COMPTROLLER GENERAL'S REPORT ON ESTABLISHMENT OF HEALTH CARE FINANCING ADMINISTRATION IN HEW

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

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FIRST SESSION

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COMPTROLLER GENERAL'S REPORT ON ESTABLISHMENT OF HEALTH CARE FINANCING ADMINISTRATION IN HEW

THURSDAY, JULY 21, 1977

U.S. SENATE,
SUBCOMMITTEE ON HEALTH
OF THE COMMITTEE ON FINANCE,
Washington, D.C.

The subcommittee met, pursuant to notice, at 9:05 a.m. in room 2221, Dirksen Senate Office Building, Hon. Herman E. Talmadge (chairman of the subcommittee) presiding.

Present: Senators Talmadge and Matsunaga.

Senator TALMADGE. The hearing will be in order.

The Subcommittee on Health is holding two hearings this morning.

The first hearing is for the purpose of receiving the report of the General Accounting Office on the reorganization of medicare and medicaid into a new Health Care Financing Administration.

The second hearing, which I anticipate will begin about 10:30, is for the purpose of considering legislative proposals designed to expand medicare coverage of services provided in rural clinics.

[The committee press release announcing this hearing follows:]

[Press Release]

COMMITTEE ON FINANCE,
SUBCOMMITTEE ON HEALTH,
U.S. SENATE.

FINANCE COMMITTEE ANNOUNCES HEARING TO RECEIVE COMPTROLLER GENERAL'S REPORT ON ESTABLISHMENT OF HEALTH CARE FINANCING ADMINISTRATION IN HEW

Senator Herman E. Talmadge (D., Ga.), Chairman of the Subcommittee on Health of the Senate Finance Committee, announced today that the Subcommittee will hold a hearing on Thursday, July 21, 1977 at 9:00 A.M. in Room 2221 Dirksen Senate Office Building, to receive testimony from representatives of the Comptroller General concerning the recent reorganization of the Medicare and Medicaid programs within the Department of Health, Education, and Welfare.

The investigation by the Comptroller General of the development of the organizational structure of the new Health Care Financing Administration was formally requested by the Subcommittee on June 7, 1977. The request stemmed from concern with apparent: (1) proliferation of new supergrade employees in the new agency; (2) fragmentation of authority and responsibility; and (3) a proliferation of new and overlapping bureaus, offices, and divisions superimposed over the Medicare and Medicaid operating agencies.

At the conclusion of his detailed request to the Comptroller General for the investigation. Senator Talmadge stated: "Quite simply, the basic questions are: Does this organizational structure enhance or impair effective and timely coordinated policymaking and operations? Are duplicative or parallel functions and jobs consolidated or eliminated at central and regional levels?" Senator Talmadge said that, "the Subcommittee looks forward to the Comptroller General's answers to these and related questions."

Senator Talmadge also noted that, following testimony from the General Accounting Office, the Subcommittee would then proceed to consideration of legislation designed to expand Medicare reimbursement of rural health clinics at approximately 10:30 A.M. of the same day.

WRITTEN STATEMENTS.—Those individuals or organizations who desire to present their views to the Subcommittee should submit a written statement for inclusion in the record of the hearings. These written statements should be submitted to Michael Stern, Staff Director, Committee on Finance, Room 2227 Dirksen Senate Office Building not later than August 1, 1977.

Senator TALMADGE. In the last Congress, joined by many of my colleagues, I introduced legislation to reform the administrative and reimbursement aspects of the medicare and medicaid programs.

A key section of that proposal, S. 3205, was designed to consolidate medicare, medicaid and the Bureau of Quality Assurance into a new Health Care Financing Administration.

My intention was to streamline and consolidate policymaking and operations.

I was pleased when President Carter and Secretary Califano announced the administrative establishment of the Health Care Financing Administration as the principal element of the President's first major reorganization.

But, from the beginning, the implementation appeared to bear little resemblance to the concept.

Instead of the desired consolidation and coordination, there appeared to be: proliferation of new supergrade employees in the new agency; fragmentation of responsibility and authority; and proliferation of new and overlapping bureaus, offices and divisions superimposed upon the medicare and medicaid operating agencies.

The subcommittee and its staff have expressed these concerns formally and informally from the inception of the reorganization.

I believe these efforts have borne fruit.

With respect to supergrade bureaucrats—quite a few of the proposed plums have been pruned.

Nonetheless, there were and are serious questions remaining concerning whether the Health Care Financing Administration served, in good part, as a bureaucratic breeding ground or a more effective and economical means of serving the American people.

At our hearing on S. 1470 last month, I expressed my concerns over the reorganization in detail.

The subcommittee agreed to request to Comptroller General to evaluate the reorganization and to report his findings to the subcommittee.

In that regard, I ask that the detailed request of the subcommittee to the Comptroller General appear in the transcript immediately following opening remarks.

[The material referred to follows:]

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, D.C., June 14, 1977.

Hon. ELMER B. STAATS,
Comptroller General of the United States,
General Accounting Office, Washington, D.C.

DEAR MR. STAATS: On June 7, 1977, during hearings before this Subcommittee, the Subcommittee, on formal motion, agreed to request your Office to review the development and organization of the Health Care Financing Administration in the Department of Health, Education and Welfare. Subsequently, members of our respective staffs have been in consultation on this request.

As you know, the concept of bringing the Medicare and Medicaid programs, health standards activities, and the Professional Standards Review Organizations program under one organization was included in my bill S. 3205 introduced in the last session.

Because of my concern that this organization has been attributed to a concept closely identified with myself, on May 5, 1977, I wrote to Secretary Califano expressing my dissatisfaction with respect to the new reorganization. Specifically, my concerns dealt with—(1) the apparent proliferation of new supergrades, (2) the fragmentation of authority and responsibility through the submergence of the principal operating bureaus (Medicare, Medicaid, and Health Standards and Quality), and (3) the proliferation and possible overlapping of staff activities reporting directly to the Administrator.

By letter dated June 2, 1977, the Secretary responded to my concerns. However, in the judgment of the Subcommittee, this response was not satisfactory. In fact, detailed information received by the Subcommittee on Health subsequent to my May 5 letter has served to reinforce the concerns expressed in that letter.

Therefore, I am requesting the General Accounting Office to make an immediate review of this new organization with emphasis on the following issues:

A. PROLIFERATION OF SUPERGRADES

1. How many supergrades were authorized in the operating agencies consolidated?

2. Immediately prior to the HEW reorganization, how many supergrade positions were authorized in the Social and Rehabilitation Service? Of these, how many were vacant? With the reorganization on March 8, 1977, the Service was disbanded and its functions were distributed to the new Health Care Financing Administration, the Office of Human Development, and the Social Security Administration. In these organizations (i.e., HCFA, OHD, and SSA) how many supergrades positions were designated and how many supergrade employees were assigned?

3. We understand that supergrade-level job classifications are subject to approval by the Civil Service Commission. What is the status of the approval process—both within CSC and OMB—for the supergrade positions being proposed for the Health Care Financing Administration?

4. What has been the result of prior reviews by the Civil Service Commission of the grade structure of the Social and Rehabilitation Service as it pertained to supergrades as well as Grades GS-14's and 15's?

5. Of the supergrades being proposed, how many would be assigned to a staff function as opposed to a line or operating function and does the General Accounting Office believe that the mix would be appropriate?

B. FRAGMENTATION OF AUTHORITY AND RESPONSIBILITY

1. Obtain the views of key officials of the operating bureaus as to their role in the new organization and as to whether they view operating effectiveness and policymaking enhanced or diminished.

In connection with any interviews, it would be appreciated, where requested by the individual concerned, that confidentiality as to his identity be observed.

2. Over the years a basic problem at HEW has been the timely promulgation of regulations pertaining to the health programs. If possible, please provide a flow chart showing how proposed regulations dealing with (a) reimbursement, and (b) Professional Standards Review, would be developed through the hierarchy of the new Health Care Finacing Administration.

3. Historically, the heads of the operation bureaus for Medicare and Medicaid have been authorized to submit program related instructions to intermediaries, to carriers, and to the States. Will this authority remain or will it be diluted under the new organization? Specifically, what will be the authority of the Bureau operating heads with respect to developing and signing correspondence to members of Congress and the public, and what will be their authority and responsibility in issuing instructions to contractors and State agencies?

4. To what extent will staff offices (such as the Associate Administrator for Policy, Planning and Research) be involved in the flow of official communications between the Bureau heads and the Administrator or Deputy Administrator?

C. PROLIFERATION AND POSSIBLE OVERLAPPING OF STAFF ACTIVITIES

1. Identify any evidence of duplication or overlapping from the functional statements of the various offices and Bureaus, and divisions of the Health Care Financing Administration.

2. Does the General Accounting Office see any opportunities to combine or consolidate any of the offices or divisions of the new organization?

3. Is there any evidence that the structure was designed to accommodate grades and personnel rather than to serve to enhance functional efficiency in timely policymaking and operations?

4. Is there any evidence of duplication or overlapping of stated functions between the Bureaus' offices and divisions of the Health Care Financing Administration and the similar organizational elements of other organizations within HEW? For example, what functions of the Associate Administrator for Policy, Planning and Research in the Health Care Financing Administration are duplicated or overlap among the functions of the Office of the Actuary in the Social Security Administration, and the National Center for Health Statistics and the National Center for Health Resources Research in the Public Health Service?

Our current bill, S. 1470, proposes reforms of the administrative and reimbursement procedures for Medicare and Medicaid, including a provision for the legislative establishment of a Health Care Financing Administration. Therefore, it is requested that you or your representatives be prepared to provide the results of their review no later than July 18, 1977, for the Subcommittee's consideration in connection with S. 1470. We realize that many of the issues pertaining to the HEW reorganization involve judgments; nevertheless, because of your staff's extensive experience in auditing the administration of the health programs involved, their views would be of obvious value to the Subcommittee. In this connection, we noted that, in his testimony of June 7, Secretary Califano also welcomed this study of the HEW reorganization which includes the establishment of the Health Care Financing Administration.

Quite simply, the basic questions are: Does this organizational structure enhance or impair effective and timely coordinated policymaking and operations? Are duplicative or parallel functions and jobs consolidated or eliminated at central and regional levels?

With every good wish, I am

Sincerely,

HERMAN E. TALMADGE,
Chairman, Subcommittee on Health.

Senator TALMADGE. Representatives of the General Accounting Office are here this morning to present their findings in response to our request.

Would you gentlemen please identify yourselves and then proceed?

Before that, let me read into the record a statement by Senator Dole. He is at another committee meeting, and will be here momentarily.

As you noted, there has been considerable attention given to the issuance of Government reorganization by many administrations in the past. The burgeoning bureaucracy that the American public has been forced to deal with has become more frustrating as time flows by.

Because of this, I too, am pleased that President Carter has chosen to give this serious matter his attention. The Department of Health, Education, and Welfare has been one of the most glaring examples of organizational proliferation.

The President and Mr. Califano had a complex and demanding job in reorganizing this agency.

Mr. Chairman, your efforts in this area have not gone unnoticed and deserve the appreciation of many of us. Your proposal last year and again this year has provided an excellent opportunity for us to address this issue. As I noted during the hearings held on S. 1470 last month, I was distressed to learn that the implementation of your concept to streamline and consolidate medicare and medicaid in the Bureau of Health Insurance was experiencing a good deal of difficulty. It was for that reason that I asked the subcommittee to request the Comptroller General to evaluate the situation.

I join you this morning in welcoming representatives of the General Accounting Office and look forward to their comments.

Now, if you will please, identify yourselves and proceed.

STATEMENT OF GREGORY J. AHART, DIRECTOR, HUMAN RESOURCES DIVISION, GENERAL ACCOUNTING OFFICE; ACCOMPANIED BY ROBERT IFFERT, ASSISTANT DIRECTOR

Mr. AHART. Thank you, Mr. Chairman. We are pleased to be here this morning.

I am Gregory J. Ahart, Director of Human Resources Division of the General Accounting Office. At my side is Robert Iffert, Assistant Director of that Division. We will be joined shortly by two other members of our staff who are involved in the detail of the study, Thomas Dowdal, who works with Mr. Iffert, and also Ms. Mae Wanda.

Senator TALMADGE. Please proceed.

Mr. AHART. The committee asked us to determine if the organization of HCFA had resulted in the proliferation of supergrades, fragmentation of authority and responsibility, and/or proliferation and possible overlapping of staff activities.

One problem we had, Mr. Chairman, in conducting our review was that not all of the decisions relating to HCFA's organization had been made at the time HCFA was considered as operational on June 20.

Thus, this organization is in a constant state of flux with changes in the organizational elements, responsibilities occurring almost daily.

As you mentioned on March 8, the Secretary announced reorganization initiatives; as a part of those initiatives, he disestablished the Social and Rehabilitation Service, transferring SRS's income security program to the Social Security Administration, the social services program to the Office of Human Development; and the medical assistance program, medicaid, to the newly established HCFA.

In addition to medicaid, HCFA was given the responsibility for administering the medicare program and the standards and certification and professional standards review organization program, which would transfer to it from SSA and the Public Health Service.

Basically, HCFA receives the program responsibilities and most of the personnel from five organizational components: SSA's Bureau of Health Insurance; the Division of Health Insurance Studies in SSA's Office of Research and Statistics; PHS's Bureau of Quality Assurance; PHS's Office of Longterm Care; and finally, SRS's Medical Services Administration.

HCFA also received about half of SRS's support and staff personnel to perform similar functions for HCFA. As a result of these transfers in functions, HCFA is now responsible for administering both medicare and medicaid and most of the activities which support these two programs.

The subcommittee asked us a number of questions relating to the supergrade structure of HCFA. We believe that the issue of supergrade positions can be viewed from two perspectives.

First, if the establishment of HCFA is viewed as essentially the merging of four operational components and one staff component,

then there has been an increase in the number of requested supergrades. However, this increase has been somewhat reduced since the subcommittee questioned the issue and the increase could well be reduced further based on Civil Service Commission review of the supergrade justification.

On the other hand, if the establishment of HCFA is viewed as an integral part of the dissolution of the Social and Rehabilitation Service—which is the hard reality to the people most directly involved—then it could be argued that there could be a net reduction in the number of supergrades.

The first proposal that we were able to identify relating to the number of supergrade positions for HCFA was one for 49 supergrade and executive level positions submitted to HEW's Acting Deputy Assistant Secretary for Management on or about April 8, 1977.

The list was characterized by an official as a "wish list." The Acting Deputy Assistant Secretary rejected it.

When the Secretary testified before the subcommittee on June 7, 1977, it was contemplated that HCFA would have 21 supergrades in its headquarters and possibly an additional five in its regional offices. At that time, HCFA was also requesting three executive level positions. The organization as contemplated about that time is shown on chart No. 1. I am sorry that they are not large enough to see. As you see, if we made boxes large enough for you to read everything on it, we would have a chart bigger than this room.

Since the Secretary's testimony, the number of supergrades being requested by HCFA has been reduced by one, the number of executive level positions has been reduced by one, and the grade level of four positions have been reduced, for example from GS-18 to GS-17.

On page 6 of my statement there is a summary of the number requested on April 8, the number requested as of June 7 and the numbers as they stood on July 11.

Lowering of the supergrade positions will make it more difficult to request additional supergrade positions in the future without first justifying the upgrading of the lowered positions.

In addition to the supergrade positions for HCFA headquarters, requests were also made for regional office supergrades. As of April 8, there were 10 of these. These were reduced to five by June 2, and as of July 11, the Under Secretary had notified HCFA that HEW had approved five, but that, since supergrade resources were not available, HCFA could not proceed with attempting to obtain authorization for the positions from the Civil Service Commission until further notification.

If you desire, Mr. Chairman, we can provide a list of the executive positions as proposed on April 8 and proposed on June 2 and June 11, along with the names of the individuals acting in these positions and their former grades and positions. The organization as contemplated on July 11, 1977 is shown over here on chart No. 2.

Senator TALMADGE. Would you submit that for the record?

Mr. AHART. We certainly will, Mr. Chairman.

[The following material was subsequently submitted for the record:]

Health Care Financing Administration—(as of April 8, 1977)

Administrator	[1] Level IV.
Deputy Administrator	[1] Level V.
Assistant Administrator for Regional Affairs	GS–16.
Assistant Administrator for Information Utilization and Coordination.	GS–16.
Regional H.C.F.A. Administrators (10)	GS–16.
Associate Administrator for Financing Operations	Level V.
Assistant Administrator for Medicare Financing	GS–18.
Deputy Assistant Administrator for Medicare Financing.	GS–17.
Deputy Assistant Administrator for Medicare Program Policy.	GS–17.
Assistant Deputy Assistant Administrator for Medicare Program Policy.	GS–16.
Deputy Assistant Administrator for Medicare Program Operations.	GS–17.
Assistant Deputy Assistant Administrator for Medicare Program Operations.	GS–16.
Deputy Assistant Administrator for Medicare Program I Monitoring.	GS–16.
Assistant Administrator for Medicaid Financing	GS–18.
Deputy Assistant Administrator for Medicaid Financing.	GS–17.
Deputy Assistant Administrator for Medicaid Program Policy.	GS–16.
Deputy Assistant Administrator for Medicaid Program Operations.	GS–16.
Deputy Assistant Administrator for Medicaid Program Monitoring.	GS–16.
Associate Administrator for Policy/Planning	GS–18.
Assistant Administrator for Policy/Actuary	GS–18.
Deputy Associate Administrator/Assistant Administrator for Planning.	GS–17.
Deputy Assistant Administrator for Evaluation	GS–16.
Deputy Assistant Administrator for Demonstrations.	GS–16.
Assistant Administrator for Research and Statistics	GS–16.
Associate Administrator for Health Care	210G or GS–18.
Assistant Administrator for Quality Assurance	210G or GS–17.
Deputy Assistant Administrator for Quality Assurance.	210G or GS–16.
Assistant Administrator for Standards/Certification	GS–17.
Deputy Assistant Administrator for Standards	GS–16.
Associate Administrator for Program Integrity	GS–18.
Assistant Administrator for Program Review	GS–17.
Assistant Administrator for Fraud and Abuse	GS–16.
Associate Administrator for Management/Personnel	GS–18.
Deputy Associate Administrator/Assistant Administrator for Budget.	GS–17.
Assistant Administrator for Administrative Services	GS–16.
Assistant Administrator for Personnel	GS–16.
Associate Administrator for External Relations	GS–17.
Assistant Administrator for Public Affairs	GS–16.
Assistant Administrator for Intergovernmental Affairs and External Organizations/Deputy.	GS–16.
Assistant Administrator for Legislative Liaison	GS–16.

[1] Based on the Secretary's desire to upgrade senior staff, it is anticipated that these positions will be resubmitted at levels III and IV respectively at some future date.

Mr. AHART. As of July 11—because justification documentation had not been submitted, no supergrade positions actually have been authorized by HCFA.

As of March 9, there were 13 supergrade positions authorized for the five operating agencies being merged. Overall, the net difference between these 13 supergrade positions and the 20 positions currently requested for HCFA represents a Deputy Director for Operations which the Administrator does not contemplate filling at this time, an actuary position for which there is some question as to whether the function will remain with SSA, a position for the consolidation of the Program Integrity function, and an additional supergrade position for the PSRO function.

According to HEW, the remaining three additional supergrades represent staff and support supergrade positions in the parent organizations of the five units which should now be allocated to HCFA to perform its staff and support functions.

Of the 22 supergrade and executive level positions being requested by HCFA, 16 are line positions and 6 are staff positions. In comparison, SRS had 1 executive level and 11 supergrade line positions, and 5 staff supergrade positions.

Six HEW officials we interviewed expressed concern that the HCFA organizational structure was designed to accommodate preexisting grade structures, protect grade levels for employees below the supergrade level, and/or to provide for future expansion of the number of supergrades.

These concerns were based on what these HEW officials perceived as unnecessary layering of supervisory positions, expanded numbers of offices and divisions below the primary executive positions, and/or broad functional statements for organizational elements. They also saw these as possible structural problems which could inhibit policymaking and decisionmaking in HCFA.

It was also pointed out to us that if the administration's legislative proposal pertaining to downgrading resulting from reorganization is enacted, it could result in HCFA having more supergrade employees than it has supergrade positions. As of July 11, no position management studies had been conducted in HCFA to ensure proper position alinements or to assess potential impact of supergrades and supervisory positions on other positions in the HCFA organization.

Additionally, no manpower analyses or work measurement studies have been initiated, and no technical assistance relating to supergrade positions have been requested from or provided by the Assistant Secretary for Personnel Administration to assure that all procedures prescribed by the Civil Service Commission had been appropriately followed.

If the merger of the five units is viewed as part of the disestablishment of SRS, the number of headquarter supergrades has been reduced by one.

This reduction is shown in the table on page 10 of my statement.

In addition, SRS had eight regional office GS–16 supergrade positions at the time of the reorganization of which two were vacant. As previously noted, action to request authorization from the Civil Service Commission for these positions has been held in abeyance.

The subcommittee asked several questions relating to fragmentation of authority and responsibility for HCFA programs. We interviewed key HEW personnel about this. We also reviewed available documen-

tation including approved and draft functional statements and delegations of authority.

Most of the officials we talked with felt that the HCFA organization would result in better management of medicare and medicaid programs through enhanced and speedier policy and decisionmaking. The exception was the hospital insurance portion of medicare which, it was felt, was already well-managed and operated efficiently.

Althought the officials almost unanimously agreed that the reorganization would improve the management of the health financing programs, they did see several problems that could develop. I will discuss some information on these problem areas.

The first relates to PSRO and standards policy split from the operation of those programs.

The reorganization resulted in HCFA having responsibility for operating the PSRO and standards program while PHS retained responsibility for setting policy for these programs. The Secretary in his testimony before this subcommittee on June 7 gave his rationale for this split.

He said that he did not believe he had actually separated policy from operations but rather the intent of the reorganization was to "retain some element of quality control within the Office of the Assistant Secretary for Health" because PHS "has some programs over which it has control that need quality control"—for example, HMO's and community health centers—and because "the broad medical doctor input was important to have on a continuing basis into HCFA."

Some officials told us that another reason the Secretary took this action was to assure the Assistant Secretary for Health would have an important role in national health insurance and to retain certain personnel expertise in PHS.

The Office of Quality Standards is the PHS element that will provide quality assurance policy guidance to HCFA. The functional statement for this office was dated June 19, 1977 and published in the Federal Register on June 28, 1977.

The notice in the Federal Register said that PHS's Bureau of Quality Assurance was abolished and all its functions except for issues relating to coverage of specific procedures and provider proficiency testing, were transferred to HCFA.

The notice also established the Office of Quality Standards. Its functional statement states that it provides policy guidelines to HCFA for developing and applying health care standards and that it will review and clear all HCFA regulations in the areas of standards and quality assurance.

We interpret this to mean that PHS has retained policy control over the standards and PSRO areas since the office that provides policy guidance and then reviews and clears regulations in effect sets the policy. We also noted that HCFA was not given the opportunity to comment on the final form of this functional statement before it was published. We understand that the Secretary has since asked for HCFA comments on it.

All the HCFA officials we interviewed said they thought problems would arise because of the policy/operation split in the standards and

PSRO programs. The degree of perceived problems ranged from minor to major. One PHS official also foresaw major problems.

Several HCFA officials said that to leave the National PSRO Council in PHS while transferring PSRO operations to HCFA would impede policymaking and one said it "flies in the face of Senator Talmadge's amendment." The Council is responsible for advising the Secretary on policy matters pertaining to the PSRO programs, providing for the development and distribution of information to PSROs and State-wide PSRO Councils, and reviewing regional norms of medical care used by PSROs.

PHS officials said that some of the National PSRO Council members felt the Council should be transferred to HCFA. The PHS officials also said that the American Medical Association and several other provider groups wanted the Council to stay under the jurisdiction of PHS.

One PHS official stated that:

Senator Talmadge's concerns over the reorganization are correct because the reorganization is not going to do anything to improve the way in which standards are developed.

Most of the PHS officials and one HCFA official said that they believed only minor problems, if any, would be caused by the split in policy and operational responsibility for standards and PSROs. They said three factors would alleviate the problems:

The points of view will now be limited to two organizations—PHS and HCFA—whereas before often three points of view existed—PHS, SSA, and SRS;

PHS will only be involved in broad, long-range policy primarily involving medical issues, and not operational policy;

PHS and HCFA personnel have close working relationships and will work out most problems informally.

However, all of these officials agreed that there is a large "gray area" between what is definitely operating policy and definitely broad policy and that no formal system for determining when PHS will become involved in policy questions has been developed. These officials also agreed that they were largely depending on the informal organizational or interpersonal relationships to alleviate any problems that might arise.

In our reviews of the PSRO program, we have generally found that the track record for program effectiveness has not been good where there is policy setting responsibility without the commensurate line authority to follow through and implement such policies. Specifically, our work in the PSRO program area before the reorganization, when PHS had PSRO policy and direction responsibility but SSA and SRS dictated to a great extent program implementation, showed numerous problems in getting the program moving. My testimony before the Subcommittee on Oversight, House Committee on Ways and Means, on April 4, 1977, which we can provide for the record, listed a number of problems and gave some examples of the problems caused by this split.

The role of Commission of Social Security as Secretary of Boards of Trustees of the medicare trust funds. Under sections 1817 and 1841 of the Social Security Act, the Commissioner of Social Security has

been designated as the Secretary of the Boards of Trustees of the two medicare trust funds. Accordingly, the annual trust fund reports required by law, including statements of the actuarial status of the trust funds, have been prepared under the direction of SSA's Office of the Actuary.

With the transfer of responsibility for managing the medicare program from the Commissioner of Social Security to the Administrator of HCFA, we believe it is important that the role of the Commissioner—particularly in the area of providing the actuarial expertise for estimating disbursement from the trust funds should be clarified.

Because the functional statement of HCFA's Office of Policy, Planning, and Research assumes that HCFA will have its own actuarial capability, although there is some question as to whether it will retain this function, we are concerned about the duplication or overlapping of the actuarial functions unless the Commissioner's responsibilities are clarified.

One alternative would be a statutory change which would designate the Administrator of HCFA as the Secretary of the Medicare Boards of Trustees.

With regards to policy development within HCFA, some of the officials we interviewed believe that problems could arise from HCFA's organizational structure for policy development. Their main concern was that the responsibility for policy development was not clearly delineated between the staff and line offices.

It was generally agreed that the staff offices would not get involved in operational-type policy but would instead concentrate on long-range policy issues. However, it was recognized that many policy questions are not clearly either operational or long-range issues. No formal system has been devised to determine which policies will require staff input and which will not. Most of the officials believed this could be worked out through an informal system.

Another possible problem area in policy development raised by HCFA officials was the role of the Office of the Executive Secretariat. This office will receive an review all policy issues going to the administrator. Its activities are supposed to ensure that all points of views within HCFA are presented and all pertinent issues raised.

Also, the Executive Secretariat will be the point within HCFA of final review and clearance for policies and regulations. The Acting Executive Secretary viewed this review and clearance process as primarily editorial, but with some degree of substantive review. Earlier proposals relating to the functions of the Executive Secretariat saw its function as one of substantive review and formal clearance. HCFA officials expressed concerns that the Executive Secretariat might evolve into something with the powers envisioned for the office in early versions of its functions. The officials felt that such an evolved organization would greatly impede and hinder HCFA policymaking.

With regard to HCFA communications, historically, the medicare and medicaid program heads have been able to issue instructions and communications to carriers, intermediaries and States. While the draft delegations of authority transfer all of the authority of the old agency head positions to the HCFA bureau heads, some of the HCFA officials we interviewed expressed concern that this may not ultimately be the case.

These officials attributed their concerns to the fact that HCFA was considering using an overall directive system which would affect the authority of the program heads to issue instructions.

The president of the union which had the bargaining rights for SRS Local 41 of the American Federation of Government Employees, sent us a letter, along with a number of documents, in which the union's concerns regarding the reorganization were expressed.

We could provide a copy of that letter from the president of the union for the record.

Senator TALMADGE. Please do so.

[The following material was subsequently submitted for the record:]

AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES,
Washington, D.C., July 7, 1977.

Mr. ROBERT IFFERT, Jr.,
Assistant Director, Manpower and Welfare,
General Accounting Office, Washington, D.C.

DEAR MR. IFFERT: In spite of the lofty aspirations indicated by Secretary Califano in his announcement of the reorganization on March 8, the reorganization has been accomplished in a manner contrary to the policies of the Secretary indicated in his announcement message to HEW employees and in correspondence to the National President of the AFGE (attachments 1 and 2).

The lower level bureaucrats in HEW in charge of the reorganization have violated the contract with Local 41 AFGE, circumvented Civil Service Regulations (and perhaps violated them) dealing with the transfer of function (FPM 351), and have weakened the ADP approval process for FFP, established as a result of GAO recommendations in 1965.

The mess created by Don Wortman and his selected crew has raised objections by several State agencies, the APWA, and the National President of the AFGE. During the process of the reorganization, Don Wortman and staff have deliberately withheld information from Local 41 who represent the employees and have refused until June 1977 to negotiate the reorganization as required by the Executive Order 11491, as amended.

The staff of the reorganization have not followed their own declared rules by failing to include in HCFA individuals in OSSO who were performing 80 percent of their work on MMIS (one of the requirements for transfer to HCFA).

The reorganization in HEW has been carried out by individuals who were technically incompetent in training and experience in management information systems and in management methods in spite of the fact that the Office of the Secretary and other organizational units in HEW have competent staff who could have structured an adequate reorganization.

It is highly unlikely that the goal of improved management of the Medicaid/Medicare programs will be accomplished under the poorly planned mess created by the reorganization.

One of the consequences of the poorly planned reorganization is that many individuals have had a significant portion of their duties transferred elsewhere and new duties have not been assigned by the receiving organization with the result that they are doing nothing and do not know what their new duties will be.

The incompetence of the leader of the reorganization has produced a situation in which adverse actions will result from the poor planning of the reorganization staff. Proper planning could have avoided this unnecessary adverse impact on the employees.

The membership of Local 41 AFGE recognizes the need for an improvement in the management of the Medicare/Medicaid programs and supports the efforts of the Secretary in that direction. Our concern is that the job was poorly planned and accomplished by incompetents. We would like to have GAO conduct a thorough investigation of the entire process of the reorganization and will provide additional information, if required.

A member of the GAO staff has been provided with a folder containing information which will substantiate statements made in this letter. If clarification of this material is necessary, Local 41 will cooperate.

Sincerely yours,

THOMAS W. DENNISON,
President, Local 41 AFGE.

Mr. AHART. Turning now to whether the reorganization permits proliferation and overlapping of staff activities, as you requested, we reviewed functional statements of all HCFA and other relevant HEW organizational components. Many of the HCFA functional statements have not yet been approved and were, therefore, still in draft form.

In addition to the question of whether the actuarial expertise should be with the Commissioner of Social Security as secretary of the boards of trustees of the medicare trust funds, or with the Administrator of HCFA as operating head of the medicare program, we observed the following examples where the language of the functional statements of HCFA organizational components were similar to the stated functions of other organizations.

First, the Deputy Assistant Secretary for Planning and Evaluation (Health) has a Division of Health Financing and Cost Analysis which is charged with performing quantitative studies and evaluations of medicare and medicaid including formulating and analyzing alternative legislative proposals, and evaluating the efficiency of existing and potential programs in terms of costs, effectiveness, and economic impact.

HCFA's Office of Policy, Planning and Research has an Office of Legislative Planning which also develops and evaluates recommendations concerning legislative proposals for changes in health care financing. Its Office of Research is supposed to direct the development and conduct of research concerning the impact of medicare and medicaid on the health care industry, program beneficiaries, and providers. Its Office of Policy Analysis is supposed to direct evaluations aimed at assessing the effectiveness of the medicare and medicaid programs and policies.

We see some possible duplication there.

Second, the National Center for Health Statistics includes a Health Economics Analysis Branch in its Division of Analysis which is charged with conducting analysis of the supply and demand for health services, factors affecting costs and the impact of costs on the availability of supply and the characteristics of demands and the impact of financing requirements.

HCFA's Office of Policy, Planning and Research includes a Division of Economic Analysis which is supposed to conduct research on factors which affect the demand and supply of health care services.

In addition to sponsoring or conducting reimbursement studies—which many components of HEW are involved in—the National Center for Health Services Research is responsible for analyzing alternatives for national health insurance, testing different options and evaluating the impact of different approaches.

HCFA's Office of Policy, Planning and Research is charged with developing and maintaining a simulation model to assess the economic impact of national health insurance proposals.

We see some possibility of duplication there.

Turning to the possible overlapping within HCFA itself, we observed the following examples in which there were marked similarities in stated functions:

First, the 1972 amendments extended medicare coverage to insured individuals and their dependents who are afflicted with end-stage

renal disease. Currently, about 36,000 people are receiving medicare benefits totaling about $600 million annually.

In addition to medicare operating and policy divisions involved in the day-to-day development of cost report forms and overseeing the bills for renal disease services by intermediaries and carriers, at least four HCFA or PHS offices—medicare's Division of Special Operations and the Office of Policy, Planning, and Research's Division of Health Systems and Special Studies; the Bureau of Health Standards and Quality's end-stage renal disease staff; and PHS' Office of Quality Standards—have responsibility for studying, monitoring, coordinating or directing this program.

Second, the HCFA's Office of Reimbursement Practices and Cost Containment is charged with the responsibility for examining and studying existing and proposed reimbursement policies utilized by the various HCFA programs. Additionally, it is anticipated that this office will carry out cost containment functions if Congress passes the proposed cost containment legislation.

In addition to the Office of Reimbursement Practices and Cost Containment which has line responsibility for studying reimbursement policies. HCFA's Office of Policy, Planning and Research, with staff responsibility for studying reimbursement policies, has five organizational components which perform reimbursement studies. All five divisions are charged with making recommendations for modification of existing program reimbursement policy and legislation.

In addition to these organizational components, HCFA's Medicare Bureau contains a unit, the Division of Provider and Medical Services Policy, which also evaluates and studies reimbursement policies of provider services under part B, including those for services provided by HMO's, group prepaid practice plans, and ambulatory care centers.

Third, systems development pertaining to measuring and analyzing fraud and abuse. The Office of Program Integrity in HCFA is charged with planning, administering, and assessing programs designed to prevent fraud and abuse in the medicaid and medicare programs. It develops and applies systems designed to measure and analyze the level and nature of improper expenditures attributable to fraud and abuse.

However, there are two organizational elements in HCFA's Office of Policy, Planning and Research which are expected to perform similar functions.

The functions for HCFA's Office of Personnel include providing the overall directions for the following personnel management activities: Recruitment and placement, employee and labor relations, employee development and training, and special employee development activities.

However, two HCFA program bureaus apparently are charged with performing the same functions.

You asked the question whether there are opportunities to combine or consolidate any of the offices or divisions of the new organization. Based on our analysis, we believe there are at least five opportunities. Specifically, these are in the area of: End-stage renal disease. The statement of function for the end-stage renal disease staff identifies 10

functions and activities which may be categorized into three major areas. First, planning and special studies; second, operations such as monitoring performance and operating a medical information system; and finally, quality assurance. Since other HCFA and PHS components are involved in these three types of functions, we believe that such a component could be abolished and its functions transferred to HCFA components whose mission statement indicates that they are doing the same thing.

Second, in the area of reimbursement studies, because the functional statements indicate that there are six other components of HCFA engaged in reimbursement studies and because the Office of Reimbursement Practices had no staff assigned as of July 8, 1977, we believe that the organization could be abolished pending legislative action to establish a cost containment program for hospitals at which time a separate organizational unit reporting directly to the HCFA Administrator would probably be justified to plan and implement such a program to minimize disturbing ongoing operations.

Also, the functional statement for the Medicare Bureau's Division of Provider and Medical Services should be revised to eliminate the reimbursement studies function.

SURVEYS AND STUDIES IN THE AREA OF FRAUD AND ABUSE

Since the functions for program integrity have been centralized in the Office of Program Integrity, we feel that the sample survey and special studies functions related to fraud and abuse, which are currently located in the Office of Policy, Planning, and Research should be eliminated, since the Office of Program Integrity is already supposed to be performing these functions.

PERSONNEL MANAGEMENT

Based on our discussions with HCFA officials and relevant documents, we understand that the functions for personnel management are to be centralized int he Office of Personnel. However, our observation of functional statements for two bureaus—that is, Medicare and Health Standards and Quality—indicate that the two Bureaus are sharing the personnel management functions of the Office of Personnel. While we have no particular preference on the issue of centralization or decentralization of personnel activities, it seems it should be one way or the other.

FINALLY, OFFICE OF POLICY, PLANNING AND RESEARCH

As indicated by the chart, this organization of about 200 people primarily consisting of the nucleus of one Division of SSA's Office of Research and Statistics, now include 6 offices and 12 divisions. We believe various consolidations could be made, particularly at the division level, to eliminate apparent overlapping of functions and to avoid the appearance that the Office has been structured to accommodate a particular GS grade structure.

In summary, we believe that the following overall conclusions can be drawn from our limited review.

Because the organizational structure including the authorization of specific supergrade positions is still developing, it is hard to draw any hard and fast conclusions. Nevertheless, HCFA's requests for numbers of supergrade and executive level staff has been cut in half since the initial proposal and some reductions have occurred since the subcommittee questioned the matter.

Many of the HCFA and PHS officials we interviewed foresaw problems with the continued split between PHS and HCFA with respect to administering or managing the health financing programs authorized by the Social Security Act.

We can see evidence of duplication and overlapping based on HCFA functional statements and those of other elements of HEW.

Finally, the primary areas where real consolidation has occurred is in program integrity and the administration of standards and provider certifications.

Overall, we believe that just the fact that medicare, medicaid, and quality and standards have been placed primarily under the direction of one agency head should result in improved management of the programs through coordination of efforts and exchange of information. Hopefully, HCFA's organization as presently conceived, and as it will evolve over the years, will add to and not detract from this basic plus for program management.

That concludes our statement, Mr. Chairman. We would be happy to respond to any questions.

Senator TALMADGE. Mr. Ahart, thank you for a very comprehensive statement.

How many different offices and divisions will there be in the operating agencies being consolidated?

Mr. IFFERT. Initially, there were 43.

Senator TALMADGE. How many are in the new Health Care Financing Administration?

Mr. IFFERT. Seventy-five.

Senator TALMADGE. Forty-three to seventy-five?

Mr. IFFERT. That is right.

Senator TALMADGE. In your statement, you point out what was essentially 1 division of SSA's Office of Research and Statistics was reorganized into 6 offices and 12 divisions. Would you say that this is the way to go about consolidating and streamlining the bureaucracy?

Mr. AHART. I certainly do not think that is the way to go about it, Mr. Chairman. The office you are referring to is basically one where a lot of things that were formerly organized as teams and working groups have been elevated to division status.

Certainly looking at the before and after situation in that case, I would not call it streamlining or shortening lines of communications. It is more fragmentation.

Senator TALMADGE. What is the effect on overall grade levels from 1 division split into 6 offices and 12 divisions?

Mr. AHART. Generally, the tendency in upgrading different offices to division status would be to elevate the grade level of the heads of those groups and would tend to pull up the grade levels of those underneath them. It has a general tendency to upgrade and raise the level of the general GS structure.

Senator TALMADGE. Are there other examples of one former organizational unit being split into two or more units?

Mr. AHART. We do have some additional examples of that. Mr. Iffert, perhaps you can answer that?

Mr. IFFERT. The Medical Services Administration, SRS had a Division of Resource Management which was responsible for preparing the medicaid budget and preparing the salaries and expense budget and handling manpower management, providing various types of administrative support to the units within the Medical Services Administration.

These functions are now performed by two divisions within two offices of HCFA's Medicaid Bureau.

Senator TALMADGE. Has there been an evaluation of the effect of new supergrade and supervisory positions on the grade structure of the Health Care Financing Administration?

Mr. AHART. It is our understanding that there has not been, Mr. Chairman.

Senator TALMADGE. Is this an important consideration in controlling the growth of the bureaucracy?

Mr. AHART. Yes; we certainly think it is. We think it is important from two aspects: Controlling the growth of the bureaucracy but, more importantly, a reorganization such as this offers an opportunity to get rid of fat in the system if there was fat before. That is more easily done at the time of the reorganization, I believe, than if you have an ongoing bureaucracy that you have to deal with.

Senator TALMADGE. The Secretary, in his June 2 response to the subcommittee, was concerned about the lines of authority within the new agency and stated that each office within HCFA has a clearly defined and distinct area of responsibility.

Does your evaluation of HCFA support this statement?

Mr. AHART. Basically no, Mr. Chairman. As I pointed out in my statement, we found several areas where the functional statement indicated overlapping responsibilities or duplications of activities.

In our statement, we made some suggestions for consolidation or abolishment of some of those functions. We have talked to the Administrator about these, and I hope that they will give them consideration.

Senator TALMADGE. You stated that the number of offices and divisions in the operating proposal has been increased from 43 to 75. Only the Bureau of Health Insurance has managed to hold the line in this respect.

You also stated that the establishment of new offices and divisions served to justify new supervisory positions which, in turn, justified higher grade level.

You further stated in your testimony that six HEW officials expressed concern that the HCFA organizational structure was designed to accommodate preexisting grade structures, protect grade levels of employees below the supergrade level, and provide for future expansion of the number of supergrade positions.

I am not aware that the reorganization of HCFA is a part of the administration's economic stimulus package. With that kind of growth in less than 6 months, perhaps it should be.

It seems to me that there is plenty of room for further consolidation beyond what has taken place and, in fact, the overlapping confusion in the function of the various components may be the result of too many organizational components.

Would you agree with that?

Mr. AHART. Yes; based on our analysis, we would certainly agree with that, Mr. Chairman.

Senator TALMADGE. Prior to the reorganization, the medicare program, a federally operated $22 billion program with over 2,300 employees, is being administered by six supergrade employees. Medicaid on the other hand, an $18 billion program is, by and large, administered by the States. There were approximately 230 employees, including 3 supergrades, in the Medical Services Administration, the Federal operating agency responsible for medicaid.

According to information made available to this subcommittee, the most liberal estimate of SRS personnel involved in the medicaid program was approximately 200, and there was a real question concerning many of these SRS people were necessary in the medicaid operation. In an effort to justify the number of supergrades coming into HCFA and SRS, the Secretary, in his June 2 memo, stated that 15 supergrade positions in SRS were either being utilized or assignable to the Health Care Finance Administration.

You state the Secretary's view, or the subcommittee's view, is defensible, depending on the perspective. It seems to me that if one took the Secretary's view, one would have to assume that all 15 of the SRS supergrades were, in fact, working in the medicaid program.

Does your audit experience with medicaid support the proposition that 15 SRS supergrade employees were directly involved in the medicaid program?

Mr. AHART. No.

In terms of a full-time basis, Mr. Chairman, as I understand it, there were three supergrades that were directly involved in the Medical Services Administration who will be devoting full time to the medical assistance program. There were an additional five supergrades, I believe, in SRS who were devoting full time in other direct program responsibilities, leaving seven or eight, which would be in staff positions, supporting the program operations. Those seven would have been spending, I am sure, some of their time on the MSA programs as well as some of Social Service's programs and AFDC and so on, but they certainly were not spending full time on the Medical Services program.

I think it would be very difficult to say what full time equivalents were, in fact, in SRS, spending their time on the medicaid program. I suspect it would be somewhat less than the 10 or 15 mentioned by the Secretary.

Senator TALMADGE. In your testimony, you indicate that HEW's own job classification reviews reveal significant overgrading in HEW, including SRS.

What do you mean by "significant," and have there been Civil Service Commission reports on the issue as it pertains to SRS?

Mr. AHART. It is my understanding that the HEW found that 17 percent of the sample that they audited in HEW to be overgraded or improperly classified.

I would like to ask Mr. Iffert to provide any details he may have on SRS or any further details on what we may have in the way of Civil Service reports.

Mr. IFFERT. HEW also did some classification studies and, for SRS, the positions reviewed by HEW indicate at least 22 of 129 positions sampled, or about 17 percent, as overgraded. The only Civil Service Commission report that we identified involved the July 1974 report on the special Civil Service Commission inquiry that confirmed allegations of preselection for career positions and an August 1976 Civil Service report pertaining to SRS' Dallas Regional Office that concluded that about 13 of the 32 positions that were sampled were overgraded or required some sort of classification action.

Senator TALMADGE. Again, based on your experience with HEW, would you characterize the former SRS as being an efficient and well-managed agency?

Mr. AHART. We have looked at a lot of programs in HEW over the years. Quite frankly, I would not want to characterize any of them as being well managed or awfully efficient, but I would have to temper that with the fact that in our work we are basically looking for problems and areas that need improvement.

We have found this is the case with SRS. I do not think it was a terribly efficient organization, and we have made a lot of recommendations over a lot of years for improvements in the administration of the medicaid program which was one of its responsibilities, as well as other programs that come under its jurisdiction.

Senator TALMADGE. Which agency, SRS or BHI, has a better reputation for administrative efficiency?

Mr. AHART. BHI has a better reputation for that. It is a little bit difficult to compare the two agencies, one for one, because of the basic differences in the structures of the programs they administer.

BHI basically administers the federally directed and managed program; SRS directs a program which is basically carried out by the States and where the Federal directive authority is somewhat tenuous.

Senator TALMADGE. If SRS were overstaffed, overgraded, and inefficient to begin with, why in Heaven's name would these positions be disproportionately allocated to the Health Care Financing Administration?

Mr. AHART. I am not sure about the disproportionate part of it, Mr. Chairman. I would comment, as I indicated before, I think when we go through a reorganization such as this, every opportunity should be taken to try to, if there was fat in an organization, if it was inefficient, to try to revise that in a way that improves the efficiency, gets rid of the fat if it is there, and so on.

I think this opportunity should be taken here, to the extent that it can be.

Senator TALMADGE. What were the agency affiliations of the persons who comprised the so-called core staff which was responsible for making recommendations on the organization of HCFA?

Mr. AHART. I think the core staff was basically made up of SRS people. They did not make all the decisions on this. The senior people from each of the components that were being consolidated, they were acting on, presumably, the recommendations of the core staff.

We do have a specific makeup of the core staff here.

Senator TALMADGE. Would you please submit that for the record?

[The following material was subsequently submitted for the record:]

CORE STAFF (Supporting Don Wortman) [1]

Name and previous position:

David Weinman, Acting, Executive Secretary/SRS.
Larry McDonough, Detailed from the Office of the Secretary to SRS.
Carolyn Betts, Commissioner of Public Services, Administration/SRS.
Virginia Smyth, SRS Regional Commissioner Region IV.
John Berry, Director, Manpower Management Staff Administrator's Office SRS.
Gallen Benjamin, Supervisory, Staffing and Employee Relations, Office of Personnel/SRS.

WORK GROUP (Supporting HCFA's senior staff [1] on HCFA's organization)

David Weinman, Acting, Executive Secretary/SRS.
Greg Banks, Program Analyst/BQA-PHS.
John Ball, M.D., Deputy Director, Division of Peer Review/BQA-SRS.
Edith Karris, Executive Secretariat/SRS.
Ruth Hanft, Consultant.
Lawrence Levinson, Medicaid/SRS.
Judith Moore, Medicaid/SRS.
Parker Jayne, Assistant Secretary for Management and Budget Management Control Staff.
Peter Gness, Assistant Secretary for Management and Budget (very brief period).
Bill Reid, Management Division/BHI.
Lucille Reifman, Program Analyst/MSA-SRS.
Wayne Rickey, Office of Long Term Care/PHS.
Bob Sermier, Office of Assistant Secretary for Management and Budget.
Ron Schwartz, SRS Assistant Administrator Office of Legislation.

HCFA EXECUTIVE AND SUPERGRADE POSITIONS AND ACTING OFFICIALS

Position titles	Grades proposed as of June 2, 1977	Grade proposed as of July 11, 1977	Name of individual acting in position as of July 11, 1977	Former position/grade of individual acting in position
Administrator	Level IV	Level IV	Robert Derzon [1]	Not in Government.
Deputy Administrator	Level V	Level V	William Fullerton [1]	Do.
Deputy Administrator for Operations.	Level V	GS-18	Vacant	Not applicable.
Associate Administrator for Policy, Planning, and Research.	GS-18	GS-17	Clifton Gaus	Director, Division of Health Insurance Studies, Office of Research and Statistics, SSA, GS-16.
Associate Administrator for Health Standards and Quality.	GS-18	GS-18 [2]	Michael Goran	Director, Bureau of Quality Assurance Health Services Administration PHS, GS-17.
Associate Administrator for Medicaid. [1]	GS-18	GS-18	Thomas Tierney	Director, Bureau of Health Insurance, SSA, GS-18.
Associate Administrator for Medicaid.	GS-18	GS-18	Keith Weikel	Commissioner, Medical Services Administration, SRS, GS-18.
Assistant Administrator for PSRO's.	GS-17	GS-17 [2]	Michael Goran	Director, Bureau of Quality Assurance, Health Services Administration, PHS, GS-16.
Assistant Administrator for Standards and Certification.	GS-17	GS-16	Gerald Sheinbach	Assistant Bureau Director, Division of State Operation, Bureau of Health Insurance, SSA GS-15.
Deputy Associate Administrator for Policy Analysis,	GS-17	GS-16	Vacant	Not applicable.
Assistant Administrator for Program Integrity.	GS-16	GS-16	Donald Nicholson	Director, Division of Utilization Control, Medical Services Administration, SRS, GS-15.

[1] Although the CORE staff was primarily concerned with the reorganization of DHEW, there was the Work Group which also submitted organizational plans to the HCFA senior staff.

HCFA EXECUTIVE AND SUPERGRADE POSITIONS AND ACTING OFFICIALS—Continued

Position titles	Grades proposed as of June 2, 1977	Grade proposed as of July 11, 1977	Name of individual acting in position as of July 11, 1977	Former position/grade of individual acting in position
Deputy Associate Administrator for Medicare.	GS-17	GS-17	James Williamson	Chief Executive Officer, Bureau of Health Insurance, SSA GS-16.
Deputy Associate Administrator for Medicaid.	GS-17	GS-17	Paul Willging	Deputy Commissioner, Medical Services Administration, SRS, GS-16.
Assistant Associate Administrator for Medicare Program Policy.	GS-17	GS-17	Melvin Blumenthal	Deputy Director for Program Policy, Bureau of Health Insurance, SSA, GS-17.
Assistant Administrator for Management and Budget.	GS-16	GS-16	David Weinman	Director, Executive Secretariat, SRS, GS-15.
Assistant Associate Administrator for Medicare Program Operations.	GS-17	GS-17	Mildred Tyssowski	Deputy Director for Program Operations, Bureau of Health Insurance, SSA, GS-17.
Assistant Administrator for Congressional Liaison.	GS-16	GS-16	Suzanne Hassett	Acting Chief, Policy and Legislation Branch, Medical Services Administration, SRS.
Director, Office of Financial and Actuarial Analysis.	GS-17/18	GS-17	Vacant	Not applicable.
Assistant Administrator for Research.	GS-16	GS-15	Not applicable	Not applicable.
Assistant Associate Administrator for Medicaid Program Operations.	GS-16	GS-16	Thomas Laughlin	Associate Commissioner for Program Coordination, Medical Services Administration, SRS' GS-16.
Deputy Assistant Administrator for PSRO's.	GS-16	GS-16	Vacant	Not applicable.
Chief Medical Officer	GS-17	GS-17 [2]	Roger Egeberg, M.D.[1]	Special Assistant to the Secretary for Health Policy, GS-17.
Director, Division of Peer Review.	GS-16	GS-15	Not applicable	Not applicable.
Regional Administrator, Region II.	GS-16	[3]	William Toby	SRS Regional Commissioner, Region II, GS-16.
Regional Administrator Region IV.	GS-16	[3]	Virginia Smyth	SRS Regional Commissioner, Region IV, GS-16.
Regional Administrator Region V.	GS-16	[3]	Larry McDonough	Director of HEW Refugee Task Force, GS-15.
Regional Administrator, Region III.	GS-16	[3]	Alwyn Carty, Jr	SRS Regional Commissioner Region III, GS-16.
Regional Administrator, Region IX.	GS-16	[3]	Joe Maldonado	Acting HEW Regional Director, Region IX, GS-17.
Deputy Assistant Associate Administrator Medicare Program Operations.	GS-16	GS-16	Lamont Williamson	Assistant Director, Division of Contract Operations, Bureau of Health Insurance, SSA, GS-16.

[1] Person has been appointed to the position and is not acting in it.
[2] This is a nonquota supergrade position. The Assistant Secretary for Personnel Administration has not made HEW's official determination on whether the position or grade is justified.
[3] The Deputy Secretary has informed HCFA that this position is justified for a supergrade. However, since HEW had no supergrade positions to allocate for this position, further action on obtaining CSC authorization has been postponed indefinitely.

Senator TALMADGE. Which individuals had direct responsibility for preparing the initial list of the 49 supergrades and executive level positions, and did those involved have continuing responsibility in developing the supergrade structure?

Mr. AHART. Yes.

The "core staff," as I understand it, came up with the initial list. As I understand it, it was seen, however, by the Administrator and by Don Wortman, Acting Administrator, prior to the Administrator's appointment.

I assume that they reviewed it and approved it.

Senator TALMADGE. Who was involved?

Mr. AHART. The core staff was headed by David Weinman.

Senator TALMADGE. What are their current positions and current or proposed grade levels?

Mr. AHART. Mr. Weinman, as I understand it, was a grade 15 in his former position and is moving, I believe to be the Acting Assistant Administrator for Management and Budget. I think that is a grade 16 position.

Senator TALMADGE. Would it be fair to say that the organization of the Health Care Financing Administration was heavily influenced by former SRS employees?

Mr. AHART. That is difficult to say. The core group, obviously, was made up largely of SRS. I am sure that that influenced the way that things came out. There were people in senior positions that were reviewing these recommendations without actually knowing what had happened to the recommendations through the process.

I could not comment on how heavy that influence was. Mr. Iffert may have a better feel for that than I would.

Mr. IFFERT. I think it is also fair to say that all the merger organizations were equally represented in this so-called senior staff. There was some balance there.

Senator TALMADGE. Did medicare senior staff agree with the proposed staffing structure?

Mr. AHART. Mr. Iffert, can you comment on that?

Mr. IFFERT. I would rather not. Under the Chairman's directive, in all discussions with everybody in the organization, we promised them complete confidentiality if they desired it. I would not want to characterize the views of any particular groups.

Senator TALMADGE. Did the Bureau of Quality Assurance senior staff feel that way?

Mr. AHART. There would be the same response. In doing this kind of work and getting views of senior officials, we protect the confidentiality of their statements, which may influence some people in their relationships in the future. To identify them by specific organizations, I think we would run that risk.

Senator TALMADGE. Did medicaid senior staff agree?

Mr. AHART. Again, the same response.

Senator TALMADGE. I think your response speaks more eloquently than if you replied in the affirmative.

Senator Matsunaga?

Senator MATSUNAGA. Mr. Chairman, thank you for giving me the privilege of listening to Mr. Ahart. I was testifying before another committee, which accounts for my tardiness, but going over your statement, I want to commend you for your comprehensiveness.

Mr. AHART. We would be happy to answer any questions that you may have.

Senator TALMADGE. Mr. Ahart, on behalf of the subcommittee, I want to thank you and your associates from the General Accounting Office for your timely response to the committee request. I am aware that there is a limit to what one can accomplish in the short span allowed for this report, and it is to the credit of the General Accounting Office that it got such a firm grasp of the issues during this time.

Without objection, I would suggest that a summary of the subcommittee findings be forwarded to Secretary Califano for his response. Further, I would suggest that the subcommittee request that the General Accounting Office continue its close monitoring with HCFA and

report to the subcommittee monthly during the next 12 months on the status of the organization.

Mr. AHART. We will be happy to consider that. We will work with your staff in trying to work out the best arrangement we can to keep the subcommittee informed as to the results of our monitoring effort.

Senator TALMADGE. Thank you very much.

[The prepared statement of Mr. Ahart follows:]

STATEMENT OF GREGORY J. AHART, DIRECTOR, HUMAN RESOURCES DIVISION

Mr. Chairman and Members of the Subcommittee: We are pleased to appear here today to discuss the results of our review of the development and organization of the Health Care Financing Administration (HCFA) in the Department of Health, Education, and Welfare (HEW).

The Subcommittee asked us to determine if the organization of HCFA had resulted in:

Proliferation of supergrades;

Fragmentation of authority and responsibility; and

Proliferation and possible overlapping of staff activities.

We discussed the objectives and effects of the reorganization with high-rankingHEW headquarters officials, some regional office personnel, and with representatives of the Office of Management and Budget and the Civil Service Commission. We reviewed available documentation of staffing patterns—numbers, grade-levels, and position descriptions—before and after the creation of HCFA. We also discussed the effects of staffing patterns with Civil Service Commission officials.

One problem we had in conducting our review was that not all of the decisions relating to HCFA's organizations had been made at the time HCFA was considered as operational on June 20, 1977. Thus, its organization is in a constant state of flux with changes in the organizational elements responsibilities occurring almost daily.

OBJECTIVES OF HEW'S REORGANIZATION

On March 8, 1977, HEW Secretary Joseph A. Califano, Jr., announced a series of reorganization initiatives designed to (1) streamline HEW operations, (2) improve delivery of services, and (3) reduce opportunities for fraud and abuse.

To accomplish these goals, the HEW consolidated the educational loan programs within the Office of Education and disestablished the Social and Rehabilitation Services (SRS) transferring SRS's income security program (aid to families with dependent children) and related activities to the Social Security Administration (SSA), SRS's social services program to the Office of Human Development (OHD), and SRS's medical assistance program (Medicaid) to the newly established HCFA. In addition to Medicaid, HCFA was given responsibility for administering the Medicare program which was transferred from SSA, and the standards, certification, and professional standards review organization (PSRO) programs which were transferred from the Public Health Service (PHS).

Basically, HCFA received the program responsibilities and most of the personnel of five organizational components, (1) SSA's Bureau of Health Insurance, (2) the Division of Health Insurance Studies in SSA's Office of Research and Statistics, (3) PHS's Bureau of Quality Assurance, (4) PHS's Office of Long-Term Care, and (5) SRS's Medical Services Administration. HCFA also received about half of SRS's support and staff personnel to perform similar functions for HCFA.

As a result of these transfers of functions, HCFA is now responsible for administering both Medicare and Medicaid and most of the activities which support these two programs. Medicare and Medicaid are similar in many respects, but also differ significantly. For example, both programs usually use the same health facility standards and certification programs, Medicaid payments are limited to Medicare's reimbursement rates, and both programs contract extensively with private companies for claims processing functions. However, Medicare is a Federal program with uniform eligibility and rembursement criteria natonwide while Medicaid is basically a State program in which the Federal Government sets broad policy and participates in program costs with State gov-

ernments setting all or some of the eligibility and reimbursement standards. Thus, there is one Medicare program, but 53 Medicaid programs.

The Secretary said an immediate benefit of consolidating Medicare and Medicaid would be an energetic program of reviews to determine major abuses in health care financing programs. He said that hundreds of millions of dollars may be saved through a vigorous program of reviews, audits, and investigations to detect fraud, abuse, and overpayments. Another benefit, he said, would be the simplification and strengthening of health policy development.

We will now address the issues contained in the Subcommittee's request of June 14, 1977.

POSSIBLE PROLIFERATION OF SUPERGRADES

The Subcommittee's letter to us asked a number of questions relating to the supergrade structure of HCFA.

We believe that the isuse of supergrade positions can be viewed from two perspectives:

If the establishment of HCFA is viewed as essentially the merging of four operational components and one staff component, then there has been an increase in the number of requested supergrades. However, this increase has been somewhat reduced since the Subcommittee questioned the issue and the increase could well be reduced further based on Civil Service Commission review of the supergrade justification; and

On the other hand if the establishment of HCFA is viewed as an integral part of the dissolution of the Social and Rehabilitation Service—which is the hard reality to the people most directly involved—then it could be argued that there could be a net reduction in the number of supergrades; however, if the Congress passes legislation protecting the grades of individuals from adverse actions resulting from reorganizations then the argument for this second view should be modified. In any event, we believe either view is defensible depending upon the perspective.

The first proposal we were able to identify relating to the number of supergrade positions (GS–16–18) for HCFA was one for 49 supergrade and executive level positions (including 10 regional administrators) submitted to HEW's Acting Deputy Assistant Secretary for Management on or about April 8, 1977, in response to the Acting Deputy Assistant Secretary's request for information with which to prepare HEW's annual request for supergrade positions. The 49 positions, according to one official, was arrived at by looking at the positions authorized such other Federal agencies as SRS and the old Office of Economic Opporounity. No analysis of available supergrade positions and of workload was made to determine HCFA's needs for supergrades and the list of 49 was characterized by an official as a "wish list". The Acting Deputy Assistant Secretary rejected this list.

When the Secretary testified before the Subcommittee on June 7, 1977, it was contemplated that HCFA would have 21 supergrades in its headquarters and possibly an additional 5 in its regional offices. At that time, HCFA was also requesting 3 executive level positions. The organization as contemplated about that time is shown on chart number 1.

Since the Secretary's testimony, the number of supergrades being requested by HCFA has been reduced by one, the number of executive level positions has been reduced by one, and the grade level of four positions have been reduced, for example from GS–18 to GS–17. The following table gives by grade the number of executive and supergrade positions requested for HCFA headquarters as of April 8, June 2, and July 11.

	Number requested as of—		
	April 8	June 2	July 11
Level IV	1	1	1
Level V	2	2	1
GS–18	7	5	[1] 4
GS–17	10	8	8
GS–16	19	8	8
Total	39	24	[1] 22

[1] 1 of the GS–18 positions is that of Deputy Administrator for Operations. We have been informed that the Administrator does not contemplate filling this position at this time.

Lowering of the supergrade levels will make it more difficult to request additional supergrade positions in the future without first justifying the upgrading of the lowered positions.

In addition to the supergrade positions for HCFA headquarters, requests were also made for regional office supergrades. As of April 8, 10 regional office supergrades were being requested. This was reduced to 5 as of June 2. As of July 11, the Under Secretary had notified HCFA that HEW had approved 5 regional supergrades but that, since supergrade resources were not available, HCFA could not proceed with attempting to obtain authorization for the positions from the Civil Service Commission until further notification.

Mr. Chairman, if the Subcommittee desires, we can provide a list of the executive positions as proposed April 8. We can also provide a list as proposed as of June 2, and as they were proposed July 11 along with the names of the individuals acting in these positions and their former grades and positions. The organization as contemplated on July 11, 1977, is shown on chart number 2.

When HCFA requested the supergrade and executive level positions, it did not provide the Acting Assistant Secretary for Personnel Administration with proposed staffing charts, evaluation statements, position descriptions, or justifications for the supergrade positions. The Acting Assistant Secretary requires these documents in order to obtain CSC approval for the allocations of the supergrade positions. Therefore, as of July 11, 1977, no supergrade positions had been authorized for HCFA.

As of March 9, 1977, there were 13 supergrade positions authorized for the 5 operating agencies being merged. Overall the net difference between these 13 supergrade positions (including one vacancy) and the 20 position currently requested for HCFA represents a Deputy Director for Operations which the Administrator does not contemplate filling at this time, an actuary position for which there is some question as to whether the function will remain with SSA, a position for the consolidation of the Program Integrity Function, and an additional supergrade position for the PSRO function. According to HEW, the remaining 3 additional supergrades represent staff and support supergrade positions in the parent organizations of the 5 units which should now be allocated to HCFA to perform its staff and support functions. Since the documentation supporting the request for the supergrade positions was not available, we made no further inquiries into the matter pending submission of the justifications to the Office of the Secretary and then to the Civil Service Commission. It should be noted that CSC will have to review and approve the positions before they can be authorized by HCFA.

Of the 22 supergrade and executive level positions being requested by HCFA, 16 are line positions and 6 are staff positions. In comparison, SRS had 1 executive level and 11 supergrade line positions, and 5 staff supergrade positions.

Six HEW interviewees we interviewed expressed concern that the HCFA organizational structure was designed to accommodate pre-existing grade structures, protect grade levels for employees below the supergrade level, and/or to provide for future expansion of the number of supergrades. These concerns were based on what these HEW officials perceived as unnecessary layering of supervisory positions, expanded numbers of offices and divisions below the primary executive positions, and and/or broad functional statements for organizational elements. The officials also saw these as possible structural problems which could inhibit policy making and decision making in HCFA.

Additionally, it has been pointed out to us that if the Administration's legislative proposal pertaining to downgrading resulting from reorganization is enacted, it could result in HCFA having more supergrade employees than it has supergrade positions. This could result because the proposal would protect employees from being downgraded because of reorganizations and HCFA has several nonsupergrades acting in supergrade positions while several supergrade employees are not acting in supergrade positions.

Also, we noted that CSC has extended to December 31, 1979, the time HEW has to comply with the HEW classification reviews from February 1974 through 1976; including those for SRS, which reported significant overgrading of positions in grades below the supergrade level. Thus, those SRS employees transferred from SRS to HCFA and to other organizations can already have their grades protected for 2½ years. Also, if H.R. 6953 is enacted, employees whose positions were overgraded and the positions subsequently reduced, would retain their grade-level for as long as they stayed in the downgraded position. When they left the position, the new employee would be at the reduced grade.

As of July 11, 1977, no position management studies had been conducted in HCFA to ensure proper positions alignments or to assess potential impact of supergrades and supervisory positions on other positions in the HCFA organization. Additionally, no manpower analyses or work measurement studies have been initiated, although HCFA plans to initiate a manpower analysis of the Office of Personnel in the near future. No technical assistance relating to supergrade positions has been requested from or provided by the Assistant Secretary for Personnel Administration to assure that all procedures prescribed by the Civil Service Commission have been appropriately followed.

If the merger of the five units is viewed as part of the disestablishment of SRS, the number of headquarter supergrades has been reduced by one, calculated as follows:

Before reorganization

Organizations:	*Authorized supergrades*
SRS (including Medical Services Administration)	16
Bureau of Health Insurance (SSA)	6
Office of Research and Statistics (SSA)	1
Bureau of Quality Assurance (PHS)	2
Office of Long-Term Care (PHS)	1
Total	26

After reorganization

Organizations:	*Requested supergrades*
HCFA	20
SSA	2
OHD	3
Total	25

In addition, SRS had eight regional office GS-16 supergrade positions at the time of the reorganization of which two were vacant. HCFA is presently requesting five regional positions at the GS-16 level, but as noted previously, action to request authorization from the Civil Service Commission has been held in abeyance.

SRS was authorized 16 headquarters supergrade positions at the time it was abolished. Of these, 4 were vacant. We have been informed by HEW that 12 incumbents have been placed in HEW agencies or resigned as follows:

3 assigned to HCFA;
3 assigned to Office of Human Development;
1 assigned to SSA;
1 detailed to the Office of the Inspector General;
1 detailed to the Office of the Assistant Secretary for Management and Budget;
1 detailed to the Office of Education;
1 detailed to HCFA; and
1 is no longer with HEW.

Also, one of the vacant supergrade positions has been assigned to SSA.

DID THE REORGANIZATION RETAIN PRIOR OR RESULT IN NEW FRAGMENTATION OF AUTHORITY AND RESPOSIBILITY

The Subcommittee's letter to us asked several questions relating to possible fragmentation of authroity and responsibility for HCFA programs. As you requested, we interviewed key HEW personnel about this. We also reviewed available documentation including approved and draft functional statements and delegations of authority.

Most of the officials we talked with felt that the HCFA organization would result in better maangement of Medicare and Medicaid programs through enhanced and speedier policy and decision making. These improvements were attributed by the officials to the following factors:

One agency head is now responsible for the operation of Medicare, Medicaid, standards and certification, and quality asurance whereas three agency heads were formerly responsible for these functions.

For the Medicaid and quality assurance program, the number of bureaucratic layers and coordination points through which decisions had to pass before they were finalized has been reduced.

Headquarter's offices now believe they have direct line authority over their regional office counterparts thereby ensuring more uniform policy interpretation and guidance to agencies and individuals external to HCFA.

The program integrity functions of Medicare and Medicaid have been consolidated which should result in better interchange of information and techniques between the programs.

The consolidation of the standards and quality of care programs with the financing programs in one agency should improve and help make uniform the application of quality assurance programs.

Overall, the officials we interviewed believed that the operation of and policy and decision making for the HCFA programs should be enhanced. The exception was the hospital insurance portion of Medicare which most felt was already well managed and operating efficiently. Most officials stated that some of Medicare's effectiveness in policy making and operations might be lost because of the reorganization. On the other hand, the officials also generally agreed that the other programs would benefit by drawing on Medicare's management capabilities.

Although the officials almost unanimously agreed that the reorganization would improve the management of the health financing programs, they did see several problem areas that could develop. Their views and other information we have gathered relating to these possible problem areas follows.

PSRO and standards policy/operation split

The reorganization resulted in HCFA having responsibility for operating the PSRO and standards program while PHS retained responsibility for setting policy for these programs. The Secretary in his testimony before this Subcommittee on June 7 gave his rationale for this split. He said that he did not believe he had actually separated policy from operations but rather the intent of the reorganization was to "* * * retain some element of quality control within the Office of the Assistant Secretary for Health" because PHS "has some programs over which it has control that need quality control"—for example, HMOs and community health centers—because "the broad medical doctor input was important to have on a continuing basis into [HCFA]." Some officials told us that another reason the Secretary took this action was to assure the Assistant Secretary for Health would have an important role in nationa lhealth insurance and to retain certain personnel expertise in PHS.

The Office of Quality Standards is the PHS element that will provide quality assurance policy guidance to HCFA. The functional statement for this office was dated June 10, 1977, and published in the Federal Register on June 28, 1977. The notice in the Federal Register said that PHS's Bureau of Quality Assurance was abolished and all its functions, except for issues relating to coverage of specific procedures and provider proficiency testing, were transferred to HCFA. The notice also established the Office of Quality Standards. Its functional statement states that it provides policy guidelines to HCFA for developing and applying health care standards and that it will review and clear all HCFA regulations in the areas of standards and quality assurance. We interpret this to mean that PHS has retained policy control over the standards and PSRO areas since the office that provides policy guidance and then reviews and clears regulations in effect sets the policy. We also noted that HCFA was not given the opportunity to comment on the final form of this functional statement before it was published. We understand that the Secretary has since asked for HCFA comments on it.

All the HCFA officials we interviewed said they thought problems would arise because of the policy/operation split in the standards and PSRO programs. The degree of perceived problems ranged from minor to major. One PHS official also foresaw major problems.

Several HCFA officials said that to leave the National PSRO Council in PHS while transferring PSRO operations to HCFA would impede policy making and one said it "flies in the face of Senator Talmadge's amendment." The Council is responsible for advising the Secretary on policy matters pertaining to the PSRO programs, providing for the development and distribution of information to PSROs and State-wide PSRO Councils, and reviewing regional norms of medical care used by PSROs. PHS officials said that some of the National PSRO Council

members felt the Council should be transferred to HCFA. The PHS officials also said that the Americal Medical Association and several other provider groups wanted the Council to stay under the jurisdiction of PHS.

One PHS official stated that "Senator Talmadge's concerns over the reorganization are correct because the reorganization is not going to do anything to improve the way in which standards are developed."

Most of the PHS officials and one HCFA official said that they believed only minor problems, if any, would be caused by the split in policy and operational responsibility for standards and PSROs. They said three factors would alleviate the problems:

The points of view will now be limited to two organizations (PHS and HCFA) whereas before often three points of view existed (PHS, SSA, and SRS).

PHS will only be involved in broad, long-range policy, primarily involving medical issues, and not operational policy.

PHS and HCFA personnel have close working relationships and will work out most problems informally.

However, all these officials agreed that there is a large "grey area" between what is definitely operating policy and definitely broad policy and that no formal system for determining when PHS will become involved in policy questions has been developed. These officials also agreed that they were largely depending on the informal organizational or interpersonal relationships to alleviate any problems that might arise.

In our reviews of PSRO program, we have generally found that the track record for program effectiveness has not been good where three is policy setting responsibility without the commensurate line authority to follow through and implement such policies. Specifically, our work in the PSRO program area before the reoragnization, when PHS had PSRO policy and direction responsibility but SSA and SRS dictated to a great extent program implementation, showed numerous problems in getting the program moving. My testimony before the Subcommittee on Oversight, House Committee on Ways and Means, on April 4, 1977, which we can provide for the record, listed a number of problems and gave some examples of the problems caused by this split.

Role of Commissioner of Social Security as Secretary of Boards of Trustees of the Medicare Trust Funds

Under sections 1817 and 1841 of the Social Security Act, the Commissioner of Social Security has been designated as the Secretary of the Boards of Trustees of the two Medicare Trust Funds. Accordingly, the annual Trust Fund reports required by law, including statements of the actuarial status of the Trust Funds, have been prepared under the direction of SSA's Office of the Actuary.

With the transfer of responsibility for managing the Medicare program from the Commissioner of Social Security to the Administrator of HCFA, we believe it is important that the role of the Commissioner—particularly in the area of providing the actuarial expertise for estimating disbursements from the Trust Funds should be clarified. Because the functional statement of HCFA's Office of Policy, Planning, and Research assumes that HCFA will have its own actuarial capability, although there is some question as to whether it will retain this function, we are concerned about the duplication or overlapping of the actuarial functions unless the Commissioner's responsibilities are clarified.

One alternative would be a statutory change which would designate the Administrator of HCFA as the Secretary of the Medicare Boards of Trustees.

Policy development within HCFA

Some of the officials we interviewed believe that problems could arise from HCFA's organizational structure for policy development. Their main concern was that the responsibility for policy development was not clearly delineated between the staff and line offices. It was generally agreed that the staff offices would not get involved in operational-type policy but would instead concentrate on long range policy issues. However, it was recognized that many policy questions are not clearly either operational or long range issues. No formal system has been devised to determine which policies will require staff input and which will not. Most of the officials believed this could be worked out through an informal system.

Another possible problem area in policy development raised by HCFA officials was the role of the Office of the Executive Secretariat. This office will receive and review all policy issues going to the Administrator. Its activities are supposed to ensure that all points of view within HCFA are presented and all

pertinent issues raised. Also, the Executive Secretariat will be the point within HCFA of final review and clearance for policies and regulations. The Acting Executive Secretary viewed this review and clearance process as primarily editorial, but with some degree of substantive review. Either proposals relating to the functions of the Executive Secretariat saw its function as one of substantive review and formal clearance. HCFA officials expressed concerns that the Executive Secretariat might evolve into something with the powers envisioned for the Office in early versions of its functions. The officials felt that such an evolved organization would greatly impede and hinder HCFA policy making.

HCFA communications

Historically, the Medicare and Medicaid program heads have been able to issue instructions and communications to carriers, intermediaries, and States. While the draft delegations of authority transfer all of the authority of the old agency head positions to the HCFA bureau heads, some of the HCFA officials we interviewed expressed concern that this may not ultimately be the case. These officials attributed their concerns to the fact that HCFA was considering using an overall directive system which could affect the authority of the program heads to issue instructions.

Also, prior to the reorganization, the BHI Director was authorized to develop and sign correspondence to members of Congress and the public. However, under the reorganization it appears that the Office of the Executive Secretariat, through which all correspondence flows, will make the determination of where incoming correspondence is distributed and who will sign outgoing correspondence. This would seem to limit the authority of the program heads in the correspondence area.

Employee union concerns

The president of the union which had the bargaining rights for SRS, Local 41 of the American Federation of Government Employees, sent us a letter, along with a number of documents, in which the union's concerns regarding the reorganization were expressed. Through the letter and discussions with Local 41 officials we were informed that the union believes HEW had violated the union contract and CSC regulations by not consulting and negotiating with the union concerning employee's rights under the reorganization and that the reorganization had resulted in fragmentation of responsibility in the automated management information system approval process for welfare programs.

Regarding management information systems, the union pointed out that whereas SRS had consolidated the approval process for such systems for AFDC, Medicaid, and social services in one office (the Office of Information Systems), the approval process was now split three ways: (1) SSA for AFDC systems, (2) HCFA for Medicaid systems, and (3) OHD for social systems. The union expressed the view that this would cause hardships on the States and long delays in obtaining systems approval since often all three types of management information systems are combined in one but would have to be sent to three agencies.

Mr. Chairman, if the Subcommittee wishes, we will provide the letter from the President of Local 41 for the record.

DOES THE REORGANIZATION PERMIT PROLIFERATION AND OVERLAPPING OF STAFF ACTIVITIES?

Mr. Chairman, your letter to us also posed several questions regarding proliferation and possible overlapping of staff activities. More specifically, we were requested to identify any evidence of duplication or overlapping of stated functions between HCFA's organizational elements and other similar HEW organizational elements, as well as to identify any evidence of duplication or overlap between the various offices and bureaus within the Health Care Financing Administration. As you requested, we reviewed functional statements of all HCFA and of other relevant HEW organizational components. Many of the HCFA functional statements have not been approved and were, therefore, still draft documents.

Evidence of overlapping of functions between organizational components of HCFA and other organizations within HEW

In addition to the question of whether the actuarial expertise should be with the Commissioner of Social Security as Secretary of the Boards of Trustees of

the Medicare Trust Funds, or with the Administrator of HCFA as operating head of the Medicare program, we observed the following examples where the language of the functional statements of HCFA organizational components were similar to the stated functions of other organizations.

1. The Deputy Assistant Secretary for Planning and Evaluation (Health) has a Division of Health Financing and Cost Analysis which is charged with performing quantitative studies and evaluations of Medicare and Medicaid including formulating and analyzing alternative legislative proposals, and evaluating the efficiency of existing and potential programs in terms of costs, effectiveness, and economic impact.

HCFA's Office of Policy, Planning and Research has an Office of Legislative Planning which also develops and evaluates recommendations concerning legislative proposals for changes in health care financing. Its Office of Research is supposed to direct the development and conduct of research concerning the impact of Medicare and Medicaid on the health care industry, program beneficiaries, and providers. Its Office of Policy Analysis is supposed to direct evaluations aimed at assessing the effectiveness of the Medicare and Medicaid programs and policies.

2. The National Center for Health Statistics includes a Health Economics Analysis Branch in its Division of Analysis which is charged with conducting analysis of the supply and demand for health services, factors effecting costs and the impact of costs on the availability of supply and the characteristics of demands and the impact of financing arrangements. HCFA's Office of Policy, Planning, and Research includes a Division of Economic Analysis which is supposed to conduct research on factors which affect the demand and supply of health care services.

3. In addition to sponsoring or conducting reimbursement studies—which many components of HEW are involved in—the National Center for Health Services Research is responsible for analyzing alternatives for national health insurance, testing different options and evaluating the impact of different approaches. HCFA's Office of Policy, Planning, and Research is charged with developing and maintaining a simulation model to assess the economic impact of national health insurance proposals.

Evidence of overlapping of functions between organizational components within HCFA

We observed the following examples in the functional statements of various HCFA organizational components in which there were marked similarities in stated functions.

1. End-stage renal disease.—The 1972 amendments extended Medicare coverage to insured individuals and their dependents who are afflicted with end-stage renal disease. Currently, about 36,000 people are receiving Medicare benefits totaling about $600 million annually.

In addition to Medicare operating and policy divisions involved in the day-to-day development of cost report forms and overseeing the payment of bills for renal disease services by intermediaries and carriers, at least four HCFA or PHS offices (Medicare's Division of Special Operations; the Office of Policy, Planning, and Research's Division of Health Systems and Special Studies; the Bureau of Health Standards and Quality's End-Stage Renal Disease Staff; and PHS's Office of Quality Standards) have responsibility for studying, monitoring, coordinating, or directing this program.

2. Reimbursement studies.—The HCFA's Office of Reimbursement Practices (and Cost Containment) is charged with the responsibility for examining and studying existing and proposed reimbursement policies utilized by the various HCFA programs. Additionally, it is anticipated that this Office will carry out cost containment functions if Congress passes the proposed cost containment legislation. This office is also charged with examining and ascertaining potential alternatives for reimbursement mechanisms and processes, as well as analyzing the impact of these alternatives on the health care community and on the objectives and financing of programs. This Office, as of July 8, 1977, and no staff.

In addition to the Office of Reimbursement Practices (and Cost Containment) which has line responsibility for studying reimbursement policies, HCFA's Office of Policy, Planning, and Research, with staff responsibility for studying reimbursement policies, has five organizational components which perform reimbursement studies. More specifically, this policy group's Office of Demonstrations and

Evaluations houses four of these organizational components—i.e., the Division of Long-Term Care Experimentation, Division of Hospital Experimentation, Division of Health Systems and Special Studies, and the Division of Evaluation. All four divisions study alternative reimbursement mechanisms and the achievement of cost containment and cost effective alternatives. There also is a separately identifiable unit, the Division of Reimbursement Studies, in the Office of Research which assesses the implications of alternative reimbursement methods for providers (including hospitals, long-term care facilities, ambulatory care centers, physicians, physician extenders, etc.) All five divisions are charged with making recommendations for modification of existing program reimbursement policy and legislation.

In addition to these organizational components, HCFA's Medicare Bureau contains a unit, the Division of Provider and Medical Services Policy, which also evaluates and studies reimbursement policies of provider services under Part B, including those for services provided by HMOs, Group Prepaid Practice Plans, and ambulatory care centers.

3. Systems development pertaining to measuring and analyzing fraud and abuse.—The Office of Program Integrity in HCFA is charged with planning, administering, and assessing programs designed to prevent fraud and abuse in the Medicare and Medicaid programs. It develops and applies systems designed to measure and analyze the level and nature of improper expenditures attributable to fraud and abuse.

However, there are two organizational elements in HCFA's Office of Policy, Planning, and Research which are expected to perform similar functions. The Division of Statistical Methods is charged with the function of carrying out sample surveys dealing with overpayments and fraud cases. Additionally, the Division of Health Systems and Special Studies directs the development of cross-cutting special studies in the minimization of fraud and abuse.

4. Personnel Management.—The functions for HCFA's Office of Personnel include providing the overall directions for the following personnel management activities: recruitment and placement, employee and labor relations, employee development and training, and special employee development activities. However, two HCFA program bureaus apparently are charged with performing the same functions.

The Medicare Bureau's Office of Central Operations includes a Division of Management which is expected to conduct a manpower management program encompassing recruitment and placement, employee development, fair employment, and employee-management relations and to direct and implement the Buureau's training program for employee development. Similarly, the functions to be performed by the Health Standards and Quality Bureau's Office of Program Support i nclude providing the administrative services in personnel management and acquiring and allocating staff resources.

Are there opportunities to combine or consolidate any of the offices or divisions of the new organization?

Based on our analysis of proposed statements of functions for HCFA, we believe that there are at least five opportunities for combining functions or consolidating organizational components. Specifically, these opportunities are:

1. End-stage renal disease.—The statement of function for the End-Stage Renal Disease Staff identifies 10 functions and activities which may be categorized into 3 major areas—i.e., (1) planning and special studies (2) operations such as monitoring performance and operating a medical information system, and (3) quality assurance.

In view of the three categories of functions in this organizational component and since other HCFA and PHS components are involved in these three types of functions, we believe that such a component could be abolished and its functions be transferred to HCFA components whose mission statement indicate they are doing the same thing—i.e., the planning and studying functions should be transferred to the Office of Policy, Planning, and Research, all operational functions transferred to the Medicare Bureau, and all quality assessment functions be combined with the Health Standards and Quality Bureau's regular quality control functions.

2. Reimbursement studies.—Because the functional statements indicate that there are six other components of HCFA engaged in reimbursement studies and because the Office of Reimbursement Practices had no staff assigned as of July 8, 1977, we believe that the organization could be abolished pending legislative ac-

tion to establish a cost containment program for hospitals at which time a separate organizational unit reporting directly to the HCFA Administrator would probably be justified to plan and implement such a new program to minimize disturbing ongoing operations. Also, the functional statement for the Medicare Bureau's Division of Provider and Medical Services should be revised to eliminate the reimbursement studies function.

3. Surveys and studies pertaining to fraud and abuse.—Since the functions for program integrity have been centralized in the Office of Program Integrity, we feel that the sample survey and special studies functions related to fraud and abuse, which are currently located in the Office of Policy, Planning, and Reseach should be eliminated, since the Office of Program Integrity is already supposed to be performing these functions.

4. Personnel management.—Based on our discussion with HCFA officials and relevant documents, we understand that the functions for personnel management are to be centralized in the Office of Personnel. However, our observation of functional statements for two bureaus—i.e., Medicare and Health Standards and Quality—indicate that the two bureaus are sharing the personnel management functions of the Office of Personnel. While we have no particular preference on the issue of centralization or decentralization of personnel activities, it seems it should be one way or the other.

5. Office of Policy, Planning, and Research.—As indicated by the chart, this organization of about 200 people primarily consisting of the nucleus of one division of SSA's Office of Research and Statistics, now includes 6 offices and 12 divisions. We believe various consolidations could be made particularly at the division level to eliminate apparent overlapping of functions and to avoid the appearance that the Office has been structured to accommodate a particular GS grade structure.

CONCLUSIONS

In summary, we believe that the following overall conclusions can be drawn from our limited review.

Because the organizational structure including the authorization of specific supergrade positions is still developing, it is hard to draw any hard and fast conclusions. Nevertheless, HCFA's requests for numbers of supergrade and executive level staff has been cut in half since the initial proposal and some reductions have occurred since the Subcommittee questioned the matter.

Many of the HCFA and PHS officials we interviewed foresaw problems with the continued split between PHS and HCFA with respect to administering or managing the Health Financing programs authorized by the Social Security Act. In fact most acknowledged that the formal structure would not resolve the prior problems but that they were assuming that informal arrangements and the goodwill of the people involved would overcome those difficulties. However, the manner in which the PHS functional statement of June 19, 1977, was published—without formal or informal comment or concurrence from HCFA—raises questions as to the validity of this assumption.

We can see evidence of duplication and overlapping based on HCFA functional statements and those of other elements of HEW. Most, however, were in the area of planning or carrying out evaluations, studies and research where the identification of precise duplication based on broad functional statements is very difficult. We have identified specific boxes on HCFA's organization chart which would be consolidated or eliminated and we have communicated our conclusions to HCFA management.

Finally, the primary areas where real consolidation has occurred is in program integrity and the administration of standards and provider certifications. Little other consolidation of Medicaid and Medicare functions has occurred, presumably because of the major differences in the legislation for the two programs.

Overall, we believe that just the fact that Medicare, Medicaid, and quality and standards have been placed primarily under the direction of one agency head should result in improved management of the programs through better coordination of efforts and exchange of information. Hopefully, HCFA's organization as presently conceived, and as it will evolve over the years, will add to and not detract from this basic plus for program management.

Senator TALMADGE. The subcommittee will stand in recess now until 10:30.

[Thereupon, at 9:55 a.m., the subcommittee recessed to reconvene at 10:30 a.m., this same day.]

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