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Report to Congressional Requesters

April 1996

DISTRICT OF COLUMBIA

Information on Health Care Costs

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GAO

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Accounting and Information
Management Division

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April 22, 1996

The Honorable James T. Walsh
Chairman
The Honorable Julian C. Dixon
Ranking Minority Member
The Honorable Rodney P. Frelinghuysen
Member
Subcommittee on the District of Columbia
Committee on Appropriations
House of Representatives

At your request, we are providing baseline information on the District of Columbia's health care system to help evaluate the various restructuring proposals the District is considering in light of consistently rising health care expenditures, limited resources, and pending legislative changes. Specifically, you asked us to answer questions concerning the District's health care budget and the composition of the District's health care system such as the number of Medicaid recipients and uninsured and distribution of hospitals and clinics. To respond to your questions, we looked at many aspects of health care in the District. In doing so, we also identified several additional issues that we thought would benefit your deliberations. This letter and the accompanying appendixes discuss those issues as well as respond to your specific questions.

Recent studies[1] on the District's health care system have concluded that the District's health care problems are aggravated by social factors, such as high rates of poverty, crime, substance abuse, and unemployment in the city. Such factors, these studies found, in turn contribute to (1) a certain segment of the population that does not seek or obtain preventive health care and is unable to pay for its health care, (2) the inappropriate use of D.C. General Hospital for primary care services, and (3) a large number of trauma care recipients at area hospitals. It is critical that any action taken by the District also consider these social factors.

Throughout this report, we cite numerous figures for the District's health care expenditures. We did not perform an audit to verify that these figures were correct, but rather only summarized and performed financial analyses of the information provided by District officials. In some cases,

[1]Final Report of the Mayor's Blue Ribbon Panel on Health Care Reform Implementation, February 1995; District of Columbia Health Sector Analysis Final Report, Lewin-VHI, Inc., December 5, 1995; and Final Report of the Mayor's Task Force on Long Term Strategies to Improve the District of Columbia's Public Health Care Delivery System, January 1994.

we found discrepancies between figures cited in reports with those maintained in District accounting records for data that was supposed to be reporting the same thing. Also, in some instances, we received conflicting information about program expenditures from the same source. Wherever possible in this report, we used figures as recorded in the District's accounting records—Financial Management System (FMS)[2]—which were audited by an independent accounting firm for fiscal years 1991 through 1994. Fiscal year 1994 data was used, unless otherwise specified, because, at the time of our review, complete information regarding fiscal year 1995 was not available.

Background

The District's involvement with the health care system is extensive and complex. The Department of Human Services' (DHS) mission is to meet the health and welfare needs of individuals and families in the District by ensuring the development and implementation of health and social service policies. This is accomplished through the activities of the following four separate commissions:

(1) The Commission of Public Health sets public health care policy, administers the District's preventive care and alcohol and drug abuse service programs, and provides health care services directly at D.C. Village nursing home and the 11 neighborhood health clinics. D.C. Village nursing home provides long-term care and neighborhood clinics provide various services such as dental and pediatrics services to many citizens who cannot afford to pay for health care.

(2) The Commission on Health Care Finance sets Medicaid program policy, such as optional services that will be provided and changes to its eligibility criteria. It also administers and finances the Medicaid program.

(3) The Commission on Mental Health Services administers the District's mental health care system, which includes the operation of Saint Elizabeths Hospital, a 360-acre historic landmark.

(4) The Commission on Social Services processes applications to determine applicants' eligibility for various social programs, including Medicaid.

[2]FMS is the District's accounting system which tracks budget and actual expenditures.

In addition to the activities of the four commissions, the District also provides public health services to all District residents at D.C. General Hospital public hospital.

On March 1, 1996, Mayor Marion Barry introduced to the D.C. City Council legislation creating a public benefit corporation intended to consolidate many of the functions just described above. The Mayor stated that the corporation, which is intended to be financially self-sustaining in the near future, will compete in the private health care arena by (1) integrating District government health care services, (2) emphasizing preventive care, and (3) dedicating D.C. General Hospital to critical care and specialized medicine.

Scope and Methodology

To analyze the District's health care budget, Medicaid program, cost of District medical services, the placement of health care facilities, and the financial condition of District hospitals, we

- performed detailed analyses of the District's FMS and the Medicaid Management Information System (MMIS) database of Medicaid claims processed during the period covered in our review;
- performed detailed analyses of patient information and expenditures from D.C. General and Saint Elizabeths and the audited financial statements for the 13 private hospitals;
- reviewed Medicaid cost settlements and cost reports for hospitals and long-term care facilities, federally required Health Care Financing Agency reports, the District's cost reimbursement method for the 11 public clinics, reports analyzing and offering recommendations on the District's health care system and on the uninsured, and literature on national health care trends;
- interviewed officials in the Mayor's Office, each of the commissions under the Department of Human Services, the D.C. Hospital Association, other private health care experts, officials at all of the 13 private District hospitals, and officials at First Health, the District's Medicaid claims processor; and
- performed numerous site visits, including visits to all of the private hospitals operating in the District, D.C. General, Saint Elizabeths, the District-run nursing home (D.C. Village), several District operated public clinics, and one private clinic.

We conducted our work between July 25, 1995, and December 15, 1995, in accordance with generally accepted government auditing standards. Appendix V provides further details of our scope and methodology.

Results in Brief

The District's health care expenditures[3] increased 25 percent from fiscal years 1991 to 1994. In fiscal year 1994, the District's health care expenditures totaled a reported $1.246 billion, representing approximately 27 percent[4] of total District expenditures for fiscal year 1994. Our review showed that four programs—Medicaid, mental health, D.C. General Hospital, and public health—accounted for $1.16 billion, or about 93 percent, of the District's 1994 total health care expenditures and that the Medicaid program alone contributed $768 million, or about 62 percent of all health care expenditures.

Medicaid is the District's fastest growing health care program. Medicaid program expenditures increased 53 percent over the 4 fiscal years from 1991 to 1994, compared with a 52-percent increase in Medicaid expenditures nationwide. Although expenditures for mental health and D.C. General still represented about 20 percent of the District's total health care expenditures in 1994, they have decreased about 9 percent and 7 percent, respectively, since 1991. Public health expenditures increased about 17 percent over the same time period.

We also found the following:

- The District does not collect much of the specific cost information, such as the type and cost of services provided in its MMIS system. This information is generally recognized as vital for measuring and managing Medicaid and thus the District is impaired in attempting to reliably know and control its program costs. Although District officials stated that this information can be collected from other sources, the data cannot easily be converted into a usable form for data analysis.
- Saint Elizabeths Hospital and its surrounding buildings are in disrepair. Costs to renovate were estimated at $119 million in 1985, the most recent renovation information available. And, resources needed to maintain the

[3]Fiscal year 1994 data was used, unless otherwise specified, because, at the time of our work, complete information regarding fiscal year 1995 was not available.

[4]The District of Columbia Comprehensive Annual Financial Report, Year Ended September 1994, reported total expenditures of $4.7 billion.

facility have not been available for many years, thus accelerating deterioration.

- The District government runs both the public hospital and the public clinics, but it does not coordinate fully between D.C. General Hospital, the hospital-run clinics, and the neighborhood clinics. In addition, from fiscal years 1991 to 1994, the District provided a total of $309 million in subsidies, $75 million of which was characterized as loans, to cover large operating deficits. And, in fiscal year 1994, D.C. General reported nearly $78 million in uncompensated care. Several studies have called for closing D.C. General because of the costs to renovate the facility, the hospital's inefficient operations, and the concern over the quality of care provided.

Purpose of Appendixes

Appendix I contains our responses to specific questions your office asked about trends in the District's health care budget and actual expenditures of health care and Medicaid programs, the financial condition of District hospitals, statistics on Medicaid recipients and the uninsured population, the cost of medical services, and the placement of health care facilities.

Appendix II provides information on the additional issues that we think would be beneficial to your deliberations on health care. It provides additional information on Medicaid, Saint Elizabeths, public health, and D.C. General Hospital—the four programs that constitute the primary sources of the District's health care expenditures for fiscal year 1994.

Appendix III contains specific recommendations from various comprehensive studies of the District's health care system. It includes the current status of the recommendations, which indicates that, overall, very little action has been taken.

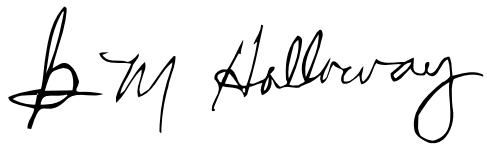
Appendix IV summarizes the results of a study of the District's public sector health facilities—such as D.C. General and its clinics—performed by the U.S. Public Health Service, Office of Engineering Services. This study, referred to as the Deep Look Survey, consisted of a site visit, an in-depth inspection of the facilities, and follow-up recommendations with cost estimates. Our summary describes the facility being studied, the problems cited, and the costs to repair them.

Agency Comments

In commenting on a draft of this report, the Mayor of the District of Columbia generally agreed with the findings and stated that the report could be useful in evaluating the District's progress in transforming its

health care system. The Mayor also responded that his proposed Public Benefit Corporation (PBC), legislation for which was forwarded to the City Council on March 1, 1996, would serve as the umbrella agency for providing cost-efficient health care for the District. The Mayor listed key functions of the proposed PBC, which include reorganizing D.C. General and the District's 11 community health clinics into a 24-hour integrated delivery system and consolidating health care systems such as pharmacy and information systems to allow for better planning and linkages between public and private health care resources. A copy of the Mayor's comments is included in appendix VI.

If you have any questions about the information in this report, please call me at (202) 512-9510 or Deborah Taylor of my staff at (202) 512-9395. Major contributors are listed in appendix VII.



Gregory M. Holloway
Director, Governmentwide Audits

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Abbreviations

AFDC	Aid to Families With Dependent Children
CMHS	Commission on Mental Health Services
DHS	Department of Human Services
FMS	Financial Management System
HCFA	Health Care Financing Agency
HMO	health maintenance organization
ICF/MR	intermediate care facilities for the mentally retarded
DCHA	District of Columbia Hospital Association
MMIS	Medicaid Management Information System
NHC	neighborhood health clinic
PBC	Public Benefit Corporation

Responses to Questions on the District's Health Care System

Budget Questions

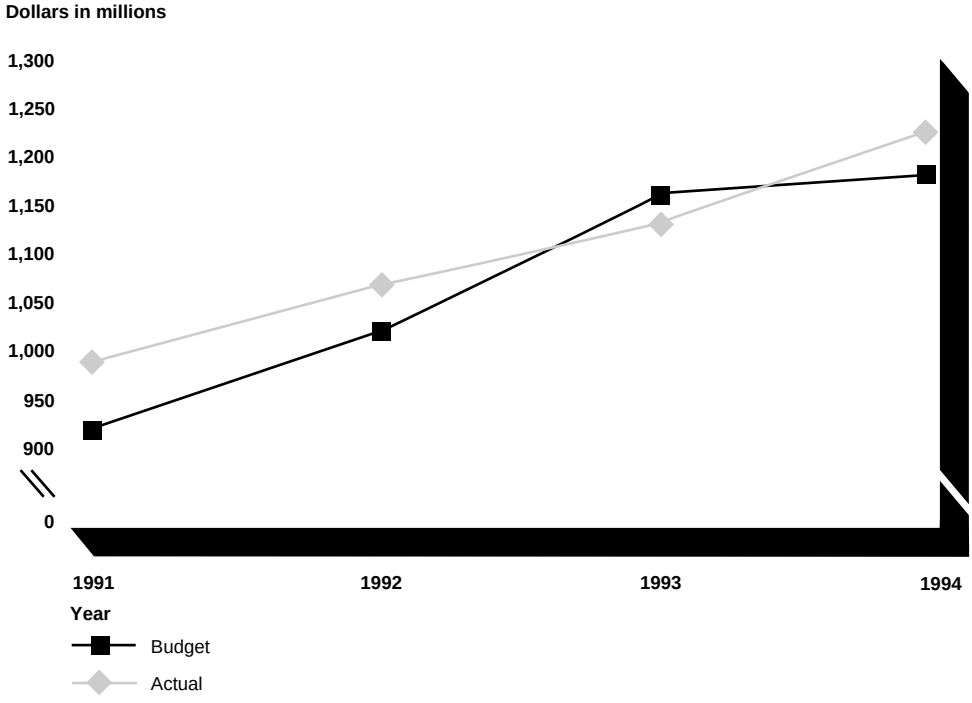
Question One

What were the District's total health care budget and actual expenditures for each of the last 4 years and how were the budgets allocated among the various programs and activities?

GAO Response

As shown in figure I.1, both the District's actual and budgeted health care expenditures have experienced steady growth from fiscal years 1991 through 1994.[1] Actual spending by the District for health care programs grew 25 percent, from $997 million in fiscal year 1991 to $1.245 billion in fiscal year 1994. However, except for fiscal year 1993, the District's health care budget did not keep pace with District spending.

Figure I.1: Health Care Budget and Actual Expenditures 1991-1994



Source: District's Financial Management System and the DHS Controller's office.

[1]At the time of our work, actual expenditures for fiscal year 1995 were not available.

The District's Financial Management System (FMS) does not organize health care programs into one health care budget. For our analysis, we included about 97 percent of the District's health care related programs—both the appropriated and nonappropriated funds. We did not include certain miscellaneous items for which the District incurs health care related expenses, such as police, fire, and corrections department medical services. These items accounted for approximately $44 million of expenditures for fiscal year 1994. Further, we did not include employee-related health care benefits, such as health care insurance and disability compensation. We considered these as costs of employment rather than health care costs.

We segmented the District's health care system into the four largest programs. The remaining programs were grouped together and categorized as "other." Table I.1 compares the District's health care budget and actual expenditures for fiscal years 1991 through 1994.

Table I.1: The District's Health Care Budget and Actual Expenditures

Dollars in millions

Program	Fiscal year 1991	Fiscal year 1992	Fiscal year 1993	Fiscal year 1994
Medicaid				
Budget	$427	$513	$677	$727
Actual	501	589	680	768
Difference	(74)	(76)	(3)	(41)
Public Health				
Budget	138	152	159	151
Actual	122	121	132	142
Difference	16	31	27	9
Mental Health				
Budget	165	158	137	136
Actual	156	145	138	142
Difference	9	13	(1)	(6)
D.C. General				
Budget	99	108	93	81
Actual	117	128	103	108
Difference	(18)	(20)	(10)	(27)
Other				
Budget	102	98	87	85
Actual	102	89	81	85
Difference	0	9	6	0
Total				
Budget	**$931**	**$1,029**	**$1,153**	**$1,181**
Actual	**$998**	**$1,072**	**$1,134**	**$1,245**
Difference	**$(67)**	**$(43)**	**$19**	**$(64)**

Note: Budget amounts reflect the revised budget, which may have included any supplemental budget amounts received.

Source: FMS and DHS Controller's office.

From fiscal years 1991 through 1994, spending for the Medicaid program consumed an increasing share of the District's total health care expenditures—from 54 percent of total health care expenditures in fiscal year 1991 to 62 percent in fiscal year 1994. With the exception of public health, the remaining portions of the District's health care categories have decreased since fiscal year 1991.

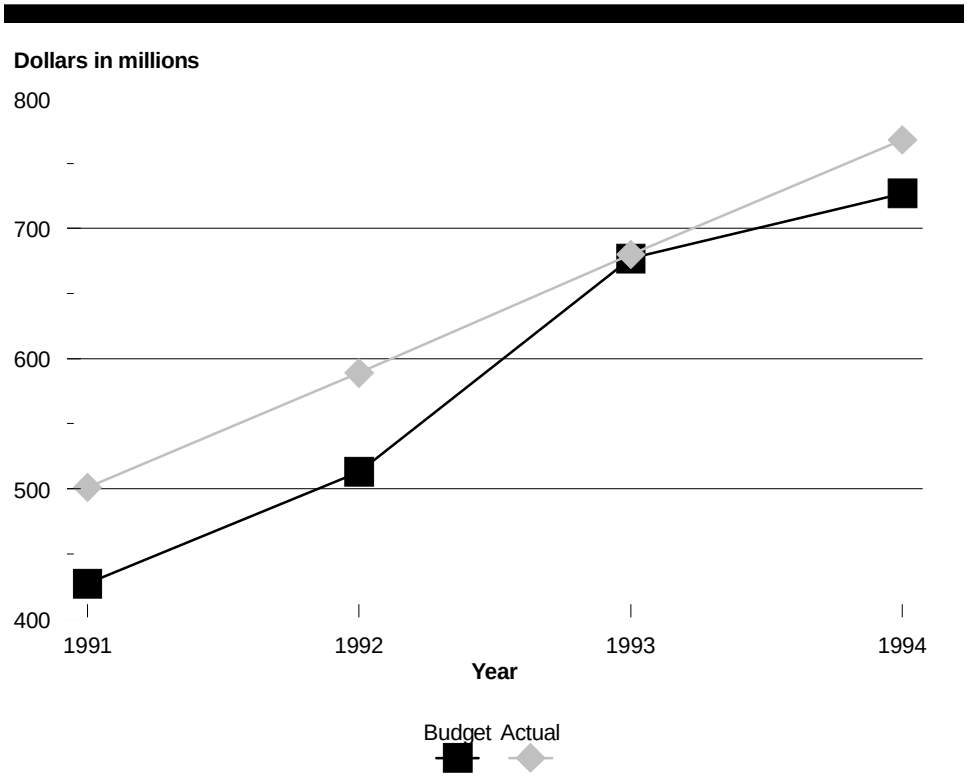
Question Two

What were the District's Medicaid budgets and actual expenditures for the last 4 fiscal years for which information is available? Provide a detailed breakdown for fiscal years 1993 and 1994—the 2 most current, complete years.

GAO Response

As shown in figure I.2, Medicaid expenditures increased 53 percent from $501 million in fiscal year 1991 to $768 million in fiscal year 1994. Although the Medicaid budget also increased from fiscal year 1991 to fiscal year 1994, actual Medicaid spending exceeded the Medicaid budget in each year during that period. Fiscal year 1993 is the only year that Medicaid expenditures approximated the Medicaid budget.

Figure I.2: District Medicaid Program Budget and Actual Expenditures 1991-1994



Source: District's Financial Management System and the DHS Controller's Office.

Historically, the three largest expenditures for the District's Medicaid program have been for inpatient hospital services, nursing facility services, and intermediate care facilities for the mentally retarded (ICF/MR). During fiscal year 1994, these three Medicaid services accounted for 72 percent of total Medicaid spending.

We analyzed the Medicaid Management Information System (MMIS) database for the fiscal years 1993 and 1994, and through July 31, 1995. This database contains the District's Medicaid claim and payment information. Since the 1995 data were incomplete, table I.2 shows the trend in spending for the three largest Medicaid expenditures only for fiscal years 1993 and 1994.

Table I.2: Three Largest Medicaid Expenditures

Dollars in millions

Medicaid service	Fiscal year 1993	Percent of total	Fiscal year 1994	Percent of total
Inpatient hospital	$279	42	$349	45
Nursing facility	134	20	149	19
ICF/MRs	64	10	64	8
Other	190	28	217	28
Total	**667**	**100**	**779[a]**	**100**

[a]District officials could not reconcile total Medicaid payments per MMIS to FMS-recorded expenditures for fiscal year 1994.

Source: First Health—Unaudited MMIS data.

Inpatient hospital services have historically been the single largest Medicaid program expenditure and accounted for about 45 percent of total Medicaid expenditures in fiscal 1994. From fiscal years 1993 to 1994, inpatient hospital expenditures increased 25 percent, from about $279 million to $349 million.

Nursing facility services have historically been the second largest Medicaid expenditure. While the elderly population of the District historically accounts for about 10 percent of Medicaid recipients, nursing facility services accounted for about 19 percent of total Medicaid spending in fiscal year 1994. From fiscal year 1993 to fiscal year 1994, nursing facility services expenditures increased 11 percent.

Expenditures for intermediate care services for the mentally retarded (ICF/MR) have historically been the third largest Medicaid expenditure.

ICF/MR expenditures remained flat from fiscal years 1993 to 1994, totaling $64 million for both fiscal years.

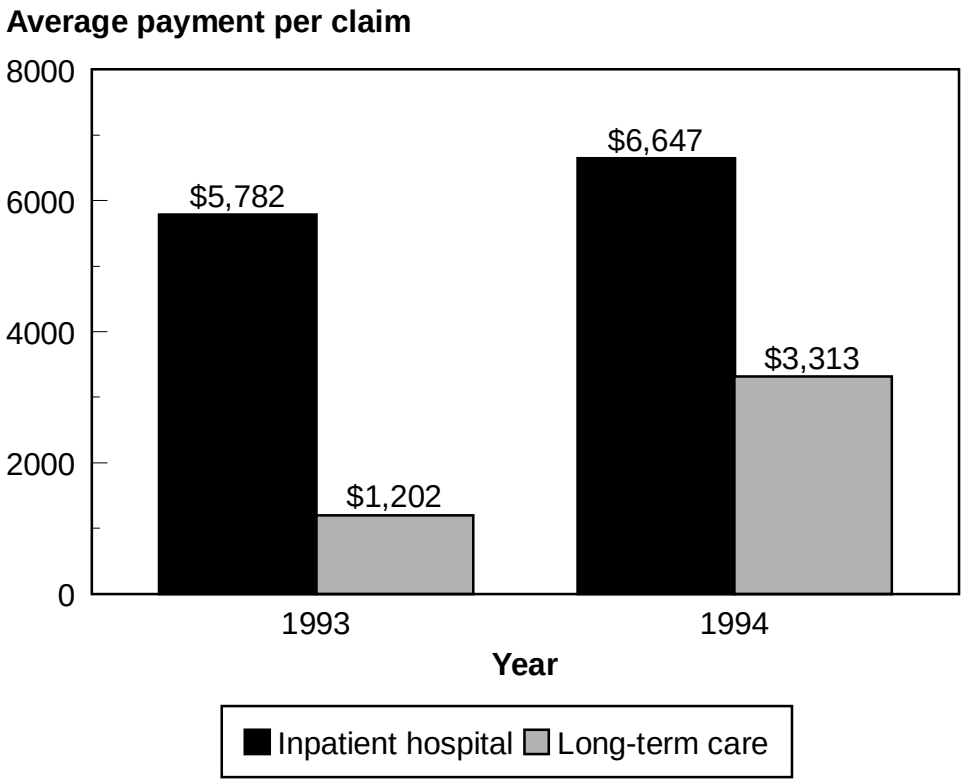
Question Three

For Medicaid recipients, what are the most costly Medicaid services in the District—for example, physicians visits, hospital stays, trauma care, emergency care, acute care, long-term care, etc.? What are the most costly services provided to the uninsured?

GAO Response

Based on our analysis of Medicaid claims processed through the MMIS, the two categories of claim types which had the highest average payment per claim were for inpatient hospital stays and long-term care, which includes nursing facility services and ICF/MR. Figure I.3 shows the average payment per claim during fiscal years 1993 and 1994. Fiscal year 1995 data are not shown since we could not analyze a complete year.

Figure I.3: Medicaid Services With the Highest Cost per Claim



Source: Unaudited MMIS data.

For fiscal year 1995 (through July 31, 1995), we identified additional information recorded in MMIS regarding the diagnosis categories with the highest billed costs for inpatient hospital services, the largest Medicaid claim type. Table I.3 summarizes this information.

Table I.3: Diagnosis Categories With the Highest Billed Costs

Inpatient hospital diagnosis	Number of claims	Total billed charges[a] (in millions)
HIV	1,043	$14.9
Single live birth	3,844	10.2
Pneumonia	1,057	8.7
Newborn respiratory problems	267	6.2
Single live born— caesarean section	1,054	5.2
Congestive heart failure	584	5.0
Respiratory failure	87	4.0
Dehydration—alcohol/drug detoxification	479	3.5
Schizophrenia	523	3.4
Respiratory distress newborn	86	3.1
Total	**9,024**	**$64.2**

[a]Billed charges usually represent amounts greater than the District's payment to providers for claims processed. Our analysis showed that approximately 75 percent of total billed charges were paid to providers by the District.

Source: First Health—Unaudited MMIS data.

Our analysis of the inpatient hospital claims also showed that treatment for burn-related injures had one of the highest single costs per claims. For claims paid through July 31, 1995, four claims submitted by hospitals for burn-related services had billed charges totaling more than $1.5 million.

Detailed information about the largest cost of health care services provided to the uninsured was not available because there is no system like MMIS that captures claims for the uninsured. However, our work at all District hospitals[2] showed that live births were the service most often provided by hospitals to uninsured patients. In addition, uninsured patients with HIV-related conditions, drug and alcohol treatment, and full-term deliveries with major problems were some of the most resource-intensive, and therefore the most costly, services to provide. Also, because St. Elizabeths provides approximately 77 percent of its care to uninsured persons, psychiatric care is another costly service.

[2]Although we performed work at all District hospitals, this analysis was performed on 10 of the hospitals, including St. Elizabeths. The remaining 5 hospitals could not provide us this information.

Demographics Questions

Question One

What is the current number of Medicaid recipients, the number of uninsured residents, the number of Medicaid and Medicare enrollees, and the number of privately insured residents?

GAO Response

We could not obtain exact numbers of uninsured and privately insured individuals within the District. The District does not maintain information about its residents' health care insurance status. However, several organizations have estimated the number of uninsured persons living in the District.

Table I.4 represents the most current information available on the number of District Medicaid recipients, Medicaid and Medicare enrollees, nonelderly uninsured residents, and the number of privately insured residents accessing services in District hospitals. The sources of this information are also provided. We could not substantiate the accuracy of this information.

Table I.4: Insurance Status of District Residents

Category	Most current fiscal year available	Total number of persons	Source of information (all information is unaudited)
Number of Medicaid recipients	1995	124,000	District of Columbia Fiscal Year 1996 Operating Budget, Volume II
Number of Medicaid enrollees	1994	141,000	Commission on Health Care Finance
Number of Medicare enrollees	1993	81,320	Department of Health and Human Services (HHS)
Number of (nonelderly) uninsured residents	1993	100,000 to 125,000	Employee Benefit Research Institute (EBRI)
Number of privately insured	1994	74,515	Hospital data based on number of discharges

Question Two

How many current Medicaid recipients and uninsured residents are "working poor?"

GAO Response

The number of Medicaid recipients and uninsured residents considered to be "working poor" was not readily available from any of the sources we

researched. However, based on an average of 100,000 uninsured, the Blue Ribbon Panel[3] estimates that 80,000 are working poor. We could not confirm the accuracy of this number. Also, we could not find any information that estimated the number of Medicaid recipients considered to be working poor.

Question Three

How many of the District's children are currently without health care coverage?

GAO Response

Based on a recent GAO report,[4] it was estimated that in 1993, 23,850, or 16.7 percent, of the District's children were uninsured. Also according to the same report, in 1993, 64,962, or 45.4 percent, of the District's children were on Medicaid. We could not readily obtain more current information.

Question Four

What is the District's current physician distribution rate?

GAO Response

The physician distribution rate, according to the Blue Ribbon Panel Report, is defined as the ratio of physicians that maintain a practice within a specific location to the specified location's population. We could not determine the District's physician distribution rate. However, this report states that the private physician distribution rate is highest in parts of the city with moderate and high income populations, such as Wards 1 and 2. Wards 1 and 2 also represent the District's central business area and contains the three teaching hospitals—Howard University, Georgetown University, and George Washington University. The ratio of private practice physicians to population is lowest in areas of the city with concentrations of the neediest populations, such as Wards 7 and 8.

Question Five

How many public health clinics are currently in the District, how are they distributed throughout the District, what are the conditions of the clinics, and how are they paid for (nonprofit, taxpayer-funded, etc.)?

[3]Final Report of the Mayor's Blue Ribbon Panel on Health Care Reform Implementation, February 1995.

[4]Health Insurance for Children: Many Remain Uninsured Despite Medicaid Expansion (GAO/HEHS-95-175, July 19, 1995).

GAO Response

The District maintains 11 publicly funded clinics which are administered by the Commission of Public Health. These clinics are located in all wards except Wards 3 and 4. The greatest concentration of clinics is in Ward 2 (three clinics). Wards 5, 6,[5] and 7 each have two clinics. The remaining two clinics are located in Wards 1 and 8. All DHS clinics have limited hours, operating from 8:15 a.m. to 4:45 p.m., Monday through Friday.

In addition to the 11 public health clinics, there are several clinics located within D.C. General Hospital. D.C. General is in Ward 6. These clinics have the same schedule as the DHS clinics, but services vary depending on the day of the week. For example, on Mondays the clinics may offer dental services and, on Tuesdays, they may offer vision services.

We identified 25 private clinics which were mentioned on several lists as being the District's private health care clinics; therefore, we included these as the primary private clinics. There may be other private clinics in the District. Lastly, there are three federally funded and operated clinics in the District. These clinics are funded and operated by the U.S. Department of Health and Human Services.

Table I.5 shows each neighborhood health clinic (NHC) we could readily identify and its location, except for those clinics located within D.C. General Hospital.

[5]Ward 6 now has three clinics, due to the relocation of the Eckington Child Health Clinic from Ward 5.

Table I.5: Clinics Operating in the District and Ward Location

Ward	D.C. (DHS) government clinics	Private and/or free clinics	Federally funded and operated clinics
1	Adams Morgan NHC	Whitman Walker New Summit Medical Center Zacchaeus Free Clinic Columbia Road Health Services So Others Might Eat Mary's Center Community Medical Center Spanish Catholic Center Community of Hope	Upper Cardozo Health Center (adult and children)
2	Walker-Jones NHC Claridge Clinic Southwest NHC	Health Care for the Homeless Washington Surgi-Clinic Planned Parenthood Women's Comprehensive Clinic Center for Ambulatory Surgical, Inc. Yater Clinic	None
3	None	Washington Clinic	None
4	None	The Women's Clinic (Washington Hospital Center) The Washington Free Clinic La Clinica del Pueblo Greater Washington Health Center Hillcrest Women's Surgi-Clinic, NW	None
5	Woodridge NHC Eckington Child Health Clinic	Center for Life (Providence Hospital)	None
6	15th Street NHC Anacostia NHC	Columbia Hospital Teen Center	None
7	Hunt Place NHC Benning Heights NHC	Hillcrest Women's Surgi-Clinic, SE	East of the River Health Center (adults and children) Washington Senior Center (adults only)
8	Congress Heights NHC	S.E. Medical Clinic	None
Total	**11 DHS clinics**	**25 private clinics**	**3 federal clinics**

Source: District's Commission of Public Health, District of Columbia Hospital Association (DCHA), Final Report of the Mayor's Blue Ribbon Panel on Health Care Reform Implementation, February 1995, and private clinics.

Table I.6 illustrates the type of services offered and the number of patient visits for each public clinic.

Table I.6: Public Clinics, Services Offered, Ward, and Number of Patient Visits During 1994

Public Clinic	Services offered	Ward	Number of visits, 1994
Hunt Place NHC	Full service,[a] pediatrics, and pharmacy	7	13,587
Congress Heights NHC	Full service, pediatrics, and pharmacy	8	11,635
Southwest NHC	Full service, pediatrics, and pharmacy	2	10,785
15th Street NHC	Full service and pediatrics	6	10,257
Anacostia NHC	Full service, pediatrics, and pharmacy	6	9,800
Benning Heights NHC	Full service and pediatrics	7	8,903
Walker-Jones NHC	Full service, pediatrics, and pharmacy	2	8,356
Woodridge NHC	Full service and pediatrics	5	5,309
Eckington Child Health Clinic	Pediatrics	5	1,518
Claridge Clinic	Limited services	2	1,177
Adams Morgan NHC	Full service	1	1,108

[a]Full service clinics offer the following services—adult medicine, OB/GYN, family planning, and dental.

Source: District's Commission of Public Health.

A recent study[6] of the D.C. public sector health facilities, performed by the U.S. Public Health Service, Office of Engineering Services, determined that many of the DHS clinic facilities are substandard. Examples of substandard conditions range from lack of accessibility for the disabled to electrical code violations. The cost to renovate the clinics was estimated at $9 million. In addition, the cost to renovate clinics located at D.C. General Hospital was estimated at $849,000. (See appendix IV for a summary of the results of the study.)

Question Six

What is the current general financial condition of District hospitals? How many are privately-owned? What is the number of beds per capita? How many emergency rooms are there and where are they located? Per capita, are the District's numbers above or below the national average? Are they above or below those of other local jurisdictions?

GAO Response

We evaluated the hospitals' financial performance by reviewing measures of their profitability. Our analysis was based on the hospitals' fiscal year 1994 financial statements, the most recently available. For 11 of the 15

[6]U.S. Department of Health and Human Services, Public Health Service, Deep Look Survey - D.C. Public Sector Health Facilities, August 1995.

District hospitals, operating profit margins were below the 1993 national average of 3.02 percent (the most recent year available), with 6 reporting negative operating margins. The combined operating margin for the 15 hospitals during their fiscal year 1994 was –$214,583,157 on operating revenues of $2,067,878,592 or a net loss of 10.4 percent. Table I.7 shows the hospitals' operating profit margins, which measure the hospitals' profitability with respect to providing patient care.

Table I.7: District Hospitals' Operating Profit Margin

Hospital	Operating profit margin as a percentage of operating revenue (Fiscal year 1994)	Operating Margin (in thousands)
Psychiatric Institute of Washington, D.C.	–172.2	$(9,669)
D.C. General Hospital	–116.7	(87,287)[a]
Saint Elizabeths Hospital	–110.8	(95,192)[a]
Howard University Hospital	–17.5	(34,677)
Children's National Medical Center	–7.2	(15,104)
George Washington University Hospital	–1.0	(2,077)
Washington Hospital Center	.5	2,261
Georgetown University Hospital	1.1	2,730
Greater Southeast Community Hospital	1.4	2,827
National Rehabilitation Hospital	1.6	944
Hadley Memorial Hospital	2.2	538
Nationwide average (1993)	**3.02**	Not applicable
Providence Hospital	3.1	3,627
Columbia Hospital for Women	3.1	2,301
Sibley Memorial Hospital	5.9	6,004
Hospital for Sick Children	20.5	8,190

[a]In our financial analysis for the District's two public hospitals, we excluded the $47 million subsidy provided to D.C. General and $104 million appropriation provided to St. Elizabeths, in fiscal year 1994, because these amounts are not operating revenue and thus should not be included when calculating operating margins.

Source: Hospitals' audited 1994 financial statements, except for George Washington University Hospital, Saint Elizabeths, and the Psychiatric Institute of Washington, D.C., whose financial statements were unaudited.

As of June 30, 1995, 15 nonfederal hospitals operated 4,877 beds within the District of Colombia.[7] Of the 15 hospitals, 2 are operated by the District of Columbia, 11 are not-for-profit hospitals, and 1 is a for-profit hospital

[7]Two federal hospitals, the Veterans Affairs Medical Center and the Walter Reed Army Medical Center, also operated 501 and 680 beds, respectively, in the District as of June 30, 1995.

owned by a partnership. Eleven of the 15 hospitals, operating 3,558 beds, provide acute care services (for patients admitted with severe, but not chronic, conditions), while the remaining 4 operating 1,319 beds provide other types of inpatient care, primarily long-term psychiatric care. Table I.8 lists the 15 hospitals, the number of beds they operate, and their ownership type.

Table I.8: District Hospitals' Capacity and Ownership (as of June 30, 1995)

Hospital name	Bed capacity	Ownership
Saint Elizabeths Hospital	941	District-owned
Washington Hospital Center	874	Not-for-profit
Greater Southeast Community Hospital	387	Not-for-profit
Howard University Hospital	375	Not-for-profit
Georgetown University Hospital	359	Not-for-profit
Providence Hospital	342	Not-for-profit
George Washington University Hospital	318	Not-for-profit
Sibley Memorial Hospital	275	Not-for-profit
D.C. General Hospital	258	District-owned
Children's National Medical Center	188	Not-for-profit
National Rehabilitation Hospital	160	Not-for-profit
Hospital for Sick Children	119	Not-for-profit
Columbia Hospital for Women	110	Not-for-profit
Psychiatric Institute of Washington, D.C.	99	For-profit
Hadley Memorial Hospital	72	For-profit
Total bed capacity in D.C.	**4,877**	Not applicable

Source: District of Columbia Hospital Association and hospital financial statements.

Table I.9 shows the location of District hospitals by ward and which hospitals operated emergency rooms and/or trauma centers as of June 30, 1995.[8]

[8]Trauma centers typically have higher costs to operate than emergency rooms because they handle patients with life-threatening injuries, such as gunshot wounds, trauma from automobile accidents, and heart attacks.

Table I.9: District Hospital Location and Emergency Room Services Provided

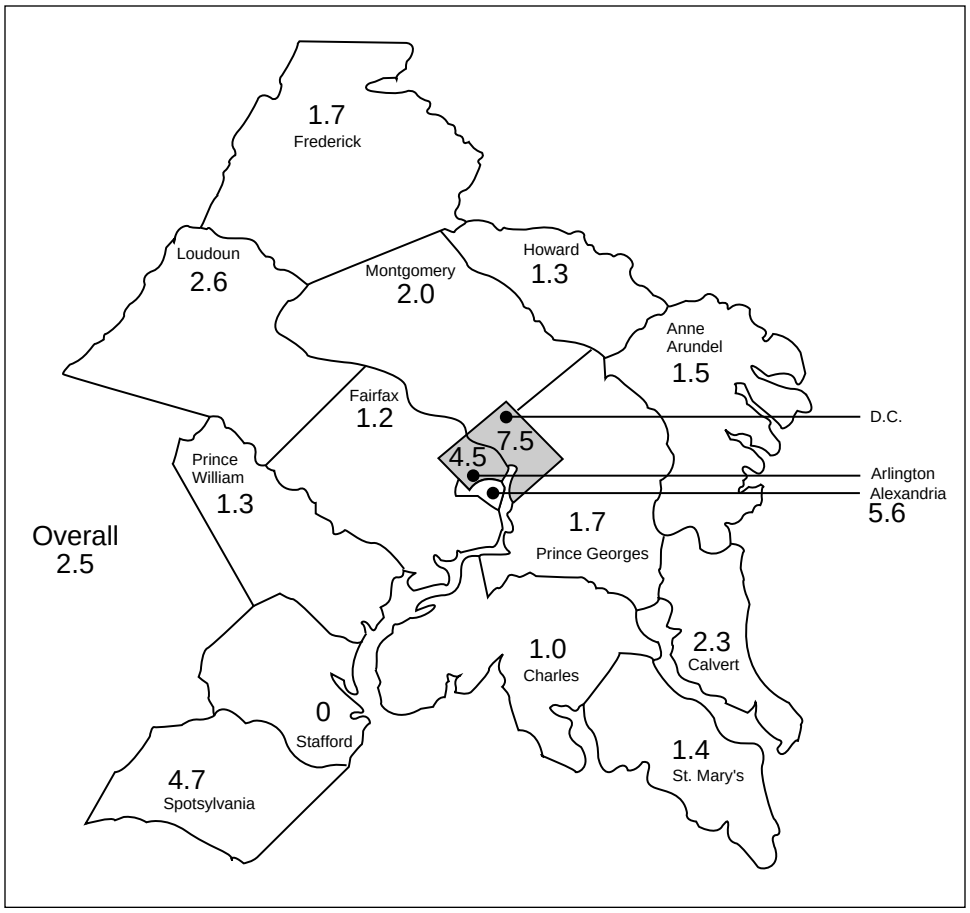
Ward	Hospital	Emergency room	Trauma center
1	Howard University Hospital	Yes	Yes
2	Georgetown University Hospital	Yes	Yes
	George Washington University Hospital	Yes	Yes
	Columbia Hospital for Women	No	No
3	Sibley Memorial Hospital	Yes	No
	Psychiatric Institute of Washington, D.C.	No	No
4	Children's National Medical Center	Yes	Yes
	National Rehabilitation Hospital	No	No
	Washington Hospital Center	Yes	Yes
5	Providence Hospital	Yes	No
	Hospital for Sick Children	No	No
6	D.C. General Hospital	Yes	Yes
7	None		
8	Saint Elizabeths Hospital	No	No
	Hadley Memorial Hospital	Yes	No
	Greater Southeast Community Hospital	Yes	No
Total	**15 hospitals: 2 public 13 private (2 for-profit, 11 not-for-profit)**	**10 emergency rooms**	**6 trauma centers**

Source: District of Columbia Hospital Association information.

As shown in table I.9 above, 10 of the 15 hospitals provide emergency room services, and 6 of the 10 hospitals operate both an emergency room and a trauma center.

Finally, in 1993, the most recent data available, the District had the highest acute care bed per captita ratio in the Washington metropolitan region—7.5 beds per 1,000 person. The regional average was 2.5 beds per 1,000 person. Figure I.4 shows the number of acute care beds per 1,000 population for the District and surrounding jurisdictions in 1993.

Figure I.4: Washington Metropolitan Region Acute Care Beds per 1,000 Population-1993



Source: SACHS Market Planner and 1992 AHA Guide to Healthcare.

Question Seven

On what basis are hospitals, public clinics, and emergency rooms strategically placed? Is a master plan or a patient needs analysis used to determine their location?

GAO Response

There is no master plan or patient needs analysis for determining the location of hospitals, clinics, or emergency rooms. According to the Blue Ribbon Report, the District maintains the same health care system that existed 30 years ago. Hospital administrators decide the placement of hospitals, community services offered, and types of emergency services offered. The Commission of Public Health decides the placement of community clinics, hours of operation, and services offered.

Question Eight

Are there any unique circumstances in the District compared to other major cities that would result in higher costs for the District to provide health care?

GAO Response

While we did not identify any circumstances unique to the District, District hospital officials stated that there were three factors that contributed to hospitals' operating costs:

- high salaries for professional staff,
- high cost of treatment due to complexity of patient cases, and
- high cost of medical malpractice insurance.

Hospital officials stated that these costs were generally higher in the District than national averages or in surrounding jurisdictions. We did not verify this information.

Trends in District Health Care

To respond to specific questions you asked (see appendix I for our responses to those questions), we analyzed information relating to many aspects of the District's health care system. During our analyses, we uncovered several issues that we felt were extremely important to any study of health care in the District. This appendix discusses those issues in detail.

Summary

First, prior GAO work[1] has shown that more extensive use of managed care may have the potential to control Medicaid expenditures. Our work has also indicated that good information on the cost and use of services plays a critical role in overseeing managed care to realize cost savings and assure quality of care. Our review of the District showed that, currently, the city does not collect much of this vital information or conduct the analyses needed to effectively manage its programs.

Second, according to hospital officials and a planning study,[2] Saint Elizabeths Hospital and surrounding buildings are in serious disrepair. The District's Commission on Mental Health Services (also known as Saint Elizabeths Hospital) spent approximately $142 million,[3] or 11 percent of total District health care expenditures, in fiscal year 1994. The majority of its expenditures were related to providing patient care. The most recent renovation information available is a 1985 estimate of $119 million. Also, hospital officials state that resources needed to fully maintain the buildings and systems of the west and east campuses have not been available for many years. Officials stated and the planning study reported that, as a result, deterioration of the buildings and system was accelerated.

Third, our work and studies[4] showed that although the District government runs both the public hospital and the public clinics, it does not coordinate medical services, preventive care programs, or patient information between D.C. General Hospital, the hospital-run clinics, and the neighborhood clinics. Expenditures at D.C. General Hospital were

[1]Arizona Medicaid: Competition Among Managed Care Plans Lowers Program Costs (GAO/HEHS-96-2, October 4, 1995).

[2]A Master Plan for the West Campus of Saint Elizabeths Hospital; Devouax and Purnell Architects - Planners, P.C., September 1993.

[3]Total operating expenses for Saint Elizabeths were $207 million for fiscal year 1994. This includes $65 million of Medicaid expenses, as well as depreciation and accruals.

[4]Final Report of the Mayor's Blue Ribbon Panel on Health Care Reform Implementation, February 1995 and District of Columbia Health Sector Analysis Final Report, Lewin-VHI, Inc., December 5, 1995.

$108 million,[5] or 9 percent of total District health care expenditures, in fiscal year 1994. The District provided D.C. General $74 million in subsidies, of which $27 million was characterized as loans, during fiscal year 1994 to offset its expenditures. In addition, expenditures to operate the District's public health clinics for this period totaled $21 million. District officials acknowledge that the failure to integrate its public facilities contributes to the costliness of delivering public health care. For example, recipients obtain costly services at a hospital that could be provided at less cost at a public clinic were the facilities integrated.

Several external studies[6] concluded that D.C. General Hospital, in its present state, is not competitive relative to the 13 private hospitals operating in the District. The studies provide immediate short-term changes to improve the operations of the hospital and the services it provides, as well as potentially lowering costs. Alternatively, because of various factors including the cost to renovate the hospital, several studies have recommended closing the facility. Recent estimates to renovate the hospital are $112 million, and estimates to build a new facility are $126 million.

The District provides additional health care services to its residents through its Commission of Public Health. During fiscal year 1994, Public Health expended $142 million,[7] or 11 percent of total District health care expenditures. Public Health administers numerous programs, the three largest, including Medicaid expenditures, are (1) the Alcohol and Drug Abuse Administration, (2) the Ambulatory Health Care Administration,[8] and (3) D.C. Village,[9] the District-run nursing facility.

[5]Total operating expenses for D.C. General were $141 million for fiscal year 1994. This includes $33 million of Medicaid expenses.

[6]District of Columbia General Hospital—Operational and Financial Viability Plan, dated May 1994, and U.S. Department of Health and Human Services, Public Health Service, Deep Look Survey - D.C. Public Sector Health Facilities, August 1995. The Deep Look Survey was a series of in-depth studies of the physical condition of D.C. General and several public clinics.

[7]Total operating expenses for the Commission of Public Health were $181 million for fiscal year 1994. This includes $38 million in Medicaid expenditures.

[8]The Ambulatory Health Care Administration is responsible for the District's 11 neighborhood health clinics.

[9]We did not perform detailed work at D.C. Village because the District plans to close the facility in April 1996. According to District officials, they are experiencing difficulty in placing residents in other nursing homes and did not believe they would be able to meet the April 1 deadline.

Background

Health care expenditures in the District rose steadily between fiscal years 1991 and 1994. In fiscal year 1991, expenditures for the four largest programs—Medicaid, mental health, public health, and D.C. General Hospital—were $895 million. These same programs accounted for $1.16 billion in expenditures during fiscal year 1994. This increase, coupled with limited resources and pending legislative changes for programs such as Medicaid, have caused the District to examine options for restructuring its health care system.

The Congress is considering major legislative changes to the Medicaid program. The changes could include (1) setting a predetermined ceiling on federal health care funds to each state rather than unlimited matching federal funds and (2) basing the ceiling on funds each state is granted on a new formula. The legislative changes would limit the growth in the District's Medicaid grants to 3.5 percent between fiscal years 1996 and 1997 and 2 percent between fiscal years 1998 and 1999. Under the current Medicaid program, the District's Medicaid grants increased 15 percent between fiscal years 1993 and 1994.

Public Health's two primary roles are to provide education and prevention programs and ensure adequate access to health care for all District residents. Many of Public Health's programs are supported by the Medicaid program or are intended to support D.C. General's mission. Therefore, we focused on Public Health as it relates to these two roles. We do not discuss Public Health separately, but rather the need for basic information from the Medicaid program to make management decisions about the placement and types of education and prevention programs in our Medicaid discussion. Also, our work at the 11 neighborhood clinics is discussed along with that on D.C. General and the lack of integration between the clinics and the hospital.

Numerous studies have been performed to identify problems with the District's health care system and to suggest solutions. Recommendations from some of these reports are summarized in appendix III.

Medicaid Program Lacks Essential Cost Information

Health care providers submit claims for eligible services provided to District Medicaid recipients to First Health, a District contractor. First Health processes the claims through the Medicaid Management Information System (MMIS) to determine the amounts to be paid for each claim. MMIS either approves or denies the claims based on various parameters within the system, such as an approved provider or Medicaid

recipient number. Denied claims are sent back to the providers. The District sends approved payments directly to the providers and draws down the related federal share payment from its annual federal matching Medicaid grant.

Reimbursements to hospital, long-term care,[10] and Health Maintenance Organization (HMO) providers comprised more than 75 percent of Medicaid expenditures in 1994. However, the program's information system either does not collect sufficient cost and service data for these providers or the District does not utilize available information to determine if funds are being spent most effectively. Providers are reimbursed costs based on (1) cost reports which detail total operating costs of hospitals and long-term care facilities and which are audited often 2 years after the providers' operating year-end and (2) pre-established rates for HMO providers.

The District attempted to determine the HMO provider rates by using the full cost of Medicaid services for the Aid to Families With Dependent Children (AFDC) population, discounted by 7.5 percent. However, data needed to perform this calculation was not readily available in the District's information system. As a result, the pre-established rates for reimbursing HMOs do not reflect the true cost to provide these services and may be excessive. In addition, the District does not capture data necessary to ensure that those rates are competitive. Until the District is able to determine its providers' actual costs for delivering each type of health care service, it will not be able to determine reasonable reimbursement rates to effectively control costs, nor will it be able to recognize unreasonable reimbursement requests.

The MMIS system collects information on all Medicaid claims and groups them in 13 claim types, the largest of which were inpatient hospital, long-term care, and outpatient care for fiscal year 1994. Our analysis of MMIS showed the following.

- The District does not routinely reconcile detailed amounts in the MMIS database to its accounting records—Financial Management System (FMS)—which records payments made to providers for Medicaid claims. Although District officials attempted to reconcile 1994 amounts in response to our review, they could not explain an $11 million difference between MMIS data ($779 million) and FMS data ($768 million).

[10]Long-term care includes nursing facilities services and intermediate care facilities for the mentally retarded.

- Detailed information about the type of services provided and the cost of those services is not maintained for many of the claim types in the MMIS system. For example, an analysis of the HMO claims data—the largest category of claims reimbursed on a pre-determined, negotiated rate (known as the capitation rate)— revealed that the type of services provided by a practitioner, such as prenatal care versus well-baby visits, and the itemized costs of providing each type of service are not captured in the system. Instead, all services provided under HMO claims were described as "other." District officials state that it does collect information on the service utilization of HMO members, but the information is in aggregate form, and is not comprehensive enough to allow for any kind of systematic financial or programmatic analysis. According to District officials, the Commission on Health Care Finance is now in the process of expanding these reporting requirements to address these shortcomings.
- Hospital claims data—the largest category of claims paid—contained information about the type of services provided and billed charges; however, no analysis is conducted to compare costs of treating the same condition across hospitals to determine which hospitals are least expensive.
- MMIS inpatient hospital claims data for 52,577 claims totaling $347 million did record diagnosis; however, payment data was not recorded for each claim.

Lack of descriptive information about specific services provided and cost hampers the District's ability to (1) compare and contrast the cost-effectiveness of providers, (2) determine the reasonableness of cost reimbursements, (3) assess the appropriate levels of patient care, (4) forecast future health trends, and (5) determine what education and prevention programs should be provided.

To illustrate, it would be useful for the District to know what services a patient participating in an HMO received and their costs. This basic information would allow the District to compare providers delivering a similar service and determine who was providing care at the least cost. This would subsequently enable the District to more effectively evaluate the cost-effectiveness of HMOs and use this information as a tool for evaluating proposed capitation rates and selecting HMOs to participate in its managed care program. This information could also be used by the District in performing quality reviews of providers to assess whether the appropriate levels of care are being administered.

Our work also revealed instances where the information that is collected was not useful.

- The District does not collect cost information about optional Medicaid services in a manner that is useful for cost containment. Each state may elect to provide an additional 34 services[11] above those services required under federal regulations. District officials estimate that these optional services, such as physical therapy and hospice care, cost approximately $180 million, or 23 percent, of total Medicaid spending. However, we could not substantiate this figure because of the way costs were grouped in the MMIS database. While some optional services are easily identified, such as dental services, others are not. For example,
  - Under federal government regulations, "eyeglasses" are an optional service states can choose to provide. Although the District provides this service, the claims data we analyzed did not use "eyeglasses" to define services under this claim type, but rather categorized all vision related claims under the broad category "vision." Therefore, the District cannot determine how much it spends on providing eyeglasses to its Medicaid population.
  - Similarly, "physical therapy," another option provided by the District, is not a recognized service in the database and, thus, the District cannot determine how much it spends to provide this service.

In instances where the District has collected necessary information, it did not always use the information to adequately oversee the program. For instance, our analysis of the MMIS database showed that 7 percent of total claim payments, or $29 million, processed in 1994 was for recipients with zip codes outside the District. Since MMIS did not include payments of approximately $342 million for inpatient hospital claims, this amount is probably understated. District officials stated that these claims were for individuals who lived outside of the city but were still wards of the state, such as children in foster care and individuals in nursing homes. However, the District does not investigate any of these cases and continues to pay claims as long as individuals have a valid Medicaid recipient number. Thus, an individual may move out of the city and continue to receive the District's Medicaid benefits for an undetermined period.

Given the District's resources and rising health care costs, this type of information is important to the District. Obtaining information on the cost of providing specific optional services will be critical to the District not

[11]According to the U.S. Health Care Financing Administration, the District elected to provide 26 of the 34 optional services; nationwide, the average was 24.

only in making informed decisions about what services should be continued or eliminated, but also in quantifying potential cost-savings. The District could also make better use of the information it collects to monitor the Medicaid program.

Our work also revealed anomalies in the MMIS database that District officials could not explain. These are discussed in detail in appendix V. For instance, long-term care claim types contained (1) claims where the gender codes were categorized as unknown and (2) claims that had negative amounts paid. Although the District has a system to capture demographics on those eligible for Medicaid, the MMIS is not designed to routinely report demographics on Medicaid recipients. Thus, the District does not have an accurate demographic profile of its Medicaid recipients nor does it know the financial impact of the negative amounts paid.

Facilities at Saint Elizabeths Hospital Not Being Adequately Maintained

The Commission on Mental Health Services (CMHS) administers the District's mental health system within DHS. Inpatient and some outpatient services are provided at Saint Elizabeths Hospital. The District houses inpatients on the east campus and uses a portion of the west campus for administrative purposes and some patient care. As a result of actions taken under the Saint Elizabeths Hospital and District of Columbia Mental Health Services Act, the District currently owns most of the east campus and the federal government owns most of the west campus.[12] The Secretary of the Interior designated Saint Elizabeths Hospital a national historic landmark in 1990.

The federal government's portions of the west campus are vacant. The District pays for the maintenance and upkeep of the entire west campus but is not reimbursed by any other source. Costs to annually maintain the west campus were estimated at $6 million in 1993.[13] Hospital officials estimated costs to maintain vacant, federally owned buildings at approximately $1 million per year through fiscal year 1991. According to hospital officials, some of the west campus is necessary for the operation of the east campus since (1) the current configuration of the east campus

[12]The Saint Elizabeths Hospital and District of Columbia Mental Health Services Act, Public Law No. 98-621 (1984), authorized the Secretary of Health and Human Services to transfer to the District of Columbia all property at Saint Elizabeths Hospital needed by the District's Department of Human Services to provide mental health and other services under the District's comprehensive mental health system plan. On September 30, 1987, the Secretary transferred title to almost all of the portion of Saint Elizabeths that is commonly referred to as the east campus and several buildings on the portion of Saint Elizabeths that is commonly referred to as the west campus for these purposes.

[13]A Master Plan for the West Campus of Saint Elizabeths Hospital; Devouax and Purnell Architects - Planners, P.C., September 1993.

could not provide all patient services without substantial improvements, including significant asbestos removal, and (2) the boiler plant, which is the main source of heat for the east campus, is located on the west campus; however, the boiler is in serious disrepair.

Section 4(f)(1) of the act required the Secretary of Health and Human Services (HHS) to contract for a physical plant audit of the existing facilities at Saint Elizabeths Hospital to assist the Mayor in developing a comprehensive mental health system plan. The physical plant audit was required to recognize any relevant national and District codes and estimate the useful life of existing facility support systems. Section 4(f)(2) provided that, after the audits, the Secretary was to initiate and complete repairs and renovations of the physical plant and facility support systems—as necessary to meet any applicable code requirements or standards—of Saint Elizabeths Hospital that were to be used by the District of Columbia under the comprehensive mental health system plan. In 1991, section 4(f)(2) was amended to authorize the Secretary to provide the Mayor with funds to complete such repairs and renovations.

In 1985, the U.S. Department of Health and Human Services conducted the required physical plant audit of all existing facilities of Saint Elizabeths Hospital. At the time, the estimated cost to bring the physical plant and facility support system into compliance with applicable laws and codes was $56.5 million. This audit assumed that the District would temporarily use the west campus for its operations, but that eventually all hospital operations would be consolidated on the east campus. The District has filed a complaint in the United States Court of Federal Claims seeking recovery of amounts the District alleges the United States owes it under various provisions of the act. The complaint alleges that the United States neither made nor provided the District all the funds necessary to make the repairs and renovations indicated by the 1985 audit. The complaint seeks about $60 million based on the difference between the estimated cost of the repairs and the amount the United States previously provided the District, as adjusted for inflation.

The District also hired a contractor to estimate the additional costs to renovate the facility for patient use. These costs were estimated at $62 million. The additional costs were not necessary to comply with the requirements of the transfer. Even if the District prevails in its suit and recovers the amount claimed, it is unclear how the District intends to fund the remaining repairs and renovations to Saint Elizabeths identified by the District's audit. In addition, it is unclear how much the historic landmark

designation has affected the 1985 audit's cost projections for repairs and renovations. However, it is not unreasonable to assume that they will increase as a result of the designation.

Section 8(b) of the act required the Mayor to submit to the Congress for approval a master plan for the use of the remaining untransferred property at Saint Elizabeths. The plan was submitted to the Congress in December 1993.[14] Section 8(b) provides that if a law is enacted approving the plan, the Secretary is required to transfer the property to the District in accordance with the approved plan without compensation. The plan submitted to the Congress called for renovating and restoring the west campus for institutional, retail, and support-type facilities, using the guidelines for historical properties. However, the planners noted that the market for such users at this location was weak. During the process of developing the master plan, three alternatives consistent with the historic landmark designation were examined. Their costs ranged from $116 million to $128 million. No other comparable use plan was prepared.

The plan also recommended that the transfer of the west campus not proceed until the mutual interests of the federal and district governments were reconciled since, according to the planners, the District "does not have the resources to undertake adaptive reuse of the west campus and that current transfer would adversely impact both the historic resource and its potential contribution to the national and local economies." Also, it states that the Commission on Mental Health's budget to fully maintain the buildings and systems of the west and east campuses has been severely underfunded for so long that the "inevitable deterioration of the buildings and system has been accelerated," and the District must address the most critical conditions on a crisis management basis.

According to District officials, the majority of its fiscal year 1994 mental health expenditures were for patient care. We did not perform an audit or efficiency study of these costs, but hospital officials estimate that patient costs will remain relatively constant over the next few years. Since most of the budgeted mental health funds are used for patient care, such as physician and staff salaries and contracts for outpatient community housing, hospital officials stated that they have not been able to dedicate substantial funds for facilities improvement. Currently, the District is in the process of studying its mental health care system to identify ways to reduce costs and improve efficiency.

[14]A Master Plan for the West Campus of Saint Elizabeths Hospital; Devouax and Purnell Architects - Planners, P.C., September 1993.

Operations of Public Health Care Are Inefficient and Facilities Are Deteriorating

Operating expenses for D.C. General Hospital were $141 million in fiscal year 1994. Several studies[15] on the hospital, including our comparison of fiscal year 1994 operating results (see table I.7 in appendix I) show that, in its present state, D.C. General is not competitive relative to the 13 private hospitals operating in the District. The studies provide immediate short-term changes which could improve the operations of the hospital and the services it provides, as well as potentially lower costs.

The number of patients served at D.C. General has decreased, and the physical condition of its 53-year old facility has deteriorated. Some of the decrease in patients served is attributed to the shift of Medicaid recipients by the District to managed care organizations such as HMOs and the hospital's poor physical condition. In addition, none of the four HMOs serving the Medicaid AFDC population are associated with D.C. General and thus would not routinely send their members there for treatment.

The District's 11 public clinics are not integrated with D.C. General. The clinics and D.C. General Hospital do not (1) share patient data, (2) maintain a referral network, or (3) coordinate patient care and programs. This lack of coordination

- allows recipients to obtain services at the public hospital which, according to District officials, could be provided for less at a public clinic;
- prevents the District from adopting a strategic outlook to delivering public health care;
- forces the public facilities to compete for resources which would possibly be better shared; and
- may cause duplicative and unnecessary services to be provided to citizens.

For instance, during our visit to D.C. General, we observed patients who used the walk-in emergency room services to refill a prescription or obtain treatment for a headache. One asthmatic patient received treatment for a condition which, according to hospital officials, could have been more appropriately treated by the patient's primary care physician. Because patient records were not available at the hospital, hospital staff had to run routine tests before treating the patient. This information would have been readily available if the patient had gone to his or her primary care physician. Also, during our visit, hospital officials stated, and we observed, that patients had gone to the emergency room and lab work had been performed, but that the patients left before the results were known.

[15]Four Years Later—The Rivlin Report Revisited: An Assessment of Progress in the District of Columbia, Final Report, December 1994, and District of Columbia General Hospital—Operational and Financial Viability Plan, May 1994.

Hospital officials stated that often these individuals return to the emergency room another day and the tests are done again. In some cases, a patient's condition worsens between visits and the patient has to be hospitalized.

During fiscal year 1995, the Office of Engineering Services in the U.S. Department of Health and Human Services conducted a survey[16] of the hospital and concluded that it was in such disrepair that it would exceed $112 million to renovate or $126 million to build a new facility. The $112 million cost to renovate does not include an additional $849,000 which the same study estimates is the cost to repair the public clinics located within the hospital. The report cited serious deficiencies including poor heating, ventilation, and air conditioning; asbestos; unsanitary conditions in the obstetrics and gynecology department; inoperative laundry equipment; and inadequate ventilation in the surgical pathology lab.

In addition, the same survey identified numerous deficiencies at seven of the public clinics. Estimates to repair the deficiencies exceed $9 million. The deficiencies include poor heating, ventilation, and air conditioning; filthy and clogged filters; no emergency power or fire alarm system; and overcrowding. Appendix IV summarizes the results of this study.

These same studies (see footnotes 15 and 16) also reported that (1) the hospital facilities are in major disrepair—estimates to repair or renovate the facility exceed $112 million, (2) hospital operations are inefficient and noncompetitive with the private sector, and (3) the quality of health care could be improved. In addition, D.C. General reported nearly $78 million of uncompensated care during fiscal year 1994. From fiscal year 1991 through 1994, the District provided a total of $309 million in subsidies, of which $75 million was characterized as loans, to cover large operating deficits. Detailed recommendations for solving problems at D.C. General and the public clinics have been provided to the District. These recommendations, which range from closing the hospital to integrating the clinics with the hospital, are summarized in appendix III.

[16]U.S. Department of Health and Human Services, Public Health Service, Deep Look Survey - D.C. Public Sector Health Facilities, August 1995.

Status of Recommendations

Over the past several years, various comprehensive studies have been conducted on the District's health care system. We reviewed four of these studies and categorized the resulting recommendations into "fully implemented," "partially implemented," and "not implemented," based on our analysis. Many of the recommendations relate to the establishment of a Public Benefit Corporation (PBC). This corporation would restructure the District's health care system to separate the health delivery functions from public health policy and regulatory functions. According to District officials, the establishment of this corporation is still in the planning stages, with partial implementation anticipated by April 1996 and completion by September 30, 1996. We view initiatives that are still in the development or planning stages as ongoing, but continue to categorize them as "not implemented."

Additionally, the status of these recommendations reflects the representations of District officials. We did not confirm the status of implementation nor did we evaluate the effectiveness of the District's actions to implement the recommendations. The four studies we reviewed are

- Four Years Later: Rivlin Report Revisited, December 1994 (RII);
- Final Report of the Mayor's Task Force on Long-Term Strategies to Improve the District of Columbia's Public Health Care Delivery System, January 1994 (LTS);
- Final Report of the Mayor's Blue Ribbon Panel on Health Care Implementation, February 1995 (BR); and
- District of Columbia General Hospital - Operational and Financial Viability Plan, May 1994 (K).

Issue	Recommendation	Fully implemented	Partially implemented	Not implemented
Public health care delivery system	(1) Create a new Public Benefit Corporation to separate the health delivery functions from public health policy and regulatory functions. (RII, BR, LTS)			X Plan for partial implementation by 4/1/96, completion by 9/30/96.
	(2) Reconstitute the current Commission of Public Health to a cabinet-level Department of Health. (BR, LTS)		X Anticipated completion 9/30/96.	
	(3) Restructure D.C. General (and Saint Elizabeths-RII) under the new Public Benefit Corporation, with D.C. General to serve as an acute care facility. (BR)			X Part of PBC. Partial implementation by 4/1/96, completion by 9/30/96.
	(4) Effectively use health professionals such as nurse practitioners, nurse midwives, and physician assistants. (BR)			X Ongoing.
	(5) Involve health professionals in any government-organized group or initiative seeking ways to improve the delivery of health care in the District. (LTS)	X Effective 10/95.		
	(6) Develop an organized system to collect, analyze, and report health statistics and information; establish mechanisms for data uniformity and linkage; and provide valid and timely data capable of supporting program and management decisions and forecasting future health trends. (LTS)			X Developing new system in coordination with the federal government.
	(7) Create an oversight board with representatives of the city and community to set policy for the hospitals and the clinics. (RII)		X Advisory Board for D.C. Gen. Legis. to explore establishment of PBC board.	
	(8) Create a private, not-for-profit, self-sustaining corporation working in cooperation with the new D.C. Department of Public Health to create and administer health research projects. (LTS)			X Ongoing. Anticipated completion 9/30/96.
	(9) Establish an office or bureau within the Department of Public Health to collect and disseminate health statistics in the District uniformly. (LTS)	X Reestablished 1/96.		

(continued)

Issue	Recommendation	Fully implemented	Partially implemented	Not implemented
	(10) Direct the Department of Public Health to work with public and private hospitals and other providers to develop a comprehensive approach to ensure access for all residents to acute care services. (LTS)		X Anticipated completion 9/30/96.	
	(11) Support the operation of the D.C. General Hospital Association. (LTS)			X
	(12) Establish a formal relationship between the Department of Corrections Health Services and the new Department of Public Health. (LTS)		X	
	(13) Determine whether to transfer the Emergency Medical Service (EMS) Bureau of the D.C. Fire Department (DCFD) to the new Department of Public Health, or whether it should remain as a separate bureau within the DCFD.(LTS)			X Final determination being made. Discussions concern privatizing ambulance services.
	(14) Evaluate the current EMS response system to determine what improvements, if any, should be made to the dispatch system and how EMS responds to calls for assistance. (LTS)		X New dispatch system in place. Additional evaluation ongoing.	
	(15) Direct EMS and the Department of Public Health to develop a patient monitoring system to follow up and refer patients seen by EMS staff for post-emergency treatment. (LTS)			X Centralized trauma registry to be established in FY 1996.
Primary care	(1) Develop a system of primary care by redirecting a significant amount of public health resources from acute and chronic care to preventive health services. (BR, LTS)			X Ongoing.
	(2) Replace the current 11 public clinics with a reduced number of regional primary care centers. (RII, BR)			X
	(3) Integrate the District's public clinics, including their information systems, into the operation of various hospitals, with a view towards improving referral relationships between the clinics and District hospitals. (K, LTS)		X Currently integrating clinics with D.C. General	
	(4) Establish a central authority responsible for coordinating primary health care services provided by the public sector to the District's most vulnerable populations. (BR)			X Part of PBC. Partial implementation by 4/1/96, completion by 9/30/96.

(continued)

Issue	Recommendation	Fully implemented	Partially implemented	Not implemented
	(5) Identify the public sector resources that will be required to deliver necessary health services in an economical and effective manner to the citizens of the District of Columbia. (LTS)			X Ongoing. Anticipated completion 9/30/96.
	(6) Increase the cultural sensitivity and bilingual resource capability of employees throughout the public health care system, and promote primary health care education throughout the community, including the Spanish-speaking population. (LTS)			X Ongoing.
	(7) Increase access to primary and preventive care through incentives directed at the private health care sector. (LTS)			X Ongoing.
	(8) Support national efforts to increase the number of primary care practitioners by offering incentives to medical and dental students and health care providers to enter into primary care. (LTS)		X Primary care cooperative agreement and grants being implemented.	
	(9) Support training for individuals from different cultural backgrounds to be health care providers. (LTS)			X
	(10) Support continued cooperation between the Commission of Public Health and the D.C. Public Schools to provide health services in D.C. public schools and support for public health programs for students. (LTS)	X		
	(11) Direct the Department of Public Health to work with the D.C. Public Schools to develop programs to promote the mental and physical well-being and environmental needs of school-aged children in order to promote good health into adulthood. (LTS)			X Ongoing.
	(12) Support continued training for careers in health services by the D.C. Public Schools and the University of the District of Columbia. (LTS)			X Ongoing.
Long-term care	(1) Provide a unified case management system for continuity of care and appropriate level of care for persons being treated in public and private long-term facilities. (LTS)			X

(continued)

Issue	Recommendation	Fully implemented	Partially implemented	Not implemented
	(2) Evaluate the need for the District government to continue to operate long-term care facilities in light of current and projected future incentives for private sector initiatives in this area. (LTS)		X	
D.C. General Hospital	(1) Contract with the new Public Benefits Corporation (PBC) for prison care and specify levels of care for the medically indigent population. (K)		X Completion anticipated 9/30/96.	
	(2) Replace the core building of D.C. General, purchase and remodel an existing hospital for D.C. General, or close D.C. General and distribute patients to area hospitals. (RII)			X
	(3) Establish a Facility Practice Plan for physicians currently employed at D.C. General and the public clinics. (K)		X Tentative frame work developed.	
	(4) Integrate the public clinics with D.C. General Hospital to improve the quality and cost-effectiveness of care provided through the sharing of operational resources and management systems. (K)			X Part of PBC. Partial implementation by 4/1/96, completion by 9/30/96.
	(5) Identify a financial team to target a reduction in net accounts receivable from 119 days to 75 days. (K)	X		
	(6) Implement all nonlabor expense reduction recommendations. (K)	X		
	(7) Reorganize the administrative support functions and responsibilities. (K)			X Part of PBC. Partial implementation by 4/1/96, completion by 9/30/96.
	(8) Put the goals and objectives of the Leadership/Management section of the hospital strategic plan into operation. (K)			X Part of PBC.
	(9) Transfer hospital employees to the PBC and allow the corporation to establish a personnel system, including recruitment and retention policies and wage and salary administration. (K)			X Part of PBC.
	(10) Track and monitor length of stay information by DRG. (K)	X		
	(11) Implement a DRG optimization program and apply for a "fee-for-service" provider designation to allow the hospital to function as a managed care provider. (K)			X Evaluation underway.

(continued)

Issue	Recommendation	Fully implemented	Partially implemented	Not implemented
	(12) Reduce linen usage through internal controls and education. (K)	X		
	(13) Implement inventory reduction and control recommendations. (K)	X		
	(14) Enforce and monitor the policy requiring proof of D.C. residency as a prerequisite for registration for nonemergency care. (K)	X		
	(15) Consolidate the inpatient pharmacy and implement a co-payment policy for the outpatient pharmacy. (K)			X
	(16) Develop a plan to reconfigure outpatient pharmacy services, similar to other public hospitals. (K)			X
	(17) Consolidate the administrative support structure for the Georgetown and Howard Ambulatory Care Clinics into one outpatient center. (K)	X		
	(18) Integrate the Emergency Services (ECC, Psychiatry Emergency, and Pediatric Emergency) into one Emergency Care Center. (K)		X Completion anticipated 7/31/96.	
	(19) Undertake a systematic review of all programs, clinical and academic, to assess the relative contribution of each program to the hospital's mission and the specific role of each in the hospital's future. (K)			X
	(20) Reduce workforce to levels consistent with industry norms. (K)	X		
Saint Elizabeths	(1) Develop a community mental health care system. (RII)	X		
	(2) Reallocate staff to direct patient care. (RII)	X		
	(3) Hire additional physicians. (RII)	X Currently underway.		
Independent commission	(1) Establish an independent commission to further develop and implement the reform initiatives recommended in the Blue Ribbon report. (BR)			X
Regulatory reform	(1) Adopt tort reform measures with provisions which are comparable to those of Maryland and Virginia, including those relating to caps on noneconomic loss, attorney fees, collateral source, periodic payments, statute of limitations, and certificate of merit. (BR)			X

(continued)

Issue	Recommendation	Fully implemented	Partially implemented	Not implemented
	(2) Enact insurance reform in the small employer market. (BR)			X
	(3) Designate the new D.C. Department of Public Health as the State Health Authority for the District of Columbia with the responsibility to implement and coordinate the District's Health Care Reform Initiative, which includes establishing health alliances, certifying health plans, monitoring quality/availability of health care, and implementing insurance reform. (LTS)			X Part of PBC. Partial implementation by 4/1/96, completion by 9/30/96.
	(4) Transfer licensing authority for health care providers in the District of Columbia from the Department of Regulatory Affairs to the new Department of Public Health. (LTS)			X Part of PBC. Partial implementation by 4/1/96, completion by 9/30/96.
	(5) Transfer the licensing of hospitals and health facilities to the new Department of Public Health. (LTS)			X Part of PBC. Partial implementation by 4/1/96, completion by 9/30/96.
Managed care	(1) Develop a managed care program—could include the Supplemental Security Income (SSI) Medicaid eligible and, possibly, the indigent. (RII)		X Half of Aid to Families With Dependent Children (AFDC and AFDC-related) enrolled in HMO.	X Full implementation by 8/96.
	(2) Vigorously explore use of a Medicaid waiver to develop models such as those which are being implemented in other states, designed to better use resources. (BR)			X Full implementation by 9/30/96.
Financing/ expenditures	(1) Expand use of Medicaid reimbursement for residential care facilities for delinquent youth in out-of-state facilities (for mental health) and to create prenatal care package to be financed by Medicaid. (RII)	X Implemented in 1992.		
	(2) Seek an increase in the inpatient and outpatient Medicaid reimbursement rates by enactment of the State Health Plan Amendment. (K)		X	
	(3) Initiate on-site Medicaid enrollment at the time of admission or initial encounter at D.C. General. (K)	X		

(continued)

Issue	Recommendation	Fully implemented	Partially implemented	Not implemented
	(4) Consider doing a feasibility study on establishing a hospital cost review and cost setting commission for District hospitals to control cost and capacity, as well as a mechanism for the equitable distribution of uncompensated care among District hospitals. (BR)			X
	(5) The District should vigorously pursue an improved Medicaid match. (BR)			X Ongoing.
	(6) Facilitate the Medicaid enrollment process, especially for those with language and/or social impediments. (BR)			X Ongoing.
	(7) Establish a mechanism to review the Medicaid benefit package and identify opportunities to reduce optional benefits. (BR)			X Proposed cuts planned in FY 1997.
	(8) Create an indigent care trust fund to spread costs to subsidize health care costs for the uninsured. (RII)			X
	(9) Reduce District health expenditures in the range of $80 to $100 million (from fiscal year 1994 base) to bring District expenditures closer in line with other jurisdictions. (BR)			X Planning to cut approximately $80 million in FY 1997.

Deep Look Survey Costs to Fix or Replace District Health Care Facilities

During fiscal year 1995, the Office of Engineering Services in the U.S. Department of Health and Human Services conducted a survey of D.C. General Hospital, its surrounding clinics, and seven of the District's public clinics. The surveys consisted of site visits, in-depth inspection of the facilities, and follow-up recommendations. Each recommendation includes a cost estimate to fix noted deficiencies. However, since the inspections were limited, additional costs could accrue.

Public health facility	Total costs to fix/repair	Age	Size (sq. ft.)	Description of problems
D.C. General and Surrounding Clinics				
D.C. General Hospital	$112,266,586[a]	Ranges from 1927 to 1979 Average 53 years	1,039,076	(1) Poor roofs and floors; (2) Evidence of asbestos; (3) Poor heating, ventilation, and air conditioning (HVAC); (4) Poor maintenance of hospital and evidence of vandalism; (5) Patient toilets deteriorating and not well maintained; (6) Hazardous material and specimens not stored in locked areas; (7) Laundry equipment not properly working; (8) Exterior clinic wall crumbling; (9) Severe sanitation problems in OB/GYN; (10) Elevator out of service; (11) Handicap ramp in disrepair; (12) Flooded mechanical room and inoperative emergency generator; (13) Ventilation in surgical pathology lab inadequate and a health hazard; (14) Ceiling problems; and (15) Violation of life safety codes in Archibold Hall.
Sexually Transmitted Disease (STD) Clinic at D.C. General Hospital	$144,701 (renovate) $50,000 (annual maintenance contract)	Built in 1943 and renovated in 1987 Was intended to be temporary	9,824	(1) Severely overcrowded[b]; (2) Hazardous conditions in pipe crawl space; (3) Education center not operating due to lack of funds; (4) Faulty windows and water damaged ceiling; (5) Roof damaged; (6) HVAC upgrades needed; and (7) Lack of routine maintenance and shortage of hot water.
Tuberculosis (TB) Clinic at D.C. General Hospital	$224,705 (renovate) $50,000 (annual maintenance contract)	Built in 1943 and renovated in 1987 Was intended to be temporary	10,560	(1) Preventive maintenance necessary; (2) Fire door holders needed; (3) Air flow inadequate—poor ventilation; (4) HVAC system energy efficient, but not the preferred design for reducing risk of TB transmission; (5) Portable air filters not effective; and (6) TB infection control guidelines not met.

(continued)

Public health facility	Total costs to fix/repair	Age	Size (sq. ft.)	Description of problems
Karrick Hall at D.C. General Hospital	$269,237 (renovate) $75,000 (annual maintenance contract)	Built in 1964 Was intended to be temporary	Not stated	(1) Patient rooms need refurbishing; (2) Asbestos abatement needed for pipe insulation removal; (3) Electrical work needed; (4) Smoke detectors not spaced correctly; (5) Handicap access problems; (6) HVAC repairs needed; (7) Plumbing fixtures need replacement; (8) Laundry equipment not fully operational; (9) One or two elevators broken; and (10) Routine preventative maintenance needed.
Detox Center at D.C. General Hospital	$83,487 (renovate) $60,000 (annual maintenance contract)	Built in 1943 and renovated in 1987 Was intended to be temporary	Not stated	(1) Bathrooms need refurbishing; (2) Repair of walls and replacement of windows needed; (3) Repair of rear security door needed; (4) Handicap access problems; (5) Repair of air conditioning system needed; (6) Additional water fountains needed; (7) Replacement of ceiling tiles needed; and (8) Preventive maintenance needed.
TRAIN II Clinic at D.C. General Hospital	$64,948 (renovate) $50,000 (annual maintenance contract)	Built in 1943 and renovated in 1987 Was intended to be temporary	14,400	(1) Preventive maintenance needed; (2) Repair of windows needed; (3) Replacement of door frames and hardware needed; (4) Air flow inadequate—poor ventilation; (5) Replacement of ceiling tile needed; (6) Removal of debris from roof and drains needed; (7) Handicap access problems; and (8) Poor ventilation and air flow—heat and humidity cause pneumatic controls to malfunction.
Women's Services Center at D.C. General Hospital	$62,265 (renovate) $50,000 (annual maintenance contract)	Built in 1943 and renovated in 1987 Was intended to be temporary	11,000	(1) Preventive maintenance needed; (2) Closed circuit T.V. system needs repair; (3) Holes in floors—drill covers needed; (4) Carpet in children's play area should be replaced with new safety floors; (5) Inadequate air flow—poor ventilation; (6) Repair and replacement of doors and ceiling tiles necessary; (7) Handicap access problems; (8) Heat and humidity have caused pneumatic controls to malfunction; and (9) Electrical problems.
Cost to renovate D.C. General Clinics, excluding maintenance costs	**$849,343**			

(continued)

Public health facility	Total costs to fix/repair	Age	Size (sq. ft.)	Description of problems
Public Clinics				
Benning Heights Health Clinic	$441,120	23 years	5,750	(1) Undersized exam rooms; (2) No departmental waiting; (3) Not handicap accessible; and (4) Poor ventilation and temperature controls.
Walker-Jones Health Center	$728,165	20 years	6,380	(1) Deteriorated exterior; (2) Not handicap accessible; (3) Ventilators and lavatories are old and need replacing; (4) Obsolete electrical equipment with code violations; and (5) Boilers, pumps, water piping, and insulation need replacing.
Adams Morgan Health Center	$199,770	18 years	3,100	(1) Ceiling damaged; (2) Inadequate air flow—poor pneumatic controls; (3) Obsolete electrical equipment with code violations; (4) Various obsolete systems needing replacement; and (5) Handicap access problems.
Anacostia Health Center	$812,015	27 years	6,750	(1) Severe overcrowding; (2) Life safety code problems; (3) Patient care guideline problems; (4) Poor HVAC and controls do not work; and (5) Electrical code violations.
Claridge Health Center	$294,510	28 years	1,650	(1) Damaged floors, walls, and ceilings from water leaks and lack of maintenance; (2) Space does not meet program requirements—needs complete renovation and upgrade; (3) Handicap access problems; (4) Inoperative cooling system; (5) No fresh air circulation—filters are filthy and clogged; (6) No emergency power or fire alarm system; and (7) Electrical code violations.

(continued)

Public health facility	Total costs to fix/repair	Age	Size (sq. ft.)	Description of problems
Southwest Health Center	$2,261,669	56 years	19,860	(1) Severe overcrowding; (2) Poor space configuration; (3) Numerous life safety code and patient care guideline problems; (4) First and second floors need major renovation; (5) Replace elevator to correct code violations; (6) Damaged exterior, doors, windows, and roof need replacing; (7) Handicap access problems; (8) Health and cooling units are not controllable; (9) Poor ventilation; (10) New chiller needed; (11) Asbestos problems; (12) No sink in exam room and lab; (13) Possible underground fuel leaks; and (14) Normal and emergency power systems need replacing.
RAP, Inc. (drug treatment center)	$4,288,615	40 years	36,000	(1) Exterior and interior damage and disrepair on a large-scale[c]; (2) Major renovation and space utilization planning needed; (3) Doors, windows, and portions of roof need replacing; (4) Handicap access problems; (5) Facility would be extremely expensive to renovate; and (6) Mechanical, electrical, and plumbing systems need replacing.
Total cost to renovate public clinics	**$9,025,864**			

[a]This is the cost to renovate D.C. General Hospital. The cost to build a new hospital and renovate the Ambulatory Critical Care Center is $126,492,766. The survey concludes that it would be more cost-effective to build a new, smaller facility, rather than renovate the existing hospital complex.

[b]STD clinic lost the lease to its second clinic site, which causes this site to be severely overcrowded.

[c]Building was abandoned for 4 years and exterior and interior reflect universal, large-scale damage and disrepair.

Source: Individual survey reports provided by Dr. Marlene Kelly, D.C. Commission of Public Health.

Scope and Methodology

To analyze the District's health care budget and actual expenditures for fiscal years 1991 through July 31, 1995, we

- performed a detailed analysis of the District's Financial Management System (FMS), the accounting system which tracks the District's health care budget and actual health care expenditures.

To address your questions on the Medicaid program, we

- performed a detailed analysis of the MMIS database of Medicaid claims processed during fiscal years 1993, 1994, and as of July 31, 1995;
- interviewed (1) officials in the Mayor's office, in each of the Commissions under the Department of Human Services, at the D.C. Hospital Association, at all of the 13 private District hospitals, and at First Health (the District's Medicaid claims processor) and (2) other private health care experts;
- reviewed Medicaid cost settlements for hospitals and long-term care facilities for fiscal years 1993 and 1994; and
- compared MMIS payment information, federally required Health Care Financing Agency (HCFA) reports, and FMS accounting data.

To respond to your questions on the cost of medical services, we

- performed a detailed analysis of the MMIS database of claims processed during fiscal years 1993, 1994, and as of July 31, 1995;
- interviewed (1) officials in the Mayor's office, in each of the Commissions under the Department of Human Services, at the D.C. Hospital Association, at all of the 13 private District hospitals, and at First Health and (2) other private health care experts;
- reviewed Medicaid cost reports for hospitals and long-term care facilities for fiscal years 1993 and 1994;
- interviewed officials in the Commission of Public Health to determine the District's cost reimbursement method for the 11 public clinics; and
- performed a detailed analysis of fiscal year 1994 patient information and expenditures from the D.C. General Hospital and Saint Elizabeths Hospital.

To respond to your questions on the placement of health care facilities, we

- interviewed officials in the Mayor's office, in each of the Commissions under the Department of Human Services, at the D.C. Hospital Association, and at all of the 13 private District hospitals;

- reviewed reports analyzing and offering recommendations on the District's health care system; and
- performed numerous site visits, including visits to all 13 private District hospitals, D.C. General Hospital, Saint Elizabeths Hospital, the District-run nursing home (D.C. Village), several public clinics, and one private clinic.

To address issues on the financial condition of District hospitals, we

- interviewed officials in the Mayor's office, the Commission on Mental Health Services, D.C. General Hospital, the D.C. Hospital Association, and the 13 private District hospitals;
- reviewed reports analyzing and offering recommendations on the District's health care system;
- performed a detailed analysis of financial statements for the 13 private hospitals (for the two most recent fiscal years available audited statements were used when possible);
- compiled and analyzed hospital cost data for all 15 hospitals for calendar years 1993 and 1994;
- reviewed literature on national health care trends;
- performed a detailed analysis of fiscal year 1994 patient information and expenditures from the D.C. General Hospital and Saint Elizabeths Hospital; and
- performed numerous site visits, including visits to all of the private hospitals operating in the District, as well as D.C. General Hospital and Saint Elizabeths Hospital to understand their operations and observe their facilities.

To obtain information on the uninsured, we

- reviewed numerous reports from experts on the uninsured and
- examined the methodologies for obtaining these statistics.

During our review, we identified the following limitations to the data we analyzed:

- The Medicaid database contained numerous anomalies, such as gender codes categorized as unknown and unexpected negative values, which District officials could not explain.
- The data from the MMIS database could not be reconciled to FMS data.
- Detailed Medicaid cost data for hospitals is not provided to the District. Instead, reports with summary costs are submitted by hospitals at varying year-ends and subsequently audited by a District contractor. We did not

examine the adequacy of the audits. In addition, the District is at least 2 years behind in having the audits performed.

- Detailed demographic data is tracked by the MMIS database. However, much of the hospital costs for fiscal years 1993, 1994, and part of 1995 were not included in the database. As a result, demographic information for these costs is not available.
- Some of the hospital information we analyzed to assess the financial condition of the hospitals was unaudited.
- The patient data we analyzed from Saint Elizabeths and D.C. General Hospital were unaudited.
- Estimates of the number of uninsured ranged from 100,000 to 125,000. More exact figures could not be obtained.

We performed our work from July 25, 1995 to December 15, 1995, in accordance with generally accepted government auditing standards.

Comments From the Mayor of the District of Columbia

THE DISTRICT OF COLUMBIA
WASHINGTON, D.C. 20001

MARION BARRY, JR.
MAYOR

MAR 2 9 1996

Gene L. Dodaro
Assistant Comptroller General
Accounting and Information Management Division
United States General Accounting Office
Washington, D.C. 20548

Dear Mr. Dodaro:

The following is the District of Columbia's response to the GAO Report on Health Care Costs in the District. The report is in response to a Congressional request for answers to questions concerning the District's health care budget and the composition of the District's health care system. We have reviewed the findings of the GAO report and found several areas in which clarification is necessary. To this end, we provide these comments.

The District has taken initial steps to transform its health care delivery system and many of the recommendations indicated in the GAO report are in various stages of implementation. Specifically, on March 1, 1996, I forwarded legislation to the Council of the District of Columbia that would establish a Public Benefit Corporation (PBC), which will be the umbrella for providing a seamless, cost efficient health service delivery system.

Key functions of the PBC include:

- Reorganizing D.C. General Hospital and our 11 community health clinics into a 24 hour integrated delivery system, for which preliminary work has already begun.
- Establishing a primary care delivery system consisting of a range of services that is preventative and patient centered.
- Consolidating health care systems such as pharmacy and information systems to allow for better planning and linkages between public and private health care resources.
- Expediting and streamlining the purchasing process for medical supplies and equipment.
- Enhancing capital financing opportunities.

- Operating under a governing board charged with providing oversight and setting policy.

We believe that the GAO report has the potential to serve as a useful tool for evaluating our progress as we move forward with operationalizing transformation initiatives. I appreciate the opportunity to provide our comments and am confident that any future analyses will reflect a new and improved health care delivery system.

Sincerely,

Marion Barry, Jr.

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