



July 2022

WORLD TRADE CENTER HEALTH PROGRAM

Quality Assurance Program Should Include Monitoring of Access to Health Services

Accessible Version

GAO Highlights

Highlights of [GAO-22-105303](#), a report to congressional committees

Why GAO Did This Study

The World Trade Center Health Program provides health services, such as monitoring and treatment for conditions related to the September 11, 2001, attacks, through clinics in the New York City area and the NPN. The program is required to ensure reasonable access to health services through the NPN. However, program stakeholders have reported delays with members' access to these services.

The James Zadroga 9/11 Health and Compensation Reauthorization Act included a provision for GAO to review the World Trade Center Health Program. This report examines the extent to which (1) program spending on health services increased, and (2) NIOSH's quality assurance efforts included assessing the timeliness of access to health services for members through the NPN. GAO analyzed data on claims paid by the program. GAO also interviewed NIOSH officials and reviewed program documents on its quality assurance governance structure and strategic priorities.

What GAO Recommends

GAO is making three recommendations to NIOSH: (1) add ensuring timely access to health services as a program strategic priority, (2) establish metrics for assessing the timeliness of access to health services through the NPN, and (3) ensure that the Quality Assurance Committee review metric data. The agency concurred with our recommendations.

View [GAO-22-105303](#). For more information, contact Michelle B. Rosenberg (202) 512-7114 or RosenbergM@gao.gov.

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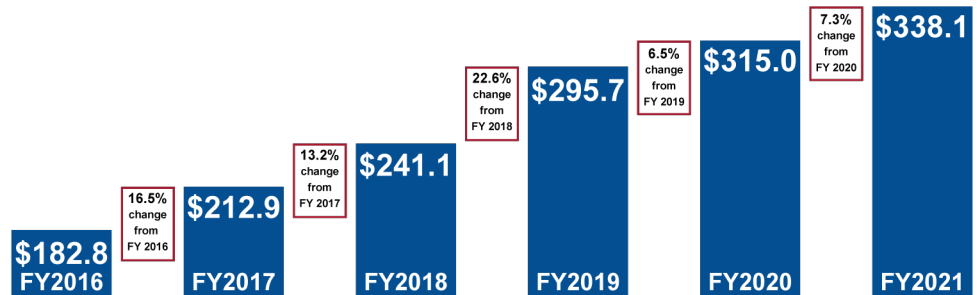
Quality Assurance Program Should Include Monitoring of Access to Health Services

What GAO Found

The World Trade Center Health Program, administered by the National Institute for Occupational Safety and Health (NIOSH), provides health services to eligible responders and survivors of the September 11, 2001, attacks at no cost. NIOSH contracts with clinics in the New York City area and a Nationwide Provider Network (NPN) to provide health services to these individuals—known as members. Spending on health services by the program increased by about 85 percent from fiscal year 2016 through 2021. (See figure.) Clinics that serve responders in the New York City area accounted for the majority of health services spending. Clinics that serve survivors in the New York City area and through the NPN accounted for a growing share of total spending over the time period reviewed.

World Trade Center Health Program Spending on Health Services, Fiscal Years 2016 through 2021

Cumulative percent change in fiscal year (FY) 2016 to 2021 spending: **85%**



Dollar amount of FY spending on health services (in millions)

Source: GAO analysis of World Trade Center Health Program (WTCHP) data. | GAO-22-105303

Accessible Data for World Trade Center Health Program Spending on Health Services, Fiscal Years 2016 through 2021

Fiscal year	Dollar amount of FY spending on health services (in millions)	Percent change in spending from previous FY
2016	\$182,757,333	16.5%
2017	\$212,932,576	13.2%
2018	\$241,119,153	22.6%
2019	\$295,721,244	6.5%
2020	\$314,983,538	7.3%
2021	\$338,109,568	na

Cumulative percent change in fiscal year (FY) 2016 to 2021 spending: **85%**

The World Trade Center Health Program Quality Assurance Committee is comprised of senior program leadership. It was established to develop quality assurance objectives, formulate plans to achieve those objectives, and monitor

related activities throughout the program. This is to be accomplished, for example, by recommending the development of performance metrics. In addition, NIOSH developed strategic priorities for the program. According to officials, NIOSH also applies resources, including quality assurance staff, to support these priorities.

Timely access to health services is an important component of quality health care. However, NIOSH has not specified ensuring timely access among the program's strategic priorities. In addition, the Quality Assurance Committee has not assessed the extent to which members have timely access to health services through the NPN because there are no quality assurance metrics for this. However, information previously collected by the NPN contractor, which was not provided to the Quality Assurance Committee, indicates there were potential problems with the timeliness of members' access to health services. Absent prioritizing timely access to health services, establishing metrics, and reviewing metric data, there is increased risk that reported delays in some members' access to NPN-provided health services may continue and negatively affect those members' morbidity, mortality, and quality of life.

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Abbreviations

CCE	Clinical Center of Excellence
CDC	Centers for Disease Control and Prevention
FY	Fiscal Year
HHS	Department of Health and Human Services
NIOSH	National Institute for Occupational Safety and Health
NPN	Nationwide Provider Network
QA	Quality Assurance
WTC	World Trade Center
WTCHP	World Trade Center Health Program

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July 29, 2022

The Honorable Patty Murray
Chair
The Honorable Richard Burr
Ranking Member
Committee on Health, Education, Labor and Pensions
United States Senate

The Honorable Frank Pallone, Jr.
Chairman
The Honorable Cathy McMorris Rodgers
Republican Leader
Committee on Energy and Commerce
House of Representatives

The September 11, 2001, attacks on the World Trade Center (WTC), the Pentagon, and over Shanksville, Pennsylvania, caused great loss of life and directly affected the long-term physical and mental health of many exposed to these events. In particular, in the New York City area, the collapse of the WTC and the burning of adjacent buildings produced a dense dust and smoke cloud containing toxic compounds. Responders and survivors exposed to these and other hazards have experienced a wide range of physical and emotional trauma following the attacks.

In light of these health problems, the James Zadroga 9/11 Health and Compensation Act of 2010 (Zadroga Act) was enacted in 2011 to establish the World Trade Center Health Program (WTHCP).¹ The WTCHP is administered by the Centers for Disease Control and Prevention's (CDC) National Institute for Occupational Safety and Health (NIOSH), an agency within the Department of Health and Human Services (HHS). The WTCHP provides health services at no cost to

¹Pub. L. No. 111-347, tit. I, § 101, 124 Stat. 3623, 3624-3659 (2011). Prior to the establishment of the WTCHP, Congress provided appropriations to provide limited health screening and treatment services to persons involved in rescue, recovery, and cleanup operations around the former site of the WTC. This program was known as the WTC Medical Monitoring and Treatment Program. Officials with the National Institute for Occupational Safety and Health, the agency that administers the WTCHP, have previously noted that survivors also received health services prior to establishment of the WTCHP through the WTC Environmental Health Center Community Program.

members—eligible responders and survivors enrolled in the program.² Members are eligible to receive health screening, monitoring, and treatment, among other health services, depending upon, for example, whether the member is a responder or survivor or has a covered condition. As of fiscal year (FY) 2021, the WTCHP had about 114,000 members.³

The WTCHP maintains a list of covered conditions for which treatment may be provided to a member if the program certifies that the condition is related to exposure to airborne toxins or other hazards associated with the September 11 attacks. The WTCHP provides and pays for members' treatment of these covered conditions, as well as other health services, without any deductibles, copayments, or other costs to members.⁴ To provide health services to WTCHP members, NIOSH contracts with eight Clinical Centers of Excellence (CCEs) in the New York City area, as well as a Nationwide Provider Network (NPN) that consists of an external network of providers. The CCEs and the NPN are collectively referred to

²Eligible responders include individuals who performed rescue, recovery, or other related services at any of the three disaster sites and meet eligibility criteria relating to exposure to airborne toxins, other hazards, or adverse conditions resulting from the September 11, 2001, terrorist attacks. Eligible survivors are individuals who were affected by the attack on the WTC and meet other criteria related to being in the New York City disaster area, such as (1) being in the disaster area in the dust or dust cloud on September 11, 2001, or (2) working, residing, or attending school, child care, or adult day care in the disaster area for at least 4 days during the 4-month period after the attacks, or at least 30 days during the period beginning on September 11, 2001, and ending on July 31, 2002. The New York City disaster area is the area of Manhattan south of Houston Street, including the former site of the WTC, and any block in Brooklyn within a 1.5-mile radius of the former site of the WTC. Individuals who were previously enrolled for the health services that were in place prior to the establishment of the WTCHP were grandfathered into the program.

³In this report, we rounded NIOSH enrollment data to the nearest thousand because the data overstate the number of active members in any given fiscal year. Specifically, NIOSH officials told us that the available WTCHP enrollment data includes all individuals who enrolled in the program since its establishment, including members who are now deceased.

⁴Although the Zadroga Act generally requires that the WTCHP is to be the primary payer for these health services, the act establishes the program as a secondary payer in certain circumstances, such as when a member has a covered condition that is work-related and has filed an applicable workers' compensation claim (except if the responder is covered under a workers' compensation plan administered by New York City) or when a member has a covered condition that is not work-related and is covered by a public or private insurance plan. We previously reported that the program ultimately pays for the vast majority of claims. See GAO, *World Trade Center Health Program: Improved Oversight Needed to Ensure Clinics Fully Address Mandated Quality Assurance Elements*, [GAO-17-676](#) (Washington, D.C.: August 10, 2017).

as the clinics. The Zadroga Act requires that NIOSH develop and implement a WTCHP Quality Assurance (QA) program related to the monitoring and treatment provided to members.⁵

According to a 2021 CDC study, total WTCHP enrollment increased by around 68 percent from 2012 to 2020, with enrollment among members seeking health services through the NPN increasing by around 310 percent during that same period. Additionally, there has been an increase in the number of members in certain states, which is creating a need for providers in new locations. The study also noted that as members age, their use of health services and related costs to the program are expected to increase.⁶

The timeliness with which members can access health services is relevant to the CCEs and the NPN, according to NIOSH officials. However, officials stated providing timely access to health services is more complicated for the NPN given its distribution across all 50 states and reliance on an external network of providers. The Zadroga Act requires that the NPN ensure reasonable access to health services and that the WTCHP Administrator report annually on the program's performance in providing timely evaluation of, and treatment to, members.⁷ However, program stakeholders have noted issues related to the timeliness with which members may be able to access health services through the NPN, and a news organization recently reported that members have been experiencing delays in accessing these services.⁸

⁵Pub. L. No. 111-347, div. O, tit. III, § 101, 124 Stat. 3625-26 (adding PHSA § 3301(e)) (classified at 42 U.S.C. § 300mm(e)).

⁶Centers for Disease Control and Prevention, "World Trade Center Health Program – United States, 2012-2020," *Morbidity and Mortality Weekly Report*, vol. 70, no. 4 (2021). The authors note that chronic diseases, comorbidities, and other health conditions unrelated to the September 11 attacks are more common in older populations, which might complicate the clinical management of their covered conditions.

⁷The Zadroga Act established the NPN to ensure reasonable access to benefits for members residing outside the New York metropolitan area. Pub. L. No. 111-347, 124 Stat. 3647 (adding PHSA § 3313) (classified at 42 U.S.C. § 300mm-23(a)). Further, the Zadroga Act requires that the WTCHP Administrator, who is the Director of NIOSH, submit an annual report to Congress on specified content, including information on the performance of the program in providing timely evaluation of, and treatment to, eligible individuals. Pub. L. No. 111-347, 124 Stat. 3626 (adding PHSA § 3301(f)(2)(D)(i)) (classified at 42 U.S.C. § 300mm(f)(2)(D)(i)).

⁸See NBC News, "I feel betrayed': Some 9/11 responders still face major health care obstacles," accessed Sept. 10, 2021, <https://www.nbcnews.com/news/us-news/i-feel-betrayed-some-9-11-responders-still-face-major-n1278849>.

NIOSH and NPN contractor officials briefed members of Congress in September 2021 to address the members' questions about the NPN's performance, including health services appointment turnaround times.⁹

In 2015, the James Zadroga 9/11 Health and Compensation Reauthorization Act reauthorized the WTCHP and extended health services for members through fiscal year 2090.¹⁰ The act also included a provision for GAO to review the WTCHP. In this report, we

1. describe the extent to which WTCHP spending on health services increased from FY 2016 through 2021, and
2. examine the extent to which NIOSH's QA efforts included assessing the timeliness with which WTCHP members outside of the New York City area can access health services through the NPN.

To describe the extent to which WTCHP spending on health services increased, we analyzed WTCHP data, including data on claims paid by the WTCHP for health services provided through the clinics from FY 2016 through 2021. Fiscal year 2021 was the most recent fiscal year for which data were available at the time of our review.¹¹ Additionally, we interviewed NIOSH officials as well as WTCHP contractors involved in claims processing who are responsible for maintaining the data. We also reviewed related documentation, such as a dictionary of data elements and data reporting requirements, and performed checks to identify any discrepancies with data reporting requirements. Based on these steps we found these data sufficiently reliable for the purposes of our reporting objective.

To examine the extent to which NIOSH's QA efforts included assessing the timeliness with which WTCHP members outside of the New York City

⁹House Committee on Oversight and Reform, "Maloney, Nadler, Garbarino Request Information About New Federal Contract for 9/11 Survivors' and Responders' Medical Care" (Washington, D.C.: March 22, 2022), accessed June 14, 2022, <https://oversight.house.gov/news/press-releases/maloney-nadler-garbarino-request-information-about-new-federal-contract-for-911>.

¹⁰Pub. L. No. 114-113, div. O, tit. III, 129 Stat. 2242, 2996 (2015).

¹¹The WTCHP data included the following for each of the eight CCEs and the NPN: (1) total number of members enrolled; (2) number of members who received health services, by type of health service; (3) total cost of claims paid by the program; and (4) the cost of claims paid by type of health service and for certain types of health services by the type of health condition for which the service was provided. The cost data are not adjusted for inflation.

area can access health services through the NPN, we interviewed NIOSH officials, including those involved in NPN contract management as well as WTCHP QA oversight. We also interviewed program stakeholders from the WTC Responders and WTC Survivors Steering Committees and a 9/11 advocacy organization.¹² We reviewed contract performance information related to timely access to NPN-provided health services from October 2019 through November 2021. November 2021 was the most recent month for which information was available at the time of our review. We also reviewed program information on member complaints made from 2018 through 2021 to identify those related to access. Additionally, we reviewed the WTCHP QA Plan, which outlines the program's strategic priorities and describes the program's QA governance structure and oversight responsibilities, among other things. We evaluated NIOSH's QA oversight efforts in light of these responsibilities and against federal internal control standards related to designing control activities, risk tolerance, and using quality information.¹³

We conducted this performance audit from June 2021 to July 2022 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

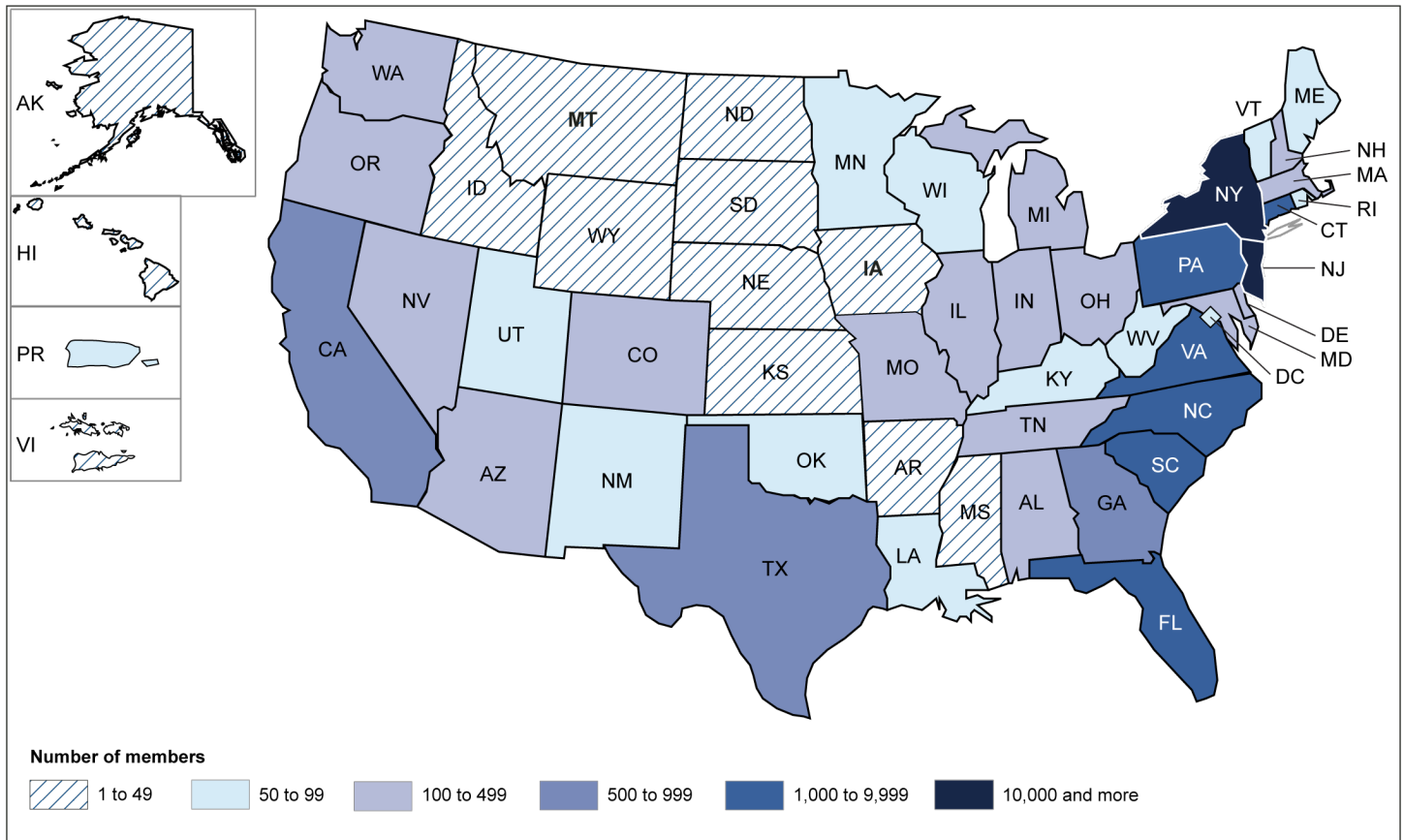
The WTCHP, administered through NIOSH, contracts with clinics throughout the country to provide health services to eligible responders and survivors of the September 11, 2001, attacks. Specifically, the

¹²The WTCHP Administrator is required to consult with the WTC Responders and WTC Survivors Steering Committees on the administration of the WTCHP, and the committees represent and provide input from program stakeholders. See Pub. L. No. 111-347, div. O, tit. III, § 101, 124 Stat. 3627 (adding PHS § 3302) (pertinent provision classified at 42 U.S.C. § 300mm-1(b)). We interviewed a representative from 9/11 Health Watch, an advocacy organization whose mission includes tracking the implementation of the Zadroga Act, addressing any lapses in the delivery of services, and suggesting changes that may be needed.

¹³GAO, *Standards for Internal Control in the Federal Government*, [GAO-14-704G](#) (Washington, D.C.: Sept. 2014). Internal control is a process effected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved.

program contracts with eight CCEs in the New York City area—six that serve responders and two that serve survivors—and the NPN, which serves both responders and survivors outside the area. As of FY 2021, about 82,000 WTCHP members were responders and 32,000 were survivors, and there were members residing in every state. (See fig. 1.) (See app. I for information on enrollment by clinic type.)

Figure 1: World Trade Center Health Program Enrollment, by State, Calendar Year 2021



Source: GAO analysis of World Trade Center Health Program (WTCHP) data. | GAO-22-105303

Note: The WTCHP provides health services to members—eligible responders and survivors of the September 11, 2001, attacks enrolled in the program. Officials from the National Institute for Occupational Safety and Health, the agency that administers the WTCHP, told us that WTCHP enrollment data includes all individuals who enrolled in the program since its establishment, including members who are now deceased. Therefore, the enrollment data overstate the number of active members in the program in fiscal year 2021.

The WTCHP maintains a list of covered conditions for which treatment may be provided to a member if the program certifies that the condition is related to the September 11 attacks, known as WTC-related health

conditions.¹⁴ The list includes certain acute traumatic injuries (such as burns), airway and digestive disorders (such as asthma), cancers (such as lung cancer), mental health conditions (such as post-traumatic stress disorder), and other health conditions.¹⁵ Responders are eligible to enroll in the program regardless of whether they have symptoms of a WTC-related health condition, but survivors need to have symptoms of such a condition to be eligible for enrollment.

The WTCHP provides five types of health services to members: (1) initial health evaluations, (2) monitoring exams, (3) cancer screenings, (4) diagnostic evaluations, and (5) treatment services.¹⁶ Enrolled responders are automatically eligible to receive monitoring exams and certain cancer screenings through the clinics. They are also eligible to receive a diagnostic evaluation related to any covered condition for which they have symptoms, and treatment services if NIOSH certifies that the condition is WTC-related.¹⁷ Enrolled survivors are eligible to receive a one-time initial health evaluation, which includes a diagnostic evaluation related to any

¹⁴The Zadroga Act established an initial list of covered conditions and gave the WTCHP Administrator authority to add to the list through the rulemaking process. See Pub. L. No. 111-347, div. O, tit. III, § 101, 124 Stat. 3640 (adding PHSA § 3312(a)(3)) (classified at 42 U.S.C. § 300mm-22(a)(3)). The WTCHP Administrator has, for example, added certain types of cancer to the list as well as some non-cancer conditions, such as traumatic injuries. For more information on the addition of cancer to the list of covered conditions, see GAO, *World Trade Center Health Program: Approach Used to Add Cancers to List of Covered Conditions Was Reasonable, but Could Be Improved*, [GAO-14-606](#) (Washington, D.C.: July 23, 2014).

¹⁵See 42 C.F.R. § 88.15 for the list of covered conditions.

¹⁶The WTCHP Administrative Manual describes seven member benefit plans: (1) the survivor screening benefit plan, which covers initial health evaluations; (2) the monitoring benefit plan, which covers annual medical examinations and long-term health monitoring and analysis; (3) the cancer screening benefit plan, which cover preventive screening of certain types of cancer; (4) the diagnostics and (5) cancer diagnostics benefit plans, which cover evaluative services used to determine if a member has covered condition; as well as the (6) treatment and (7) cancer treatment benefit plans, which cover related services for members diagnosed with such conditions. For the purposes of this report, we combined the services covered by the diagnostics and cancer diagnostics benefit plans into one category (diagnostic evaluations) and services covered by the treatment and cancer treatment benefit plans into one category (treatment services).

¹⁷Prior to NIOSH certifying a condition, a clinic physician must determine that (1) the condition is on the list of covered conditions (or the condition is medically associated with a WTC-related condition), and (2) September 11-related exposure is “substantially likely to be a significant factor in aggravating, contributing to, or causing” the condition. See Pub. L. No. 111-347, div. O, tit. III, § 101, 124 Stat. 3639, 3652 (adding PHSA §§ 3312 and 3322) (classified at 42 U.S.C. §§ 300mm-22 and 300mm-32). For more information on the certification process, see [GAO-17-676](#).

covered condition for which they have symptoms, as well as certain cancer screenings. If NIOSH certifies that the condition is WTC-related, they can receive treatment, as well as monitoring exams, through the program.

Health Services Utilization

NIOSH data show that the number of members who received health services annually through the WTCHP grew from about 43,000 in FY 2016 to 63,000 in FY 2021, an increase of about 46 percent.¹⁸ (See app. II for information on utilization by type of health service.) This increase may be a result of more individuals becoming eligible for, and receiving, certain services through the program—such as by members receiving initial health examinations or monitoring exams after newly enrolling in the program. It could also be a result of members becoming eligible for and receiving treatment services because they have had a new condition certified by the program. For example, program enrollment increased about 51 percent over this period, and the number of members with one or more certified condition increased about 75 percent. (See app. III for data on the number of members with certified conditions.)

NIOSH officials and program stakeholders identified several factors that may have contributed to increases in enrollment or certified conditions, and thus increases in health services utilization, over this period, including the following.

- **Aging.** Officials and a representative of a stakeholder group noted that as eligible individuals age, they may be more likely to enroll in the program. Additionally, officials explained that members who are already enrolled may be more likely to receive additional health services as they age. For example, officials stated that complex conditions and comorbidities are more common among older

¹⁸Not all members receive health services through the program every year. For example, although an enrolled responder who does not have a WTC-related health condition may receive a monitoring exam every 12 months, according to NIOSH officials it may take longer for the exam to occur based on, for example, a responder's availability.

populations and may complicate the treatment of certified conditions.¹⁹

- **Disease latency.** Officials said certain WTC-related health conditions—such as cancers—may not develop until years after September 11-related exposures. Therefore, they stated that eligible individuals may not have enrolled in the program until they became sick, and those already enrolled may not yet have had a condition certified through the program. Moreover, according to officials, the program requires a minimum amount of time to have elapsed between members' September 11-related exposures and their initial cancer diagnoses for NIOSH to certify these conditions as WTC-related.²⁰
- **September 11th Victim Compensation Fund Eligibility Rules.** Officials said that the Department of Justice changed the Victim Compensation Fund eligibility rules in 2016. Prior to 2016, individuals could be eligible for benefits from the Victim Compensation Fund if a private physician certified their conditions as being related to the September 11 attacks. However, as a result of the 2016 change in eligibility rules, officials said that most individuals are now required to enroll in and have their WTC-related health conditions certified by the WTCHP in order to receive fund benefits.²¹ Officials and a representative of a stakeholder group stated that this change contributed to an increase in WTCHP enrollment. According to

¹⁹These comorbidities may not be WTC-related health conditions. However, officials stated that the program covers the treatment of some of these comorbid conditions, or certain symptoms of these comorbid conditions, if necessary to manage, improve, or cure a co-occurring WTC-related health condition. In FY 2016, 46 percent of members were 55 or older and by FY 2021, 64 percent of members were aged 55 or older. During that time period, the number of members with more than one certification increased by about 67 percent.

²⁰For example, 11 years must have elapsed between an individual's September 11-related exposure and their initial diagnosis of Mesothelioma before the program will certify the condition as WTC-related. Therefore, the earliest acceptable date for the WTCHP to certify a Mesothelioma diagnosis was September 11, 2012 (assuming an exposure date of September 11, 2001). From FY 2016 through 2021, the number of members with a certification for cancer increased 315 percent. (See app. III for data on the number of members with cancer certifications.)

²¹The Victim Compensation Fund is administered by the Department of Justice and provides compensation to individuals—or representatives of a deceased individual—who suffered physical harm or who died as a result of the terrorist attack or its immediate aftermath. NIOSH officials said that although this rule took effect in 2016, the Department of Justice did not begin to require WTCHP certification until 2017.

officials, subsequently, the number of members seeking such certifications from 2017 through 2019 increased.

Nationwide Provider Network

The WTCHP provides health services to members who reside outside of the New York City area through the NPN. The Zadroga Act requires that such members have reasonable access to health services through this network. Unlike the institutions that operate the CCEs, which serve a large member population in a relatively small geographic area and have dedicated clinics for WTCHP members, NIOSH officials noted that providers in the NPN are part of an external network that serves other patients, in addition to WTCHP members.²²

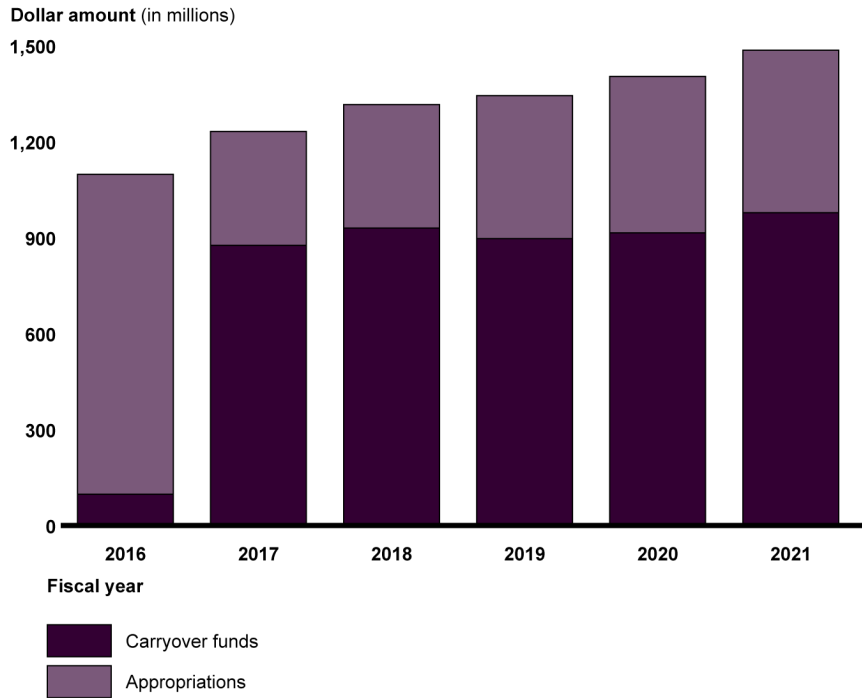
NIOSH data show that as of FY 2021, there were about 26,000 members enrolled in the NPN, an increase of about 162 percent since FY 2016. Additionally, in 2021, there was at least one WTCHP member living in each of the 50 states, as well as in the District of Columbia, Puerto Rico, and the Virgin Islands.

WTCHP Overall Funding and Spending

Funding available for WTCHP spending increased from about \$1.1 billion in FY 2016 to about \$1.5 billion in FY 2021. (See fig. 2.)

²²As of May 2022, the NPN was operated by Logistics Health Incorporated (a subsidiary of OptumServe). Logistics Health Incorporated's contract to operate the NPN began in 2016. According to NIOSH, in late summer or fall 2022, Managed Care Advisors-Sedgwick will begin to operate the NPN under a new contract award made in November 2021, following a transition period.

Figure 2: World Trade Center Health Program Funding, Fiscal Years 2016 through 2021



Source: GAO analysis of Department of Health and Human Services budget data. | GAO-22-105303

Accessible Data for Figure 2: World Trade Center Health Program Funding, Fiscal Years 2016 through 2021

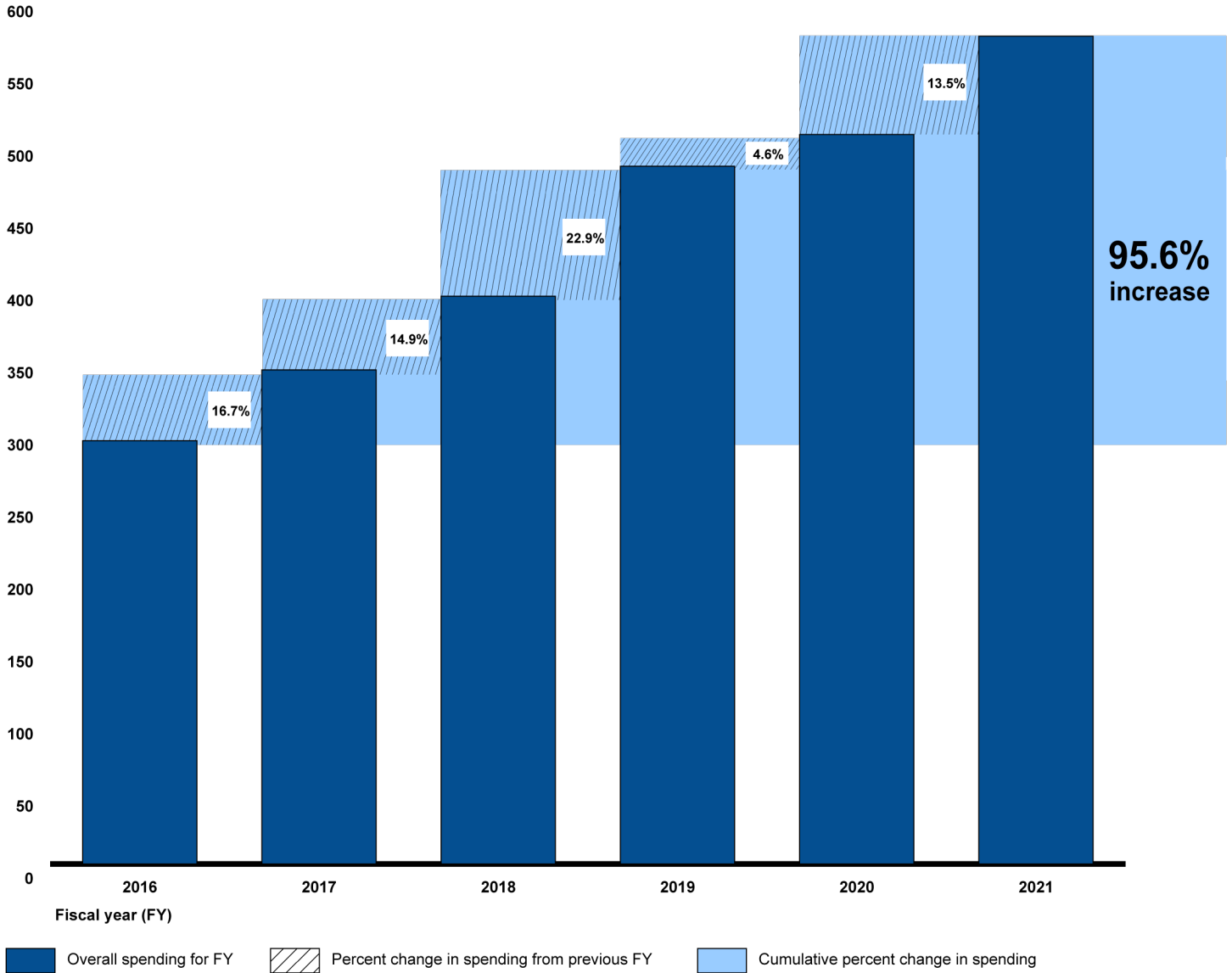
Fiscal year	Carryover funds (dollar amount, in millions)	Appropriations (dollar amount, in millions)
2016	98	1000
2017	876	356
2018	930	386
2019	897	447
2020	915	489
2021	978	508

Note: The Zadroga Reauthorization Act appropriated a total of about \$4.7 billion for the program for fiscal years 2016 through 2025, and extended the availability of unexpended prior year appropriations—which we refer to as carryover funds—until expended or through fiscal year 2090. Therefore, the carryover funds reported for each fiscal year reflect the cumulative amount of appropriated funds from prior fiscal years that remain available.

In addition to paying for health services for members, the Zadroga Act authorizes the WTCHP to spend funds on certain other program activities. This includes education and outreach to eligible responders and survivors and research on WTC-related conditions. Overall WTCHP spending—that is, spending on health services and other program activities—grew from about \$293 million in FY 2016 to about \$573 million in FY 2021, an increase of about 96 percent. Overall spending increased every year in this period, with the largest annual increase occurring between FY 2018 and FY 2019, and the smallest annual increase occurring the following year. (See fig. 3.)

Figure 3: World Trade Center Health Program Overall Spending, Fiscal Years 2016 through 2021

Dollar amount (in millions)



Source: GAO analysis of Department of Health and Human Services budget data. | GAO-22-105303

Accessible Data for Figure 3: World Trade Center Health Program Overall Spending, Fiscal Years 2016 through 2021

Fiscal year	Overall spending for fiscal year	Percent change in spending from previous FY
2016	293.0000000	16.7%
2017	342.0000000	14.9%
2018	393.0000000	22.9%
2019	483.0000000	4.6%
2020	505.0000000	13.5%
2021	573.0000000	

Cumulative percent change in spending: 95.6%

Note: Overall program spending reflects total World Trade Center Health Program outlays for a given fiscal year. It includes spending on health services provided to members and other program activities, such as education and outreach to eligible responders and survivors and research on World Trade Center-related conditions. Spending has not been adjusted for inflation.

WTCHP Quality Assurance Program

In 2016, NIOSH developed a WTCHP QA Plan to define the QA program, which is one component of NIOSH’s oversight of health services. NIOSH has revised the plan several times, most recently in October 2021. The plan includes strategic priorities that, according to NIOSH officials, identify aspects of the WTCHP for which NIOSH intends to dedicate resources for conducting QA activities. Further, the plan describes QA metrics that NIOSH developed in 2018 to address legally mandated QA elements such as adherence to monitoring and treatment protocols.²³ The QA metrics measure, for example, the proportion of members who received various tests at their most recent monitoring visits, and whether test results are communicated to members within established time frames. The clinics are required to report data on these metrics to NIOSH on a semiannual basis.²⁴

²³See Pub. L. No. 111-347, div. O, tit. III, § 101, 124 Stat. 3625-26 (adding PHSA § 3301(e)) (classified at 42 U.S.C. § 300mm(e)).

²⁴The clinics currently report on 11 such QA metrics. The QA metrics are intended to address three Zadroga Act mandated QA elements: (1) adherence to monitoring and treatment protocols, (2) appropriate diagnostic and treatment referrals for participants, and (3) prompt communication of test results to participants. For information on the WTCHP’s oversight of these three QA elements, see [GAO-17-676](#).

The QA Plan also describes the WTCHP QA governance structure. That governance structure consists of the WTCHP QA Committee. According to NIOSH officials, the QA Committee was established in July 2020 and is comprised of senior program leadership—including senior officials from the program’s various units (such as the chiefs of the member services and enrollment, medical benefits and certification, and contracts units) and others. The QA Committee establishes QA objectives for the WTCHP; formulates plans to achieve those objectives; and provides guidance, feedback, and direction on QA activities and results. The QA committee generally meets quarterly to conduct these activities, according to NIOSH officials.

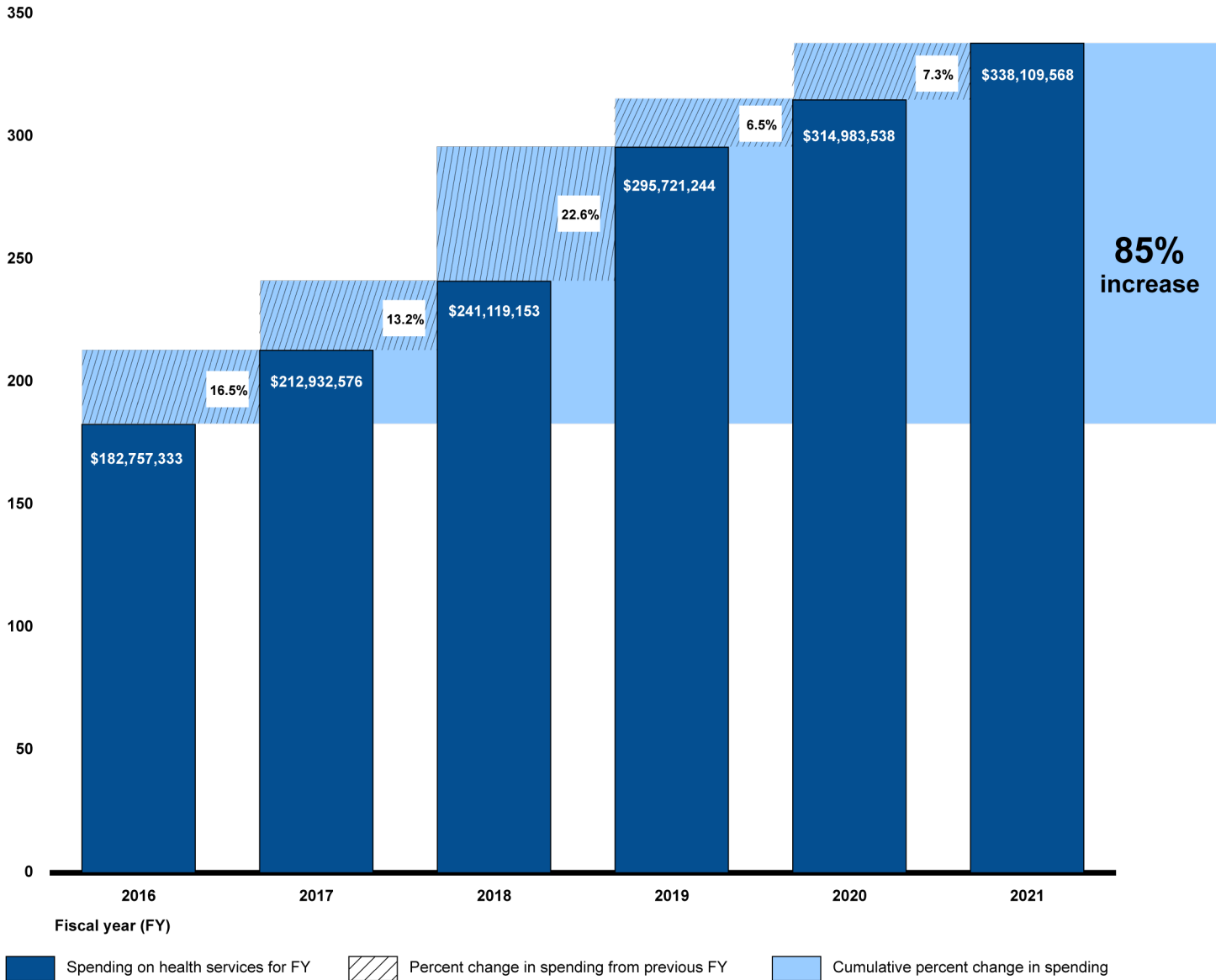
WTCHP Spending on Health Services Increased About 85 Percent from FY 2016 through 2021

Similar to the trend in overall program spending, our analysis of NIOSH claims data shows that WTCHP spending on all health services provided by the clinics grew from about \$183 million in FY 2016 to about \$338 million in FY 2021, an increase of about 85 percent.²⁵ Spending on health services increased every year of this period, with the largest annual increase occurring between FY 2018 and FY 2019 and the smallest increase occurring the next year. (See fig. 4.)

²⁵WTCHP spending on health services accounted for about 59 to 62 percent of the program’s overall spending each year from FY 2016 through 2021.

Figure 4: World Trade Center Health Program Spending on Health Services, Fiscal Years 2016 through 2021

Dollar amount (in millions)



Source: GAO analysis of World Trade Center Health Program data. | GAO-22-105303

Accessible Data for Figure 4: World Trade Center Health Program Spending on Health Services, Fiscal Years 2016 through 2021

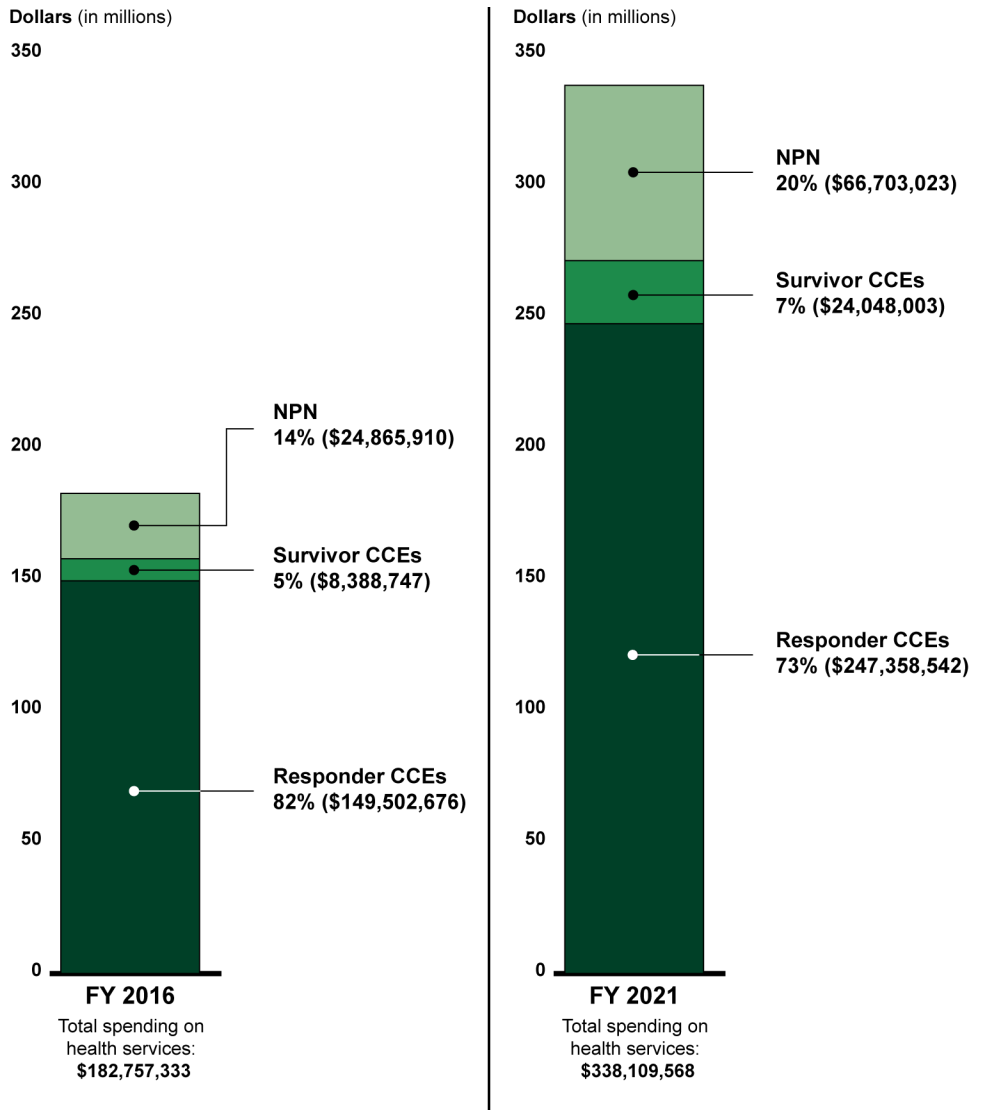
Fiscal year	Spending on health services for FY	Percent change in spending from previous FY
2016	\$182,757,333	16.5%
2017	\$212,932,576	13.2%
2018	\$241,119,153	22.6%
2019	\$295,721,244	6.5%
2020	\$314,983,538	7.3%
2021	\$338,109,568	na

Cumulative percent change in spending: 85%

Note: According to officials, spending data are for the fiscal year in which claims for health services were paid, not the fiscal year the health services were provided. As a result, health services provided in one fiscal year may be reflected in the spending for a subsequent fiscal year. Spending has not been adjusted for inflation.

Spending on health services by clinic type. WTCHP spending on health services provided by each type of clinic (the six responder CCEs, the two survivor CCEs, and the NPN) increased from FY 2016 through 2021. While the spending for the responder CCEs accounted for the majority of spending on all health services over this period, spending for the survivor CCEs and the NPN accounted for a growing share of total spending over the time period we reviewed. (See fig. 5.) Appendix IV provides information on spending on health services by type of clinic and year from FY 2016 through 2021.

Figure 5: World Trade Center Health Program Spending on Health Services, by Type of Clinic, Fiscal Years 2016 and 2021



Legend: CCEs=Clinical Centers of Excellence; FY=fiscal year; NPN=Nationwide Provider Network.

Source: GAO analysis of World Trade Center Health Program (WTCHP) data. | GAO-22-105303

Accessible Data for Figure 5: World Trade Center Health Program Spending on Health Services, by Type of Clinic, Fiscal Years 2016 and 2021

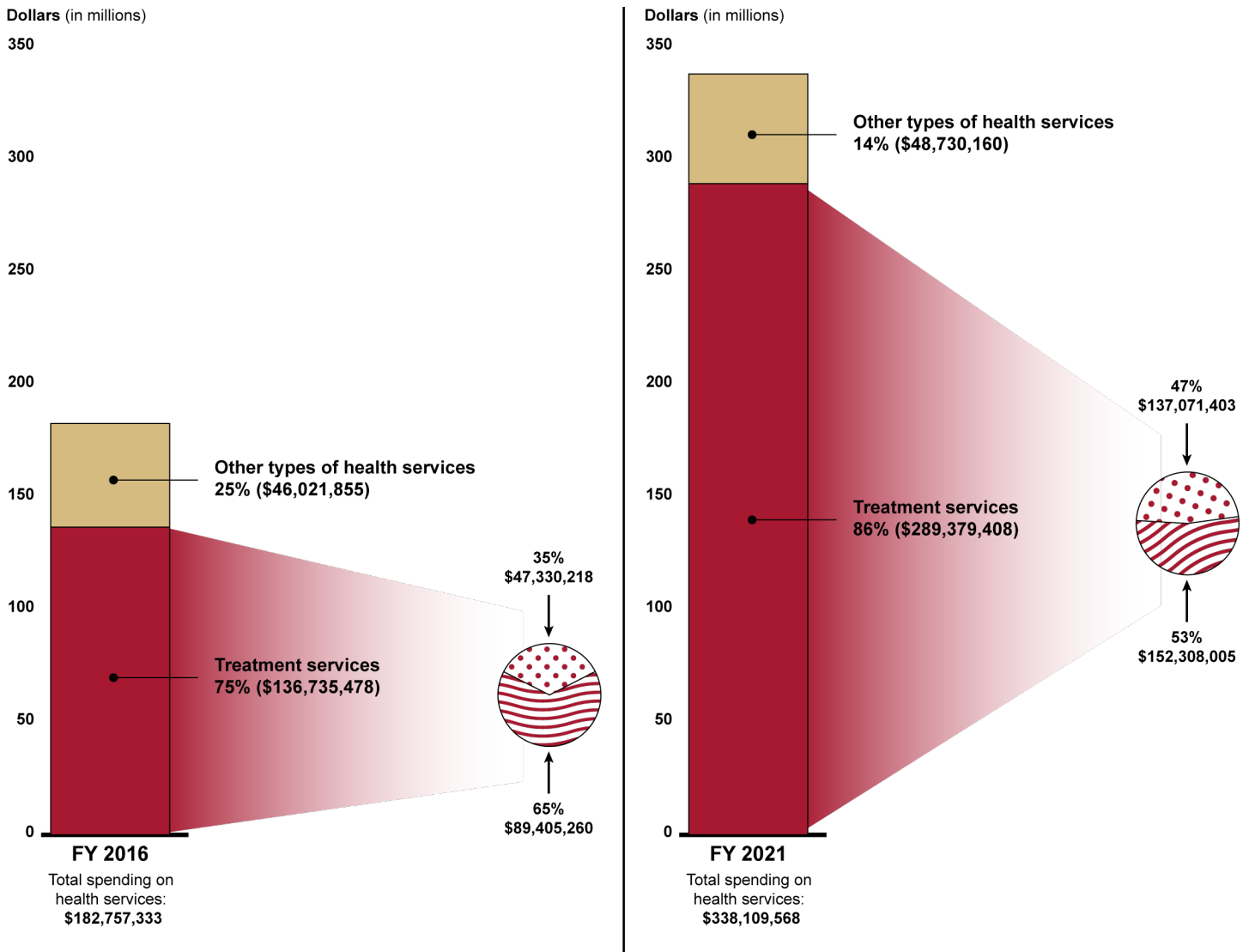
Na	FY 2016	FY 2016	FY 2021	FY 2021
Category	Dollars (in millions)	Percentage	Dollars (in millions)	Percentage
Respond CCE	149.503	82%	247.359	73%
Survivor CCE	8.38875	5%	24.048	7%
NPN	24.8659	14%	66.703	20%
na	Total spending on health services: \$182,757,333	Total spending on health services: \$182,757,333	Total spending on health services: \$182,757,333	Total spending on health services: \$182,757,333

Legend: CCEs=Clinical Centers of Excellence; FY=fiscal year; NPN=Nationwide Provider Network.

Note: The WTCHP provides health services to eligible responders and survivors through eight CCEs in the New York City area, as well as the NPN. Of the eight CCEs in the New York City area, six serve responders and two serve survivors; the NPN serves both responders and survivors. According to officials, spending data are for the fiscal year in which claims for health services were paid, not the year health services were provided. As a result, health services provided in one fiscal year may be reflected in the spending for a subsequent fiscal year. Percentages may not add up to 100 due to rounding. Spending has not been adjusted for inflation.

Spending on health services by service type. Treatment services—such as medication or procedures to manage, improve, or cure a certified WTC-related health condition—accounted for the majority of health services spending from FY 2016 through 2021. Spending on treatment services increased from 75 percent to 86 percent of total health services spending over this period. The remaining spending on health services was for members’ initial health evaluations, monitoring exams, cancer screenings, and diagnostic evaluations. Among the treatment services provided, spending was higher on treatment of non-cancer conditions. However, the proportion of spending for treatment services dedicated to cancer increased from 35 to 47 percent over this period. (See fig. 6.) Appendix V provides more information on spending by type of health service and year from FY 2016 through 2021.

Figure 6: World Trade Center Health Program Spending, by Type of Health Service, Fiscal Years (FY) 2016 and 2021



Cancer conditions Non-cancer conditions

Source: GAO analysis of World Trade Center Health Program data. | GAO-22-105303

Accessible Data for Figure 6: World Trade Center Health Program Spending, by Type of Health Service, Fiscal Years (FY) 2016 and 2021

na	FY 2016	FY 2016	FY 2021	FY 2021
Category	Dollars (in millions)	Percentage	Dollars (in millions)	Percentage
Treatment services	136.735	75%	289.379	86%
Other types of health services	46.0219	25%	48.7302	14%
Cancer conditions	\$47,330,218	35%	\$137,071,403	47%
Non-cancer conditions	\$89,405,260	65%	\$152,308,005	53%
na	Total spending on health services: \$182,757,333		Total spending on health services: \$338,109,568	

Note: According to officials, spending data are for the fiscal year in which claims for health services were paid, not when the health services were provided. As a result, health services provided in one fiscal year may be reflected in the spending for a subsequent fiscal year. Treatment services include, for example, medications and procedures necessary to manage, improve, or cure conditions that the program has certified as being related to the September 11, 2001, attacks. Other types of health services include (1) initial health evaluations, (2) monitoring exams, (3) cancer screening tests, and (4) diagnostic evaluations. Spending has not been adjusted for inflation.

NIOSH Has Not Conducted Quality Assurance Assessments of Timeliness of Access to Health Services for Members Nationwide

NIOSH’s WTCHP QA Committee has not assessed the timeliness of members’ access to treatment or other types of health services provided through the NPN. As a result, the committee has not been in a position to identify and take steps to address any needed improvements. The committee held six meetings between July 2020 (when it was established) and May 2022 to discuss selected topics. According to NIOSH officials, these meetings are the committee’s primary forum for discussing and making decisions related to QA initiatives. Members’ timely access to health services provided through clinics, including the NPN, was not a topic on any of the committee’s agendas for its six meetings held to date. Additionally, the committee’s meeting minutes do not indicate that access to health services was discussed.

WTCHP Quality Assurance Staffing

The National Institute for Occupational Safety and Health (NIOSH), an agency within the Centers for Disease Control and Prevention (CDC) that administers the World Trade Center Health Program (WTCHP), established a WTCHP Quality Assurance (QA) Committee in July 2020. NIOSH officials explained that availability among staff who serve on the QA Committee was a factor in determining the feasibility of addressing a topic during committee meetings, as participation in the committee is collateral duty for most staff.

According to NIOSH officials, as the WTCHP has grown in size and complexity, NIOSH has identified the need to increase staffing resources to support quality assurance efforts. They said that while the number of program staff for whom quality assurance is a primary responsibility has increased, previously, hiring staff to fill core operational roles was a higher priority. However, in May 2022, NIOSH officials told us that they have received approval from CDC leadership to hire additional staff. As part of this hiring effort, according to NIOSH officials, they plan to onboard an additional staff member in June 2022 whose primary responsibility will be quality assurance, and have received approval to hire four additional staff who will support quality assurance, among other responsibilities.

Source: GAO interviews with NIOSH officials. | GAO-22-105303

NIOSH officials told us the QA Committee selects agenda topics that are relevant across the program—that is, across all clinics or program units—and thus affect the most members; are considered to be a program priority at the time of each meeting; and could feasibly be addressed by the committee at the time based on program resources. As previously mentioned, according to officials, timely access to health services is relevant across the program, and is more complicated for the NPN to achieve given its distribution across all 50 states and reliance on an external network of providers. Nevertheless, other issues, such as case management, were identified as being of greater priority at the time of the QA Committee meetings and most feasible for the committee to address, according to NIOSH officials.

One reason the QA Committee has not assessed the timeliness of members' access to health services provided through the NPN—and may have difficulty doing so in the future—is because the committee lacks metrics for making such an assessment. The QA metrics on which the

clinics are required to report data do not measure timely access to health services. Although the QA Committee reviewed some of the clinic QA metrics, including the metric that measures the frequency with which members receive monitoring exams, the committee did not review this metric to assess the timeliness of members' access to this health service.²⁶ The monitoring exam-related metric is intended to assess members' retention in the WTCHP, not timely access to this health service.²⁷ Further, the QA metrics on which the clinics are required to report data do not include measures of timely access to the other four types of health services.²⁸

In March 2021, the committee discussed whether any measures should be created and added to the existing set of clinic QA metrics; however, metrics to assess timely access to any of the five types of health services were not among the possible new metrics considered.²⁹ NIOSH officials told us that the committee may be better positioned to assess the timeliness of members' access to health services if the program developed (1) metrics for this purpose, (2) wait-time standards specifying the maximum amount of time members should wait for different types of health service appointments (when none exist), and (3) benchmarks specifying the minimum percentage of members who have appointments meeting the wait-time standards in order for a clinic to be considered providing timely access.

Further, the QA Committee has not assessed the timeliness of members' access to health services provided through the NPN because NIOSH has not specified ensuring timely access—provided through the NPN or

²⁶One of the 11 QA metrics on which the clinics are required to report data measures the proportion of members who received monitoring exams provided by each CCE and the NPN within the past 18 months.

²⁷NIOSH officials noted the metric could also be used to help assess members' access to monitoring exams.

²⁸NIOSH officials indicated that the QA metric related to monitoring exams addresses timely access to initial health evaluations for survivors. However, the guidance on this metric for the clinics indicates that it measures the proportion of eligible responders and survivors who received an annual monitoring exam only.

The QA metrics include measures of the proportion of members who received colorectal and lung cancer screenings, but not the timeliness of those screens. Additionally, the QA metrics do not include measures of timely access to the other two types of cancer screenings covered by the program—breast cancer and cervical cancer.

²⁹Citing the lack of QA metrics on mental health (one of the five categories of WTC-related health conditions), the QA Committee discussed, for example, creating new metrics on antidepressant medication management and suicide risk assessment.

through all of the clinics—among the strategic priorities in the WTCHP QA Plan. NIOSH officials told us that they believe that the strategic priorities currently in the QA Plan implicitly relate to access. However, they also noted that specifying timely access among the QA Plan’s strategic priorities may be important, as NIOSH applies program resources, including staff (such as those who participate in the QA Committee) to support the strategic priorities specified in the QA Plan. Thus, they acknowledged that explicitly including timely access to health services provided through all of the clinics as a strategic priority could help ensure that the QA Committee focuses on this issue. This could include assessing the timeliness with which these services are provided through the NPN.

The Zadroga Act requires that the WTCHP Administrator report annually on the program’s performance in providing timely evaluation of, and treatment to, members.³⁰ Furthermore, the Institute of Medicine’s framework for quality assessment identified timeliness—defined as reducing wait times and sometimes harmful delays for those who receive care—as one of six aims of quality health care.³¹ We have similarly reported that appointment timeliness is an essential component of quality health care, and NIOSH officials acknowledged that timely access to health services is a goal for the WTCHP.³²

According to NIOSH officials and the QA Plan, the QA Committee is responsible for supporting QA-related decisions and QA-related monitoring. The plan specifies that the QA Committee’s goal is to continually monitor and evaluate QA activities throughout the program by, among other things, recommending the development of performance metrics that are compared against established benchmarks.

However, NIOSH’s omission of timely access as an explicit strategic priority and lack of an assessment of the timeliness of access to NPN-provided health services is inconsistent with federal standards for internal controls, which the QA Plan cites as one of the bases for the WTCHP QA

³⁰According to NIOSH officials, the report has not been submitted to Congress since FY 2013.

³¹The Institute of Medicine is now known as the National Academy of Medicine. Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century*, (Washington, D.C.: National Academy Press, 2001).

³²See, for example, GAO, Veterans Community Care Program: Improvements Needed to Help Ensure Timely Access to Care, [GAO-20-643](#), (Washington, D.C.: Sept. 28, 2020).

program. Federal standards for internal controls state that agencies need objectives defined in specific terms so they are understood at all levels, so they can design control activities in response to the entity's objectives and at the appropriate level in the organization structure. In this case, that would include establishing an explicit WTCHP strategic priority of ensuring timely access to health services and ensuring that the QA Committee continually assess or monitor the timeliness of members' access to health services. These standards also state that agencies should use the entity's objectives to identify the information requirements needed to achieve the objectives. This could include developing QA metrics to facilitate the QA Committee's assessment.³³

The fact that the QA Committee has not assessed the timeliness of members' access to health services, and that NIOSH has not explicitly made ensuring timely access a strategic priority, is concerning in light of apparent delays with access to NPN-provided services. Specifically, information that the NPN contractor collected for the period October 2019 through November 2021 that was to be reviewed by the contracting officer representative indicate potential problems with the timeliness of services.³⁴

- For example, the information shows that from October 2019 through March 2021 less than one-third of members' initial exams occurred within previously established time frames. Further, from October 2019

³³[GAO-14-704G](#). Federal standards for internal control cites reviews of performance as an example of a control activity. This could include the NPN's performance on providing timely access to health services.

³⁴The Federal Acquisition Regulation requires that all agencies develop a Quality Assurance Surveillance Plan for services acquired under performance-based contracts. See 48 C.F.R. subpts. 37.6 and 46.4 (2022). The Quality Assurance Surveillance Plan for Logistics Health Incorporated, the outgoing NPN contractor, included performance objectives that measured: (1) the number of miles members traveled to the nearest provider, and turnaround times for members' (2) initial exams, (3) monitoring exams, and (4) diagnostic and treatment services (combining both types of health services into one objective), among others. The performance objectives on health service turnaround times established time frames in which these services were expected to occur. There was no performance objective related to cancer screenings.

NIOSH awarded a new contract to operate the NPN to Managed Care Advisors in November 2021, and the NPN is currently undergoing a contract transition. According to NIOSH officials, they expect to finalize a Quality Assurance Surveillance Plan for the new NPN contractor, Managed Care Advisors-Sedgwick, in late summer or fall 2022, prior to completion of this transition. Thus, it is not known whether the Quality Assurance Surveillance Plan for the new NPN contractor will include the same performance objectives as used for the prior contract.

through September 2020, less than 40 percent of members' monitoring exams occurred within previously established time frames.

- In addition, from October 2019 through November 2021, about 70 percent of members' initial diagnostic and treatment appointments occurred within previously established time frames.

The expectation was generally that 90 percent of these exams and appointments were to occur within the previously established time frames during the periods noted.³⁵

NIOSH officials told us that the contracting officer representative—who is responsible for ensuring that technical requirements set forth in the contract are met by the delivery date and within the cost of the contract—was not expected to provide the QA Committee with the information and also did not do so. In addition, officials stated that the contracting officer representative was not required to initiate a corrective action process related to underperformance by the NPN contractor and did not do so following the NPN contractor reporting this information.

Our review of member complaints and interview with a program stakeholder also identified examples of what appear to be delays in members accessing health services provided through the NPN. These examples pertained to delays in member appointments for initial health evaluations, monitoring exams, and treatment services for cancer and mental health conditions. For example, one member with metastatic cancer reported waiting approximately 3 months to obtain an initial health evaluation related to her cancer. The member continued to experience delays after being certified as having a WTC-related health condition—after waiting another 3 months past the initial health evaluation to receive notification that the certification had been made. We have previously reported that delays in care have been shown to negatively affect patients' morbidity, mortality, and quality of life.³⁶ Absent the QA Committee establishing QA metrics to assess and continuously review timely access to health services provided through the NPN, and NIOSH specifying this as a strategic priority within the WTCHP QA Plan, there is increased risk that the QA Committee will not have full information on this issue, and NIOSH will not be able to make program resource adjustments

³⁵The exception to the 90 percent benchmark was for initial exams that occurred between October 2020 and March 2021. Seventy-five percent of such exams were to occur within the established time frame.

³⁶[GAO-20-643](#).

as needed. Thus, these potentially harmful delays may continue or worsen.

Conclusions

The WTCHP is an important source for needed health services for responders and survivors of the September 11, 2001, attacks. More than half of WTCHP members have developed one or more health conditions related to the attacks, including certain cancers, mental health conditions, and many other health problems. In recent years, the number of members seeking health services to monitor for the presence of or to treat these conditions has increased, particularly among members seeking such services through the NPN.

Ensuring timely access to health services is a critical component to quality health care. Although NIOSH officials acknowledged that ensuring timely access to health services is a goal for the WTCHP, it is not specified as one of the program's strategic priorities. Furthermore, while the WTCHP established a QA Committee to conduct QA-related monitoring, the committee has yet to develop QA metrics to facilitate its assessment of timely access to health services provided through the NPN. Without prioritizing timely access to health services and conducting such an assessment, the QA Committee may not have needed information related to members' access to health services, and NIOSH may not be able to appropriately apply resources to any delays—potentially causing them to continue.

Recommendations for Executive Action

We are making the following three recommendations to NIOSH:

The Director of NIOSH should update the WTCHP Quality Assurance Plan's strategic priorities to include ensuring timely access to the five types of WTCHP health services and update program activities to align with this priority. (Recommendation 1)

The Director of NIOSH should establish quality assurance metrics related to the timeliness with which members can access WTCHP health services provided through the Nationwide Provider Network, and as appropriate the Clinical Centers of Excellence. Such metrics should

account for the five types of WTCHP health services and include wait time standards and benchmarks. (Recommendation 2)

The Director of NIOSH should ensure that the WTCHP Quality Assurance Committee review data on the timeliness with which members can access WTCHP health services provided through the Nationwide Provider Network, and as appropriate the Clinical Centers of Excellence, on at least an annual basis to identify and take steps to address any needed improvements. At a minimum, this should include reviewing the data on the quality assurance metrics related to access to care for the five types of WTCHP health services after they are established. (Recommendation 3)

Agency Comments and Our Evaluation

We provided a draft of this report to HHS for review and comment. HHS provided written comments, which are reproduced in Appendix VI, and technical comments, which we have incorporated as appropriate. In its written comments, HHS concurred with our recommendations.

In concurring with our second recommendation that NIOSH establish quality assurance metrics related to timely access to WTCHP health services, HHS indicated that the program plans to develop, or may consider developing, metrics related to members' timely access to three of the five types of services—initial health evaluations, diagnostic evaluations, and treatment services. However, HHS stated that setting defined endpoints for the other two types of services—monitoring exams and cancer screenings—is not appropriate, as members can schedule these services 11 months or more in advance. We acknowledge that the type of metric that may be appropriate to assess timely access could vary by type of service. For monitoring exams or cancer screenings, NIOSH could choose to develop metrics that include standards for the maximum amount of time in which the appointment for the exam or screening should be scheduled and occur based on a member's availability regardless of how far in advance a member requests such an appointment.

Regarding our third recommendation that the QA Committee review data on timely access to health services and take steps to address any needed improvements, HHS noted that such data should be reviewed by subject matter experts and any underperformance addressed in tandem with contracting officials. HHS also stated that depending on the access

barriers that need to be resolved, the QA Committee might not be the best forum to review such information. We acknowledge that it might be appropriate for other officials to review and resolve access barriers. However, the QA Committee is, as we reported, responsible for supporting WTCHP QA-related decisions and QA-related monitoring. Thus, we continue to believe that the committee should review these data on at least an annual basis. This would enable the committee to support QA activities conducted by others within the program, including by monitoring actions taken and progress made to address any underperformance related to timely access to health services.

We are sending copies of this report to the appropriate congressional committees, the Secretary of Health and Human Services, and other interested parties. In addition, the report is available at no charge on the GAO website at <http://www.gao.gov>.

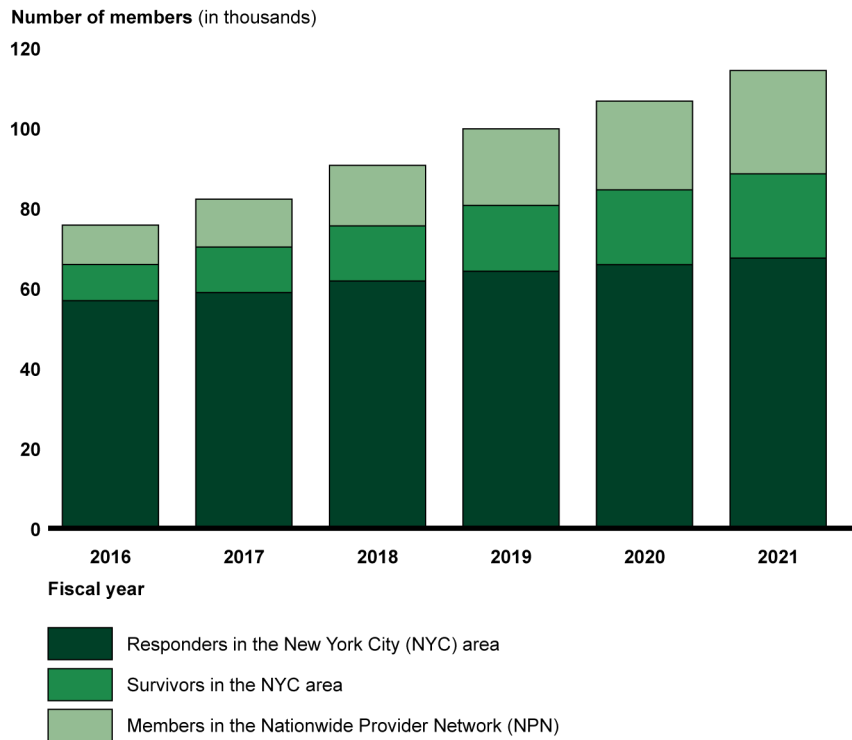
If you or your staff have any questions about this report, please contact me at (202) 512-7114 or at RosenbergM@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix VII.



Michelle B. Rosenberg
Director, Health Care

Appendix I: World Trade Center Health Program Member Enrollment

Figure 7: Number of World Trade Center Health Program Members Enrolled in the Program, by Clinic Type, Fiscal Years 2016 through 2021



Source: GAO analysis of World Trade Center Health Program (WTCHP) data. | GAO-22-105303

Accessible Data for Figure 7: Number of World Trade Center Health Program Members Enrolled in the Program, by Clinic Type, Fiscal Years 2016 through 2021

Fiscal year	Responders in the New York City (NYC) area (in thousands)	Survivors in the NYC area (in thousands)	Members in the Nationwide Provider Network (NPN) (in thousands)
2016	56.813	9.067	9.829
2017	58.876	11.359	11.955
2018	61.768	13.734	15.141

**Appendix I: World Trade Center Health
Program Member Enrollment**

Fiscal year	Responders in the New York City (NYC) area (in thousands)	Survivors in the NYC area (in thousands)	Members in the Nationwide Provider Network (NPN) (in thousands)
2019	64.205	16.434	19.129
2020	65.822	18.687	22.157
2021	67.466	21.043	25.794

Note: The WTCHP provides health services to members through contracts with eight Clinical Centers of Excellence in the NYC area—six for responders and two for survivors, as well as the NPN, which serves responders and survivors who live outside of the NYC area.

Officials from the National Institute for Occupational Safety and Health, the agency that administers the WTCHP, told us that the WTCHP enrollment data includes members who are now deceased. Therefore, the enrollment data overstate the number of active members in any given fiscal year.

Appendix II: World Trade Center Health Program Health Services Utilization

Table 1: Number of World Trade Center Health Program Members Receiving Health Services, by Type of Health Service, Fiscal Years 2016 through 2021

Type of health service	2016 (fiscal year)	2017 (fiscal year)	2018 (fiscal year)	2019 (fiscal year)	2020 ^a (fiscal year)	2021 (fiscal year)	Cumulative percent change (%)
Monitoring and screening ^b	35,101	34,002	34,263	45,003	37,279	44,463	27
Diagnostic evaluations ^c	20,258	21,547	23,237	27,888	22,959	21,780	8
Treatment services ^d	24,417	26,352	28,989	32,890	36,136	37,524	54

Source: GAO analysis of World Trade Center Health Program (WTCHP) data. | GAO-22-105303

Note: The number of members receiving health services in a given fiscal year is based on the year in which claims for health services were paid, not when health services were provided to members. According to officials, members can receive more than one type of health service in a given year and thus the data cannot be added to total the number of members receiving services in that year.

^aOfficials from the National Institute for Occupational Safety and Health, the agency that administers the WTCHP, told us that the COVID-19 pandemic decreased utilization for certain health services due to disruptions, such as temporary clinic closures and suspension of certain health services, and some members putting off scheduling maintenance-related health services during this time.

^bMonitoring and screening include initial health evaluations (a one-time evaluation to determine if enrolled survivors have a condition related to the September 11, 2001, attacks) and monitoring exams (annual health monitoring for all enrolled responders and enrolled survivors who have a condition related to the September 11, 2001, attacks).

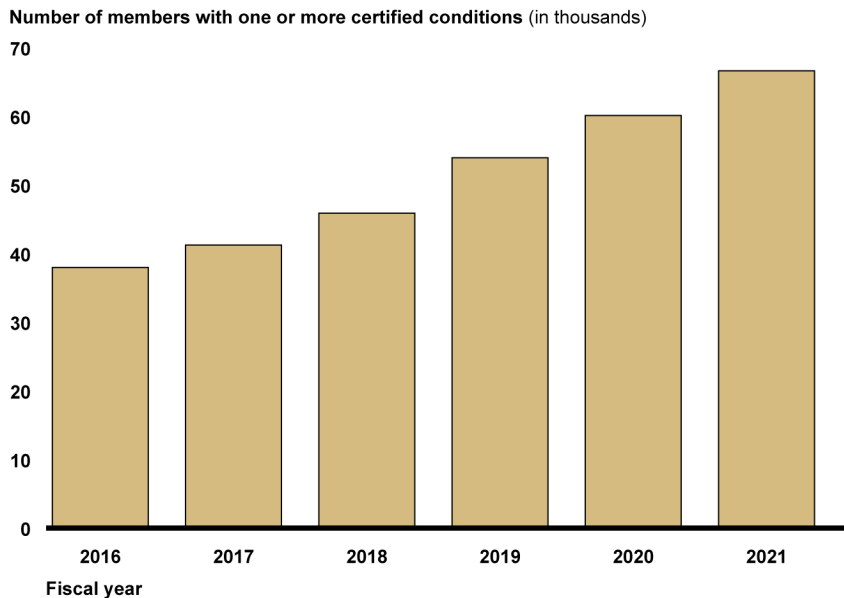
^cDiagnostic evaluations include cancer screening and diagnostic evaluations, which includes evaluative services used to determine if a member has a condition related to the September 11, 2001, attacks that is eligible for treatment services through the program.

^dTreatment services are provided to members for conditions that the program has certified as being related to the September 11, 2001, attacks.

Appendix III: World Trade Center Health Program Certifications

The World Trade Center Health Program provides treatment services to members who have one or more condition that the program has certified as being related to the September 11, 2001, attacks. Figure 8 provides information on the number of members who had certified conditions from fiscal years 2016 through 2021 and table 2 provides information on the categories of certified conditions.

Figure 8: Number of World Trade Center Health Program Members with One or More Certified Conditions, Fiscal Years 2016 through 2021



Source: GAO analysis of World Trade Center Health Program (WTCHP) data. | GAO-22-105303

Accessible Data for Figure 8: Number of World Trade Center Health Program Members with One or More Certified Conditions, Fiscal Years 2016 through 2021

Fiscal year	Number of members with one or more certified conditions (in thousands)
2016	37.977
2017	41.242
2018	45.894
2019	53.97

Appendix III: World Trade Center Health Program Certifications

Fiscal year	Number of members with one or more certified conditions (in thousands)
2020	60.115
2021	66.629

Note: The WTCHP maintains a list of covered conditions—which includes certain acute traumatic injuries (such as burns), airway and digestive disorders (such as asthma), cancers (such as lung cancer), mental health conditions (such as post-traumatic stress disorder), and musculoskeletal disorders (such as carpal tunnel syndrome)—for which treatment may be provided to a member if the program certifies the condition as being related to the September 11, 2001, attacks.

Officials from the National Institute for Occupational Safety and Health, the agency that administers the WTCHP, told us that the available certification data includes members who are now deceased. Therefore, the data overstate the number of active members with certified conditions in any given fiscal year.

Table 2: Number of World Trade Center Health Program Members with Certified Conditions, by Category of Condition, Fiscal Years 2016 through 2021

	2016 (fiscal year)	2017 (fiscal year)	2018 (fiscal year)	2019 (fiscal year)	2020 (fiscal year)	2021 (fiscal year)	
Category of condition	Number of Members	Number of Members	Number of Members	Number of Members	Number of Members	Number of Members	Cumulative percent change (%)
Airway and digestive	32,516	34,732	37,487	42,171	45,071	48,045	48
Cancer	5,622	7,486	10,078	14,755	17,934	23,331	315
Mental health	12,618	13,490	14,432	16,592	18,849	19,188	52
Musculoskeletal and acute traumatic injuries	447	495	528	545	566	581	30

Source: GAO Analysis of World Trade Center Health Program (WTCHP) data. | GAO-22-105303

Note: The WTCHP maintains a list of covered conditions for which treatment may be provided to a member if the program certifies that the condition is related to the September 11, 2001, attacks. Members may have a certified condition in more than one category. For example, a member may have a certified cancer condition as well as a certified mental health condition, meaning they would be counted once in each of those respective categories within the table. According to officials, the data shown in this table only includes members who were alive at some point during the fiscal year. The WTCHP also maintains data on the number of deceased members who had certifications in each of these categories and publishes those data on its website. See WTCHP, "World Trade Center Health Program at a Glance, as of September 30th, 2021," accessed January 14, 2022, <https://www.cdc.gov/wtc/ataglance.html>.

Appendix IV: World Trade Center Health Program Spending on Health Services by Clinic Type

Appendix IV: World Trade Center Health Program Spending on Health Services by Clinic Type

Table 3: World Trade Center Health Program Spending on Health Services by Type of Clinic, Fiscal Years 2016 through 2021

Clinic type	2016 (fiscal year)	2017 (fiscal year)	2018 (fiscal year)	2019 (fiscal year)	2020 (fiscal year)	2021 (fiscal year)
	Spending amount (proportion of total spending on health services)	Spending amount (proportion of total spending on health services)	Spending amount (proportion of total spending on health services)	Spending amount (proportion of total spending on health services)	Spending amount (proportion of total spending on health services)	Spending amount (proportion of total spending on health services)
Responder Clinical Centers of Excellence (CCE)	\$149,502,676 (82%)	\$169,230,887 (80%)	\$194,847,045 (81%)	\$220,658,845 (75%)	\$224,463,360 (71%)	247,358,542 (73%)
Survivor CCEs	8,388,747 (5)	10,789,107 (5)	13,240,796 (6)	22,375,186 (8)	25,054,334 (8)	24,048,003 (7)
Nationwide Provider Network (NPN)	24,865,910 (14)	32,912,581 (16)	33,031,313 (14)	52,687,213 (18)	65,465,844 (21)	66,703,023 (20)
Total	\$182,757,333	\$212,932,576	\$241,119,153	\$295,721,244	\$314,983,538	\$338,109,568

Source: GAO analysis of World Trade Center Health Program (WTCHP) data. | GAO-22-105303

Note: WTCHP provides health services to eligible responders and survivors through eight CCEs in the New York City area, as well as the NPN. Of the eight CCEs in the New York City area, six serve responders and two serve survivors; the NPN serves both responders and survivors. According to officials, spending data are for the fiscal year in which claims for health services were paid, not the year health services were provided. As a result, health services provided in one fiscal year may be reflected in the spending for a subsequent fiscal year. Percentages may not add up to 100 due to rounding. Spending has not been adjusted for inflation.

Appendix V: World Trade Center Health Program Spending on Health Services by Health Service Type

Table 4 provides information on World Trade Center Health Program (WTCHP) spending on health services by types of health services provided, and table 5 provides information on WTCHP spending on treatment by category of condition.

Table 4: World Trade Center Health Program Spending on Health Services, by Type of Health Service, Fiscal Years 2016 through 2021

Health service type	2016 (fiscal year)	2017 (fiscal year)	2018 (fiscal year)	2019 (fiscal year)	2020 (fiscal year)	2021 (fiscal year)
	Spending amount (proportion of total spending on health services)	Spending amount (proportion of total spending on health services)	Spending amount (proportion of total spending on health services)	Spending amount (proportion of total spending on health services)	Spending amount (proportion of total spending on health services)	Spending amount (proportion of total spending on health services)
Treatment ^a	\$136,735,478 (75%)	\$169,103,970 (79%)	\$196,201,842 (81%)	\$236,101,755 (80%)	\$268,476,028 (85%)	\$289,379,408 (86%)
Other types of health Services ^b	46,021,855 (25)	43,828,605 (21)	44,917,312 (19)	59,619,489 (20)	46,507,510 (15)	48,730,160 (14)
Total	\$182,757,333	\$212,932,576	\$241,119,153	\$295,721,244	\$314,983,538	\$338,109,568

Source: GAO analysis of World Trade Center Health Program data. | GAO-22-105303

Note: According to officials, spending data are for the fiscal year in which claims for health services were paid, not when the health services were provided. As a result, health services provided in one fiscal year may be reflected in the spending for a subsequent fiscal year. Spending has not been adjusted for inflation.

^aTreatment services are provided to members for conditions that the program has certified as being related to the September 11, 2001, attacks.

^bOther types of health services include (1) initial health evaluations, (2) monitoring exams, (3) cancer screening tests, and (4) diagnostic evaluations.

**Appendix V: World Trade Center Health
Program Spending on Health Services by
Health Service Type**

Table 5: World Trade Center Health Program Spending on Treatment, by Category of Condition, Fiscal Years 2016 through 2021

	2016 (fiscal year)	2017 (fiscal year)	2018 (fiscal year)	2019 (fiscal year)	2020 (fiscal year)	2021 (fiscal year)
Category of condition	Spending amount (proportion of total spending on health services)	Spending amount (proportion of total spending on health services)	Spending amount (proportion of total spending on health services)	Spending amount (proportion of total spending on health services)	Spending amount (proportion of total spending on health services)	Spending amount (proportion of total spending on health services)
Cancer	\$47,330,218 (35%)	\$66,593,973 (39%)	\$78,830,346 (40%)	\$105,588,246 (45%)	\$122,021,227 (45%)	\$137,071,403 (47%)
Non-cancer	89,405,260 (65)	102,509,997 (61)	117,371,496 (60)	130,513,509 (55)	146,454,802 (55)	152,308,005 (53)
Total	\$136,735,478	\$169,103,970	\$196,201,842	\$236,101,755	\$268,476,028	\$289,379,408

Source: GAO analysis of World Trade Center Health Program data. | GAO-22-105303

Note: According to officials, spending data are for the fiscal year in which claims for health services were paid, not when the health services were provided. As a result, health services provided in one fiscal year may be reflected in the spending for a subsequent fiscal year. Spending has not been adjusted for inflation.

Appendix VI: Comments from the Department of Health and Human Services

**Appendix VI: Comments from the Department
of Health and Human Services**



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

July 15, 2022

Michelle B. Rosenberg
Director, Health Care
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Ms. Rosenberg:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, **"WORLD TRADE CENTER HEALTH PROGRAM: Quality Assurance Program Should Include Monitoring of Access to Health Services"** (GAO-22-105303).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

Melanie Anne Egorin

Melanie Anne Egorin, PhD
Assistant Secretary for Legislation

Attachment

**GENERAL COMMENTS FROM THE DEPARTMENT OF
HEALTH & HUMAN SERVICES ON THE GOVERNMENT
ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED —
WORLD TRADE CENTER HEALTH PROGRAM: Quality
Assurance Program Should Include Monitoring of Access to Health
Services (22-105303)**

The U.S. Department of Health & Human Services (HHS) appreciates the opportunity from the Government Accountability Office (GAO) to review and comment on this draft report.

General Comments

Recommendation 1

The Director of NIOSH should ensure that the WTCHP Quality Assurance Committee review data on the timeliness with which members can access WTCHP health services provided through the Nationwide Provider Network, and as appropriate the Clinical Centers of Excellence, on at least an annual basis to identify and take steps to address any needed improvements. At a minimum, this should include reviewing the data on the quality assurance metrics related to access to care for the five types of WTCHP health services after they are established. (Recommendation 3)

HHS Response

HHS Concurs with GAO's recommendation.

Data on timely access reported to the Program must be reviewed by subject matter experts (SMEs) and Program quality standards must be enforced. However, depending on the specific barriers to access that need to be resolved, the Quality Assurance Committee may not be the best forum to review this data. More likely, the Quality Management and Program Evaluation Unit and Program leadership will identify underperforming contractors through document/data review, observation, and audits—which will then be addressed in tandem with the Contracting Officer and Contracting Officer's Representative.

Recommendation 2

The Director of NIOSH should establish quality assurance metrics related to the timeliness with which members can access WTCHP health services provided through the Nationwide Provider Network, and as appropriate the Clinical Centers of Excellence. Such metrics should account for the five types of WTCHP health services and include wait time standards and benchmarks. (Recommendation 2)

**Appendix VI: Comments from the Department
of Health and Human Services**

HHS Response

HHS Concur with GAO's recommendation.

In FY 2022 as part of recompeting some of the major contracts – Nationwide Provider Network (NPN), Clinical Centers of Excellence (CCEs), Pharmacy Benefit Manager (PBM), Data Centers (DCs) – the WTCHP, hereafter referred to as the Program, has begun restructuring how it monitors and standardizes quality of services through the Quality Assurance Surveillance Plans (QASP). As part of this effort, the Program is taking into consideration how to accurately gauge contractor performance while respecting members' rights to opt in and out of services.

For example, the new NPN vendor and the Program have agreed to implement an updated QASP metric that 75% of initial health exams occur within 6 months of the member being deemed eligible for program participation, excluding members who are deceased, have stated they do not want to participate in any aspect of the Program and do not want to be contacted again, or have no valid contact information on file and therefore cannot be reached. This metric will be similarly implemented across the CCE vendors and gauges timeliness of initial health exams (includes initial health evaluation for survivors and first monitoring exam for responders).

Monitoring exams and cancer screening. Setting defined endpoints for monitoring exams and cancer screening isn't appropriate, as these can be scheduled 11 months or more in advance. Furthermore, the Program has metrics to ensure that members are appropriately receiving monitoring exams and cancer screening.

Initial health evaluations. For initial health evaluations, the Program concurs tracking timely access is appropriate. There is a related Retention Workgroup goal for new Program enrollees, whereby 75% of members or more should be seen for an initial exam within 6 months of CCE/NPN assignment. This goal is tracked by the Retention Workgroup and findings are reported quarterly to the Responder Steering Committee. The Program may also consider adding a CCE/NPN metric for timely completion of initial health evaluations and to ask CCEs/NPN to track the time from clinic assignment to initial health evaluation visit.

Diagnostic Evaluations and Treatment Services: For diagnostic evaluations and treatment services, the Program concurs tracking timely access is appropriate. One example can be found in the QASP for NPN, where Logistics Health Incorporated (LHI), who is the NPN contractor through July 2022, has a metric titled "Treatment and Diagnostic Appointment Turnaround Time." LHI's methodology for this metric is "90% of initial appointments shall occur within 45 days of acquiring member availability. For calculation purposes, this will exclude appointments made by the contractor to accommodate members' schedules that result in scheduling beyond 30 days." The Program may consider adding a metric for timely access to diagnostic evaluations and treatment services for the CCEs and new NPN contractor, modeled after the above LHI metric.

Recommendation 3

Accessible Text for Appendix VI: Comments from the Department of Health and Human Services

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Director, Health Care
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HHS Response

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HHS Response

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Recommendation 3

The Director of NIOSH should update the WTCHP Quality Assurance Plan's strategic priorities to include ensuring timely access to the five types of WTCHP health services and update program activities to align with this priority.
(Recommendation 1)

HHS Response

HHS Concurrs with GAO's recommendation.

The five types of WTCHP health services are 1) initial health evaluations; 2) monitoring exams; 3) cancer screening procedures; 4) diagnostic evaluations; and 5) treatment services. However, setting defined endpoints for monitoring exams and cancer screening may not be appropriate. See the response for Recommendation 2 for more information.

Appendix VII: GAO Contact and Staff Acknowledgments

GAO Contact

Michelle B. Rosenberg, (202) 512-7114 or RosenbergM@gao.gov.

Staff Acknowledgments

In addition to the contact named above, Hernán Bozzolo (Assistant Director), Karen Belli (Analyst-in-Charge), Sam Amrhein, Moira Lenox, Sarah Prokop, and Jeffrey Tamburello made key contributions to this report. Also contributing were George Bogart, Jacquelyn Hamilton, and Vikki Porter.

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