table 3.).

Table 3
Section-330-Funded Urban and Rural Community Health Centers Compared

	URBAN	RURAL
CASELOAD		
Average increase in the number of prenatal clients at each center, 1988 to 1990:	23%	20%
SERVICES		
Percentage of survey respondents that did not offer any perinatal services on site between 1988 and 1991:[a]	6%	20%
Percentage of centers that reported an increase in demand for perinatal services:	89%	75%
Percentage of the above centers that reported that capacity to meet this demand had decreased or remained the same:	34%	42%
Percentage of centers that reported that the range of perinatal services had increased between 1988 and 1990:	78%	63%
Percentage of centers that offered on-site assistance with Medicaid enrollment in 1990:	66%	49%
Percentage of centers that offered on-site assistance with WIC enrollment in 1990:	81%	54%
CASE MANAGEMENT		
Percentage of centers that reported that they provide case management for all services recommended by PHS:	44%	32%
REVENUES[b]		
Percentage increase in total center revenues between 1988 and 1990:	31%	20%
PHS Section-330 grants as a percentage of total center revenues in 1990:	35%	44%
Medicaid reimbursements as a percentage of total center revenues in 1990:	25%	13%
TIMING OF CARE		
Percentage of centers that offered an initial prenatal visit within two weeks of a positive pregnancy test:	60%	76%
Percentage of each center's clients enrolled during the first trimester:	51%	59%
Percentage of each center's first-trimester enrollees who received at least nine prenatal visits:	74%	82%
LIMITATIONS		
Percentage of centers that reported serious medical staff shortages:	59%	67%[c]
Percentage change in the number of full-time-equivalent obstetricians, family physicians, and certified nurse midwives at centers between 1988 and 1990:	12%	-1%[c]
Percentage of centers that reported serious difficulties stemming from high malpractice insurance costs:	56%	55%[d]
Percentage of centers that experienced serious problems as a result of Medicaid policies and procedures:	76%	70%[d]
Percentage of centers that reported serious problems with community coordination, community support, or limited hospital admitting privileges:	79%	73%[d]
Percentage of centers that reported serious space limitations:	64%	48%

Source: OIG Survey of Community Health Centers, June 1991
N=167 for Urban Centers; N=202 for Rural Centers

[a] These were not included in the calculation of other statistics presented in the this report (see appendix A for methodology).
[b] These data were provided by the Public Health Service (see note 20). Statistical significance was not determined.
[c] The differences noted are statistically significant at the 0.1 level.
[d] The differences noted are not statistically significant.

KEY AREAS FOR ACTION

In recent years, government at all levels has looked to the community health centers to play a more prominent role in providing perinatal care to poor, high-risk women. The growing financial investment in centers reflects heightened expectations for their performance. These expectations rest on the assumptions of many policy makers that centers are able to meet the growing demand for comprehensive, timely perinatal services.

As the data in this report suggest, the capacity of centers to provide perinatal services has increased substantially since 1988. More women are being served, a wider range of services is being offered, and total revenues for all center services have increased.

At the same time, there is reason for concern about the capacity of the community health centers to deliver all that is expected of them. The findings of this report, based on the most current and comprehensive data available, confirm that many centers are burdened by major problems that limit their capacity to provide care. These difficulties reflect problems of access and cost in the nation's health care system, and, as such, are, in part, dependent for resolution on broader national reforms.

Independent of such reforms, however, we believe there are important actions that policy makers can take now to strengthen the capacity of centers to provide care. The data in this report suggest four areas in particular that warrant immediate attention. Below we identify these four critical areas and offer suggestions for action.

Federal, State, and local policy makers should take steps to:

- **Address the staffing needs of the centers.**

If community health centers are to serve more women, reach them earlier in their pregnancies, and provide adequate care, they need a sufficient supply of obstetricians, family physicians, certified nurse midwives, and nurse practitioners.

Centers need to be better able to attract, retain, and utilize various types of clinical staff who are skilled in providing perinatal care; who are motivated to serve poor, high-risk women; and who are allowed to practice, without undue restriction, consistent with their training and experience. Thus, it is vital for policy makers to identify cost-effective steps they can take to:

(1) ensure an adequate supply of those types of clinicians needed to provide perinatal services in ambulatory primary care settings such as centers;[43]

(2) develop more effective incentives for clinicians trained with public funds to locate in underserved areas. In this regard, it is particularly important

that the revitalized National Health Service Corps maximize its potential for addressing staffing needs through its loan repayment program, support training for an appropriate mix of clinical disciplines, and ensure that its recruitment and placement policies enhance the attractiveness of the program to young clinicians; and

(3) ease undue restrictions on the credentialing of certified nurse midwives, nurse practitioners, and physician assistants to allow their fuller participation in perinatal service delivery.

▸ **Assure that recent legislation effectively relieves the centers of the high cost of medical malpractice insurance.** The high cost of malpractice insurance, particularly for clinicians providing perinatal care, has limited the centers' ability to offer services.

In late 1992, Congress took initial steps to address this problem by passing legislation that extends medical malpractice liability protection under the Federal Tort Claims Act (FTCA) to health care providers at certain Federally supported health care clinics, including Section-330-funded community health centers.[44] Under the FTCA, center providers will be defended by the Justice Department in any malpractice litigation, and any judgments will be paid out of a Justice Department fund, into which the centers will pay annual contributions. This extension will be in effect for a trial period of three years, after which the financial benefits of the arrangement will be assessed.

This coverage is intended to help alleviate the burden on the centers of malpractice insurance costs. It is necessary to monitor this new arrangement to ensure that it effectively addresses the centers' concerns.

▸ **Continue to improve ties between the centers and the Medicaid program.** An effective link between centers and the Medicaid program is vital given the high proportion of Medicaid-insured women served by the centers and the expanded Medicaid coverage now available for their prenatal care. It is crucial for public health and Medicaid officials to take steps to:

(1) continue to expedite the application and eligibility determination processes for Medicaid to improve the access of high-risk women to more timely perinatal care. In this regard, it is particularly important to simplify the application forms, to streamline enrollment procedures, and to ensure that eligibility workers are outstationed at the centers; and

(2) ensure that the Federally Qualified Health Centers mandate, which allows centers to be reimbursed for reasonable costs, has been fully implemented and is working optimally.

Steps such as these are consistent with the current directions of the Department's Interagency Committee on Infant Mortality and with the recommendations and

suggestions of other studies including two recent OIG reports on Medicaid coverage for prenatal care.[45]

- **Continue to strengthen relationships between the centers and other health and social service providers in the community.**

The perinatal services offered by the centers must be linked more effectively with those of other health and social service agencies. This coordination must go beyond the mere sharing of information to include effective working relationships for referral of clients and delivery of services.[46] It is particularly important to search for ways to increase the number of obstetric providers who are willing to serve Medicaid patients.[47]

Moreover, strategies to locate multiple programs at a single site and to provide eligibility determination, complete program enrollment, and the delivery of services at a single site deserve further emphasis. Other strategies warranting continued attention are those that encourage more extensive use of common application forms and generic eligibility workers.

It is particularly important to link centers and hospitals more effectively. Centers must rely on hospitals to provide inpatient care, including delivery services, for their patients; yet many centers have difficulty securing hospital privileges for their physicians and certified nurse midwives. Such privileges are critical for delivering the comprehensive, continuous care that the centers' high-risk perinatal clients need.

Thus, it is important for policy makers to identify ways to ensure that center physicians and midwives who meet appropriate requirements for licensure and training have staff membership at hospitals in their communities. This membership should encompass both admitting and delivery privileges. At present, the National Health Service Corps statute requires hospitals, as a condition of their participation in Medicare, to grant privileges to corps physicians. This approach might be used to obtain privileges for other clinical staff.[48] Alternative approaches to explore include linking the licensure or tax-exempt status of hospitals to their guarantees of broader privileges for center staff.

RECOMMENDATION

The Assistant Secretary for Health, the Administrator of the Health Care Financing Administration, and the Assistant Secretary for Planning and Evaluation should develop a plan of action to address the key areas outlined above.

The PHS and HCFA should, individually and collaboratively, develop plans of action that incorporate specific targets and concrete steps to ensure that the key areas for action are addressed. The ASPE should review these plans and assure that they are compatible and adequate to meet the nation's goals for the year 2000 to reduce infant mortality rates and increase access to perinatal care. The ASPE should coordinate activities and monitor implementation of the plans.

The PHS cannot effectively address these problems alone. Other Departmental components, State and local government agencies, and nongovernmental organizations must be involved in planning and implementation. Of particular importance is cooperation between public health and health care financing agencies at both the Federal and State levels.

Only through concerted action to address the key problem areas identified above can the potential for the community health centers be more fully realized. Strategies for improving perinatal care, such as expanded insurance coverage and aggressive outreach programs, will be successful only to the extent that centers can provide sufficient clinical services linked effectively with other health and social services. Unless the serious problems affecting the community health center system are addressed, the centers' capacity to meet increased demand and heightened government expectations will continue to be strained and the system will remain vulnerable.

COMMENTS ON THE DRAFT REPORT

We solicited and received formal comments on our draft report from the Public Health Service (PHS), the Office of the Assistant Secretary for Planning and Evaluation (ASPE), and the Health Care Financing Administration (HCFA). We respond here to the major themes contained in the comments. We first summarize the comments, and then provide our response in italics. We include the complete text of the agencies' comments in appendix C.

The PHS and ASPE concurred with our recommendation that PHS, ASPE, and HCFA work together in developing and implementing a plan of action addressing the key areas for concern identified in the report. These include the staffing needs of the centers, the high cost of medical malpractice insurance, the ties between the centers and the Medicaid program, and the relationship between the centers and other health and social service providers in the community. The HCFA did not concur with our recommendation.

To implement our recommendation, PHS will develop an action plan and will then host a meeting of representatives of other agencies to review the plan and help formulate steps involving offices outside PHS. Among the Department of Health and Human Service agencies that will be asked to participate are ASPE, HCFA, the Office of the Assistant Secretary for Management and Budget, and the Administration for Children and Families. Also asked to participate will be the Department of Agriculture's Food and Nutrition Service, which administers the WIC program.

The ASPE proposed that it review a jointly developed PHS-HCFA plan, assure that this plan meets national objectives for the year 2000 to reduce infant mortality rates and increase access to perinatal care, and incorporate the plan into those actions already in progress to meet the Secretary's Program Directions.

The HCFA did not concur with our recommendation. It suggested that the key areas for action we identified are being addressed by current efforts in the Department. The HCFA expressed concern that implementation of our recommendation could result in a duplication or delay of these ongoing efforts.

The development and implementation of an interagency action plan by PHS, ASPE, and HCFA is critical to the strengthening of the community health centers' perinatal care capacity. We are pleased that ASPE and PHS have agreed with our recommendation for an interagency effort to address the key areas for action that we identified.

We continue to believe that the participation of HCFA, which plays a vital role in support of the community health centers' provision of perinatal care, is important to this effort, and we urge that HCFA reconsider its position.

We recognize that PHS, ASPE, and HCFA are involved in ongoing initiatives that address concerns about infant mortality and perinatal care. We urge PHS, ASPE, and HCFA to consider these current activities as resources upon which to draw in developing a comprehensive plan that incorporates both specific targets and concrete steps to ensure that the key areas for action are addressed. We suggest that the drafting and implementation of such a plan be used as an opportunity to bring sharper focus to efforts addressing persistent problems, and that the agencies not duplicate or delay current work. We hope the interagency effort will also provide an opportunity to further involve State and local policy makers in a concerted plan to support the centers' provision of perinatal care.

Technical Comments

Medical Malpractice Liability

After our draft report was released, Congress passed legislation (P.L. 102-501) that extends medical malpractice liability protection under the Federal Tort Claims Act (FTCA) to health care providers at certain Federally supported health care clinics, including Section-330-funded community health centers. Under the FTCA, center providers will be defended by the Justice Department in any malpractice litigation, and judgments will be paid out of a Justice Department fund, into which the centers will pay annual contributions. This liability protection will be provided for three years, at which time the financial benefits of the arrangement will be assessed.

We have revised our report to reflect the new legislation. We believe that the centers' medical malpractice insurance concerns warrant continued attention, and we urge PHS, ASPE, and HCFA to incorporate into their action plan an effort to monitor the implementation of the law and assess the centers' experience with the new arrangement.

Methodology

The HCFA expressed concern that our report might be based on incomplete information because we did not interview representatives of HCFA or State Medicaid agencies.

Our report focuses on trends in the community health centers' capacity to provide perinatal care. As a basis for our findings, we relied primarily on information reported by the centers. A comprehensive assessment of the Department's efforts relevant to infant mortality and perinatal care would be beyond the scope of this report. We have revised our report to indicate more explicitly the focus and methodology of our study.

The Implementation of Recent Medicaid Reforms

The HCFA cites information on the outstationing of Medicaid eligibility workers and the implementation of FQHC cost-based reimbursement that is more recent than that in our report.

Our information on the outstationing of Medicaid eligibility workers came from centers' responses to our survey in June 1991. Our information on the implementation of FQHC cost-based reimbursement to the centers was provided by PHS and was accurate as of May 1991.

We expect that progress should have been made in both areas since the time of our study. The centers cited several additional Medicaid factors as serious limitations to their provision of perinatal care, however, and we continue to believe that the ties between the centers and the Medicaid program need to be improved.

APPENDIX A

METHODOLOGY

We obtained information for this report through a mail survey of all community health centers receiving Section-330 funds as of June 1991, site visits to several centers, a series of interviews, and a review of relevant literature and data. Our findings are based primarily on the centers' responses to our survey.

Mail Survey: We sent a mail survey of perinatal services to all Section-330 grant recipients in June 1991. Of 514 centers, 431 (84 percent of rural and 84 percent of urban centers) responded, including centers in every HHS region and every State and territory in which centers are located, with the exception of Washington, D.C., and the U.S. Virgin Islands. A review of geographic and demographic information suggests no significant differences between respondents and nonrespondents.

Of the 431 respondents, 62 (14 percent) provided no perinatal services on site during the 1988-91 period. The numbers and percentages in the body of this report, unless otherwise noted, reflect the responses of those 369 centers (72 percent of all centers) that offered services on site in at least 1 year during the 1988-91 period.

Of the 369 respondents that provided services on site during the study period, 235 (64 percent) received CPCP funds. For the purposes of this report, a "CPCP-funded" center is any center that received CPCP grant funding at any time during the past 3 years, regardless of the year in which its initial grant was awarded.

Not all respondents provided complete information. We calculated the trends presented in the body of this report from the responses of those centers that provided the relevant information for all years.

Unless otherwise noted, the statements in the body of this report that compare groups of centers (for example, rural and urban centers) reflect statistical significance at the .05 level. In reporting responses to survey questions that solicited information on a scale, we combined responses of "moderately" and "substantially" and reported them as "seriously" or "serious."

Site Visits: The study team conducted site visits to nine centers: three in Massachusetts, two in Connecticut, and one each in Texas, Wisconsin, Ohio, and Oregon. The team toured these facilities and interviewed management and clinical staff. The study team also conducted a telephone interview with administrative and clinical staff at a center in Mississippi. We choose the centers based on discussions with regional PHS staff and with consideration of geographic representation and community size. Of the ten centers, seven had received CPCP funding.

Interviews: The study team held discussions with (1) officials in PHS's Bureau of Primary Health Care (BPHC) (at that time called the Bureau of Health Care Delivery and Assistance), both in headquarters and in those regional offices responsible for the oversight of site-visit centers; (2) State primary care association and cooperative agreement staff in those States and regions in which site-visit centers are located; and (3) infant and community health experts, including staff at the Children's Defense Fund, the National Commission to Prevent Infant Mortality, and the National Association of Community Health Centers.

Literature and Data Review: The team reviewed extensive literature in the areas of infant and community health. The Public Health Service provided us with financial data that were collected from the centers through the Bureau's Common Reporting Requirements reports, and with financial and user data that were collected from CPCP applicants through the Perinatal User Profile reports.

APPENDIX B

URBAN AND RURAL SURVEY RESPONSES

The Office of Inspector General survey was mailed to 514 community health centers in May 1991. Of the 431 (84 percent) that responded, 62 provided no perinatal services on site during the 1988-91 period. Below we present the frequencies and mean responses for those 369 centers that did provide services at some point during this period. Not all centers answered every question. The number of respondents to each field (N) is indicated in parentheses as appropriate.

Any discrepancies between the responses below and the data presented in the body of this report are a result of the methods used in aggregating data and caluculating trends. Please see appendix C for a discussion of statistical methodology.

Number of centers that offered perinatal services on site in each year:

1988: **Yes**=331 **No**=33
1989: **Yes**=341 **No**=26
1990: **Yes**=352 **No**=16
1991: **Yes**=349 **No**=18

A. CASELOAD	1988	1989	1990
1. Please indicate:		MEAN (N)	
a. the number of women who received *prenatal* care at your center:	359 (283)	391 (323)	406 (345)
b. the percentage of these clients who were **high-risk**, as defined by your center:	31% (222)	33% (259)	33% (288)
c. the percentage of these clients who were **low-risk**, as defined by your center:	55% (217)	55% (255)	56% (279)
d. the number of births to your center's clients:	253 (259)	273 (296)	310 (284)
2. Of the women who gave birth in your service area, what percentage received prenatal care at your center?	37% (199)	40% (218)	43% (214)

B. COMMUNITY COORDINATION

1. Does your center currently participate in a consortium of perinatal care providers?

Yes =240 **No** =128 If **YES**, please continue.

2. Which of the following participate in the consortium? (Please check all that apply):

a. state health department:	107	f. nonteaching hospitals:	84
b. local health department:	173	g. private-practice physicians:	113
c. health clinics:	116	h. gov. social service agencies:	104
d. schools:	67	i. non-profit organizations:	116
e. teaching hospitals:	122	j. other:	24

3. On the last page of this survey, briefly describe the coordination of consortium activities and your center's involvement.

C. CLINIC SITES AND HOURS

	1988	1989	1990
1. Please indicate the number of:		MEAN (N)	
a. clinic sites operated by your center:	2.2 (351)	2.3 (353)	2.4 (357)
b. clinic sites at which prenatal care was provided:	1.7 (357)	1.7 (359)	1.8 (361)
2. On how many days a week did your center provide scheduled prenatal appointments either **before 8AM** or **after 6PM**?	1.0 (344)	1.1 (347)	1.2 (351)
3. On how many **saturdays** a month did your center provide scheduled prenatal appointments?	0.5 (340)	0.5 (342)	0.6 (347)

D. Funding

1. Compared with 1988, the amount of funding available for perinatal care at your center in 1990 was:

Larger=185 **Smaller**=47 **Unchanged**=114

2. Please indicate the percentage of your center's 1990 perinatal clients covered by: **MEAN (N)**

a. Private insurance:	10.3% (318)	c. Medicaid:	66.9% (319)
b. No insurance:	18.9% (321)	d. Other:	3.1% (330)

3. To what extent have the following factors resulted in increased demand for perinatal services at your center over the past three years?

	Not at all/ Somewhat	Moderately/ Substantially
a. Medicaid eligibility expansions:	134	194
b. Medicaid presumptive and continuous eligibility provisions:	150	174

E. PERINATAL OUTREACH

1. To which of the following groups does your center currently target specific perinatal outreach efforts? (Please check all that apply)

a. Teenagers:	310	c. Non-English speakers:	157
b. Substance abusers:	133	d. Other:	106

2. At which of the following locations does your center currently conduct perinatal outreach? (Please check all that apply)

a. Community centers:	179	d. Schools:	238
b. Shops:	47	e. Welfare offices:	120
c. Door-to-door in the neighborhood:	76	f. Churches:	107
		g. Other:	128

3. Through which of the following media does your center currently conduct perinatal outreach? (Please check all that apply)

a. Television:	61	d. Radio:	104
b. Newspapers:	180	e. Other:	97
c. Pamphlets:	283		

4. Compared with 1988, your center's outreach efforts in 1990 were:

Greater=232 **Smaller**=27 **The same**=87

5. Compared with 1988, your center's outreach efforts in 1990 yielded:

More clients=245 **Fewer clients**=23 **The same number of clients**=57

F. PERINATAL SERVICES

1. Please indicate which of the following services were provided by your center. If these were offered on site, please circle **On**. If these were offered off site--either through contract, affiliation, or paid referral--please circle **Off**.

	1988	1989	1990
a. Ultrasound:	On=84 Off=230	On=101 Off=224	On=113 Off=226
b. Amniocentesis:	On=15 Off=286	On=14 Off=295	On=20 Off=297
c. Genetic counseling:	On=50 Off=237	On=53 Off=244	On=59 Off=247
d. Non-stress testing:	On=71 Off=220	On=86 Off=210	On=95 Off=211
e. Dental care:	On=201 Off=110	On=199 Off=122	On=206 Off=131
f. Nutritional services:	On=285 Off=43	On=296 Off=42	On=312 Off=27
h. Health education:	On=307 Off=27	On=319 Off=21	On=339 Off=16
i. Birthing classes:	On=161 Off=133	On=179 Off=127	On=196 Off=126
j. Parenting/infant care classes:	On=163 Off=120	On=181 Off=116	On=223 Off=96
k. Family planning:	On=326 Off=12	On=330 Off=13	On=343 Off=13
l. Smoking cessation programs:	On=137 Off=122	On=142 Off=126	On=165 Off=128
m. Substance abuse treatment:	On=63 Off=220	On=62 Off=227	On=79 Off=233
n. HIV counseling/testing:	On=179 Off=105	On=230 Off=81	On=278 Off=56

2. Compared with 1988, the **range** of perinatal services offered by your center in 1990 was:

Greater=250 **Smaller**=30 **Unchanged**=79

3. Were perinatal clients enrolled on-site at the center in the following programs?

a. Medicaid:	Yes=89 No=256	Yes=135 No=213	Yes=205 No=156
b. WIC:	Yes=212 No=136	Yes=230 No=124	Yes=241 No=121

	1988	1989	1990
4. Did other government or private social service organizations provide services on-site at your center?	Yes=98 No=247	Yes=108 No=242	Yes=138 No=224
5. Did your center facilitate access to perinatal care by providing the following services?			
a. Transportation to and from appointments:	Yes=161 No=183	Yes=186 No=164	Yes=211 No=150
b. Translation for non-English speaking clients:	Yes=205 No=113	Yes=215 No=110	Yes=230 No=99
c. Child care during center appointments:	Yes=30 No=316	Yes=34 No=319	Yes=47 No=311
d. Home visits:	Yes=161 No=184	Yes=204 No=150	Yes=230 No=131

G. STAFFING

	1988	1989	1990
1. How many **full-time equivalents** of each of the following provided perinatal services on-site at the center?		MEAN (N=369)	
a. Obstetricians:	0.64	0.70	0.66
b. Family physicians:	1.08	1.09	1.11
c. Certified nurse midwives:	0.23	0.25	0.28
d. Nurse practitioners:	0.56	0.62	0.66
e. Physician assistants:	0.29	0.31	0.34

2. Please indicate below: (i) the number of your perinatal provider positions which are **currently** vacant; (ii) the number which have been vacant for more that six months; and (iii) the number which have been vacant for more than one year **MEAN (N=369)**

	(i) Number of vacancies	(ii) More than six months	(iii) More than one year
a. Obstetrician:	0.33	0.27	0.16
b. Family physician:	0.41	0.35	0.20
c. Certified nurse midwife:	0.14	0.11	0.06

3. Compared with 1988, the percentage of your perinatal providers with admitting privileges at local hospitals in 1990 was:

Larger=93 **Smaller**=67 **Unchanged**=188

H. TIMING OF CARE

1. Please indicate the percentage of your center's 1990 prenatal clients who entered care in the:

	MEAN	(N)
a. First trimester:	55.0%	(N=337)
b. Second trimester:	34.6%	(N=334)
c. Third trimester:	10.1%	(N=302)

	MEAN (n)		
	1988	1989	1990
2. Of those clients who entered care during the first trimester, and carried to term, what percentage received at least nine prenatal medical visits?	75% (183)	76% (218)	79% (255)
3. What percentage of your center's prenatal clients returned for postpartum visits during the first eight weeks after delivery?	68% (205)	70% (263)	73% (303)
4. What percentage of all infants born to center prenatal clients returned for newborn visits during the first four weeks after birth?	68% (200)	70% (248)	73% (286)

I. APPOINTMENTS FOR CARE

1. If a woman called today to schedule a pregnancy test, how long would she wait for an appointment?

Pregnancy tests are offered on a walk-in basis:	228	Less than one week:	113
		One-two weeks:	20
		More than two weeks:	5

2. If the pregnancy test were negative, would she be referred to family planning services?

Yes=328 **No**=35

3. If the pregnancy test were positive, how long would she wait for her first prenatal visit?

The first perinatal visit is provided in conjunction with the pregnancy test:	59	Less than two weeks:	193
		Two-four weeks:	100
		One-two months:	9
		More than two months:	4

4. Compared with 1988, waiting room waiting times at perinatal appointments in 1990 were generally:

Shorter=121 **Longer**=59 **The same**=162

J. CASE MANAGEMENT

1. Does your center currently provide case management to promote the coordination of services for perinatal clients?

Yes=337 **No**=32 If **YES**, please continue.

2. Case management at your center is primarily conducted by (please check only one):

The client's primary care doctor:	32
The client's primary care nurse:	37
The appointments secretary:	2
A multidisciplinary team:	123
A center employee whose main responsibility is case management for perinatal clients:	126
Other:	18

3. Case management at your center is provided for (please check only one):

All perinatal clients:	272
All high-risk perinatal clients:	43
Only certain groups of perinatal clients:	23

4. Case management of perinatal clients at your center comprises (please check all that apply):

a. Risk assessment:	320
b. Planning of care:	314
c. Assessment of adequacy and appropriateness of services:	278
d. Client advocacy:	277
e. Contact with other organizations to arrange for services / schedule appointments:	322
f. Assistance with paperwork related to WIC, Medicaid, and other programs:	299
g. Discharge planning:	186
Coordination of:	
h. Medical services provided on-site at the center:	311
i. Medical services provided off-site:	276

Continued:

j. Delivery services:	245
k. Social services provided on-site at the center:	253
l. Social services provided off-site:	243
m. Nutritional services:	313
n. Health education:	315
o. Other:	

5. Compared with 1988, the percentage of all center perinatal clients case managed by your staff in 1990 was:

Larger=266 **Smaller**=17 **Unchanged**=44

6. Does your center often encounter problems assuring the timely transfer of medical records to and from facilities to which perinatal clients are referred?

For delivery:	**Yes**=76	**No**=262
For other care:	**Yes**=84	**No**=244

7. Please estimate the percentage of cases in which your center contacts perinatal clients to reschedule missed appointments:

MEAN	**(N)**
65%	(N=309)

8. Please indicate the manner in which you contact clients to reschedule missed appointments (please check all that apply):

Mail= 305 **Phone**= 329 **Home visit**= 207 **Other**= 25

9. Are perinatal clients at your center routinely attended by either the same primary medical provider or the same provider team at each perinatal visit?

Yes=321 **No**=13

K. LIMITATIONS TO CARE Please indicate the degree to which each of the following factors limits your center's ability to provide perinatal services:

	Not at all/ Somewhat	Moderately/ Substantially
1. Shortage of medical staff:	132	227
2. Shortage of nonmedical staff:	250	95
3. High medical staff turnover:	240	105
4. High nonmedical staff turnover:	303	38
Difficulty obtaining admitting privileges at local hospitals for:		
5. obstetricians:	276	31
6. family physicians:	275	46
7. certified nurse midwives:	178	83
8. High cost of malpractice insurance:	150	190
Difficulty obtaining malpractice insurance for:		
9. obstetric providers:	255	62
10. all providers:	280	51
Difficulty arranging medical backup for:		
11. OB supervision of certified nurse midwives/ nurse practitioners:	185	102
12. OB supervision of family physicians:	209	85
13. coverage during center staff vacations, holidays, and weekends:	196	143
14. consultation for high-risk patients:	240	99
15. Limited relationships with local community and government organizations:	318	31
16. Lack of other providers in the community willing to treat uninsured or publicly insured women:	142	206
Non-acceptance of certified nurse midwives/ nurse practitioners:		
17. by the medical community:	204	108
18. by patients:	277	21
19. Inadequate center funding:	139	210
20. Difficulties related to funding obtained from many different sources:	187	147
Medicaid-related problems:		
21. slow reimbursement process:	207	141
22. inadequate reimbursement rates:	175	170
23. limited range of covered services:	206	135
24. restrictive eligibility criteria:	199	146
25. burdensome application procedures:	163	188
26. Limited case management:	246	94
27. Limited collocation of services:	242	83
28. Limited space:	156	193
29. Other	37	28

Which of these factors have become **LESS SERIOUS** or **MORE SERIOUS** limitations since 1988?

	More Serious	Less Serious
1. Shortage of medical staff:	139	49
2. Shortage of nonmedical staff:	43	44
3. High medical staff turnover:	51	45
4. High nonmedical staff turnover:	15	45
Difficulty obtaining admitting privileges at local hospitals for:		
5. obstetricians:	17	40
6. family physicians:	23	33
7. certified nurse midwives:	26	29
8. High cost of malpractice insurance:	91	25
Difficulty obtaining malpractice insurance for:		
9. obstetric providers:	32	27
10. all providers:	21	27
Difficulty arranging medical backup for:		
11. OB supervision of certified nurse midwives/ nurse practitioners:	55	29
12. OB supervision of family physicians:	45	28
13. coverage during center staff vacations, holidays, and weekends:	76	31
14. consultation for high-risk patients:	54	33
15. Limited relationships with local community and government organizations:	12	69
16. Lack of other providers in the community willing to treat uninsured or publicly insured women:	111	28
Non-acceptance of certified nurse midwives/ nurse practitioners:		
17. by the medical community:	27	50
18. by patients:	8	48
19. Inadequate center funding:	89	44
20. Difficulties related to funding obtained from many different sources:	69	22
Medicaid-related problems:		
21. slow reimbursement process:	54	66
22. inadequate reimbursement rates:	57	90
23. limited range of covered services	44	69
24. restrictive eligibility criteria:	49	110
25. burdensome application procedures:	63	80
26. Limited case management:	32	86
27. Limited collocation of services:	22	52
28. Limited space:	107	43
29. Other	8	2

L. CONCLUSION

1. Over the past three years, demand for perinatal care at your center has:

Increased=201 **Decreased**=22 **Not changed**=40

2. Over the past three years, your center's capacity to address the demand for perinatal care in your service area has:

Increased=210 **Decreased**=88 **Not changed**=64

OPEN-ENDED QUESTIONS: [Center responses are not included here]:

3. What are the three most significant barriers to delivering perinatal care that your center has faced in the past three years?

4. What special projects, initiatives, or programs has your center undertaken over the past three years to improve its ability to respond to perinatal care needs in your service area?

APPENDIX C

DETAILED COMMENTS ON THE DRAFT REPORT

In this appendix, we present the complete comments on the draft report received from the Public Health Service (PHS), the Office of the Assistant Secretary for Planning and Evaluation (ASPE), and the Health Care Financing Administration (HCFA).

DEPARTMENT OF HEALTH & HUMAN SERVICES — Public Health Service

Memorandum

Date .NOV 4 1992

From Assistant Secretary for Health

Subject Office of Inspector General Reports on the Perinatal Service Capacity of the Federally Funded Community Health Centers, OEI-01-90-02330, OEI-01-90-02331, and OEI-01-90-02332

To Acting Inspector General, OS

Attached are the Public Health Service (PHS) comments on the subject Inspector General reports. We concur with the recommendation for PHS, in coordination with the Health Care Financing Administration and the Assistant Secretary for Planning and Evaluation, to develop and implement a plan of action to address the key areas for action identified in these reports. Our comments discuss some of the actions planned or underway to improve perinatal services in the community health centers.

James O. Mason

James O. Mason, M.D., Dr.P.H.

Attachment

PUBLIC HEALTH SERVICE (PHS) COMMENTS ON THE OFFICE OF INSPECTOR GENERAL (OIG) REPORTS ON THE PERINATAL SERVICE CAPACITY OF THE FEDERALLY FUNDED COMMUNITY HEALTH CENTERS, OEI-01-90-02330, OEI-01-90-02331, AND OEI-01-90-02332

The OIG reports summarize the results of an inspection which revealed that the perinatal capacity of the community health centers (CHC) increased in several respects between 1988 and 1990. However, OIG reports that the inspection also revealed that the demand for services also increased and many clients do not receive the optimal coordinated package of care in a timely fashion. The reports note that several key constraints limit the perinatal capacity of the CHCs. OIG suggests that a cooperative effort involving government at the Federal, State, and local levels, as well as non-governmental organizations is needed to address these findings.

The OIG report describes many programs and initiatives of the Bureau of Health Care Delivery and Assistance (BHCDA). BHCDA, which is part of the PHS' Health Resources and Services Administration (HRSA), has reorganized and is now called the Bureau of Primary Health Care (BPHC). In the PHS comments which follow, we will refer to the organization responsible for managing the CHC program by this new title.

OIG Recommendation

We recommend that PHS, the Health Care Financing Administration (HCFA), and the Assistant Secretary for Planning and Evaluation (ASPE) develop and implement a plan of action to: (1) address the staffing needs of the CHCs, (2) relieve the CHCs of the high costs of medical malpractice insurance, (3) improve ties between the CHCs and the Medicaid program, and (4) strengthen relationships between the CHCs and other health and social service providers in the community.

PHS Comments

We concur with this recommendation. We are particularly appreciative of the OIG recommendation to bring together agencies throughout the Department of Health and Human Services that can work with BPHC on improving perinatal services in CHCs. Furthermore, BPHC is prepared to take the lead on development on the plan recommended by OIG. We consider it critical that the plan be the result of a process that includes the participation of Departmental agencies and other affected parties (e.g., State and local government agencies, grantees).

The HRSA and the PHS Interagency Committee on Infant Mortality (ICIM) are prepared to work with other agencies throughout the Department of Health and Human Services to address the key issues

identified in the OIG report and improve perinatal services in the CHCs. HRSA plans to take the following actions to implement this recommendation:

1. In the Autumn of 1992, convene an internal work group to outline the steps and develop an implementation plan that describe the direction BPHC and its programs will take in addressing the OIG report's recommendation. The implementation plan will be developed to coincide with discussions affecting Fiscal Year 1993 funding.

2. In collaboration with the ICIM, convene a meeting of Departmental representatives who can review BPHC's plan and help formulate steps involving offices external to BPHC. Agencies asked to participate will include other PHS components, ASPE, HCFA, the Office of the Assistant Secretary for Management and Budget, the Administration for Children and Families, and the Department of Agriculture's WIC Program.

   The HRSA plans to convene this meeting before the end of calendar year 1992 and produce a plan with administrative improvements and action steps to coincide with the budget and legislative cycle.

   We concur that ASPE approve and monitor this plan once it has been approved by the Assistant Secretary for Health.

In a directly related matter, before adjourning the Congress passed legislation (H.R. 6183) which extends Federal Tort Claims Act (FTCA) protection for three years to health care providers employed by certain Federally-funded health care entities, including CHCs. The FTCA coverage is paid for by a Judgment Fund in the U.S. Treasury, and the Department of Justice handles the cases with help from the General Counsel of each Department. The bill requires annual contributions from the relevant program, e.g., CHCs, to the Judgment Fund, based on the prior year's experience. There are maximum limits to the annual contributions. At the time these comments were prepared, the President had not signed this bill.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

JUL 16 1992

TO: Richard P. Kusserow
Inspector General

FROM: Assistant Secretary for Planning and Evaluation

SUBJECT: OIG Draft Reports on the Perinatal Service Capacity of the Federally Funded Community Health Centers, OEI-01-90-02330; OEI-01-90-02331; and OEI-01-90-02332

Thank you for submitting for my review and comment the draft copies of the subject reports. The reports provide useful information on issues pertaining to perinatal service capacity in Community Health Centers (CHCs).

I support the recommendation that the Assistant Secretary for Health and the Administrator of the Health Care Financing Administration develop a plan of action to address the key areas outlined in these reports, and that the Assistant Secretary for Planning and Evaluation review such a plan to assure that our national objectives to reduce infant mortality rates and increase access to perinatal care are met by the year 2000. The role of CHCs is increasingly important in our efforts to achieve health care reform and provide better access to underserved communities. We look forward to working with PHS and HCFA to assure that our limited health care resources are used as effectively as possible.

We intend to incorporate this action plan into the actions already in progress in the Secretary's Program Directions plan to improve pre- and perinatal care.

If you have any questions, please phone Elise Smith on 690-1870.

Nicholas Gerry for

Martin H. Gerry

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

Date OCT 19 1992

From William Toby, Jr.
Acting Administrator

Subject Office of Inspector General (OIG) Draft Reports on the Perinatal Service Capacity of the Federally Funded Community Health Centers,
OEI-01-90-02330, OEI-01-90-02331, and OEI-01-90-02332

To

Bryan B. Mitchell
Principal Deputy Inspector General

We have reviewed the three above-referenced reports on perinatal service capacity of federally-funded urban community health centers, rural community health centers, and all community health centers.

We agree that the federally-funded community and migrant health centers (C/MHCs) play an important role in national strategies to reduce infant mortality, and that Medicaid reimbursement and strong relationships between C/MHCs and State Medicaid programs are essential. In fact, because of our strong belief in this objective, we already have a variety of actions underway in concert with the Health Resources and Services Administration and with the Assistant Secretary for Planning and Evaluation (ASPE) to address better program coordination. Many of these activities go beyond the legal authorities mentioned in the OIG report.

Not all of the issues mentioned in the report relate to program coordination. A number of the issues need to be addressed directly by the Public Health Service (PHS) and the C/MHCs, such as staffing and space needs.

Partly because of the delay in collecting information and incorporating those data into the OIG reports and, partly as a result of the methodology used as the basis for the recommendations in the report, we believe the OIG overlooked a broad variety of steps the Department is taking to address the chief concerns identified in the reports. In addition, the reports fail to recognize the elements of the President's Health Care Reform plan that are responsive, albeit on a broader basis, to some of the issues raised in the audits. Limits on malpractice insurance are one example of such an element.

Consequently, we do not support the recommendation for a new initiative on the part of the Department involving ASPE, PHS and HCFA to address these concerns since we believe that such a recommendation duplicates efforts that are already under way. These current efforts are a combination of HCFA's Medicaid innovations dealing with outreach, streamlined eligibility determinations, new reimbursement approaches, special HCFA-PHS cooperative efforts, and special responses to the Secretary's Program Initiatives which are being conducted under the oversight of ASPE.

Attached for your consideration are our detailed comments. Thank you for the opportunity to review and comment on these draft reports. Please advise us if you agree with our position on the reports' recommendations at your earliest convenience.

Attachment

Comments of the Health Care Financing Administration (HCFA)
on Office of Inspector General (OIG) Draft Reports
on the Perinatal Service Capacity of the
Federally Funded Community Health Centers
OEI-01-90-02330, OEI-01-90-02331, and OEI-01-90-02332

OIG Recommendation

The Assistant Secretary for Health, the Administrator of the Health Care Financing Administration, and the Assistant Secretary for Planning and Evaluation should develop a plan of action to address the key areas outlined above.

HCFA Response

We believe that OIG has identified pertinent problems that community and migrant health centers (C/MHC) face when delivering perinatal care to low income, high risk women. However, since HCFA and the Public Health Service (PHS) are already working together to resolve many of these issues, we cannot commit to developing a new initiative which may duplicate or delay ongoing efforts. The following are activities already underway:

- Under the Department's Interagency Committee on Infant Mortality (on which the Assistant Secretary for Planning and Evaluation (ASPE) is also represented), the Directors of HCFA's Medicaid Bureau and PHS's Bureau of Health Care Delivery and Assistance co-chair an Access Work Group. Its agenda includes streamlined eligibility and outstationing eligibility workers at C/MHCs.

- HCFA has an interagency agreement with the Health Resources and Services Administration concerning federally qualified health centers (FQHCs) (i.e., federally-funded C/MHCs). Regular meetings are held to plan and assess progress in achieving mutual perinatal care strategies and Medicaid coordinated care initiatives.

- The Secretary's "Program Directions", monitored by ASPE, include several primary and perinatal care initiatives involving C/MHCs and Medicaid elements.

In summary, we believe the reports do not adequately address current issues and or departmental planning and implementation initiatives.

General Comments

The following comments are directed to the summary report: The Perinatal Service Capacity of the Federally Funded Community Health Centers (OEI-01-90-02332).

1. Discussions on pages v, 10, and 16 imply that little is being done about outstationed eligibility workers. In contrast, the National Governors' Association 1992 report, Outstationing Medicaid Eligibility Workers at C/MHCs, stated, "Most of the study C/MHCs report that outstationing also has improved the centers' fiscal condition, at least as it pertains to the delivery of perinatal services . . . . In general, the study C/MHCs are very satisfied with their outstationing arrangements . . . ."

   Discussions on pages v, 10, and 16 imply that only half the States have implemented the FQHC reimbursement provisions. All States are implementing the provisions, and all but one State plan amendment has been approved.

2. The following comments relate to the Key Areas for Action on pages iv and v:

   - Address the staffing needs of centers - OIG did not consider the five-point plan in the President's budget which calls for expanding C/MHCs and increasing funding for the National Health Service Corps.

     In addition, States set credentialing criteria. The Federal government does not play a large role in this area.

   - Relieve the centers of the high cost of medical malpractice insurance - The high cost of malpractice insurance affects the entire health care system; ongoing studies have shown that C/MHCs are particularly affected by this problem. While immediate fixes may bring temporary relief, we believe that C/MHCs would be better served by a long-term solution to our medical liability crisis. The President has addressed the issue of health care liability in his proposal for comprehensive health reform and in subsequent draft legislation submitted to Congress on July 2.

- Improve the ties between the centers and the Medicaid program - A model application form for Maternal and Child Assistance Programs was developed by the Administration for Children and Families, HCFA, PHS, and the Food and Nutrition Service of the Department of Agriculture, and was published in the Federal Register on December 9, 1991.

  Also, the Medicaid program already gives States the option to use a shortened application form, implement an expedited eligibility program for women and children, and outstation eligibility workers.

  In addition, HCFA is working closely with PHS to implement the FQHC mandate. HCFA has distributed lists of FQHCs to the States, and issued policy and review guidelines.

- Strengthen relationships between the centers and other health and social service providers in the community - HCFA believes that coordinated care is the best route to increasing access to providers. HCFA is already working with PHS on how to best integrate FQHCs into coordinated care networks.

  In addition, the Omnibus Budget and Reconciliation Act of 1989 requires States to raise Medicaid obstetric/pediatric payments to ensure that access to services by Medicaid recipients is comparable to the general population in the same area. This mandate should have the effect of strengthening the relationships between the centers and individual providers in their community.

3. Methodology - Although the reports address financing and Medicaid issues, no interviews were held with officials in State Medicaid agencies or central and regional offices of HCFA. Based on these incomplete data, we suggest that OIG include a Medicaid-related discussion in the report and arrange an information gathering conference with HCFA.

APPENDIX D

NOTES

1. National Center for Health Statistics (NCHS), 1992. The 1989 U.S. infant mortality rate was 9.8 deaths per 1,000 live births. The provisional rate for 1990 is 9.1 deaths per 1,000; and the provisional rate for 1991 is 8.9 per 1,000. These rates represent considerable improvement over the 1950 rate of 29.2, but the pace of improvement has slowed in recent years and has not been experienced equally by all segments of the population. According to the most recently published international data, the 1988 U.S. infant mortality rate for whites alone places the nation 17th lowest in the world, while the rate for blacks alone places it 36th. Native Americans and Puerto Ricans also have infant mortality rates considerably higher than the national average.

2. U.S. Public Health Service (PHS), *Healthy People 2000: National Health Promotion and Disease Prevention Objectives*, Washington, D.C., 1990, p. 366.

   PHS, *Caring for Our Future: The Content of Prenatal Care: A Report of the PHS Expert Panel on the Content of Prenatal Care*, Washington, D.C., 1989, p. 2.

3. Sarah S. Brown, editor: Institute of Medicine, *Prenatal Care: Reaching Mothers Reaching Infants*, National Academy Press, Washington, D.C., 1988, p. 4.

4. Deborah Lewis-Idema, *Increasing Provider Participation*, National Governors' Association, Washington, D.C., 1988, pp 20-23. An increasing number of physicians who practice obstetrics are unwilling to accept low-income or Medicaid-insured patients because of high malpractice premiums and low Medicaid reimbursement rates.

   In September 1990, the American College of Obstetricians and Gynecologists (ACOG) reported that, as a result of the risk of malpractice, 12 percent of its members had discontinued their obstetric practices, 24 percent had reduced or eliminated services to high-risk women, and 10 percent had decreased the number of deliveries they performed. Average obstetric premiums rose 248 percent between 1982 and 1989. (ACOG, prepared by Opinion Research Corporation, "Professional Liability and Its Effects: Report of a 1990 Survey of ACOG's Membership," Washington, D.C., September 1990.) The ACOG repeated this survey in September 1992, and found no statistically significant differences from the prior survey.

   In addition, as of 1987, 64 percent of family physicians who once provided obstetric services had discontinued such care. (American Academy of Family Physicians, "Family Physicians and Obstetrics: A Professional Liability Study," 1987.)

5. NCHS, "Advance Report on Final Natality Statistics, 1989," *Monthly Vital Statistics Report*, vol. 40, no. 8, Supplement, December 12, 1991, p. 43. These 1989 data are the most current available.

   Alan Guttmacher Institute, *Prenatal Care in the United States*, New York, N.Y., 1987, vol. I, p. vi. Adequacy of care is a function of time of entrance into care and number of visits. During the period 1984-86, 24 percent of women entered care after the first trimester, 24 percent had fewer than 9 visits, and 34 percent received less than adequate care.

6. Alice Sardell, *The U.S. Experiment in Social Medicine: The Community Health Center Program, 1965-1986*, University of Pittsburgh Press, Pittsburgh, PA, 1988, p. 66.

7. Bonnie Lefkowitz, Bureau of Primary Health Care (BPHC), PHS, "The Institutionalization of Community Health Centers," speech to the American Public Health Association, November 13, 1983, p. 4. This number represents consolidation as well as elimination of grantees.

8. All of these centers received Section-330 community health center grants. Some also received Section-329 funds for care provided to migrant workers; an additional 71 centers received only Section-329 funding.

9. Through the National Health Service Corps (NHSC), PHS offers scholarships and loan repayment to health providers who commit to work in designated Health Professional Shortage Areas for a given period. A large percentage of corps providers have traditionally worked in community health centers. After substantial cuts in program size in the early 1980's, the NHSC received increased funding in 1990; the number of loan repayment candidates is limited, however, and most scholarship recipients will not be available for service until the mid-1990's.

10. The Department of Agriculture provides vouchers through this program to address the nutritional needs of pregnant and lactating women and their infants.

11. The Rural Health Clinic Services Act of 1977 provides cost-related Medicaid reimbursement for services at rural centers in Health Professional Shortage Areas or Medically Underserved Areas. Qualifying centers must be staffed by at least one certified nurse midwife, nurse practitioner, or physician assistant, whose practice must be within the scope of State law and regulation. Prior to passage of this act, these providers were not eligible for Medicaid reimbursement in some States. Because of problems with regulation, certification, and reimbursement, however, far fewer centers than expected had availed themselves of reimbursement under the act.

12. Section 330 funding was $435 million in FY 1989, $457 million in FY 1990, and $478 million in FY 1991 (Health Resources and Services Administration (HRSA) FY 1993 Justification of Appropriations, vol. 1, p. 63.)

    Section 330 funding for FY 1992 was $532 million. The FY 1993 appropriation is $559 million. (BPHC and the Assistant Secretary for Management and Budget [ASMB].)

13. Congress has provided for: (1) **expanded eligibility:** States are now mandated to extend coverage to all pregnant women below 133 percent of the Federal poverty level, and have the option of extending coverage to women between 133 and 185 percent of the poverty level; (2) **continuous eligibility:** eligibility for coverage is now guaranteed throughout pregnancy and the postpartum period, regardless of income changes; (3) **presumptive eligibility:** States have the option of granting temporary coverage based solely on self-reported income; (4) **expanded coverage:** case management services are now reimbursable; and (5) **outstationing:** States must place eligibility workers at locations other than AFDC enrollment sites, including CHCs.

14. CPCP funding was $30 million in FY 1990 and $33 million in FY 1991. (HRSA FY 1993 Justification of Appropriations, vol. 1.)

    In fiscal years 1992 and 1993, $44.7 million was appropriated for the CPCP. (BPHC and ASMB data.)

    Eighty percent of urban and 51 percent of rural centers that responded to our survey and offered perinatal services had received CPCP funding at some point during the 1988-1991 period.

15. The HHS Office of Inspector General (OIG) has addressed the issue of perinatal care for underserved women in several prior studies: *Medicaid Expansions for Prenatal Care: State and Local Implementation* (OEI-06-90-00160), January 1992; *Comprehensive Perinatal Care Program* (OEI-01-90-00460), November 1990; *Access to Medicaid-Covered Prenatal Care* (OEI-06-90-00162), October 1990; *Evaluation of the Boston Healthy Baby Program* (OAI-01-88-01420), July 1989; and *Local Management and Implementation Strategies to Reduce Infant Mortality* (OAI-01-88-01420), July 1989.

16. Our survey inquired about the provision of a representative range of perinatal medical and health-promotion services: ultrasound, amniocentesis, genetic counseling, non-stress testing, dental care, nutritional services, health education, childbirth classes, parenting/infant-care classes, family planning, smoking-cessation programs, substance-abuse treatment, and HIV counseling/testing. Our survey also inquired about the provision of four ancillary

services that facilitate access to care: translation, transportation, home visiting, and child care during appointments.

17. Some centers completed enrollment on site. Other centers only began the enrollment process at the center and applicants had to complete it at the appropriate State offices. In some instances, centers completed all nutritional assessment and WIC paperwork on site, but clients had to obtain vouchers at a different location.

18. Bureau's Common Reporting Requirements (BCRR) Database, BPHC, PHS.

This database contains self-reported financial and caseload data from Section 330 grantees. We derived the percentage change in center revenues from data for those 146 urban centers that both responded to our survey and provided financial data to BPHC through the BCRR form for 1988 and 1990; and for 214 rural centers that provided financial data to BPHC through the BCRR form for 1988 and 1990. Some of these rural centers did not respond to our survey.

Total reported revenues for these 360 centers increased from $630 million in 1988 to $803 million in 1990. Urban center revenues increased from $415 million to $544 million; rural center revenues increased from $215 million to $259 million.

PHS Section 330 grants increased from $258 million in 1988 to $305 million in 1990. Urban centers received $163 million in 1988 and $193 million in 1990, while rural centers received $95 million and $113 million.

Medicaid reimbursements to these centers increased from $107 million in 1988 to $167 million in 1990. At urban centers, Medicaid reimbursements increased from $84 million to $134 million. At rural centers, reimbursements increased from $23 million to $33 million.

These centers received additional revenues from: Maternal and Child Health block grants, PHS Section 329 and 340 grants for migrant workers and the homeless, WIC grants, Title X grants, Title XVIII Medicare payments, Title XX payments, other third party payments, patient collections, State and local revenues, and donations.

19. We excluded these 62 centers from the calculations of the statistics presented in the body of this report (see appendix A for detailed methodology).

20. PHS, *Caring for Our Future*, p. 2.

PHS, *Healthy People 2000*, p. 366.

In our survey, we used the terms "health education" for "health promotion" and "social services" for "psychosocial services."

21. BPHC, PHS, "Program Expectations," (hereafter P.E.), May 1, 1991, p. 21. This document outlines both requirements of law and regulation and Departmental priorities for the centers.

BPHC, PHS, "Regional Program Guidance Memorandum 84-52," May 15, 1984.

22. NCHS, 1992. These 1989 data are the most current available. The average of 62.2 percent for minority women was calculated from rates for Mexican American, Puerto Rican, Cuban, Central and South American, other Hispanic, Chinese, Japanese, Filipino, Hawaiian, other Asian, American Indian/Alaskan Native, and Black women.

The BPHC provided the rate for women in federally designated Healthy Start project areas. The BPHC calculated this rate from information reported by the 15 projects for a time period between 1984 and 1989. The project areas are: Aberdeen, South Dakota (rates are for the Northern Plains Native American populations in North Dakota, South Dakota, and Nebraska); Baltimore, Maryland; Birmingham, Alabama; Boston, Massachusetts; Chicago, Illinois; Cleveland, Ohio; Detroit, Michigan; Lake County, Indiana; New Orleans, Louisiana; New York, New York; Oakland, California; the Pee Dee region, South Carolina; Philadelphia, Pennsylvania; Pittsburgh, Pennsylvania; and Washington, D.C.

23. PHS, *Healthy People 2000*, p. 381.

24. ACOG, *Standards for Obstetric-Gynecological Services*, 7th ed., Washington, D.C., 1989, p. 16.

The PHS has required that "all centers, regardless of size, must assure that the services that they deliver conform to the *Standards for Obstetric-Gynecologic Services*" ("Perinatal Care: How to Establish Perinatal Services in Community Health Centers," PHS, 1985, p. 96).

A 1989 PHS report, *Caring for Our Future: The Content of Prenatal Care*, suggests slightly different guidelines. This report recommends that healthy women receive a minimum of nine prenatal visits during a first pregnancy and seven prenatal visits during subsequent pregnancies (p. 50). The report suggests that women at risk, because of either psychosocial or physical factors, might require more prenatal visits (p. 71). Psychosocial and physical risk factors include: inadequate personal support systems, single marital status, adolescence, advanced age, high stress and anxiety, less than high school education, low income, inadequate housing, inadequate nutritional resources, communication barriers, smoking, alcohol abuse, and illicit drug use (p. 79).

25. In reporting responses to survey questions that solicited information on a scale, we have combined responses of "moderately" and "substantially" and have reported them as "seriously" or "serious."

26. Nonresponses may have resulted in an underestimate of the percentage of centers with such vacancies.

27. See note 9.

28. A substantial increase in commercial medical liability insurance rates and cutbacks in the National Health Service Corps program have resulted in dramatically increased expenditures on medical liability coverage for the centers.

According to the U.S. General Accounting Office, insurance premiums in 1990 amounted to an estimated 10 percent of the centers' total Federal grant funding--or 4.4 percent of center revenues (*Medical Malpractice: Data on Claims Needed to Evaluate Health Centers' Insurance Alternatives*, HRD-91-98, Washington, D.C., May 1991, p. 1.).

29. P.L. 102-501. Under the FTCA, center providers will be defended by the Justice Department in any medical malpractice litigation, and judgments will be paid out of a Justice Department fund, into which the centers will pay annual contributions. This liability protection will be provided for three years, after which time the financial benefits of the arrangement will be assessed.

30. P.E., pp. 4-5.

31. Our survey questions addressed only admitting privileges. During interviews, center staff reported hospital restrictions on the delivery privileges of certified nurse midwives and family physicians.

32. See note 18.

33. The Omnibus Budget Reconciliation Act of 1990 mandated that States locate eligibility workers at sites other than AFDC enrollment sites, including CHCs, by July 1991.

34. Bonnie Lefkowitz, BPHC, PHS, written communication to OIG, December 24, 1991.

In addition, only 26 States had adopted presumptive eligibility as of June 1991 (*Medicaid Expansions for Prenatal Care: State and Local Implementation*, appendix E).

According to the OIG report, *Medicaid Expansions for Prenatal Care: An*

Update (OEI-06-90-00161), three States still used an asset test to determine Medicaid eligibility as of January 1992.

35. According to an internal BPHC draft report, "CPCP 1990 Data Report: Moving Ahead," CPCP-funded centers served 33,938 pregnant teens in 1990, which they report is more than triple the number served in 1988. Also according to this report, in 1989, CPCP-funded centers provided services to 13.4 percent of all pregnant teens age 15 or younger in the United States. BPHC's CPCP data, however, does not permit a comparison of CPCP-funded centers and other centers.

36. Unless otherwise noted, the differences between groups (for example, CPCP-funded centers and other centers) cited in this report are statistically significant at the .05 level.

37. BPHC, PHS, "Supplemental Grants for the Development of a Comprehensive Perinatal Care Program in Community and Migrant Health Centers, Application Guidance," undated document, p. 9.

38. BPHC, PHS, "Supplemental Grants," p. 1.

39. Of those centers that did participate in consortia, a larger percentage of CPCP grant recipients than of other centers reported collaboration with schools, hospitals, private-practice physicians, government social-service agencies, and nonprofit organizations.

40. BPHC, PHS, "Supplemental Grants," p. 9.

41. We did not calculate the statistical significance of the difference between urban and rural center revenues. For more information on center revenues, see note 18.

42. The difference between the percentage of urban centers and the percentage of rural centers that reported medical staff shortages as a serious limitation to the provision of perinatal services was statistically significant at the .1 level.

    Additionally, the difference between the 1 percent decrease in FTE provider staff at rural centers and the 12 percent increase in FTE provider staff at urban centers is statistically significant at the .1 level.

43. PHS, *Seventh Report to the President and Congress on the Status of Health Personnel in the United States*, March 1990.

    Robert M. Politzer, Donna L. Harris, Marilyn H. Gaston, and Fitzhugh Mullan, "Primary Care Physician Supply and the Medically Underserved," *Journal of the American Medical Association*, July 3, 1991, vol. 266, no. 1, pp. 104-109.

John E. Verby, J. Paul Newell, Susan A. Andersen, and Walter M. Swentko, "Changing the Medical School Curriculum to Improve Patient Access to Primary Care," *Journal of the American Medical Association*, July 3, 1991, vol. 266, no. 1, p. 110-113.

44. P.L. 102-501.

45. See the OIG reports, *Access to Medicaid-Covered Prenatal Care* (OEI-06-90-00162), October 1990, and *Medicaid Expansions for Prenatal Care: State and Local Implementation* (OEI-06-90-00160), January 1992.

46. For an analysis of one city's experience, see OIG reports *Evaluation of the Boston Healthy Baby Program* (OEI-01-88-01420), July 1989, and *Local Management and Implementation Strategies to Reduce Infant Mortality* (OEI-01-88-01420), July 1989.

47. For a description of various State approaches to reducing Medicaid's administrative burden on physicians, see the OIG report, *Medicaid Hassle: State Responses to Physician Complaints* (OEI-01-92-00100), March 1992.

48. Sara Rosenbaum and Marilynn Sager, "Unlocking the Hospital Doors: Medical Staff Membership and Physicians Who Serve the Poor," *Yale Law & Policy Review*, vol. 9, no. 1 (1991).