



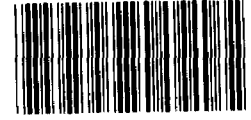
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UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

HUMAN RESOURCES
DIVISION

B-206363

FEBRUARY 18, 1982

The Honorable Richard S. Schweiker
The Secretary of Health and
Human Services



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Dear Mr. Secretary:

Subject: Medicare Equalization Factor Payments to Group
Practice Prepayment Plans Should Be Stopped
(HRD-82-39)

This letter is to advise you of our view that Medicare part B equalization factor payments to Group Practice Prepayment Plans (GPPPs), 1/ which represent payments in excess of incurred costs made supposedly for future capital needs, are not consistent with either the statutory definition of reasonable cost under section 1861(v) of the Social Security Act or Department of Health and Human Services (HHS) implementing regulations. We are bringing this to your attention because (1) over 6 years has elapsed since the Health Care Financing Administration (HCFA) was first advised of this matter by the HHS Office of General Counsel and (2) although a notice of proposed rulemaking to discontinue these payments was published in October 1980, there is no assurance that the payments will be terminated.

We met with HCFA officials on November 3, 1981, to discuss this matter and suggested that they expedite issuing the final regulations to terminate the subject payments. However, the draft regulations were still under review within HCFA as of January 26, 1982, although agency records indicate that implementing them would save an estimated \$9.4 million in fiscal year 1982. The regulations also conform other aspects of Medicare reasonable cost reimbursement for GPPPs to those for cost-based Health Maintenance Organizations (HMOs).

1/For Medicare purposes, a GPPP is an organization that has a formal arrangement with the equivalent of three or more full-time physicians to provide certain health services, generally not on a fee-for-service basis, to the plan's members. The members have contributed in advance toward the cost of the services through payments of premiums or dues (or such payments have been made on their behalf).

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SCOPE AND METHODOLOGY

Our review, which was made at HCFA headquarters in Baltimore, Maryland, was performed in accordance with the Comptroller General's current standards for audit of governmental organizations, programs, activities, and functions.

We analyzed relevant sections of the Social Security Act and HHS implementing regulations and interpretive rules. We also reviewed HHS data and records and spoke with HCFA officials responsible for administering Medicare part B payments to GPPPs and HMOs.

REIMBURSEMENT FOR MEDICARE
PART B SERVICES TO GPPPs ON
THE BASIS OF REASONABLE COST

GPPPs that serve Medicare beneficiaries can elect, pursuant to section 1833(a)(1)(A) of the Social Security Act (42 U.S.C. 13951(a)(1)(A)) to be reimbursed for medical services provided under Medicare part B on a reasonable cost, rather than a reasonable charge basis. ^{1/} Section 1861(v)(1)(A) of the act (42 U.S.C. 1395x(v)(1)(A)) explains the concept of "reasonable cost":

1/Section 1833 of the act provides:

"(a) Except as provided in section 1876 [42 U.S.C. 1395mm], and subject to the succeeding provisions of this section, there shall be paid from the Federal Supplementary Medical Insurance Trust Fund, in the case of each individual who is covered under the insurance program established by this part and incurs expenses for services with respect to which benefits are payable under this part, amounts equal to--

"(1) in the case of services described in section 1832(a)(1) [42 U.S.C. 1395k(a)(1)] 80 percent of the reasonable charges for the services; except that (A) an organization which provides medical and other health services (or arranges for their availability) on a prepayment basis may elect to be paid 80 percent of the reasonable costs of services for which payment may be made under this part on behalf of individuals enrolled in such organization in lieu of 80 percent of the reasonable charges for such services if the organization undertakes to charge such individuals no more than 20 percent of such reasonable cost plus any amounts payable by them as a result of subsection (b) * * *. (Emphasis added.)

"The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services.
* * *" (Emphasis added.)

Pursuant to section 1861(v)(1)(A), HHS issued regulations elaborating on cost reimbursement principles. These regulations are included in 42 C.F.R. Part 405, Subpart D--Principles of Reimbursement for Provider Costs and for Services by Hospital-Based Physicians. Subpart D states that, except for governmental institutions, providers receiving payment on the basis of reasonable cost must provide adequate cost data and such data are to be based on an approved method of cost allocation and on the accrual basis of accounting (42 C.F.R. 405.453(a)). The regulations further state that, under the accrual basis of accounting, "expenses are reported in the period in which they are incurred * * *" 42 C.F.R. 405.453(b)(2)). It is, therefore, clear that organizations reimbursed on a reasonable cost basis are, under the law and regulations, to be paid on the basis of incurred costs.

HHS has not issued regulations specifically implementing or defining what is meant by reasonable cost reimbursement for GPPPs under section 1833(a)(1)(A) of the act. Instead, reimbursement to GPPPs is based on administrative guidelines in HCFA's Health Insurance Manual 8 (HIM-8). However, GPPPs electing to be reimbursed on a reasonable cost basis are clearly covered by subpart D of the regulations, above. While a GPPP is not a "provider of services" as defined in the act (section 1861(u)) or by regulations applicable to subpart D, it is subject to these implementing regulations as if it were a provider of services once it elects to have payment made on a reasonable cost basis pursuant to 42 C.F.R. 405.241:

"* * * payment to a group practice prepayment plan which has furnished (or arranged for the availability of) items and services qualifying as medical and other health services, may be made on the basis of the reasonable cost of such services rather than on the basis of reasonable charges, even though such organization is other than a provider of services, if the group-practice prepayment plan elects to have payment made on a reasonable cost basis * * *." (Emphasis added.)

Consequently, we conclude that GPPPs electing to receive reimbursement for Part B services pursuant to section 1833(a)(1)(A) are subject to both the statutory definition of reasonable cost under section 1861(v) of the act and the cost reimbursement principles in subpart D of the regulations.

THE EQUALIZATION FACTOR PAYMENT

As previously mentioned, reimbursement to GPPPs is based on administrative guidelines contained in HIM-8. These guidelines (sections 402 and 403 of HIM-8) permit a GPPP that elects reimbursement under section 1833(a)(1)(A) of the act to be paid on the basis of either reasonable cost or "reasonable charges related to cost on a non-bill basis." GPPPs that elect reimbursement under section 1833(a)(1)(A) are generally reimbursed directly by HCFA. 1/

HCFA reimbursement to GPPPs on a "reasonable charge non-bill basis" differs from the methodology for GPPPs reimbursed on a reasonable cost basis only in that the equalization factor is added to the reimbursement and payments are not subject to retrospective adjustment. Section 403 of HIM-8 outlines, for Medicare purposes, "reasonable charge reimbursement on a non-bill basis." Section 403(A) permits, under this payment option, an "equalization" factor payment which, according to HCFA records, represents payments in excess of incurred costs made for future capital needs by GPPPs. The equalization factor represents not a cost actually incurred, but an allowance for a cost that may be incurred sometime in the future.

HCFA documents indicate that the decision to permit payment of an equalization factor under section 1833(a)(1)(A) was based on an administrative interpretation of the act (apparently section 1861(v)(1)(A)(i)); the charges for Medicare beneficiaries should be no less than those for other GPPP enrollees. In this regard, section 403 of HIM-8 states that

"* * * Non-Medicare members of the plan will no longer be required to subsidize the Medicare member for those amounts in excess of budgeted costs of providing medical care which the plan requires to operate effectively."

1/GPPPs that elect to be reimbursed on a reasonable charge basis pursuant to section 1833(a)(1) are assigned to the carrier for their geographic area and submit bills to that carrier.

The decision to allow an equalization factor payment was made in the early days of the Medicare program. However, in December 1975, the HHS Office of General Counsel informed the then Bureau of Health Insurance, during a review of regulations governing the reimbursement for HMOs, that it had difficulty supporting such payments--implying that the payments should not be made in view of the law's definition of reasonable cost to embrace only costs actually incurred:

"Even if the Department were willing to pay this equalization factor to providers as well as to cost-basis HMO's, we question whether such a payment is justifiable as an item of reasonable cost. The very use of the term 'equalization factor' casts significant doubt on whether there is authority to pay what you propose to pay for. The preamble recognizes that one purpose of this factor is to place Medicare payment on a par with what non-Medicare enrollees pay. The term 'reasonable costs' clearly indicates that we will pay costs, and whatever additional amounts other people pay is irrelevant to any form of reasonable cost reimbursement. Furthermore, we see difficulty in justifying making provision for capital financing as an incurred cost, as would be required under section 1861(v) of the Act."

As a result, an equalization factor payment was not recognized as an allowable cost in November 1976, when HHS issued regulations governing the principles of reimbursement for HMOs. At that time, HHS said it intended to publish regulations conforming, to the extent possible, Medicare reimbursement for GPPPs reimbursed under section 1833(a)(1)(A) of the act to those for cost-based HMOs.

Officials of HCFA's Bureau of Program Operations later prepared a proposed revision to section 403(A) of the GPPP Manual eliminating the "equalization" factor payment. HCFA reportedly obtained the informal views of the HHS Office of General Counsel, which recommended that the equalization payment be eliminated through regulations, because of potential difficulties in defending removal of these payments through a manual revision if HHS were later sued. Thus, the proposed revision to section 403(A) of HIM-8 eliminating the equalization factor payment was withdrawn in October 1978. HCFA's Division of Provider and Medical Services Policy was then preparing a notice of proposed rulemaking on Health Care Prepayment Plans (the new nomenclature for GPPPs) which, for the first time, would set forth in regulations principles of reimbursement for GPPPs.

HCFA issued its notice of proposed rulemaking on Health Care Prepayment Plans on October 31, 1980. The proposed regulations do not provide for the payment of an equalization factor since

"* * * future capital needs are not recognized in the definition of reasonable cost. (Section 1861(v)(1)(A) of the Act limits reasonable cost to costs 'actually incurred' in the efficient delivery of needed health services such as those defined in 42 C.F.R. Part 405, Subpart D.)"

Medicare payments attributable to the equalization factor amounted to an estimated \$3.6 million in calendar year 1981, and may reach \$4 million in 1982. GPPPs currently receiving such payments are the:

--Ross Loos Medical Group (in Los Angeles, California).

--Group Health Plan, Inc. (in St. Paul, Minnesota).

--Kaiser Foundation Health Plans (in Los Angeles and Oakland, California; Denver, Colorado; Cleveland, Ohio; Portland, Oregon; and Honolulu, Hawaii).

It should be noted that implementing the Health Care Prepayment Plan regulations would not only terminate the equalization factor payments, but also result in additional Medicare program savings of several million dollars by conforming other aspects of Medicare reasonable cost reimbursement for GPPPs to those for cost-based HMOs.

On September 25 and November 3, 1981, HCFA officials told us that HCFA intended to submit the final Health Care Prepayment Plan regulations to HHS for review by the end of November 1981. However, HCFA officials could not tell us when, or even if, the final regulations would be published since they are subject to review and approval within HCFA and by HHS and the Office of Management and Budget.

During our November 1981 meeting, we suggested to HCFA officials in the Bureau of Program Policy that the agency expedite the review, processing, and issuance of these regulations in order to terminate such payments by the end of calendar year 1981. On November 24, 1981, we were told that HCFA placed a priority on processing these regulations and established a goal for publication in late December with a January 1, 1982, effective date. As of January 26, 1982, however, these regulations were still being reviewed by HCFA.

CONCLUSION

Equalization factor payments made to GPPPs that receive Medicare reimbursement pursuant to section 1833(a)(1)(A) of the Social Security Act are not consistent with either the statutory definition of reasonable cost under section 1861(v) of the act or implementing regulations. Over 6 years has elapsed since HCFA was first advised of this matter.

RECOMMENDATION

Because the equalization factor payments to GPPPs are not permitted by Medicare law and regulation, we recommend that you act to terminate such payments immediately.

As you know, section 236 of the Legislative Reorganization Act of 1970 requires the head of a Federal agency to submit a written statement on actions taken on our recommendations to the House Committee on Government Operations and the Senate Committee on Governmental Affairs not later than 60 days after the date of the report and to the House and Senate Committees on Appropriations with the agency's first request for appropriations made more than 60 days after the date of the report.

Copies of this letter are being sent to appropriate congressional committees and the Director, Office of Management and Budget.

Sincerely yours,


Gregory J. Ahart
Director