UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D C 20548

CIVIL DIVISION

June 28, 1971

Dear Mr. Ball:

During a recent survey of Medicare payments involving hospital-based physicians in Illinois, we noted a situation where one hospital received, and two others may have received, excessive part B reimbursements or "windfalls" which were not adjusted by the intermediary.

We are bringing this matter to your attention so that appropriate adjustments may be made for the three hospitals.

Although we believe that the situation being questioned by us is covered under existing Medicare reimbursement regulations, we are also bringing this matter to your attention so that this type of situation may be considered in connection with the instructions--which we understand the Social Security Administration is developing--to provide for the retroactive adjustment of amounts incorrectly reimbursed to hospitals and other providers for the charges of provider-based physicians under the supplementary medical insurance (part B) portion of Medicare.

The excessive reimbursements involved a situation where the hospital-based physician, using the hospital as his billing agent, billed the part B carrier for his services to Medicare patients at the hospital and had a lease agreement with the hospital whereby the hospital retained a fixed percentage of the total charges to cover certain indirect operaing costs; the portion of the physician's charges retained by the hospital exceeded the hospital's related costs. The intermediary did not take such revenues and costs into account when making final settlements with the hospital for the cost of services under the hospital insurance (part A) portion of the Medicare program.

092615

715003

The Medicare reimbursement principle dealing with payments for the services of hospital-based physicians under these circumstances (20 CFR 405.486b) provides in part that:

> "***Where the physician bills the patient directly, costs of operating the hospital department which are borne by the physician will be reflected in his reasonable charges which are compensable under the supplementary medical insurance program; the hospital will receive reimbursement through the hospital insurance program for those costs, if any, which it incurs.
>
> Where, however, a hospital initially pays some or all of the operating expenses of a hospital department (e.g. pays the salaries of nonprofessional personnel and purchases supplies and equipment), even though subsequently those items and services for which it pays the operating expenses are furnished for the use of the physician in return for an agreed upon payment by the physician to the hospital, such operating costs are reimbursable under the hospital insurance program as hospital costs, and are not to be reflected in the reasonable charges of the physician. Any payments received by the hospital under such an arrangement shall be treated as a reduction of allowable costs of the hospital reimbursable through the hospital insurance program." (Underlining added.)

In our opinion, the Medicare Blue Cross intermediary for Illinois, Hospital Service Corporation, did not follow this principle in making recent final settlements with the DeKalb Public Hospital in DeKalb, Illinois. As a result, the hospital realized windfalls (revenues in excess of related costs), of about $9,800 and $11,100 from part B Medicare payments for the years ended April 30, 1969, and April 30, 1970, respectively. The basis for our estimates of the windfalls is shown in Appendix I.

HOSPITAL-PHYSICIAN LEASE AND COMPENSATION AGREEMENT

In May 1960, the Board of Directors of DeKalb Public Hospital entered into a 5-year agreement with a pathologist to direct its laboratory. The agreement, which included an automatic 5-year renewal clause, provided that the hospital was to furnish the pathologist with laboratory space, utilities, housekeeping services, and the use of existing equipment. The pathologist was to provide any necessary technical personnel and any new equipment and supplies.

The business manager of the hospital was designated as the pathologist's agent for the collection of laboratory fees which were to be distributed monthly on the basis of (1) 65 percent to the pathologist and (2) 35 percent to the hospital as its compensation for providing laboratory space, heat, utilities, maintenance and housekeeping services, and the use of hospital equipment; and for the billing and collection expenses.

Under this arrangement the hospital billed the Medicare part B carrier and the Medicare patients for (1) laboratory services from July 1, 1966, through October 31, 1970 and (2) the blood bank services from July 1, 1966 through September 30, 1969, and retained 35 percent of such billings.

In making final settlements with this hospital for the years ended April 30, 1969 and 1970, the intermediary did not take into account the amounts retained from the pathologist's billings and the related indirect costs and, as a result, the hospital realized substantial profits or windfalls. Two other Illinois hospitals (See Appendix II) may also have realized windfalls under similar lease agreements with the same pathologist.

INTERMEDIARY COMMENTS

We provided the Illinois Blue Cross intermediary with details of our findings and requested comments on the final settlements made with DeKalb Public Hospital. Officials of the intermediary advised that, under their interpretation of the Medicare regulations, it was proper to disregard the amounts retained from the pathologist's billings and the related costs in making final settlements. The intermediary officials apparently took this position because (1) the Medicare payments retained by the hospital for pathologist's services were made by the part B carrier on the basis of reasonable charges for physicians' services which were not the responsibility of the intermediary and (2) the regulation, as quoted above, gives examples of direct operating costs whereas the DeKalb Hospital costs related to the pathologist's charges were considered indirect costs.

In contrast, we noted that the Blue Cross intermediary for Indiana, in making final settlements with an Indiana hospital served by the same pathologist under a similar lease and compensation agreement, interpreted section 405.486b to require that the amounts retained by the hospital from the pathologist's billings be deducted from the allowable costs reimbursable under the hospital insurance program. This hospital and four additional Indiana hospitals served by this pathologist are also identified in Appendix II.

We recognize that there can be various interpretations of the language of the Medicare reimbursement regulations pertaining to hospital-based physicians. We believe, however, that the Illinois intermediary's position is inconsistent with the overriding principle established by the law and the regulations that hospitals will be reimbursed by Medicare for the reasonable costs incurred in providing services to Medicare patients.

CONCLUSIONS AND RECOMMENDATIONS

In view of the differing interpretations of section 405.486b of the Medicare reimbursement regulations by two Blue Cross intermediaries under similar circumstances, we recommend that SSA consider whether its proposed instructions to its intermediaries providing for the retroactive adjustment of amounts incorrectly reimbursed to hospitals for the professional fees of provider-based physicians should include reference to the type of situation discussed in this report.

We recommend also that SSA review the settlements made with the three Illinois hospitals identified in Appendixes I and II and require appropriate adjustments for any excessive Medicare reimbursements to the hospitals for pathologists' billings.

Copies of this report may be made available to the Blue Cross Association for its information and use. We would appreciate your comments on the matters discussed herein and advice as to any actions taken.

Copies of this report are being sent today to the Assistant Secretary, Comptroller, and the Director of the HEW Audit Agency.

Sincerely yours,

Fred D. Layton
Assistant Director

Mr. Robert M. Ball
Commissioner of Social Security
Department of Health, Education,
and Welfare

DE KALB PUBLIC HOSPITAL, DE KALB, ILLINOIS
ESTIMATED MEDICARE WINDFALL
FOR HOSPITAL YEAR ENDED APRIL 30, 1969

Pathology charges	Medicare patients	All patients
Laboratory - inpatient	$48,881	$152,016
- outpatient	-	1,827
- extended care facility	128	128
Blood bank - inpatient	3,105	8,865
- extended care facility	-	180
Total	$52,114	$163,016

Windfall computation	
Total charges	$163,016
Less, payments to pathologists (note a)	107,002
Hospital revenue	56,014
Less, indirect expenses deducted from hospital costs allowed under part A	15,402
Net hospital income not treated as a reduction of allowable costs	$40,612
Estimated windfall to hospital for Medicare patients @ 24% (note b)	$9,747

[a]Identified as direct expenses in the hospital's cost report; note that this amount slightly exceeds 65 percent of the total charges ($105,960) as the agreed percentage payment.

[b]This represents the percentage of ancillary costs apportioned to Medicare under the combination method of apportionment which the hospital had elected to use.

DE KALB PUBLIC HOSPITAL, DE KALB, ILLINOIS
ESTIMATED MEDICARE WINDFALL
FOR HOSPITAL YEAR ENDED APRIL 30, 1970

Pathology charges	Medicare patients	All patients
Laboratory - inpatient	$51,951	$183,482
- outpatient	-	2,802
Blood bank (note a)	2,563	5,737
Total	$54,514	$192,021

Windfall computation (note b)

Total charges	$192,021
Less, payments to pathologists (note c)	123,202
Hospital revenue	68,819
Less, indirect expenses deducted from hospital costs allowed under part A	17,757
Net hospital income not treated as a reduction of allowable costs	$51,062
Estimated windfall to hospital for Medicare patients @ 23% (note d)	$11,744
Less, underpayment to the hospital from exclusion of blood bank for 7-month period 10/1/69-4/30/70 in the hospital cost report and settlement	613
Estimated Medicare windfall to hospital	$11,131

[a]Portion applicable to the 5-month period 5/1/69 through 9/30/69 when direct billing applied.

[b]For laboratory full year and blood bank for 5 months.

[c]Identified as direct expenses in the cost report; note that this amount is slightly less than 65 percent of the total charges ($124,814) as the agreed percentage payment.

[d]This represents the percentage of ancillary costs apportioned to Medicare under the combination method of apportionment which the hospital had elected to use.

ADDITIONAL HOSPITALS IN ILLINOIS AND INDIANA WHERE DIRECT BILLING APPLIED FOR THE SAME PATHOLOGIST THAT SERVED THE DE KALB PUBLIC HOSPITAL

	Direct billing through
Illinois Hospitals	
Sycamore Municipal Hospital (14-0142)	Continues
Sandwich Community Hospital (14-0203)	12/31/70
Indiana Hospitals	
Garrett Community Hospital (15-0055) (note a)	
Marshall County Parkview Hospital (15-0076)	
Murphy Medical Center (15-0080)	
Pulaski Memorial Hospital (15-0095)	
Starke Memorial Hospital (15-0102)	

---

[a]For this hospital, the intermediary, Blue Cross Hospital Service, treated net income for the laboratory as rental income and deducted it from other allowable hospital costs in the hospital costs reports and final settlements for the two years ended September 30, 1967.