REPORT BY THE STAFF OF THE U.S.

General Accounting Office

Reimbursement For National Health Service Corps Personnel

Local health clinics are responsible for reimbursing the Government for certain costs associated with health professionals assigned to them by the National Health Service Corps. Reimbursements have declined sharply because little attention is given to the reimbursement requirement. The amount for reimbursement did not include all pertinent costs, and the billing and collection processes were lax.

In addition, local clinics could strengthen their revenue producing practices and make greater efforts to collect delinquent accounts.

Department of Health and Human Services officials were initiating actions to correct these problems.

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PREFACE

The National Health Service Corps sends physicians, dentists, and other health professionals to communities determined by the Department of Health and Human Services (HHS) to have shortages of such personnel. These people may be volunteers or persons fulfilling a period of obligated service resulting from educational assistance provided by the Federal Government.

The Government pays these professionals' salaries, and the clinics to which they are assigned are to reimburse the Government for the cost of these people under certain circumstances.

This study is the result of our examination of several aspects of the reimbursement issue. We looked at HHS' calculations of the amounts that the clinics were expected to reimburse, its procedures for billing the clinics, the conditions under which it would waive the clinic's reimbursement, and its efforts to collect the reimbursement from the clinics. We also visited several clinics and reviewed their procedures for setting, charging, and collecting fees for the health services they provided.

During our review, HHS officials initiated actions designed to improve their billing and collection practices. These actions, if properly implemented, should improve the problems we found. Therefore, we are not recommending that additional actions be taken at this time.

We have provided copies of this staff study to various congressional committees having jurisdiction over HHS activities and to the HHS officials responsible for managing the National Health Service Corps.

Gregory J. Ahart, Director
Human Resources Division

STAFF STUDY BY THE
GENERAL ACCOUNTING OFFICE

REIMBURSEMENT FOR NATIONAL HEALTH SERVICE CORPS PERSONNEL

D I G E S T

The National Health Service Corps (NHSC) was established within the Department of Health and Human Services (HHS) in 1970 to alleviate the maldistribution of health care personnel and to improve the delivery of health services to residents of areas having a shortage of these personnel. To accomplish this, NHSC has two programs--health service delivery and scholarships. The delivery program assigns NHSC health personnel to work in areas having a shortage of such personnel, and the scholarship program helps assure an adequate supply of health personnel. (See pp. 1 and 2.)

NHSC legislation requires that patients be charged a fee for services according to their ability to pay. The fees should be based on rates generally prevailing in the area. NHSC sites are to reimburse the U.S. Treasury for the cost of NHSC personnel assigned; however, under certain circumstances sites may receive a waiver of all or part of their reimbursable cost. (See p. 2.)

NHSC's estimate of the total reimbursement obligation of sites was about $114 million through billing year 1979. Of that total, only $13 million had been collected as of September 30, 1980. (See p. 3.)

NHSC ATTEMPTS TO INCREASE SITES' REIMBURSEMENTS TO U.S. TREASURY

In recent years, reimbursements to the Treasury by sites having NHSC personnel have steadily declined. As a result, HHS has recently initiated several actions to reverse this situation. (See pp. 4 to 5.)

NHSC methods used in the past to determine reimbursable costs were inadequate because calculations used projected rather than actual salary increases which were higher and did not include

proper adjustments for variable incentive pay bonuses authorized by 1979 legislation. NHSC officials agreed that the practice of basing site bills on estimates without yearend reviews and adjustments had reduced potential revenues. Corrective actions are being taken to prevent the understatement of future bills. (See pp. 5 to 9.)

The billing technique HHS used in the past allowed sites to partially or completely eliminate their reimbursement obligation by indicating on an internal management report that revenues collected did not exceed expenses incurred and, consequently, funds were not available to meet the obligation.

A revised billing process that became effective January 1, 1981, should improve this situation. The new process requires NHSC sites to reimburse the Treasury for 20 percent of the revenues generated by NHSC personnel while keeping 80 percent to cover operating costs. Once a site has met its budgeted operating cost level, it will be required to reimburse the Treasury for 80 percent of those revenues until the obligation is fully paid. (See p. 9.)

In the past, waiver requests submitted by NHSC sites were routinely approved without being adequately reviewed or evaluated. NHSC officials acknowledged this problem and have adopted a revised review process which they said should result in fewer waivers being approved. (See pp. 9 and 10.)

NHSC officials essentially failed to pursue collections from sites. By April 1980, the delinquent accounts from NHSC sites had grown to about $29 million and were recognized as a serious problem.

HHS has acted to correct this situation by consolidating accounts, referring accounts to the Public Health Service claims division, requiring regional offices to pursue collections from sites, designating staff to work only on collecting receivables, and developing a billing management information system to better monitor receivables. (See pp. 10 to 12.)

NHSC SITES CAN IMPROVE REVENUE-PRODUCING PRACTICES

HHS headquarters, its regional offices, and NHSC sites have not given enough attention to setting and updating fees based on prevailing rates. Accordingly, the methods NHSC sites used to establish and update fees vary widely and, at some sites, fees may be lower than the rates prevailing in their service area. A key reason for these problems is that HHS has not given sites and regional offices guidance on how to develop prevailing rates.

HHS is aware that fees at many NHSC sites are lower than prevailing rates. The Department is developing policies to be followed by sites in establishing prevailing rates and by HHS' regional offices in monitoring sites' fee schedules. However, HHS is proceeding cautiously in this area so that mechanisms established do not conflict with Federal legislation relating to price fixing. (See pp. 13 to 16.)

Professional courtesy is the practice of providing free medical and/or dental care to local health professionals and others. Nine of the 11 NHSC sites GAO visited granted professional courtesy--in varying degrees--to physicians and dentists, members of sites' board of directors, staff, local rescue squad members, and in some cases the families of these individuals. This practice can result in lost revenue because these recipients may have the ability to pay for services.

Only one NHSC site GAO visited kept records that could be used to determine the value of professional courtesy services it provided. That site provided physician and dentist services at no cost to clinic employees and their families and to the board of directors and their families. At the time of GAO's fieldwork, the site had 81 employees and 18 board members and provided professional courtesy services valued at $36,823 to employees during the 1-year period ended July 31, 1980.

NHSC does not encourage professional courtesy, but it does not have written policy addressing the practice. (See pp. 17 to 18.)

Also, NHSC had no policy on how sites should pursue collections from patients with delinquent accounts, and only 3 of the 11 sites GAO visited used or planned to use collection agencies or courts to collect such accounts. Sites using these tools were having some success.

As a result of the limited efforts to collect delinquent accounts, substantial uncollected patient accounts and bad debt writeoffs existed at the sites GAO visited. HHS data showed that those 11 sites had $374,193 in unpaid accounts on June 30, 1980, and wrote off $161,320 in bad debts from July 1979 through June 1980.

HHS officials said that one step being taken to improve the delinquent account situation is the establishment of a policy concerning whether persons having delinquent accounts should be allowed to receive nonemergency medical care. (See pp. 18 to 20.)

Contents

ABBREVIATIONS

BHPDS	Bureau of Health Personnel Development and Services
GAO	General Accounting Office
HHS	Department of Health and Human Services
HPEA	Health Professions Educational Assistance Act
NHSC	National Health Service Corps

CHAPTER 1

INTRODUCTION

The National Health Service Corps (NHSC) was established by the Emergency Health Personnel Act of 1970 (Public Law 91-623) and continued under the most recent legislative authority--the Health Professions Educational Assistance Act (HPEA) of 1976 (Public Law 94-484). 1/ NHSC was established to alleviate the maldistribution of health care personnel and to improve the delivery of health services to residents of areas with shortages of health care providers. To accomplish this, NHSC sends physicians, dentists, and other health care personnel to communities determined by the Department of Health and Human Services (HHS) to have such shortages. These health care personnel may be volunteers or persons fulfilling a period of obligated service resulting from the NHSC scholarship program.

The NHSC scholarship program, authorized by the Emergency Health Personnel Act Amendments of 1972 (Public Law 92-585) and continued by HPEA, is designed to help assure an adequate supply of doctors, dentists, and nurses for NHSC. The program provides scholarships to students who agree to serve 1 year in a medically underserved area for each year they receive a scholarship, with a minimum of 2 years' service.

NHSC personnel are located in various settings, ranging from NHSC-supported rural practices to other health grant-supported urban community health centers and municipally operated ambulatory care facilities. NHSC has grown substantially since it first placed health professionals in underserved areas. In 1973, 181 personnel were serving 94 communities; by February 1981, the numbers had grown to 2,002 personnel serving 969 communities. Further substantial growth is expected in the 1980s.

Similarly, NHSC funding has increased steadily. In fiscal year 1971, it received about $3 million in appropriations for service delivery; for fiscal year 1981, appropriations are estimated to total about $79 million. In total, about $365 million will have been appropriated for service delivery from fiscal years 1971 through 1981. Since 1974, NHSC has also received more than $400 million in appropriations for the scholarship program and has awarded scholarships to about 13,175 individuals.

1/This legislation expired on October 1, 1980. The House of Representatives passed a reauthorization bill (H.R. 7203) on September 3, 1980; however, the legislative process was not completed and the bill was not enacted. Since October 1, 1980, NHSC has operated under the authority of two continuing resolutions (Public Laws 96-369 and 96-536).

NHSC represents a partnership between the Federal Government and the local community. The responsibilities of both parties are spelled out in a memorandum of agreement, a legal document forming the basic contract between the two parties. Generally, NHSC agrees to assign health personnel, and the community agrees to manage the health center or site and to provide an office, supplies, and staff support. The site is responsible for providing health services, billing, and collecting fees. To facilitate fee collection, each site must develop, implement, and update fee schedules, which must be approved by the site's governing board. The memorandums of agreement require that fees be updated annually.

NHSC LEGISLATIVE REQUIREMENTS

NHSC legislation requires that patients who receive health services provided by NHSC personnel be charged a fee designed to recover the value of the services. However, the legislation also provides that patients may receive services even when they are unable to pay the established fees. In such cases, they may receive services at a reduced rate or without charge. NHSC provides for reduced rates through a sliding fee scale which each site develops and applies to its patients as needed. The scale considers a patient's income and family size in determining how much of the established fee should be paid.

NHSC legislation also requires that sites bill and collect from third parties--such as Medicaid, Medicare, or other private insurers--when those third parties would be responsible for all or part of the cost of services provided.

Sites are also responsible for reimbursing the U.S. Treasury for the cost (referred to as the reimbursable cost) of NHSC personnel. Reimbursable costs, as discussed in this report, represent the total amount due from NHSC sites before any waivers or other adjustments are granted. Reimbursable costs include salary and allowances and a portion of NHSC's scholarship program costs. Cost items included have changed somewhat over the years, and items previously included, such as transportation and certain benefits, are no longer included. The amount of reimbursement required depends on the average reimbursable cost developed each year by HHS for each type of health professional and the length of time the individual was assigned to the site during the billing period.

Although sites have an obligation to reimburse the Treasury, HHS may waive all or part of the reimbursement under certain circumstances. The circumstances include when the site (1) is financially unable to repay the obligation or (2) is located in a health manpower shortage area in which a significant percentage of the people are elderly, are living in poverty, or have other characteristics indicating an inability to pay. The waiver provision was introduced in the Special Health Revenue Sharing Act of 1975 (Public Law 94-63) and was continued in HPEA.

MANAGEMENT OF THE NHSC PROGRAM

Before November 1980, NHSC was a component of the Bureau of Community Health Services in HHS' Health Services Administration. In November 1980, however, NHSC became part of a new Health Services Administration organization--the Bureau of Health Personnel Development and Services (BHPDS).

In addition to administering the health services and scholarship components of the NHSC program, HHS headquarters

--determines the amount reimbursable to the Federal Government by NHSC sites,

--bills sites for the cost of NHSC assignees, and

--collects the appropriate reimbursable cost.

HHS regional offices assign NHSC health professionals, approve memorandums of agreement, monitor sites' operations based on the memorandums, and review and approve sites' waiver requests.

ESTIMATE OF FULL REIMBURSABLE COST

NHSC's estimate of the full reimbursable cost of NHSC personnel to sites from inception of the program through fiscal year 1979 is about $114 million. According to HHS records as of September 30, 1980, about $55 million of the total had never been billed to the sites. About $59 million of the total had been billed; of this amount, $20 million had been adjusted and written off as uncollectible, $6 million had been waived as not collectible, $13 million had been collected, and $20 million remained outstanding. By January 31, 1981, the $20 million outstanding had been reduced to $14.6 million. However, information was not available to show how much of the $5.4 million reduction was due to adjustments, collections, or waivers.

For fiscal year 1980, HHS records show that the reimbursable cost was $67.8 million; of this total, adjustments amounted to $48.4 million, and $19.4 million was billed to the sites in February 1981 for the fiscal year 1980 billing period ended June 30, 1980.

CHAPTER 2

ACTIONS ARE BEING TAKEN TO INCREASE REIMBURSEMENTS

In recent years, reimbursements to the Treasury by sites having NHSC health personnel have steadily declined. HHS has recently initiated several actions to reverse the situation. According to the BHPDS Director, the decline in reimbursements was primarily caused by management's inattention to several matters. First, program officials were using an inadequate method of calculating amounts due from NHSC sites which probably resulted in those sites being underbilled. Second, NHSC officials were using a billing process which gave sites a disincentive to increase revenues or contain costs. Third, sites' waiver requests were routinely approved without being adequately reviewed or evaluated. Finally, NHSC officials failed to pursue collections from sites that had not reimbursed the Treasury for NHSC health personnel assigned as early as 1975.

HHS has taken some steps to correct these deficiencies. First, the method of determining sites' reimbursable costs has been changed to be more systematic and reflective of costs incurred. Second, the billing process has been modified to give sites incentives to increase revenues and become more cost effective. Third, a revised waiver review process has been adopted which should result in fewer waivers being approved. Finally, more attention is being focused on the need to collect from sites having long overdue accounts payable.

REIMBURSEMENTS HAVE DECLINED SHARPLY IN RECENT YEARS

In recent years reimbursements by NHSC sites have declined in absolute terms and as a percentage of reimbursable costs, as shown by the following HHS data.

Period	Reimbursable costs	Reimbursements	Reimbursements as a percent of reimbursable costs
7/01/72-6/30/73	$ 3,375,000	$ 207,843	6.2
7/01/73-6/30/74	5,810,000	1,187,674	20.4
7/01/74-6/30/75	6,740,000	1,791,291	26.6
7/01/75-6/30/76	12,660,000	a/3,904,615	f/30.8
7/01/76-6/30/77	13,880,000	b/2,835,481	20.4
7/01/77-6/30/78	24,710,000	c/1,580,465	6.4
7/01/78-6/30/79	46,650,000	d/710,511	1.5
7/01/79-6/30/80	67,830,000	e/1,014,495	1.5

a/Reimbursements made during the 15-month period 7/01/75 through 9/30/76.

b/Reimbursements made during 10/01/76 through 9/30/77.

c/Reimbursements made during 10/01/77 through 9/30/78.

d/Reimbursements made during 10/01/78 through 9/30/79.

e/Reimbursements made during 10/01/79 through 9/30/80.

f/The actual percentage may vary because reimbursable costs are for a 12-month period while reimbursements are for a 15-month period.

The declining reimbursements have become an issue of concern during congressional hearings. On September 24, 1980, in testifying before the Subcommittee on Health and Scientific Research, Senate Committee on Labor and Human Resources, the former NHSC Director was asked why NHSC was not reimbursing more funds to the Treasury. He responded that NHSC's performance in administering the payback provision of the law had "not been as good as it perhaps should have been." He further acknowledged that NHSC's waiver approval system was "still not up to snuff in terms of its administration."

At this hearing the former Director estimated that reimbursements from facilities having NHSC personnel would eventually total between 15 and 20 percent of the program's annual authorized funding. This estimate contrasts sharply with the declining pattern of reimbursement discussed earlier. In fact, during fiscal year 1980, the NHSC sites reimbursed only $1.01 million, which represented about 1.5 percent of the program's appropriation.

PAST METHODS FOR CALCULATING REIMBURSABLE COSTS UNDERSTATED BILLS

Methods NHSC used in the past to determine sites' reimbursement obligations were inadequate. Consequently, NHSC has consistently understated its bills to sites and reduced its potential reimbursement. For billing year 1980, billings could be understated by as

much as $2,521,000 for those aspects of the billing process that we analyzed.

Since the program began in the early 1970s, NHSC has used different methods of determining the annual reimbursement obligations of sites having NHSC personnel. Initially, sites were billed for actual salary costs, benefits, transportation, and certain other costs NHSC paid on behalf of the specific provider. Beginning in 1976, according to an HHS official, NHSC changed its calculation method. As a preliminary step, NHSC established national average costs for specific types of providers, including physicians, dentists, and others. Site bills were developed based on these average costs and on the number and type of personnel assigned. The average costs technique produced the following HHS average reimbursable cost computations.

Average Reimbursable Cost
by Type of NHSC Provider for
Billing Years 1976-80 (note a)

Billing year ended June 30	Estimated reimbursable costs					
	Physicians		Dentists		Others	
	Scholarship (note b)	Non-scholarship	Scholarship (note b)	Non-scholarship	Scholarship (note b)	Non-scholarship
1976	-	$22,036	-	$22,036	(c)	(c)
1977	-	27,600	-	23,600	(c)	(c)
1978	$35,100	35,100	$30,477	20,477	$22,675	$15,177
1979	37,000	37,000	36,000	26,000	24,500	17,000
1980	39,000	39,000	38,000	27,500	26,000	18,000

a/The available records pertaining to the average cost computations were not sufficient to enable us to verify the computations.

b/HPEA requires sites to pay applicable NHSC provider scholarship costs, but they were not included as reimbursable costs until billing year 1978.

c/During 1976 and 1977, sites were charged for other providers based on actual and not average costs.

We analyzed selected aspects of the cost computations used in developing reimbursable cost bills sent to sites for billing years 1976 through 1980. 1/

1/Billing year 1980 is the most recent period for which bills were sent.

Calculations used projected rather than actual salary increases

Our analysis showed that the reimbursement obligations for billing years 1976, 1977, 1978, and 1980 were understated primarily because they were based on projected rather than actual cost-of-living increases granted to Federal employees. The following table shows the cost-of-living percentage increases used by NHSC versus those actually given Federal employees.

Billing year ended June 30	Type of provider	Cost-of-living percentage used by NHSC	Actual cost-of-living percentage granted	Percent of overestimation or underestimation (-)
1976	Physicians	0	5.00	-5.00
	Dentists	0	5.00	-5.00
	Others	0	5.00	-5.00
1977	Physicians	6.00	a/6.10	-.10
	Dentists	6.00	a/5.40	.60
	Others	6.00	a/4.70	1.30
1978	Physicians	7.00	7.05	-.05
	Dentists	7.00	7.05	-.05
	Others	7.00	7.05	-.05
1979	Physicians	5.50	5.50	0
	Dentists	5.50	5.50	0
	Others	5.50	5.50	0
1980	Physicians	5.50	7.00	-1.50
	Dentists	5.50	7.00	-1.50
	Others	5.50	7.00	-1.50

a/Actual percentages granted varied by grade level. Percentages shown are based on average grade levels provided by BHPDS.

The use of projected cost-of-living increases in salaries reduced the potential revenues to the Federal Government. For the billing year ended June 30, 1980, the potential revenue loss was about $721,000.

The NHSC Acting Director told us that the average reimbursable costs were usually estimated before the beginning of each billing year (July 1). This was done so sites could budget for the reimbursable costs and the costs could be shown in memorandums of agreement. However, NHSC officials did not review or adjust the reimbursable cost estimates before they were actually used in developing final bills to sites to determine whether the assumptions used remained valid.

Change in variable incentive pay not included

NHSC officials also understated the 1980 billing year reimbursable cost levels because they did not properly adjust the estimate for a change in legislation authorizing variable incentive pay. During October 1979, certain Commissioned Corps physicians who had received NHSC scholarships became eligible for a single variable incentive pay bonus of $9,000. The 1980 billing estimate was developed before this date and did not include these additional costs for about 200 Commissioned Corps physicians. As a result, bills sent to NHSC sites for 1980 could be understated by as much as $1,800,000.

Actions to be taken by HHS

On February 11, 1981, the BHPDS Director agreed that the practice of basing site bills on prebilling-year estimates without yearend reviews and adjustments to correct for invalid assumptions and unforeseen events had reduced potential revenues. Although the Director believed it was too late to adjust reimbursement bills for earlier years, he said that he had requested HHS' Office of General Counsel to determine whether sites could be sent amended bills for the billing year ended June 30, 1980. Essentially, the Office of General Counsel has been asked to determine whether cost figures contained in the memorandums of agreement with the sites can be treated as adjustable estimates. If so, according to the Director, sites will be sent amended bills reflecting the increased cost.

The BHPDS Director also said that actions would be taken to prevent the understatement of future bills. Effective February 11, 1981, all cost estimates prepared for future billing years would be reviewed and adjusted to reflect actual cost-of-living increases and other events during the billing year before they were used as a basis for bills to sites. To help implement this revised approach, the NHSC Acting Director told us that he prepared a revised memorandum of agreement on February 11, 1981, which for the first time put communities on notice that reimbursable cost estimates in the memorandums are subject to adjustments to reflect actual increases in salaries and allowances paid to NHSC personnel.

HHS' General Counsel has questioned use of average costs

HHS' Office of General Counsel has concluded that the current practice of requiring repayment on the basis of average rather than actual costs may not be appropriate under existing legislation. BHPDS officials informed us that using average reimbursable costs substantially simplifies the billing process for NHSC providers and

the assigning of NHSC personnel, because it eliminates the community's consideration of a cost variable in choosing personnel. 1/ Because of this situation, HHS plans to request legislative authority in 1981 to use the average cost computation method.

MODIFIED BILLING PROCESS IS DESIGNED TO INCREASE REVENUE AND DECREASE COSTS

The billing technique HHS used in the past allowed many sites to partially or completely eliminate their reimbursement obligation by indicating on an internal management report that revenues collected did not exceed expenses incurred and, consequently, funds were not available to meet the obligation. HHS officials told us that this situation provided no incentive for sites to increase revenues or control costs because any additional funds would be paid to the Treasury.

A revised billing process, effective January 1, 1981, is designed to improve this situation. Since then, sites are permitted to keep only 80 percent of revenues collected that are attributable to NHSC personnel until they collect sufficient revenue to meet the cost associated with supporting the NHSC personnel assigned to the site. The other 20 percent is to be reimbursed to the Treasury. Once a site has generated enough revenue to meet its operating cost budget, it will be required to reimburse to the Treasury 80 percent of revenues collected until the reimbursable costs are fully paid. Sites will be permitted to retain all revenues collected after these costs are paid.

HHS officials believe the modified billing process will help to increase reimbursements. Under the new process, sites are to ensure that revenues are increased and/or costs decreased to an extent that permits the required 20-percent reimbursement. Therefore, sites that have been making only nominal reimbursements will be required to make changes that will enable them to meet the 20-percent reimbursement requirement.

In establishing the modified billing process, HHS will permit sites to continue obtaining waivers under certain conditions, as authorized by the legislation. However, HHS officials said that waivers will not be approved as readily as they were in the past.

WAIVERS WILL BE MORE THOROUGHLY REVIEWED AND EVALUATED

HPEA provides that the Secretary of HHS may, under certain conditions, waive all or part of a site's obligation to reimburse

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1/If the actual personnel cost were used, there could be as much as a $15,000 difference in the cost of training, according to HHS data.

the Treasury for the cost of NHSC personnel. These conditions essentially involve when a site is (1) financially unable to repay the obligation or (2) located in a health manpower shortage area in which a significant percentage of the population is elderly, is living in poverty, or has other characteristics indicating inability to pay. The directors of HHS' regional divisions of health services delivery are now responsible for reviewing and approving sites' waiver requests. Before billing year 1979, the NHSC Director was responsible for approving such waivers based on recommendations of regional offices.

The NHSC Acting Director said it is common knowledge that since 1976 waivers had become increasingly easy to obtain. He said that as a practical matter sites and regional offices had, until recently, assumed that waivers were approved automatically regardless of the adequacy of the sites' justification.

To remedy this situation, steps have been taken to improve the waiver review and approval process. On October 28, 1980, HHS informed regional offices that, effective January 1, 1981, individual waiver requests would have to be fully documented and that simply listing factors in support of waiver requests would not guarantee approval.

The BHPDS Director believed that the increased attention to the waiver approval process should result in more disapproved waivers and, consequently, increased reimbursements to the Treasury.

ACCOUNTS RECEIVABLE WILL BE PURSUED MORE VIGOROUSLY

Because accounts receivable from NHSC sites have grown substantially during recent years, BHPDS has taken steps to increase collections from such sites. From June 30, 1977, to April 1, 1980, accounts receivable increased from $2.6 million to about $29 million, as shown by the following HHS data.

Accounts Receivable From NHSC Sites 1977-80

Date	Accounts receivable
	(millions)
June 30, 1977	$ 2.6
June 30, 1978	5.9
June 30, 1979	8.3
April 1, 1980	29.0

Before April 1980, little was done to collect the growing accounts receivable. Although a few dunning letters were sent to some sites, the BHPDS Director told us that he was unaware of any other actions undertaken to collect from sites that failed to reimburse the Treasury.

By April 1980, the amount of outstanding receivables from NHSC sites was recognized as a serious problem requiring management attention. According to BHPDS, to improve the situation, several internal management changes were made in the NHSC collection procedures. First, the outstanding receivable situation was clarified by consolidating 1,800 annual site accounts into 500 accounts, which reflected the total amount due from each site.

Second, in May 1980 seriously past due accounts were referred to the Public Health Service claims division for collection. From that date through January 31, 1981:

--One account had resulted in payments to the Treasury.

--Two accounts had been forwarded to the Department of Justice for further actions.

--Two accounts were still being handled by the claims division.

--Two had been terminated without any collections. One of these cases involved $156,121 and was terminated because the statute of limitations had expired.

Also, HHS enlisted the help of its regional offices in resolving the overdue account situation. On September 5, 1980, it informed the regional offices that:

> "The number of overdue outstanding debts owed to the United States Government by former and operating NHSC sites is a major, continuing, unresolved concern of this Bureau, the Congress, and the General Accounting Office. The sites involved are seriously delinquent for payment of their obligation under the cost sharing provisions of P.L. 94-484."

Each region was given a detailed list of sites having seriously delinquent accounts and was requested to contact the sites to determine what amounts were collectible or whether extenuating circumstances existed. Further, the regional offices were told that the accounts listed may be referred to the Public Health Service claims division or, ultimately, the Justice Department for collection.

HHS records indicate that these actions have been somewhat successful. Accounts receivable declined from about $29 million as of April 1, 1980, to about $17 million as of June 30, 1980. In addition, the average weekly collections increased to about $100,000 in July 1980 compared to $17,000 previously. Furthermore, as of January 31, 1981, the amount of outstanding receivables had fallen to $14.6 million--about one-half of the amount in April 1980.

The BHPDS Director told us that to continue to reduce the amount of accounts receivable other actions needed to be taken. First, effective November 25, 1980, the BHPDS' division of financing services had for the first time designated two staff members to work full time on collecting current and past due receivables from sites. Second, to enhance its ability to discharge this responsibility, on January 14, 1981, BHPDS started using a billing management information system which, also for the first time, enabled regional office and headquarters staff to monitor the outstanding balances, current billings, waiver requests, adjustments, and collections of each site.

Although actions have been taken to improve collections of past due accounts, the agency has not established specific collection goals to evaluate the effectiveness of the actions. The BHPDS Director told us that goals had not been established because of an inability to accurately predict the impact of recent management changes on future collections. The Director emphasized, however, that goals would be established after BHPDS gains an understanding of how the recent changes affect collections.

CHAPTER 3

OPPORTUNITIES TO STRENGTHEN REVENUE-PRODUCING PRACTICES

The potential for sites to reimburse the Treasury for the cost of NHSC personnel depends directly on their ability to generate revenues. We developed information on three factors which relate to a site's revenue: (1) fee-setting techniques, (2) professional courtesy, and (3) delinquent account collections.

FEE SETTING

HHS headquarters and regional offices as well as NHSC sites have given little attention to setting and updating fees based on prevailing rates.

NHSC sites should charge prevailing rates

Although earlier authorizing legislation required NHSC providers to charge fees that would permit the recovery of reasonable costs, the most recent legislation requires them to charge fees that would recover the value of services.

Section 334(d) of HPEA requires NHSC personnel to charge fees that permit "recovery of the value" of services provided. Senate Report No. 94-887 (May 14, 1976) elaborated on the "recovery of the value" language. It said the new language:

> "* * * revises the provisions of the program relating to payment for services delivered by the Corps practitioners. The Committee bill provides that all individuals served by Corps personnel will be charged for services at the generally prevailing rate."

The BHPDS Director, as well as officials responsible for administering NHSC before the November 1980 reorganization, said this language has been interpreted to mean that NHSC should charge patients fees comparable with prevailing rates.

HHS' final regulations for the NHSC program, which were published in the Federal Register on February 27, 1980, contain the following provision:

> "* * * individuals receiving services from assigned National Health Service Corps personnel must be charged on a fee-for-service or other basis at a rate which is computed to permit recovery of the value of the services * * *"

In its response to comments on the proposed version of the regulations, published in the Federal Register the same day, HHS said that "The NHSC practitioners * * * are required to charge patients at competitive fee levels."

HHS has not given regional offices guidance on how they should ensure that sites charge prevailing rates

In delegating the fee approval responsibility, HHS did not give regional offices guidance on how sites were to establish fees based on prevailing rates or on how regional offices were to ensure that sites charged prevailing rates. HHS has given regional offices and sites guidance on how to establish fees based on costs.

On February 12, 1981, the BHPDS Director told us that HHS had not developed policies and procedures for regional offices to use in ensuring that sites charge prevailing rates. Furthermore, he said that the lack of guidance in this area had probably resulted in (1) the regional offices being ineffective in discharging their responsibility to review and approve sites' fee schedules and (2) the possibility that many sites do not charge fees in line with prevailing rates.

Sites' procedures for establishing and updating fees vary widely

Procedures for developing and updating fee schedules ranged from telephone surveys of local providers to adopting the maximum amounts reimbursed by a State Medicaid program. Nine of 11 sites we visited used what they considered to be prevailing rates as the basis for either developing or updating their fee schedules. At one site, an official said that, because HHS had not provided any guidance on how to determine prevailing rates, sites were attempting to establish fees based on prevailing rates, but their approaches varied considerably.

A synopsis of each site's fee-setting procedures follows.

1. Consulted with physicians in a town 45 miles away to determine rates charged; set fees at 95 percent of the surveyed rates to reflect the lower cost of living. The latest updates were in May 1980 and June 1979.

2. Has not updated its fees since 1978.

3. Latest update was effective October 1980. It was based on a survey of perceived similar practices throughout the State.

4. Informally surveyed physicians in two towns within a 27-mile radius of the clinic. The latest updates were in October 1980 and January 1979.

5. Surveyed private physicians in the county to determine their rates. This clinic adjusted its fees on an as-needed basis with the last update effective May 1979. Dental fees were based on rates used in two urban areas outside the target area during 1978. The rates will be updated as needed.

6. Telephoned area providers for rates prevailing in the area. Fees are supposedly updated as needed. The latest adjustment was effective October 1979.

7. Medical fees were believed to be based on area prevailing rates. These rates were updated on an as-needed basis with the last update effective during 1979. Dental fees were based on a 1978 certified public accountant's survey of dental rates prevailing in the State. These fees were updated in June 1980.

8. Developed a cost-based fee schedule in 1976. Since that time medical fees were updated in 1978 and again in June 1980 using prevailing rates. Dental fees were updated in February 1980 using prevailing rates.

9. Initially used a fee schedule developed specifically for a proposed Rural Health Initiative. The fees have been updated annually using copies of prevailing rates published by the State Medicare carrier and telephone surveys of rates charged by private physicians in the area.

10. Used the lowest of cost, prevailing rates, Medicare, and Medicaid profiles in establishing its rates. The basis for developing its fees is unknown, and there were no documented updates.

11. Used dental rates set by a State Medicaid program. Fees were updated in April 1980 and in 1979.

Fees charged by NHSC sites may be low

Studies by other organizations, as well as our work, suggest that some sites charge fees for health services that are lower than prevailing rates.

A June 1979 report prepared by GEOMET, Incorporated, concluded that for selected NHSC sites the full cost of providing services was 52 percent higher than the reimbursement received, on the average, from third-party payors. The report attributed the difference

primarily to the sites' policies of pricing their services below cost and below prevailing rates in the area.

In its January 1980 report, the House Appropriations Committee's Surveys and Investigations staff stated that project fees were generally less than those charged by private physicians in the immediate area. A comparison of fee charges by 12 of the sites visited by the staff showed that fees were lower in 7 cases, higher in 2 cases, and the same in 3 cases. In responding to the January 1980 report, HHS said that it planned to reiterate the need for cost-related fee schedules; however, HHS did not explain how it would ensure that sites' fees were consistent with prevailing rates.

Although we did not make a detailed comparison between fees charged by NHSC sites and prevailing rates, our work at NHSC sites generally supported the above observations. Officials at 5 of the 11 sites we visited believed their fees were lower than rates prevailing in the area. Fees for two of those five sites were estimated by these officials to be 25 percent lower than prevailing fees.

Also, many of the sites we visited were not regularly updating their fee schedules. Only 4 of the 11 sites were updating them annually as they had agreed to do in the memorandum of agreement. The fee schedules at five sites were between 1 and 2 years old; the other two sites' fee schedules were more than 2 years old. The executive director of one of the latter sites said that he had unsuccessfully attempted to update the fee schedule several times. He said the board of directors refused to update the fees because the clinic was federally supported.

Actions being taken by HHS

The BHPDS Director believed many NHSC sites may be charging medical and dental fees that are lower than prevailing rates because (1) NHSC officials have not stressed that sites should charge prevailing rates and (2) regional office personnel have not had a method by which they could ensure that sites charge prevailing rates.

To remedy the situation, the Director was developing policies and procedures to be used by sites in establishing fees based on prevailing rates and by regional offices in monitoring sites' fee schedules. As a first step, HHS' Office of General Counsel has been requested to determine what mechanisms HHS can use to ensure that sites charge prevailing rates. The Director said that this determination was necessary, in his view, to avoid establishing mechanisms that might conflict with Federal legislation relating to price fixing.

PROFESSIONAL COURTESY

Nine of the 11 sites we visited granted professional courtesy--in varying degrees--to physicians and dentists, members of sites' boards of directors, staff, local rescue squad members, and in some cases, the families of such individuals.

Nature and extent of professional courtesy at sites

Professional courtesy is the practice of providing free medical and dental care to local health professionals and others. Neither the NHSC legislation, Federal regulations, nor the memorandums of agreement specifically address whether professional courtesy should be granted by federally operated or subsidized NHSC sites. As discussed earlier, legislation does require sites to charge individuals and third parties a fee for services according to their ability to pay.

According to two project directors, granting professional courtesy to employees is a common practice in the medical profession. One director said that he would have to raise salaries to remain a competitive employer if this practice were discontinued. The other director told us that professional courtesy is extended to board members, who are also users of clinic services, to alleviate the financial impact of board decisions. These members of the board are often reluctant to make decisions, such as raising fees, which adversely affect their use of clinic services. Thus, granting professional courtesy to board members removes their resistance to efforts to improve clinic operations.

The following is a synopsis of the professional courtesy practices at the 11 sites we visited.

1. Provided free physician services to local physicians and dentists, employees and their immediate family, rescue squad volunteers, and other patients at the physician's discretion.

2. Provided free physician services to all other physicians practicing in the area and their immediate families and to site physicians, staff, and their immediate families.

3. Provided physician and dentist services at no cost to clinic employees and their families and to the board of directors and their families. At the time of our site work, the practice had 81 employees and 18 board members.

4. Provided physician services at no cost to site employees and to physicians practicing in the area. Only one physician practiced in the immediate area, and according

to the receptionist/bookkeeper, this physician had received care at the site only once in the past 3 years.

5. Provided free teeth cleaning services to staff members.

6. Provided free medical and dental care to staff members, including NHSC personnel and their immediate families.

7. Provided free medical and dental services to NHSC providers' immediate families. Staff members could receive free medical care, but their families were charged half-price. Dental staff members could receive routine fillings and cleaning services free.

8. Provided free medical and dental services to employees, board members, and their families.

9. Provided free medical services to the board of directors and staff, but they were required to pay for other things, such as lab work and X-rays. Other county doctors and dentists received a 50-percent discount on medical services only.

10. Did not provide free services to the board of directors, staff, or other health professionals; however, they had to pay only a nominal fee.

11. Did not practice professional courtesy.

Only one of the sites we visited (# 3 above) maintained records to show the value of services granted under the professional courtesy practice. That site's records showed that during the 1-year period ended July 31, 1980, it provided professional courtesy medical and dental services valued at $36,823 to its employees.

In February 1981, the BHPDS Director told us that the NHSC program does not encourage professional courtesy, but does not have written policy addressing the practice. He also told us that employees may receive health services at a reduced rate or no cost if the site's personnel policies include health care as a fringe benefit. The Director said that providing free services to other groups, such as community board members and their families and rescue squads, is not appropriate.

DELINQUENT ACCOUNT COLLECTION EFFORTS

Federal leglislation (Public Law 94-484, sec. 334(a)(1 and 2), regulations (42 CFR Part 23.9), and HHS policy require sites to make every reasonable effort to collect fees from individuals and third-party payors. However, HHS does not have a policy on how sites should pursue collections from patients with delinquent

accounts. The BHPDS Director told us that, although NHSC does not have a delinquent account collection policy, he believes that the courts and collection agencies are viable options for sites to use.

Only 3 of the 11 sites we visited used or planned to use collection agencies or courts to collect delinquent accounts. One site began turning delinquent accounts over to a local attorney for collection in February 1980. The attorney receives a fee for each case taken to court and one-third of amounts collected after a court judgment. The attorney also receives 25 percent of accounts settled out of court. Since February 1980, the site has turned over almost 300 delinquent accounts totaling about $5,500. As of September 1980, the attorney had recovered about $765 after deducting legal fees. The attorney informed us that ultimately he expected to collect 60 to 70 percent of the outstanding delinquent accounts.

Another site had taken preliminary steps to sue individuals to collect on delinquent accounts. The site had developed a list of individuals having delinquent accounts, notified the individuals of the site's intention to take them to court within 30 days, and scheduled a court appearance to obtain judgments against individuals who failed to respond to the notification.

At the third site, the executive director told us that the board of directors had recently strengthened collection policies. He said that the site expected to obtain court judgments totaling about $64,900 in delinquent accounts. He projected a collection rate of 40 percent of the total, or about $25,900. He also believed the board's actions would increase the general collections rate by 5 percent during the coming year.

As a result of the limited efforts to collect delinquent accounts, many uncollected patient accounts and bad debt writeoffs existed at the sites we visited. As shown in the following table using HHS data the 11 sites had a total of $374,193 in unpaid accounts on June 30, 1980, and wrote off $161,320 in bad debts from July 1979 through June 1980.

Site number	Unpaid patient accounts as of June 30, 1980	Bad debt writeoffs July 1979 to June 1980
1	$ 11,959	$ 900
2	17,659	2,230
3	182,890	24,047
4	9,225	622
5	14,670	17,871
6	57,350	(b)
7	a/32,892	(b)
8	4,750	114,883
9	a/30,044	682
10	a/12,754	0
11	0	85
	$374,193	$161,320

a/These sites combined their unpaid patient accounts and amounts due from third parties.

b/Site was involved in annual audit at time of our visit and had not computed amount of bad debts to be written off.

The BHPDS Director told us that one step being taken to decrease the delinquent accounts is to establish a policy on whether persons having delinquent accounts should be allowed to receive nonemergency medical care. He said that under this policy NHSC sites may be able to deny nonessential care to patients with delinquent accounts. The Director advised us, however, that denial of service could be made only after (1) the individual's circumstances had been carefully reviewed, (2) the individual had received at least two notices of overdue payments, and (3) the individual had been given at least 60 days after the second notice to make payment. Also, care may be denied only after a staff physician determines that it is not essential. The Director said that, after these conditions had been met, sites should use collection agencies and charge interest.

CHAPTER 4

OBJECTIVES, SCOPE, AND METHODOLOGY

The objectives of our review were to (1) identify and evaluate HHS' policies and practices regarding reimbursement by sites to the Treasury for the cost of NHSC personnel assigned there, (2) analyze the amount, extent, and basis of charges by sites to individuals or third-party payors for health services, and (3) evaluate the process for waiving the sites' reimbursement requirements.

Our review was made at HHS' Public Health Service in Rockville, Maryland; at HHS' regional offices in Philadelphia (Region III), Atlanta (Region IV), and Dallas (Region VI); and at 11 NHSC sites in seven States within those regions. We selected these three regions because, as a group, they contained 50 percent of all NHSC sites as of January 1, 1981, and were responsible for about 47 percent of NHSC personnel in 1980.

At HHS, we interviewed program officials and examined records relating to all phases of the reimbursement process. Individuals contacted were primarily within the Bureau of Community Health Services, where NHSC was positioned until November 1980, and included officials of NHSC, for overall policy information; the division of monitoring and analysis, where statistical data from the sites is compiled and initial billing information is developed; and the division of health services financing, which has responsibility for determining if billing adjustments and waivers were adequately supported and recommending appropriate action to NHSC. We also talked with the office of fiscal services, Health Services Administration, which handled the official billing and collection process. In addition, we talked with the Public Health Service claims division to determine the disposition of certain accounts receivable.

At the regional offices, we contacted officials and reviewed records in (1) NHSC, for overall policy and for monitoring the freestanding sites, (2) the primary care branch, which has responsibility for monitoring the grant-supported sites from a clinical standpoint, (3) the office of grants management, which has responsibility for monitoring grant-supported sites from a financial management standpoint, and (4) the planning and analysis office, which reviews sites' statistical data on both productivity and finances.

At the 11 NHSC sites we visited, we met with officials (including project directors, finance officers, office managers, billing and collection clerks, insurance clerks, and health professionals) and reviewed records relating to the sites' fee-setting practices, billings, collections from patients and third parties, and reimbursements to NHSC. We randomly selected sites from those that most closely fit the following criteria:

--A mix of both freestanding and grant supported in each region.

--In operation for about 2 years to allow the sites time to build up a clientele.

--A mix of predominantly medical with some dental sites.

--A mix of sites that were reimbursing NHSC and some that were not.

--A split between rural and urban.

--Coverage of sites in different States.

We recognize that 11 sites represent a small percentage of the 969 total NHSC sites nationwide, and no systemwide projections are made from the data developed at the sites. It should be noted, however, that the regional offices responsible for implementing HHS' policies and practices at these 11 sites were also responsible for about 50 percent of all NHSC sites.

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