UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

HUMAN RESOURCES
DIVISION

June 26, 1981

B-203746

The Honorable Richard Shelby
House of Representatives

Dear Mr. Shelby:

Subject: Information on the Health Development Corporation (HRD-81-114)

Your June 2, 1981, letter asked for information relating to the Health Development Corporation (HDC) in Tuscaloosa, Alabama. We had developed some information on HDC as part of our review of a sample of community and migrant health centers in three Department of Health and Human Services (HHS) regional offices during 1979 and early 1980.

The primary objectives of this review were to (1) determine whether community and migrant health centers were complying with certain legislative requirements under sections 329 and 330 of the Public Health Service Act, as amended (42 U.S.C. 254c), and related HHS regulations and instructions and (2) assess HHS' management and administrative practices relating to the community and migrant health center programs. We did not audit the financial statements of individual health centers; validate the financial, utilization, or productivity data submitted to HHS; or evaluate the quality of health care provided by the centers.

The enclosure summarizes the information we obtained during our fieldwork at HDC. Because of the limited scope of our work, we could not determine the overall effectiveness and efficiency of the HDC project. However, it appeared that HDC was generally

--managing its clinics well,

--complying with applicable HHS regulations and requirements, and

--moving toward its stated objective of increasing the number of primary care physicians and dentists in practice to meet the needs of the underserved rural areas of west central Alabama.

(102048)

We visited HDC during December 1979. We have not updated our information except for general facts relating to HDC's current organization, funding, and policies. This information was obtained primarily through telephone conversations with the HDC project director. Therefore, with few exceptions, the information in the enclosure reflects what we found during our December 1979 site visit.

We trust this information will be helpful to you. Please contact Mr. J. William Gadsby (443-3596) of my staff if we can be of further assistance.

Sincerely yours,

Gregory J. Ahart
Director

Enclosure

INFORMATION ON THE

HEALTH DEVELOPMENT CORPORATION

BACKGROUND

Since 1976, the Health Development Corporation (HDC)--a nonprofit firm in Tuscaloosa, Alabama--has received four Rural Health Initiative (RHI) grants totaling about $958,000 from the Department of Health and Human Services (HHS). In addition, since 1978, HDC has received two Health Underserved Rural Area grants from HHS totaling about $639,000. With these funds, it has established dental and medical clinics in six western Alabama counties with a target population of about 97,000. During 1980, HDC provided health services to about 20,800 patients. All the counties served by HDC are designated as medically underserved areas and qualify as primary medical care shortage areas. Three of them also qualify as dental manpower shortage areas.

The RHI program was implemented in 1975 to help develop health care capability in rural areas. The Health Underserved Rural Area program is primarily a research and development program for new concepts and innovative methods of delivering and financing health care services in rural areas. HDC has taken a unique approach to alleviating the health care shortage of the area in that it recruits physicians and dentists to work in its clinics and helps them to establish their own practices. Initially, HDC substantially supports a physician or dentist with financial and administrative assistance, but once the practice becomes self-sufficient, HDC withdraws its support and the provider becomes independent. As of December 1979, a total of eight clinics--six medical and two dental--had received HDC support. Of these, one medical and one dental clinic were operating independently at that time. Since then, three additional medical clinics have been funded through HDC and one other medical clinic has become independent.

HDC maintains a six-person central office staff headed by a project director. This staff is responsible for performing all accounting and billing functions, providing general management assistance and training, and recruiting staff and coordinating community involvement for all of the clinics.

In December 1979, HDC had an 18-member Board of Directors, 15 of whom were users of the services provided by HDC clinics. At each clinic, a small committee of citizens participates in local decisions on such matters as the types of services needed and helps arrange for facility and equipment needs. These citizens also serve as advisors to the HDC project director on matters of concern to the clinic.

SERVICES PROVIDED

HHS regulations require RHI grantees to provide certain primary medical care services and give grantees the option of providing supplemental services either directly or through referrals to other providers and facilities. The required services include physician services, diagnostic laboratory services, diagnostic radiology services, emergency medical treatment, transportation, preventive dental services, and various preventive health services, including family planning and health education.

As of December 1979, HDC was providing all of the required primary health care services, except transportation. The HDC project director told us that a need for transportation services had not been identified, but if a need arose, transportation would be provided. He added that the medical providers under contract with HDC make house calls after normal office hours.

In December 1979, limited family planning and health education services were provided by HDC. In June 1981, the project director told us that HDC still provided these services to a limited extent. He said patients needing more extensive services are referred to local health departments, which provide comprehensive family planning and health education services.

Regarding supplemental services--such as hospital care, mental health care, rehabilitation, ambulatory surgery, and home health care--HDC refers patients to nearby providers and facilities.

Quality assurance program

In December 1979, the HDC project director said he was not aware that RHI grantees were required by HHS regulations to implement a quality assurance program. At that time only one clinic required a second physician to periodically review the records of treatment provided by the HDC physician. The project director told us that, although HDC had not implemented the quality assurance program prescribed by HHS for all the clinics, all hospital admission recommendations were subject to a peer review process to ensure that hospitalization was appropriate. Also, periodic assessments of the propriety and quality of services provided were made by the State Medical Society.

In its January 1981 continuation grant application, HDC included detailed information on a quality assurance plan which would be implemented during the next grant period.

ACCESSIBILITY OF SERVICES

As required by HHS regulations, HDC has established policies and taken action to make the services offered by its clinics available and accessible to persons in the local communities. In this

regard HDC has recruited medical staff, developed systematic appointment procedures, and required all clinics to be open at least 40 hours a week. Also, HDC physicians follow up on patients referred to other providers and facilities and on patients with chronic illnesses.

In accordance with HHS regulations, physicians provided services regardless of the patients' ability to pay, there were no exclusionary eligibility requirements, and all groups of patients (for example, children, pregnant women, and the aged) were served by the HDC clinics.

Staffing

HDC guidelines provide that each clinic when first established be staffed by a physician or dentist, a nurse, and a receptionist; other staff and equipment are added as needs dictate. As of December 1979, HDC apparently employed an adequate number of physicians and medical staff at five of the six clinics in operation. One clinic did not have a full-time physician, but HDC had contracted with a physician to serve part time and a nurse practitioner was on duty during office hours. As of December 1979, one physician had been fired, and one dentist and one physician had resigned; however, overall, the project did not appear to have a problem retaining health providers.

Also, each HDC physician had staff privileges at the local hospital and, on a rotating basis, took calls for the other physicians and saw patients in the hospital's emergency room.

Hours of operation

HHS requires RHI grantees to make primary health care services available and accessible to those in the community. HDC requires each clinic to be open at least 40 hours a week. As of December 1979, three medical clinics and one dental clinic were open from 8:00 a.m. to 5:00 p.m., Monday through Friday (45 hours a week). One medical clinic was open from 8:30 a.m. to 5:00 p.m., Monday through Friday (42-1/2 hours a week). One clinic's normal operating hours were from 8:00 a.m. to 6:00 p.m. on weekdays, except for closing on Thursdays, and from 8:00 a.m. to 12 noon on Saturdays (44 hours a week). As mentioned earlier, physicians made house calls after normal office hours. In addition, HDC had made arrangements for emergency medical services.

Appointment system

Systematic appointment procedures were in effect at the HDC clinics as of December 1979. The average waiting time for an appointment for medical services was about 1 week. For dental services, the average waiting time was about 2 weeks. A same-day

appointment could be arranged for medical emergencies, and walk-ins were accepted by medical clinics for emergencies. Lengthy waits at the clinics did not appear to be a problem.

Followup on patients

The HDC clinics routinely referred patients to other providers for supplementary care. No uniform followup procedures existed, but all HDC physicians followed up on patients. Most often telephone calls were made to obtain followup information. In a few cases written explanations of services provided were requested by HDC physicians.

HDC physicians had developed procedures to assure that future appointments were made to track patients with chronic illnesses. Basically, each physician had a file or notebook listing patients and disorders, which was periodically reviewed to assure that the patients were being treated.

FINANCIAL MANAGEMENT

HHS regulations for the RHI program require that certain financial management practices be established. They include developing (1) a sliding fee schedule based on the patients' ability to pay for services, (2) a system to collect reimbursements from third-party medical insurers, and (3) systematic policies and procedures for collecting from patients. Also, HHS regulations require annual audits of grantee operations.

Fee schedule

HHS regulations require grantees to prepare a schedule of fees to cover the reasonable costs of providing health services and to develop a schedule of discounts based on the patients' ability to pay. The regulations provide that nominal fees may be collected from low-income individuals when this is consistent with project goals.

HDC had not developed a cost-based fee schedule for its clinics at the time of our fieldwork. Rather, it developed a fee schedule based on the usual and customary charges for health services in the area. The project director told us that it was not realistic to develop a cost-based fee schedule. (Most services under such a schedule would be more expensive.) He pointed out that the HDC fee schedule generally is in line with the Medicare and Medicaid fee schedules in the area, which are based on usual and customary fees of local physicians. As discussed below, a high percentage of collections for services provided by HDC physicians comes from Medicare and Medicaid.

HDC had prepared a sliding fee schedule, based on family annual income and size, for those able to pay part of the charges incurred. This fee schedule was posted in the waiting room of all HDC clinics.

Billing and collection

HHS regulations require each RHI grantee to make reasonable efforts

--to collect appropriate reimbursement for health services provided to persons who are entitled to Medicare or Medicaid, or financial assistance under any other public assistance or private health insurance program; and

--to obtain payment from patients for health services in accordance with the established fee schedule.

HDC has established aggressive reimbursement, billing, and collection procedures. As a result, it had collected about 61 percent of charges from all sources ($321,000 collected of $529,000 charged) from September 1977 to October 1979. For project year November 1, 1978, through October 31, 1979, HDC had collected about 76 percent of all charges.

According to the project director, in December 1979, each HDC clinic employed a clerk to work exclusively on third-party billing, and Medicaid and Medicare claims were filed on a daily basis. This staff member also initiated claims against private health insurance policies, when applicable, rather than relying on the patients to do so. The HDC central office also employed an accounts receivable specialist to visit the clinics regularly as a troubleshooter and reviewer.

Based on HDC financial data, the clinics apparently experienced relatively few problems in collecting from patients for services provided. Some of the actions taken to collect from patients are described below:

--At the end of each month, patients with balances due were billed.

--For accounts delinquent after 4 months, a letter attached to the bill requested the patient to contact the clinic.

--For accounts delinquent after 6 months, a final notice letter, warning that the bill would be referred to an attorney, was attached to the bill (no accounts under $50 were actually referred to an attorney).

--After the account was referred to an attorney, two more warning letters were sent to the patient before the attorney took the case to court for payment.

The records of patients who had been delinquent in paying their bills were identified in the file, and if the patients returned for further treatment, payment was requested. If they declined to pay, treatment could be refused, except in an emergency.

In June 1981, the project director confirmed that the above practices and procedures were still in effect at HDC. The project director told us that about 50 percent of HDC collections during project year 1979 were the result of Medicare, Medicaid, and other third-party insurance reimbursements.

Also, implementation of the collection policy seemed to be successful because, according to HDC records, only $3,309 of bad debts were written off as uncollectible from July 1978 to December 1979.

CPA audits

HHS regulations require RHI projects to have a financial audit annually by an independent certified public accountant or a public accountant licensed before December 31, 1970. HDC was audited annually as required after its first 3 grant years. The most recent audit report at the time of our fieldwork covered HDC's second year of operation, which ended October 31, 1978. This report stated that several minor weaknesses in internal controls noted during the previous year's audit had been corrected and no additional weaknesses were found.

The financial audit report covering the project year ended October 31, 1979, did not disclose any problems.

PROGRAM INDICATORS

In late 1976, HHS implemented the Common Reporting Requirements to improve the way it manages its programs and to better assure compliance with the programs' legislative intent. Grantees submit a variety of data to the Common Reporting Requirements system covering the patients, providers, costs, receipts, and utilization of each project.

HHS has identified several key data items as program indicators to be used for monitoring HHS-supported health care programs. The program indicators are used by the HHS regional offices to assess the level of project productivity and efficiency. They are reviewed before and during each budget period. During their first 2 years, projects are expected to be progressing toward achieving these standards. All projects are expected to be in

compliance with the program indicators by the third year of funding. Three of the most important program indicators and standards in effect as of January 1980 are described below:

--Between 4,200 and 6,000 on-site encounters for each full-time equivalent physician each year (medical services exclusive of psychiatrists).

--Between $16 and $24 average cost for each medical encounter (excluding laboratory, X-ray, and pharmacy).

--Not more than 16 percent of total ambulatory costs attributable to administration. (For projects with total annual operating costs of $125,000 or less, the standard is 26 percent.)

Grantees not in compliance with these standards are to be penalized in the next funding period according to how much they deviated from the standards. Grantees are ineligible to receive continuation support if they fail to submit complete reports on time.

HDC program indicators

HDC has apparently submitted the Common Reporting Requirements information as required by HHS regulations during the last 3 years. As shown in the table below, during this period, the productivity of physicians has increased and the average cost for each encounter has decreased so that both of these program indicators met HHS' standards as of December 1980. The portion of project costs attributed to administration decreased from 27 percent in 1978 to 19 percent in 1980; however, this is still 3 percent above the HHS standard of 16 percent.

HDC Program Indicators Based on Data Submitted to HHS for 1978-80 (note a)

Calendar year	Annual encounter for each full-time physician (note b)	Average cost for each medical encounter	Percent of ambulatory cost attributed to administration
1978	3,335	$30	27
1979	4,022	25	19
1980	5,086	22	19

a/These data were not validated by us.

b/A face-to-face contact between a patient and a provider of health services who exercises independent judgment in providing health services to the patients.

ENCLOSURE I

HHS officials do not compare HDC's compliance with these standards as they would other grantees over 2 years old because the HDC clinics are constantly changing; i.e., new clinics are being added and existing clinics are becoming independent.