REPORT TO THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON LABOR
AND PUBLIC WELFARE
UNITED STATES SENATE

Implementation Of A Policy Of Self-Support By Neighborhood Health Centers B-164031(2)

Department of Health, Education, and Welfare

BY THE COMPTROLLER GENERAL
OF THE UNITED STATES

MAY 2, 1973

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

B-164031(2)

The Honorable Edward M. Kennedy
Chairman, Subcommittee on Health
Committee on Labor and Public Welfare
United States Senate

Dear Mr. Chairman:

Your letter of November 14, 1972, requested information on the implementation of a policy of self-support by Neighborhood Health Centers. The report includes information on policy implementation actions taken or planned and specific information on selected centers.

We found that the current operating practices of the centers and the nature of available third-party reimbursement programs severely limit the prospect of improving the centers' current level of self-support. We believe that the centers could substantially increase their level of self-support by eliminating inefficient operating practices and by obtaining recognition as providers of services eligible under Federal and federally assisted programs.

As requested in your letter, we informally discussed this report with officials of the Department of Health, Education, and Welfare. Their comments have been considered in preparing this report. A copy of this report has been sent to Senator Jacob Javits.

We plan to make no further distribution of the report unless you agree or publicly announce its contents.

Sincerely yours,

Elmer B. Staats

Comptroller General
of the United States

Contents

ABBREVIATIONS

CHS	Community Health Service
GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare
HSMHA	Health Services and Mental Health Administration
NHC	Neighborhood Health Center
SRS	Social and Rehabilitation Service
SSA	Social Security Administration

COMPTROLLER GENERAL'S REPORT TO THE SUBCOMMITTEE ON HEALTH, COMMITTEE ON LABOR AND PUBLIC WELFARE, UNITED STATES SENATE

IMPLEMENTATION OF A POLICY OF SELF-SUPPORT BY NEIGHBORHOOD HEALTH CENTERS DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE B-164031(2)

D I G E S T

WHY THE REVIEW WAS MADE

Early in fiscal year 1973, the Health Services and Mental Health Administration (HSMHA) announced that it would develop and implement, by the end of the year, a fiscal management policy to eventually replace direct Federal support in all of its health service delivery projects with increased third-party reimbursements and other cost-reimbursable methods. HSMHA is an agency of the Department of Health, Education, and Welfare (HEW).

The Chairman of the Subcommittee on Health, Senate Committee on Labor and Public Welfare, and the ranking minority member of the Committee asked GAO to develop information on actions HSMHA has taken or planned to implement the policy. They were particularly interested in the potential impact of the policy on the Neighborhood Health Center (NHC) program funded under section 314(e) of the Public Health Service Act (42 U.S.C. 246(e)). For fiscal year 1973 HSMHA plans to provide about $91.4 million for the support of NHCs.

As requested, GAO has discussed this report informally with HEW officials. GAO considered their comments in preparing the report.

FINDINGS AND CONCLUSIONS

In implementing its announced policy, HSMHA has solicited comments, conducted orientation sessions, provided funds for technical assistance, and organized work groups. (See p. 9.)

A number of studies and audits have been completed or are underway to identify problem areas associated with the collection of third-party reimbursements. (See p. 13.)

GAO visited five NHCs to determine the extent to which they might become self-supporting. (See app. II.) GAO attempted to compile data on the following areas of specific interest to the Subcommittee.

Relationship of numbers of persons served to number covered by third-party reimbursement programs

The proportion of persons served who had coverage under third-party reimbursement programs--including Federal and federally assisted programs, private insurance, and self-pay--ranged from 44 to 76 percent for four of the NHCs. Federal and federally assisted programs provided coverage for a substantial number of the persons served.

The lack of reliable data hampered GAO at all of the NHCs visited; at one NHC it could not develop the information requested. (See p. 18.)

Relationship of third-party reimbursements and other revenues to total operating costs

In the five NHCs GAO attempted to determine the relationship of reimbursements and other revenues (excluding section 314(e) grants from HSMHA) to total operating costs. GAO found that such reimbursements ranged from less than 1 percent (in one NHC) to 40 percent or more (in two NHCs). (See p. 19.)

Relationship of potential third-party reimbursements and other revenues to total operating costs

To measure the amount of potential reimbursements and other revenues at four NHCs, GAO assumed that the NHCs (1) would be recognized providers of services under Federal and federally assisted programs, (2) would identify all patients served who had third-party coverage, (3) would bill and collect for services provided to such patients and to self-pay patients, and (4) would continue to receive funds from existing grant programs other than section 314(e). GAO estimated that the potential reimbursements would range from 7 to 46 percent of total operating costs at the four NHCs.

At the fifth NHC, GAO analyzed the records of about 2,300 patients for which there was no record of third-party coverage during 1972. Of these, 864 were found to be enrolled in the Medicaid program as of March 1973. The records of 50 of these persons showed that 58 percent of them were covered by the program--unknown to the NHC--at the time they received services from the NHC. A further analysis of 60 patients for which there was no record of third-party coverage disclosed that, on the basis of information furnished by the patients, 38 were eligible for full coverage and 15 were eligible for partial coverage under the Medicaid program. (See p. 22.)

Services provided but not covered or only partially covered by third-party reimbursement programs

GAO found that NHCs were offering a variety of services for which there was no third-party coverage. Estimates of the costs of these services at four NHCs ranged from 7 to 31 percent of the NHCs' total operating costs.

Some of these services being offered by the NHCs reviewed were medical and medically related, such as nutrition, optometry, speech therapy, and mental health and supportive activities including nursery, social, and transportation services. Other services had limited third-party coverage. These services would have to be reduced or eliminated if reliance on third-party reimbursement programs increased. (See p. 24.)

The degree to which the self-support policy can be implemented will depend on the ability of NHCs and HEW to overcome certain obstacles which cause a substantial difference between revenue and operating costs. GAO noted inefficient administrative and operating practices within the NHCs. Also, some NHCs lose substantial revenue because they are not recognized as providers under Federal and federally assisted programs. (See p. 25.)

The current operating practices of NHCs and the nature of available third-party reimbursement programs severely limit the prospect of improving the NHCs current level of self-support. NHCs could

substantially increase their level of self-support by eliminating inefficient operating practices and by obtaining recognition as providers of services eligible under Federal and federally assisted programs.

CHAPTER 1

INTRODUCTION

Early in fiscal year 1973, the Health Services and Mental Health Administration (HSMHA), Department of Health, Education, and Welfare (HEW), announced it would develop and implement, by the end of the year, a fiscal management policy to eventually replace direct Federal support in all of its health service delivery projects with increased third-party reimbursements and other cost-reimbursable methods.

The Chairman of the Subcommittee on Health, Senate Committee on Labor and Public Welfare, and the ranking minority member of the Committee asked GAO to determine what actions HSMHA has taken or planned to implement its policy. (See app. I.) They were particularly interested in the potential impact of such a policy on the Neighborhood Health Center (NHC) program funded under section 314(e) of the Public Health Service Act (42 U.S.C. 246(e)). Section 314(e) provides:

> "*** for grants to any public or nonprofit private agency, institution, or organization to cover part of the cost *** of (1) providing services *** to meet health needs of limited geographic scopes or of specialized regional or national significance, or (2) developing and supporting for an initial period new programs of health services ***."

NHCs directly or indirectly provide, to a defined target population, a range of services to meet the majority of health needs. These services include, as a minimum, preventive, diagnostic, therapeutic, and general health maintenance services.

We visited five NHCs to determine the extent to which they might become self-supporting. We specifically sought to determine, at each NHC visited:

--The number of persons being served who are covered by third-party reimbursement programs and other revenue-producing programs.

--Total third-party reimbursements and other revenues currently being received and the relationship of this amount to total operating costs.

--Total potential annual reimbursement based on existing third-party reimbursement programs and other revenue-producing programs and the relationship of this amount to total operating costs.

--Services currently being provided which are not covered by third-party reimbursement programs.

--Other factors, such as utilization of services and management practices and procedures, which affect the degree to which the NHCs might become self-supporting.

The NHCs visited are listed in appendix II. We also performed work at HSMHA headquarters in Rockville, Maryland, and at the five HEW regional offices responsible for the NHCs we reviewed.

CHAPTER 2

THE ESTABLISHMENT AND CURRENT STATUS OF THE SELF-SUPPORT POLICY

HSMHA guidelines for approving section 314(e) comprehensive health services projects state that the highest priority will be given to grant applications which propose to develop such projects and which focus on the needs of individuals and families rather than on particular diseases. The Community Health Service (CHS) is the HSMHA agency that administers health services projects funded under section 314(e).

The NHC is the principal type of comprehensive health services project supported under section 314(e). The following schedule shows, by HEW regional office, the number of NHCs, the amounts obligated for fiscal year 1972, and the planned funding level for fiscal year 1973.

Responsible HEW regional office	Fiscal year 1972 Number of NHCs	Fiscal year 1972 Amount obligated	Fiscal year 1973 Number of NHCs	Fiscal year 1973 Funding level programed
I--Boston	4	$ 2,584,203	6	$ 4,932,340
II--New York	7	13,442,818	9	15,142,590
III--Philadelphia	7	8,715,232	9	10,165,192
IV--Atlanta	9	16,420,315	10	16,896,860
V--Chicago	10	10,335,865	11	13,335,283
VI--Dallas	4	3,940,663	5	4,549,720
VII--Kansas City	5	8,123,179	5	7,136,048
VIII--Denver	3	8,608,653	3	8,324,785
IX--San Francisco	4	4,206,646	5	6,949,486
X--Seattle	2	3,514,777	3	3,967,696
Total	55	$79,892,351	66	$91,400,000

The names and locations of the 66 NHCs are shown in appendix III.

THE REQUIREMENT FOR SELF-SUPPORT OF NHCs

A July 1, 1968, policy statement contains the basic requirements for administering project grants for health

services development. The statement required that program support of health services development projects be limited to 5 years and noted that:

> "Renewal applications for support beyond a period of five years from the end date of the budget period in effect on June 30, 1967 will normally not be approved. A request for renewal of a grant beyond the period of five years may be approved only if the grant is necessary to serve a critical health need."

Specifically related to NHCs, the policy statement further noted that:

> "For projects to develop and support new programs of health services * * *, grantees are expected to increase the proportion of support from non-Federal funds each year of the approved project period to ensure continuation of the program upon termination of Federal support."

Grantees were not told how to develop other sources of revenue. However, they were provided with an incentive to maximize their reimbursements--they were permitted to retain income collected from fees and to use it to further the purposes for which the grant award was made.

January 1970 program guidelines noted specifically that projects should:

> "Seek all sources of reimbursements for medical care services, e.g., Titles XVIII [Medicare], and XIX [Medicaid] of the Social Security Act, private insurance, labor union funds, State and local welfare programs, health departments, etc."

The guidelines further noted that an applicant must estimate reimbursements before an approved grant could be funded and should deduct this amount from the total estimated cost of the project.

When the 5-year funding limitation began to expire for certain NHCs, CHS gave the NHCs a blanket exemption from the limitation. In a July 26, 1972, memorandum the Acting Chief, Grants Policy and Procedures Branch, CHS, provided all HEW Regional Health Directors with a list of policy changes. One of these policy changes stated that "For the foreseeable future a neighborhood health center will serve a critical health need so these projects will most probably be continued beyond five years."

HSMHA's July 1972 operational plan set forth a series of actions to implement its policy of replacing Federal support with third-party reimbursements and other cost-reimbursable methods. The plan called for establishing, by the end of fiscal year 1973, project goals for third-party reimbursement for fiscal year 1974. Policy and working committees were to be created, personnel were to be trained, projects' actual and potential reimbursements were to be determined, and necessary technical assistance was to be provided.

IMPLEMENTATION OF THE SELF-SUPPORT POLICY

Through March 1973 HSMHA solicited comments from interested parties, conducted orientation sessions, provided funds for technical assistance, and organized work groups concerned with policy planning and implementation. Specifically, it established:

--A Policy, Review, and Planning Committee, made up of HSMHA headquarters and regional office personnel, which meets about every 6 weeks to consider policy revisions and rewrite policy objectives.

--A regional office and program liaison group with representatives of HEW regional offices and other Federal departments and agencies administering programs affected by the policy. This group meets about every 6 weeks to (1) obtain policy updates from HSMHA headquarters, (2) obtain reports or comments on policy implementation from regions, (3) recommend policy proposals or revisions, and (4) exchange information.

In September 1972 HSMHA officials presented an interim policy statement, dated August 15, 1972, at a joint meeting

of personnel from two HEW regions to obtain their comments. At about the same time, comments were solicited from other HEW regional offices, as well as from other HEW agencies. As a result of these actions, the Policy, Review, and Planning Committee revised the original interim policy statement and reissued it in October 1972. The revised interim policy statement made no substantive change; it provided, among other things, that:

--HSMHA emphasize the use of its financial and technical resources to:

1. Help existing health care delivery systems improve their effectiveness and efficiency in meeting the health care needs of all citizens and in emphasizing the needs of the underserved.

2. Develop maximum compatibility between HSMHA projects and other federally supported programs providing reimbursements for health services.

3. Plan to systematically transfer continuing health care support activities funded by HSMHA to other funding sources.

4. Develop plans for funding ancillary services related to, but not directly supporting, health services.

--HSMHA grantees be required to:

1. Develop a financial plan and description of how they will implement the policy.

2. Implement and maintain appropriate administrative and management systems for data reporting, cost accounting, and evaluation.

3. Coordinate with other federally funded health services programs serving the same population to eliminate duplication of services.

4. Provide that all appropriate services are charged to and collected from the recipients' third-party payment programs and, at the same

time, insure that no one is denied services on the basis of his ability or inability to pay.

The interim policy statement has continued to be reviewed and revised. The HEW General Counsel has advised HSMHA that the policy had to be issued as regulations because of its impact on the grant and contract programs involved. Consequently, a "Notice of Proposed Rule Making for Health Services Funding" has been prepared for publication in the Federal Register. The notice, as submitted for approval by the Secretary of HEW, concerns the following policy areas.

1. Maximize use of other revenue sources.

2. Coordination with health planning, operating, and financing agencies.

3. Prohibition of HSMHA support to new health services delivery activities when resources other than HSMHA grant or contract funds are not likely to be available on an ongoing basis.

4. Determination of the uses to be made of income earned by projects and the impact of this income on continued funding.

The notice, which had not been published as of the end of March 1973, did not include regulations related to grantee responsibilities for implementing and maintaining appropriate management systems. HSMHA intends to include regulations related to these matters in a future "Notice of Proposed Rule Making--Health Services Management."

Throughout the development of the fiscal management policy, HSMHA has conducted orientation sessions to publicly explain the proposed policy. These sessions, which are arranged by HEW's regional offices, have included representatives from the regional offices, other Federal agencies, State governments, project grantees within the regions, and other local health and welfare agencies affected by the policy. HSMHA expects the orientation sessions to continue throughout the policy implementation stage. Topics covered

during these sessions include the status of implementation efforts, the need for technical assistance, and the development of financial plans.

For all HEW regions, except Region VIII, HSMHA has funded technical assistance activities. (See app. IV.) In Region II, for example, funds were provided to a project considered well above average at collecting third-party reimbursements to cover the cost of instructing other projects in the region about their collection methods. In Región VII a contract was awarded which provides for installing a tested billing and collecting system in several projects. In Region X a contract was awarded for developing a manual to assist projects in their collection efforts.

Efforts to determine potential for self-support of health services projects

A number of studies and audits have been completed or are underway to identify problem areas associated with the collection of third-party reimbursements. (See app. V.)

In 1971 HSMHA contracted with MACRO Systems, Inc., a private consulting firm, to study the potential for certain health services projects to collect third-party reimbursements. HSMHA estimates of third-party collections at that time were based on extremely sparse data. The study concerned six projects, two of which were NHCs.

The results of the study showed, among other findings, that:

1. Data on collections could not readily be determined from project records.

2. Existing levels of collection varied but generally were low.

3. The collections which were being made came almost entirely from the Medicare and Medicaid programs.

4. Some projects did not look first to third-party payment programs for payment of covered charges but, instead, charged grant accounts first.

5. Projects could not be expected to increase collections substantially without improving their administrative systems.

6. Existing estimates of the degree of potential self-support were invalid.

The study concluded that, if the projects were to increase their levels of collection and be able to provide reliable data for management purposes, HSMHA would have to provide individual projects with technical assistance and with a clarification of Federal policies and procedures, particularly for the Medicare and Medicaid programs.

A more recent MACRO Systems study of the collection of third-party reimbursements by ambulatory care centers such as the NHCs concluded that third-party reimbursements could be increased substantially and estimated that ambulatory care centers collectively are now receiving no more than 10 percent of their total income from third parties.

A number of audits by the HEW Audit Agency supported the findings of these studies. Several other studies were underway in March 1973 which should provide additional information on present and potential reimbursement levels and management systems within health services projects. Also, CHS has initiated a program to (1) determine the status of NHCs in obtaining third-party payments, (2) identify each NHC's problems in securing third-party payments, and (3) determine how NHCs can modify their activities to facilitate reimbursement.

CHS developed project inventory questionnaires to be used in interviews with NHC staff and with fiscal agents of the health insurance plans, including the Federal and State administrators for the Medicare and Medicaid programs and their fiscal intermediaries. As of February 1973 project inventories had been initiated in five HEW regions, and the results were being compiled and analyzed in March 1973.

A pretest of the project inventory questionnaires in HEW Region II led to the observation that the almost universal lack of records or data systems, particularly in the area of patient eligibility, was a serious deficiency in the management of NHCs.

Policy's association with and dependence on Medicare and Medicaid programs

The Medicare and Medicaid programs are the main source of third-party reimbursements to such health services projects as NHCs.

The Medicare program, authorized by the Social Security Amendments of 1965 (42 U.S.C. 1395), is the national insurance program which provides financial assistance to persons 65 or over for (1) hospital and related institutional care financed through the Federal social security and railroad retirement systems and (2) physicians' care and other health services financed through monthly insurance premiums paid voluntarily by persons 65 or over and matched by Federal contributions.

The Medicaid program, authorized by the Social Security Amendments of 1965 (42 U.S.C. 1396), is a grant-in-aid program under which the Federal Government participates in costs incurred by the States in providing medical assistance to eligible persons, regardless of age, who are unable to pay for such care.

State Medicaid programs are required by law to provide eligible persons with inpatient and outpatient hospital services, laboratory and X-ray services, skilled nursing-home services, physician services, home health services, and early and periodic screening and treatment. The State has the option of including in the program such additional elements as dental care and prescribed drugs.

The basic policies for both programs were established by the Congress and were implemented by extensive regulations and instructions issued by the Bureau of Health Insurance in the Social Security Administration (SSA), HEW, for the Medicare program and by the Medical Services Administration in the Social and Rehabilitation Service (SRS), HEW, for the Medicaid program.

Because NHCs and similar health services projects generally are in low-income, older urban areas, a significant portion of the population served by a project should qualify for assistance under the Medicare and Medicaid programs. For this reason representatives from SSA and SRS have assisted HSMHA in its policy implementation efforts. SSA and SRS have provided technical assistance, including proposals for legislative and administrative changes which will remove barriers to the flow of Medicare and Medicaid reimbursements to the health services projects covered by HSMHA's policy.

For example, all NHCs, to claim Medicare reimbursement, had to be recognized as providers or provider-equivalents by the responsible administrative agency. For NHCs controlled by hospitals or other organizations already having provider status, this presented no problem. However, the matter of recognition as a provider for an unassociated or freestanding NHC was not clear to many administrative agencies. Although Medicare regulations provide for recognizing freestanding NHCs as "physician-directed clinics," some NHCs were denied recognition. To eliminate this inconsistency, SSA recently centralized responsibilities for

dealing with freestanding NHCs in the Division of Direct Reimbursement, Bureau of Health Insurance. Currently, all freestanding NHCs meeting the criteria for physician-directed clinics qualify for reimbursements for services provided to Medicare beneficiaries.

The Medicaid program also requires that NHCs be recognized as providers or provider-equivalents before they can claim reimbursement. Although no statute or regulation bars such recognition, many freestanding NHCs are not recognized. In some cases, States deny recognition because of uncertainty about applying regulations to specific cases. In a few cases, payments have been withheld by some States because the propriety of reimbursements to federally funded projects has been questioned.

In March 1971, HEW proposed a legislative change to clarify the eligibility of qualified freestanding NHCs as providers under the Medicaid program. The Congress did not accept the suggested legislation because the wording was thought to make "clinical services" mandatory under the program. Currently, HEW plans to resubmit the legislation with modifications to clarify the purpose of the suggested change.

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HSMHA believes that vigorous application of the self-support policy can substantially increase reimbursements from third parties and other sources by the end of fiscal year 1974. Initial reaction to the policy has varied from a concern for the survival of health service projects to support of and concurrence in the policy. The comments received on the policy raise no major objection to the principle of maximizing third-party reimbursements, however, there is definite opposition to reducing project grant support without first having other sources of funding to maintain health service levels.

Appendix VI lists the currently authorized health services project grant programs which will be affected by HSMHA's fiscal management policy.

CHAPTER 3

INFORMATION REQUESTED BY THE SUBCOMMITTEE

HEW regional officials generally view their mission in implementing the self-support policy as that of providing technical assistance to maximize third-party reimbursements. Aside from the specific technical assistance efforts discussed in chapter 2, the regions generally have not developed formal implementation plans. The lack of a formal HSMHA policy statement was the reason given by one of the regions for not emphasizing implementation.

Officials from the five HEW regions unanimously believed that, given the current operating practices of NHCs and the available third-party reimbursement programs, no NHC could become self-supporting because the major existing third-party reimbursement programs do not reimburse the centers for all the services they provide and do not cover all persons served by the NHCs. One regional program director stated that he did not believe any of the NHCs in his region could become self-supporting without either severely curtailing services or restricting the patient population to only those covered by third-party programs and to those who could afford fees based on the total costs of delivering services.

An HSMHA headquarters official expanded on the above comment by stating: "As a national program, it will be impossible for neighborhood health centers to reach self-sufficiency until a federal financing mechanism is in place which will give broader entitlement."

In obtaining the information on the NHCs requested by the Subcommittee, we did not (1) evaluate the necessity for or quality of the services being furnished or (2) consider whether the services were being furnished efficiently and economically. We did note, however, certain management policies and practices which must be changed and improved if NHCs are to make significant progress in implementing the HSMHA self-support policy.

RELATIONSHIP OF NUMBER OF PERSONS SERVED TO NUMBER COVERED BY THIRD-PARTY REIMBURSEMENT PROGRAMS

The following table shows for 1972 the number of persons served and the number of persons served who were also covered by third-party reimbursement programs for four of the five NHCs reviewed.

	Estimated number of persons		Percent of persons served who were covered by	
NHC	Served	Served and covered (note a)	All programs	Medicare and Medicaid only
Matthew Walker	[b]12,128	[b] 8,732	72	36
Denver (note c)	24,182	[b]10,640	44	(d)
Wayne Miner	[b]10,438	[b] 5,786	55	49
West Oakland	9,520	7,228	76	51

[a]Estimated number of persons covered by third-party reimbursement programs may include Federal and federally assisted programs, private insurance, and persons who are able to pay partially or totally.

[b]A GAO projection based on a random sample.

[c]Estimates for a 3-month period.

[d]GAO's sample did not separate Medicare and Medicaid coverage from other programs.

Our efforts to compile this information were hampered considerably by a lack of available and reliable data. Because of this lack of reliable data, we sampled the medical records to estimate the number of persons served during 1972 at two NHCs and the number of persons served who had third-party reimbursement coverage at three NHCs. The lack of dependable data on utilization, coupled with the lack of time to do the necessary work, prevented us from estimating the number of persons served at the Sunset Park NHC.

RELATIONSHIP OF THIRD-PARTY REIMBURSEMENTS AND OTHER REVENUES TO TOTAL OPERATING COSTS

The following table shows the actual amounts received in 1972 from (1) third-party reimbursement programs, (2) patients who had the ability to pay, and (3) other financial sources excluding section 314(e) grants from HSMHA. The table also shows the total amount received by each NHC as a percentage of its annual operating costs.

Source	Sunset Park (note a)	Matthew Walker	Denver	Wayne Miner	West Oakland
Medicare	$ 9,791	$ 5,548	$ 61,283	$ 75,282	$ 26,102
Medicaid	[b]1,894,171	832	436,368	95,553	399,412
Private health insurance	-	-	8,834	4,074	6,336
Patients	43,830	[c]791	29,181	-	62,125
Other	[d]38,967	6,749	[d]2,067,297	7,387	[d]440,900
Total	$1,986,759	$ 13,920	$ 2,602,963	$ 182,296	$ 934,875
Annual operating cost	$4,325,000	$3,101,000	$10,400,000	$2,600,000	$2,158,000
Total amount received as percent of annual operating costs	46	0.4	25	7	43

[a]Year ended July 31, 1972.

[b]May include reimbursements for services not eligible for coverage under the Medicaid program. This matter will be referred to SRS for resolution.

[c]Collections from patients with the ability to pay started in July 1972.

[d]Includes funds received under other grant programs in the total amounts shown for Sunset Park and Denver, and in the amount of $367,245 for West Oakland. Funds for West Oakland also include $65,000 on a fire insurance claim.

The Sunset Park NHC receives an all-inclusive rate under the Medicaid program for each physician or dentist visit. During 1972 the Medicaid program paid the NHC $41.06 for each fully covered Medicaid patient who visited a physician or dentist.

The Medicaid program accounts for about 97 percent of the third-party reimbursements received by the Sunset Park NHC. Less than 1 percent of the NHC's reimbursements are received from the Medicare program which does not reimburse the NHC for dental care, drugs, or preventive health services. Persons who are able to pay and who live within the NHC's target area are charged a fee based on their income. The fees range from $3 to $25; the majority of the patients pay $3. Persons who live outside the target area are charged $7 for a physician or dentist visit plus fees for other services. Patient fees account for about 2 percent of total reimbursements received by the NHC.

The Matthew Walker NHC generally does not bill for medical services provided to Medicaid patients because--although the Tennessee Department of Public Health approves reimbursement for allowable medical, laboratory, and radiology services--the Department of Public Health does not reimburse NHCs for such services because it is conserving State Medicaid resources which are in short supply. However, the Tennessee State agency which administers the Medicaid drug program reimburses NHCs for prescriptions provided to eligible Medicaid patients.

In July 1972 the NHC started billing patients who had some ability to pay for services received. These billings, depending on a patient's income and number of dependents, range from 10 to 100 percent of the value of services received. In July 1972 the NHC also started charging each patient an annual registration fee based on his family income. These fees range from $0.30 to $6. No effort is made to secure reimbursement for services provided to patients with private insurance.

The Medicare program recognizes the Denver NHC as a provider; therefore, the NHC can bill for certain physician and clinical services provided to eligible Medicare patients. The Colorado Medicaid program does not recognize the NHC; therefore, the NHC can bill Medicaid only for physician

services provided as part of a clinic visit and for associated drug, laboratory, and X-ray services. Patients able to pay for services were charged a fee based on gross income and family size. Patients in the self-pay category and those with private insurance were not billed for physician services. NHC officials told us that they would start billing these patients for physician services.

The Wayne Miner NHC is not an eligible Medicaid provider because the Missouri Medicaid law does not provide for payments to clinic operations. However, the NHC is able to obtain some Medicaid reimbursement through the Medicaid provider status of its physicians. The Medicare program reimburses the NHC at a rate of $19.20 per visit for covered services to Medicare patients. The NHC has not implemented a system to bill patients who are able to pay.

The West Oakland NHC bills the Medicaid program for all medical services provided to patients known to be enrolled in the program. Private health insurance is almost nonexistent among users of the NHC. To increase collections from persons who are able to pay, the NHC sends letters to all persons whose outstanding accounts payable exceed $150 to tell them that they can no longer receive services and to request payment on the amount owed. Patients who make payments continue to receive services. NHC officials hope that this policy will reduce the bad debt rate from its current level of 25 percent of all billings for persons able to pay.

RELATIONSHIP OF POTENTIAL THIRD-PARTY REIMBURSEMENTS AND OTHER REVENUES TO TOTAL OPERATING COSTS

The following table shows our estimate of the potential reimbursements and other revenues four of the NHCs could receive annually if they (1) would be recognized as providers of services under Federal and federally assisted programs, (2) would identify all patients served who had third-party coverage, (3) would bill and collect for services provided to such patients and to self-pay patients, and (4) would continue to receive funds from existing grant programs other than section 314(e).

	Sunset Park	Matthew Walker	Denver	Wayne Miner
Potential revenues from third-party payment programs and other fees charged to patients	$2,188,000	$208,000	$1,261,000	$419,000
Funds from grant programs other than 314(e)	113,000	-	2,067,000	-
Total potential receipts	$2,301,000	$208,000	$3,328,000	$419,000
Total potential receipts as percentage of operating cost	46	7	32	16

In lieu of determining the total potential receipts for the West Oakland NHC, we considered the extent to which persons served were eligible but not participating in the Medicaid program. The results of this work are discussed on pages 23 and 24.

Each of these NHCs had missed billing opportunities by either (1) failing to bill for a service provided to a patient known to be covered by a third-party reimbursement program or capable of paying or (2) failing to identify persons covered by third-party reimbursement programs or capable of paying.

At Sunset Park we tested 3 days' billings and found that 41 visits by persons enrolled in the Medicaid program had not been billed. We also found that the NHC had not billed for services received by 69 self-pay patients.

At the Matthew Walker NHC, we reviewed the records of 100 patients who had received services during 1972. The value of the services provided to these patients was $12,255, of which $1,749 could have been collected. Of this amount, the NHC had billed for $530 during 1972 and collected only $227 as of the end of February 1973. The NHC had identified 10 of the 100 patients as being covered by Medicare and 16 by Medicaid. The NHC had billed for services received by only 3 of the 10 Medicare patients and only 1 of the 16 Medicaid patients. We found 10 additional patients who were covered--unknown to the NHC--under the Medicare and Medicaid programs.

At the Denver NHC, we reviewed the records of 197 patients who had received services during a 3-month period in 1972. Of the 197, 75 were covered by third-party reimbursement or self-pay programs. These patients had received 204 covered services, but the NHC had not billed for 33, or about 16 percent, of these services.

At the Wayne Miner NHC, our sample of the records for 92 patients showed that the NHC had billed third-party reimbursement programs for $1,617. If all 92 persons having a third-party reimbursement source had been identified and if billings had been made for all services they received, the amount billed would have increased by $1,249.

At the West Oakland NHC, the availability of appropriate records enabled us to determine the number of persons enrolled in the NHC's program who were also enrolled in the Medicaid program. We analyzed the records of 2,292 persons who had received services during 1972, for which there were no indicated third-party reimbursement sources, to determine if any were enrolled in the Medicaid program. Of these, 864 were covered by the Medicaid program as of March 1973. We further analyzed the records of 50 of these persons to determine if they were covered by Medicaid at the time they received services. This analysis showed that 29 (58 percent) of the 50 persons had Medicaid coverage, unknown to the NHC, at the time they received services.

With the assistance of the local social welfare agency, we interviewed 60 patients served by the NHC during 1972 whose records did not indicate eligibility under the Medicaid program to determine their eligibility. Of the 60, 38 were eligible for full coverage, 15 were eligible for partial coverage, 3 were ineligible, and 4 refused to be evaluated. Because of time constraints, we did not determine the cost of the services provided to those patients covered by or eligible for the Medicaid program.

SERVICES PROVIDED BUT NOT COVERED OR ONLY PARTIALLY COVERED BY THIRD-PARTY REIMBURSEMENT PROGRAMS

The following table shows for four of the five NHCs the cost of services provided during 1972 for which no part was eligible for third-party reimbursement.

	Matthew Walker	Denver	Wayne Miner	West Oakland
Cost of services provided for which there was no third-party coverage	$449,355	$2,120,616	$799,370	$161,246
Percent of operating cost	14	20	31	7

Some medical and medically related services were generally not covered by third-party reimbursement programs at the NHCs. These services included optometry; mental health; speech therapy; nutrition; and supportive activities, such as social, nursery, and transportation services.

The coverage of services by the Medicare program is standard throughout the United States, but coverage by the Medicaid program, aside from those services required by law, varies from State to State. The Medicare and Medicaid programs provide only partial coverage for certain services. For example, Medicare covers the cost of injectable drugs only and Medicaid, in many cases, covers only the services provided directly by a physician or dentist. The costs of services provided by a dental hygienist, social worker, nurse, or psychologist are not eligible for reimbursement

under many Medicaid programs. Some State Medicaid programs also limit the number of physician visits which they will pay for during a year.

If the NHCs must rely on third-party reimbursements to become self-supporting, these services probably will have to be partially or totally eliminated.

OBSTACLES TO SELF-SUPPORT THROUGH THIRD-PARTY REIMBURSEMENT PROGRAMS

Revenues received by NHCs do not cover a substantial portion of their total operating costs. The obstacles facing the NHCs in their efforts to increase their collection of third-party reimbursements and to make progress towards becoming self-supporting are both internal and external.

Internal obstacles

Although we did not attempt to determine the efficiency and economy of the NHCs' operations, our work revealed a number of operating inefficiencies. We estimated that one NHC would have been only 48 percent self-supporting if the full fees for all services provided during 1972 had been collected. Apparent overstaffing and low utilization rates for existing services contributed to this inefficiency.

Inaccurate and incomplete records were deficiencies common to all NHCs. Missed billing opportunities, incorrect billings, lack of control over accounts receivable, and other accounting system weaknesses were noted at several NHCs.

The five NHCs were deficient in identifying patients who were eligible for, or enrolled in, third-party reimbursement programs, principally the Medicaid program. Generally the NHCs obtained information on a person's ability to pay and eligibility for, or participation in, any medical insurance program only when he initially registered. Three of the NHCs did not have any comprehensive system to verify or periodically update the initial information. In many instances, information obtained at registration was inadequate to determine eligibility or ability to pay and no efforts were being made to make such determinations. As a consequence, fees which should have been charged were not.

Providing services to patients who have no third-party coverage is another problem the NHCs face in becoming self-supporting. To help alleviate this problem, some NHCs have instituted self-pay programs in which patients are charged fees based on their ability to pay as determined by income and number of dependents. Although these programs provide the NHCs with additional revenue, the fees charged normally do not cover the full cost of services. In addition, collection of these fees has proved to be difficult.

Providing services which are not covered by third-party reimbursement programs also presents a major self-support obstacle. Two of the NHCs estimated that the cost of providing these uncovered services represented 20 and 31 percent of their total operating costs.

Officials of the NHCs recognized the need to improve operating practices and were planning or undertaking a number of corrective actions at the time of our review.

External obstacles

Being recognized as a provider by the Medicare and Medicaid programs is not a problem for each NHC. However, if such recognition has not been granted, the NHCs lose substantial third-party revenues. Officials at one NHC estimated that, if the Medicaid program recognized the NHC as a provider, approximately $700,000 additional could have been collected during 1972.

Third-party payments for services, in some cases, bear little relationship to an NHC's cost of providing the services or to prevailing charges. For example, the fee schedule developed by the Wayne Miner NHC is based on average charges by practitioners and hospitals in the area, but its fees, in many instances, are higher than the Medicaid program's maximum allowable payment for the services.

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In summary, the current operating practices of the NHCs and the nature of available third-party reimbursement programs severely limit the prospect of improving the NHCs' current level of self-support. We believe that the NHCs can substantially increase their level of self-support by

eliminating inefficient operating practices and by obtaining recognition as providers of services eligible under Federal and federally assisted programs.

United States Senate
COMMITTEE ON
LABOR AND PUBLIC WELFARE
WASHINGTON, D.C. 20510

November 14, 1972

The Honorable Elmer B. Staats
Comptroller General of the United States
Washington, D.C. 20548

Dear Mr. Staats:

To assist the Subcommittee in its consideration of legislation concerned with the delivery of health services, we would appreciate having the General Accounting Office make a review and provide a report on the implementation by the Health Services and Mental Health Administration, Department of Health, Education and Welfare, of a fiscal management policy designed to replace Federal project grant support with increased third-party reimbursements and other cost-reimbursable devices.

The Subcommittee's concern is that the policy will be implemented in a manner which will result in a curtailment of health services currently being provided by project grant programs. Of particular interest to the Subcommittee are the Neighborhood Health Center programs funded under Section 314(e) of the Public Health Service Act.

The Subcommittee would like to have information on actions taken or planned by the agency to implement the policy and, for selected Neighborhood Health Center programs, the following information for each Center:

-- The number of persons being served who are covered by third-party reimbursement programs.

-- Total third-party reimbursements currently being received by the Center and the relationship of this amount to total operating costs of the Center.

-- Total potential third-party reimbursements, based on existing third-party reimbursement programs, and the relationship of this amount to total operating costs of the Center.

-- Service (type and cost) currently being provided by the Center which are not covered by third-party reimbursement programs.

Your report would be most helpful if it could be available to the Subcommittee by March 1973. In this regard, the results of your review should be discussed with agency and Center officials but, in view of the fact that the Subcommittee plans to hold hearings, it will not be necessary for your office to obtain written comments on the results of the review.

Sincerely,

Edward M. Kennedy
Chairman
Senate Health Subcommittee

Jacob K. Javits
Ranking Minority Member
Senate Labor Committee

NEIGHBORHOOD HEALTH CENTERS VISITED BY GAO

Responsible HEW regional office	Grantee	Neighborhood health center
Region II New York, New York	Lutheran Medical Center	Sunset Park Family Health Center Brooklyn, New York
Region IV Atlanta, Georgia	Meharry Medical College	Matthew Walker Health Center Nashville, Tennessee
Region VII Kansas City, Missouri	Human Resources Corporation of Clay, Jackson and Platte Counties	Wayne Miner Health Center Kansas City, Missouri
Region VIII Denver, Colorado	Denver Opportunity Denver Department of Health and Hospitals	Denver Neighborhood Health Program Denver, Colorado
Region IX San Francisco, California	West Oakland Health Council, Inc.	West Oakland Health Center Oakland, California

APPENDIX III

NEIGHBORHOOD HEALTH CENTERS FUNDED UNDER

SECTION 314(e) OF THE PUBLIC HEALTH SERVICE ACT

Region I

Community Program for Prepaid Family Health Care
135 College Street
Room 209
New Haven, Connecticut 06510

Hill Health Center
428 Columbus Avenue
New Haven, Connecticut 06519

Harvard Community Health Plan, Inc., Health Care for the Poor
690 Beacon Street
Boston, Massachusetts 02215

Columbia Point Health Center
Action for Boston Community Development
150 Tremont Street
Boston, Massachusetts 02111

Roxbury Comprehensive Community Health Center
82 Savin Street
Boston, Massachusetts 02119

Boston City Hospital Family Health Service
57 East Concord Street
Boston, Massachusetts

Region II

Trenton Neighborhood Family Health Center, Inc.
225 N. Warren Street
Trenton, New Jersey 08618

Sunset Park Family Health Center
514 49th Street
Brooklyn, New York 11220

Hunts Point Multi-Service Health Center
661 Cauldwell Avenue
Bronx, New York 11220

Gouverneur Health Services Program
9 Gouverneur Slip
New York, New York 10002

NENA Comprehensive Health Services
290 E. 3d Street
New York, New York 10009

St. Luke's Hospital Neighborhood Health Program
160 West 100th Street
New York, New York 10025

Syracuse Neighborhood Health Center
819 South Salina Street
Syracuse, New York 13202

Neighborhood Health Center of Provident Clinical Society, Inc.
584 Myrtle Avenue
Brooklyn, New York 11205

Charles Drew Neighborhood Health Center
1531-39 St. Mark's Avenue
Brooklyn, New York 11233

Region III

Luzerne County
Harvey's Lake-Noxen Health Center
Noxen, Pennsylvania 18701

Homewood-Brushton Neighborhood Health Center
7227 Hamilton Avenue
Pittsburgh, Pennsylvania 15222

The Shaw Community Health Program
1707 7th Street NW.
Washington, D.C. 20005

East Baltimore Medical Program
1223 N. Milton Avenue
Baltimore, Maryland 21213

Hamilton Health Center
2036 N. Fifth Street
Harrisburg, Pennsylvania 17102

Comprehensive Group Health Services Center[1]
2539-47 Germantown Avenue
Philadelphia, Pennsylvania 19133

West Nicetown-Tioga Family Health Center[1]
3450 North 17th Street
Philadelphia, Pennsylvania 19140

Mountaineer Family Health Plan
Appalachian Regional Hospital
Beckley, West Virginia 25801

Family Health Services
1200 Harrison Avenue
Elkins, West Virginia 26241

Region IV

Comprehensive Health Services
1000 Adams Avenue
Montgomery, Alabama 36104

Economic Opportunity Family Health Center, Inc.
Family Health Center
5601 NW. 27th Avenue
Miami, Florida 33147

Economic Opportunity Family Health Center, Inc.
Scott Health Center
7200 NW. 22nd Avenue
Miami, Florida 33147

Park-DuValle Neighborhood Health Center
1817 South 34th Street
Louisville, Kentucky 40211

Medger Evers Center For Comprehensive Health Care
Fayette, Mississippi 39069

Lincoln Community Health Center
1302 Fayetteville Street
Durham, North Carolina 27702

Alton Park Neighborhood Family Health Center
241 Wiehl Street
Chattanooga, Tennessee 37403

Comprehensive Health Services Program
1005 18th Avenue North
Nashville, Tennessee 37208

Matthew Walker Health Center
1501 Herman Street
Nashville, Tennessee 37208

Franklin C. Fetter Family Health Center
49 Nassau Street
Charleston, South Carolina 29401

Region V

Comprehensive Family Health Care Demonstrated in a Hospital-Based Family Health Center
836 W. Wellington
Chicago, Illinois 60657

Will McGaughy Center for Community Health
1501 East Broadway
E. St. Louis, Illinois 62201

Western Michigan Comprehensive Health Service, Inc.
5718 Highway M-37 Box 175
Baldwin, Michigan 49304

Comprehensive Neighborhood Health Center
Pavilion 6 - Herman Keifer Hospital
1151 Taylor
Detroit, Michigan 48202

Comprehensive Health Services for Pilot City Project
1349 Penn Avenue North
Minneapolis, Minnesota 55411

Community Comprehensive Health Services
Red Lake, Minnesota 56671

Community Health Center
4882 Jefferson Street
Bellaire, Ohio 43906

Comprehensive Health Services Project for a
Neighborhood Service Area
12th Street Health Center
210 W. 12th Street
Cincinnati, Ohio 45201

Charles R. Drew Neighborhood Health Center
1127 W. 3d Street
Dayton, Ohio 45407

Drexel Health Center
6175 West Third Street
Dayton, Ohio 45427

Mile Square Health Center
2049 West Washington Blvd.
Chicago, Illinois 60612

Region VI

North Tulsa Comprehensive Community Health Center
603 East Pine Street
Tulsa, Oklahoma 74103

Albuquerque Primary Health Care System
943 Sanford Drive NE.
Albuquerque, New Mexico 87106

Galveston County Coordinated
Community Clinics
1207 Oak Street
LaMarque, Texas 77568

San Antonio Neighborhood Health Center
University of Texas Medical School at
San Antonio
7703 Floyd Curl Drive
San Antonio, Texas 78229

Comprehensive Health Care Center for Harris
County (Settegast)
1502 Taub Loop
Houston, Texas 77025

Region VII

Model Cities Health Center
2310 East Linwood Boulevard
Kansas City, Missouri 64109

Wayne Miner Health Center
911 Michigan Avenue
Kansas City, Missouri 64127

Comprehensive Neighborhood Health Center
5471 Easton Avenue
St. Louis, Missouri 63112

Yeatman Health Care Program[1]
Yeatman Medical Center
2730 N. Grand Boulevard
St. Louis, Missouri 63122

Yeatman Health Care Program[1]
Union Sarah Center
4731 Delmar Boulevard
St. Louis, Missouri 63108

Region VIII

Denver Neighborhood Health Program[1]
Eastside Neighborhood Health Center
2900 Welton Street
Denver, Colorado 80205

Denver Neighborhood Health Program[1]
Westside Neighborhood Health Center
990 Federal Boulevard
Denver, Colorado 80204

Neighborhood Health Center
127 East 33d South
Salt Lake City, Utah 84115

Region IX

Alviso Family Health Center
1621 Gold Street
Alviso, California 95002

Rural Health Project, Inc.
210 Canal Street
King City, California 93903

West Oakland Health Center
700 Adeline Street
Oakland, California 94607

East Palo Alto Health Center
2111 University Avenue
East Palo Alto, California 94303

El Rio Santa Cruz Neighborhood Health Center
332 South Freeway
Tucson, Arizona 85721

Region X

PMSC Kaiser CHS Program
4707 S.E. Hawthorne Blvd.
Portland, Oregon 97215

Comprehensive Health Care Program
1700 East Cherry Street
Seattle, Washington 98122

Renton Group Health Cooperative of Puget Sound
1519 12th Avenue
Seattle, Washington 98122

[1]Combined NHCs in HEW Regions III, VII, and VIII.

APPENDIX IV

TECHNICAL ASSISTANCE ACTIVITIES FUNDED BY HSMHA

	Amount
REGION I ACTIVITIES:	
Implementation of utilization and cost reporting system. (Columbia Point)	$ 25,000
Conduct training in management of 22 ambulatory care centers. (Harvard Community Health Plan)	30,304
Development of an accounting information system. (Matthew Thornton Health Plan)	8,000
Retain personnel and consultants to bill and effect reimbursement. (North End Neighborhood Health Center)	27,000
Intensification of efforts regarding negotiation of prepayment contracts; includes hiring of personnel. (Community Health Care Center)	15,000
Installation of billing system and retention of personnel. (Neponset Health Center)	24,000
Implementation of mechanized billing system and improved processing of claims. (Hill Health Center)	50,000
Total	$179,304
REGION II ACTIVITIES:	
Training program for nine neighborhood health centers (HSMHA-funded) to increase reimbursement capability (Lutheran NHC)	$100,000
Increase reimbursement capability. (Syracuse NHC)	25,000
Increase reimbursement capability. (NENA NHC)	10,000
Increase reimbursement capability. (Trenton NHC)	40,000
Total	$175,000

	Amount
REGION III ACTIVITIES:	
Assessment of two projects and development of a plan regarding management and billing systems. (Beckley and Elkins, West Virginia)	$ 75,000
Secure consultation regarding organization of staff to maximize reimbursement. (Hamilton)	30,000
Retain three enrollers to market program and also to reduce backlog in billing. (East Baltimore)	15,000
Contract for technical assistance and assistance in negotiation of title 4A funds. (East Baltimore)	6,000
Contract for implementation of management information system. (East Baltimore)	4,000
Total	$130,000
REGION IV ACTIVITIES:	
Computerized billing system. (Meharry)	$ 20,000
Grant to Matthew Walker, Nashville; purpose not stated, money not used yet.	28,000
Improve bill collection; transfer administrator to specialist position. (money not spent) (Fayette)	25,000
Improve reimbursement (includes hiring a "third-party specialist"). (Montgomery)	17,000
Improve reimbursement; hired an accountant and two billing clerks. (Alton Park)	20,000
Improve reimbursement by hiring staff specialist for billing enrollment prepayment. (Park Duval, Louisville)	25,000
Improve reimbursement; hired a cashier and supervisor of billings. (Lincoln)	25,000
Total	$160,000
REGION V ACTIVITIES:	
Data processing; supplies/equipment and short-term staffing. (Drew Health Center)	$ 70,000
Implementation of intake system; hired consultants ($26,000) a Medical Records Administrator ($15,000) and installed "System" ($49,000). (Metro East Health Center)	90,000
Project closed out; money to be returned	15,000
Total	$175,000

	Amount
REGION VI ACTIVITIES:	
Development of billing systems; includes staff, equipment, training.. (Tulsa)	$ 89,636
Development of billing system; includes staff, equipment and training. (Galveston)	46,114
Development of billing system; includes staff, data processing and equipment. (Albuquerque)	47,080
Total	$182,830
REGION VII ACTIVITIES:	
Development of accounting system, financial planning module and reporting system. (Wayne Miner)	$ 15,000
Pharmacy module. (Wayne Miner)	7,169
Develop and implement a billing system. (Wayne Miner)	12,750
Professional affairs activities. (Model Cities Health Center)	25,000
Board training. (Model Cities Health Center)	14,180
Development of billing system. (Yeatman-Union Sarah Health Center)	84,908
Total	$159,007
REGION VIII ACTIVITIES:	
Allocation determined not needed in Region VIII.	$175,000
Total	$175,000
REGION IX ACTIVITIES:	
Cost accounting consultation and implementation for uniform reporting system. (Aviso)	$ 29,000
Cost accounting consultation and implementation for uniform reporting system. (West Oakland Health Center)	29,000
Cost accounting consultation and implementation for uniform reporting system. (El Rio - Santa Cruz Neighborhood Health Center, Tucson)	29,000
Implementation or reporting system only. (King City)	25,000
Total	$112,000

	Amount
REGION X ACTIVITIES:	
1. In-center consultation (including site visits).	
2. Two regional workshops.	
3. Development of standard training manual. (Kaiser)	$107,000
To improve third-party payment capability and increase management efficiency by:	
1. Employing new staff.	
2. Training staff.	
3. Establishing policy board training.	
4. Maintaining liaison with Federal and State agencies. (Farm Workers Family Health Center)	110,000
Total	$217,000

APPENDIX V

SELECTED STUDIES AND AUDITS IN PROCESS AND COMPLETED WHICH IDENTIFY PROBLEM AREAS ASSOCIATED WITH COLLECTING THIRD-PARTY REIMBURSEMENTS

STUDIES

1. Contract number-- HSM 110-70-305.

   Project title-- Implementation of an uniform accounting system for comprehensive health centers which are funded by 314(e) grants.

   Contractor's name--Wolf and Company.

   Objectives of project-- To provide projects with cost accounting capability for health services to enable comparison with other health providers and to facilitate project management and national administration and evaluation.

   Expected completion date-- May 1973.

2. Contract number-- HSM 110-70-305.

   Project title-- Procedures for developing an integrated information system for comprehensive 314(e) health care projects and implementing such procedures in selected 314(e) programs.

   Contractor's name--Bio-Dynamics, Inc.

   Objectives of project-- To develop, test, and install a completely automated information system to obtain registrant and utilization data in six comprehensive health centers.

Expected
completion date--June 1973.

3. Contract number-- HSM 110-71-258.

Project title-- Third-party collections by ambulatory care projects.

Contractor's name--Macro Systems, Inc.

Objectives of
project-- To refine HSMHA's estimate of third-party collections by certain special projects delivering ambulatory care.

Completion date-- October 1971.

4. Contract number-- HEW 05-72-169.

Project title-- Strategies for accommodating ambulatory care projects under Medicare and Medicaid.

Contractor's name--Macro Systems, Inc.

Objectives of
project-- To develop strategies for maximizing third-party collections for ambulatory care projects under the Medicare and Medicaid programs.

Completion date-- March 1973.

5. Contract number-- HSM 110-72-369.

Project title-- Pre-application evaluation of questionnaire for grantees institutions.

Contractor's Name--Macro Systems, Inc.

Objectives of
project-- To evaluate whether a project inventory questionnaire is applicable for all HSMHA ambulatory care centers.

Completion date-- February 1973.

AUDITS

Objectives of audits

HEW Audit Agency has audited or is auditing 15 NHCs in 8 HEW regions. The audits should determine whether the grantee and the delegate agency, where applicable, have:

1. Complied with HEW/OEO requirements for participation in and operation of the NHC program, as contemplated in the grant application and award.

2. Established effective policies and procedures, including systems of internal controls, accounting, and reporting to insure that grant funds are expended in accordance with the legislation, the grant conditions, and HEW/OEO program guidelines.

3. Met the short-range objectives of the program.

4. Administered the program in an efficient, effective, and economical manner.

5. Established an adequate system for self-evaluation to provide for improved program quality and performance.

Problem areas	Number of NHCs
1. Obtaining and defining the extent of grantees' cost sharing.	9
2. Establishing plans of action for financial independence after 5 years.	9
3. Maximizing reimbursements available from established health programs, such as Medicaid, Medicare, and other sources.	8
4. Establishing patient eligibility guidelines.	8
5. Maximizing use of available professional health manpower.	7
6. Procuring and controlling equipment and property.	9
7. Establishing a few schedule and collection procedures for ineligible patients who have received treatment.	5
8. Providing for continuity of care by the attending physician.	3
9. Determining the feasibility of consolidating three comprehensive health services projects.	1
10. Overpaying physicians for services.	1
11. Not providing comprehensive care to all enrollees.	2
12. Establishing indirect cost rates for the proper recovery of indirect costs.	2

APPENDIX VI

HEALTH SERVICES PROJECT GRANT PROGRAMS AFFECTED BY HSMHA'S FISCAL MANAGEMENT POLICY

PROJECT GRANT PROGRAMS AUTHORIZED BY
THE PUBLIC HEALTH SERVICE ACT:
- Migrant Health
- Health Services Development
- Family Planning
- Regional Medical Programs
- Health Maintenance Organizations
- Genetic Blood Disorders (Sickle Cell and Cooley's Anemia)

PROJECT GRANT PROGRAMS AUTHORIZED BY
THE SOCIAL SECURITY ACT:
- Health Care of Children and Youth
- Maternity and Infant Care

PROJECT GRANT PROGRAMS AUTHORIZED BY
THE COMMUNITY MENTAL HEALTH CENTERS ACT:
- Community Mental Health Centers Staffing
- Alcoholism and Alcohol Abuse
- Narcotic Addiction, Drug Abuse, and Drug Dependence

PROJECT GRANTS AND CONTRACTS AUTHORIZED BY THE
DRUG ABUSE OFFICE AND TREATMENT ACT:
- Treatment and Rehabilitation

*U.S. GOVERNMENT PRINTING OFFICE: 1973 730-641/127 1-3