REPORT TO THE CONGRESS

Problems Associated With Reimbursements To Hospitals For Services Furnished Under Medicare B-164031(4)

Social Security Administration

Department of Health, Education, and Welfare

BY THE COMPTROLLER GENERAL OF THE UNITED STATES

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COMPTROLLER GENERAL OF THE UNITED STATES
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To the President of the Senate and the
Speaker of the House of Representatives

This is our report on problems associated with reimbursements to hospitals for services furnished under Medicare. The Medicare program is administered by the Social Security Administration, Department of Health, Education, and Welfare.

Our review was made pursuant to the Budget and Accounting Act, 1921 (31 U.S.C. 53), and the Accounting and Auditing Act of 1950 (31 U.S.C. 67).

Copies of this report are being sent to the Director, Office of Management and Budget, and to the Secretary of Health, Education, and Welfare.

Elmer B. Staats

Comptroller General
of the United States

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ABBREVIATIONS

AHA	American Hospital Association
BCA	Blue Cross Association
GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare
SSA	Social Security Administration

CHAPTER 1

INTRODUCTION

The Medicare program was established by the Social Security Amendments of 1965 (42 U.S.C. 1395) enacted on July 30, 1965. This program, which became effective on July 1, 1966, provides two basic forms of protection against the costs of health care for eligible persons aged 65 and over.

One form of protection, designated as Hospital Insurance Benefits for the Aged (part A), covers inpatient hospital services and post-hospital care in extended-care facilities and in the patients' home. Part A benefits are financed by special social security taxes collected from employees, employers, and self-employed persons. Over 20 million people have part A coverage. During fiscal years 1967 through 1971, benefit payments under part A amounted to about $21.1 billion, of which about $19.5 billion was for inpatient hospital services.

Under part A, the beneficiary is responsible for paying $68 for the first 60 days of inpatient hospital services (the deductible), coinsurance of $17 a day for the 61st through the 90th days, and $34 a day for the 91st through the 150th days if he elects to use his 60-day lifetime reserve of hospital benefits.

A second form of protection, designated as Supplementary Medical Insurance Benefits for the Aged (part B), is a voluntary program and covers (1) physicians' services, including physicians employed by or compensated through hospitals, and (2) a number of other medical and health benefits, including outpatient hospital services and certain home health care. Part B is financed by premiums collected from each eligible beneficiary electing to be covered by the program and by matching amounts appropriated from the general revenues of the Federal Government. Over 19 million people have part B coverage. During fiscal years 1967 through 1971, benefit payments under part B amounted to about $7.7 billion, of which about 90 percent was for physicians' services.

Under part B, usually the beneficiary is responsible for paying the first $50 for covered medical services in each year (the deductible) and Medicare pays 80 percent of the reasonable charges for covered services in excess of $50 in each year with the beneficiary responsible for the remaining 20 percent (coinsurance).

USE OF INTERMEDIARIES AND CARRIERS

To help administer Medicare benefits, the Congress authorized the Secretary of the Department of Health, Education, and Welfare (HEW), to contract with public agencies or private organizations to pay physicians, hospitals, and other institutions for services provided to eligible beneficiaries.

Intermediaries

The organizations that usually make payments to hospitals and other institutional providers of medical services under parts A and B are called fiscal intermediaries.

These fiscal intermediaries, nominated by the providers, are responsible for

--paying the providers, at least monthly, on an estimated-cost basis for covered services furnished to Medicare beneficiaries,

--consulting with providers to develop accounting procedures which will insure that the hospitals receive equitable payment under the Medicare program,

--communicating to providers information or instructions furnished by the Secretary of HEW and serving as a channel of communication from the provider to the Secretary,

--making the necessary audits of the records of the providers to insure proper payment, and

--making final annual determinations, usually on the basis of audits, of the amounts of payments to be made.

Intermediaries are reimbursed by the Social Security Administration (SSA) for administrative costs incurred in performing these various functions. During fiscal years 1967 through 1971, the intermediaries' administrative costs to Medicare amounted to about $363 million, of which about 27 percent was for auditing the records of hospitals and other institutional providers of service.

The principal Medicare fiscal intermediary is the Blue Cross Association (BCA), which has subcontracted most of its intermediary functions to 74 individual Blue Cross plans throughout the United States. At December 31, 1971, BCA was the intermediary for about 91 percent of about 6,750 hospitals participating in the Medicare program. Other participating hospitals deal directly with SSA or with nine other intermediaries.

Carriers

The organizations under contract to HEW to make benefit payments for physicians' services are called carriers. Such payments are generally made to the patient or to the physician under the patient's assignment of his right to reimbursement. Under certain circumstances, which are discussed in more detail in chapter 3, carriers can make Medicare payments directly to hospitals for services furnished by physicians to individual patients when the physicians are employed by or compensated through the hospital.

SSA selected the carriers and at December 31, 1971, had contracts with 47 carriers to make physician payments in specific geographical areas of the country.[1] These carriers included 32 Blue Shield organizations, 14 private insurance companies, and one State agency. During fiscal years 1967 through 1971, the carriers' administrative costs for Medicare amounted to about $576 million.

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[1]The Travelers Insurance Company, operating under a contract with the Railroad Retirement Board, acts as the nationwide part B carrier for railroad-related beneficiaries and, accordingly, administers a small portion of the part B Medicare program in the same geographical areas covered by the SSA carriers.

METHODS OF PAYMENTS TO HOSPITALS

Under Medicare, payments to hospitals for inpatient services and for outpatient services are to be made on the basis of the reasonable costs of such services. The act authorizes the Secretary of HEW to prescribe regulations establishing the method or methods to be used in determining reasonable costs and states that such regulations should provide for making suitable retroactive corrective adjustment when, for any accounting period, the aggregate reimbursement to a hospital proved to be either inadequate or excessive.

In implementing these requirements, HEW issued regulations which established the principles and procedures to be used by hospitals and fiscal intermediaries in determining reasonable costs. HEW intended that these principles and procedures recognize all necessary and proper costs incurred by hospitals in furnishing services to Medicare patients and exclude any costs of providing care to non-Medicare patients.

Hospitals are paid on the basis of their estimated costs during the year. These "interim payments" are intended to approximate, as nearly as possible, the actual costs in order to minimize the amounts of the retroactive adjustments at final settlement.

The principal document used in the settlement process is the Medicare cost report submitted by a hospital. This report form was developed by SSA in consultation with hospital and intermediary groups and was designed to show what portion of a hospital's total allowable cost was applicable to covered services provided to Medicare beneficiaries.

To facilitate the settlement process, SSA instructions require hospitals to submit these annual cost reports covering 12-month periods of operations to the intermediaries. During the first year of the program--the first reporting period--the hospitals could submit reports covering the period July 1, 1966, to the end of their accounting years, if such reports covered at least 6 months.

A hospital could select any 12-month period for Medicare cost-reporting purposes. SSA instructions originally required cost reports to be submitted to the intermediary

within 90 days[1] after the end of the hospital's reporting period.

Under part B of Medicare, payments for physicians' services to individual Medicare patients are generally made on the basis of "reasonable charges." Depending on the method of billing a hospital elects, Medicare payments to hospitals for physicians' services may be made either by the intermediary--in the case of radiology and pathology services--or by the carrier. As discussed in chapter 3, when the intermediary paid for such services, the payments were included with the interim payments for other services made by the intermediary and were subject to the settlement process. When the carrier paid the hospitals for physicians' services under part B, however, these payments were not included in the settlement process.

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[1]In August 1970, SSA extended the due dates for the submission of cost reports to 120 days after the close of the hospitals' reporting periods for those hospitals electing to submit cost reports certified as accurate by their independent auditors.

PREPARATION OF COST REPORTS

Although HEW regulations offered the hospitals several alternatives in arriving at the amounts to be claimed for reimbursement, the preparation of a cost report essentially consists of four steps, as follows:

--Determination of allowable costs. Direct and indirect costs which are reasonable and necessary for providing patient care are allowable for Medicare reimbursement purposes. Certain specific costs, however, are unallowable, such as (1) bad debts applicable to non-Medicare patients, (2) fund-raising expenses, (3) costs of activities unrelated to patient care, such as research, cafeterias, and gift shops, and (4) costs of personal convenience items, such as telephone, radio, and television services.

--Allocation of allowable costs to revenue-producing activities. After a hospital has determined its total allowable costs it must allocate these costs to activities or services for which it makes charges. This process, commonly referred to as cost finding, involves allocating the costs of non-revenue-producing activities or departments (e.g., administration, laundry, and housekeeping) to those activities or departments which produce revenue (e.g., operating rooms, pharmacies, laboratories, and routine daily services).

--Apportionment of allowable costs between Medicare and non-Medicare patients. When the hospital has allocated its allowable costs to its revenue-producing activities, it apportions these costs to the Medicare program on the basis of charges applicable to Medicare patients. For example, if 40 percent of the charges of a hospital's X-ray department was applicable to the X-ray services provided to Medicare beneficiaries, then 40 percent of the allowable costs allocated to the X-ray department would be apportioned to the Medicare program for reimbursement purposes. Although the HEW regulations have offered a number of alternatives for making such apportionments, the use of charges as the basis for apportioning costs

represents a principal feature of the Medicare reimbursement system.

--Consideration of amounts received or due from the patients and the intermediary. After the hospital has apportioned its allowable costs to the Medicare program, it must then consider the deductible and coinsurance amounts paid or payable by the Medicare patients and the interim payments received or due from the intermediary for the services provided to Medicare patients during the hospital's reporting period. The difference between the allowable costs and the sum of the payments received or due from the patients and the intermediary represents the amount of the final adjustment due to, or from, the Medicare program.

STATUS OF SETTLEMENTS WITH HOSPITALS

At December 31, 1971, the Medicare program had been in effect for 5-1/2 years, therefore, Medicare had completed five reporting periods. For the first reporting period under the program--hospitals with fiscal years ended on or before June 30, 1967--about 96 percent of the hospitals had made final settlement with the intermediaries or SSA. For the second reporting period about 89 percent had made final settlements, and for the third reporting period about 80 percent had made final settlements. Overall, there were about 2,500 unsettled hospital cost reports applicable to the first 3 years of the program.[1] For the fourth reporting period about 63 percent of the hosptials had made final settlements, and for the fifth reporting period about 28 percent had made final settlements.

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[1] In June 1971, GAO issued a report to the Congress entitled "Lengthy Delays in Settling the Costs of Health Services Furnished Under Medicare" (B-164031(4)), which discussed the causes of the delays in every step of the settlement process, from the preparation of cost reports by hospitals through the audit of cost reports by intermediaries to the final settlement or agreement with the hospitals concerning their actual and reasonable Medicare costs to be reimbursed.

PRIOR REPORTS TO HEW ON QUESTIONABLE REIMBURSEMENTS

As part of our reviews of the activities of intermediaries under their contracts with HEW, we examined in detail the audits and, where applicable, the settlements of Medicare cost reports at 14 hospitals in five States. The reviews involved five Blue Cross Plans--intermediaries operating under subcontracts with BCA--servicing about 880 hospitals in Georgia, Massachusetts, New York, Ohio, and Texas.

The intermediaries' audits and related settlements pertained to the first, second, or third reporting periods under Medicare. The cost reports at 11 hospitals were audited, and settlements were made by the intermediaries in 1968, 1969, and 1970. The cost reports for the other three hospitals had been audited but not settled at the time of our fieldwork.

In total, about $20 million in Medicare costs were claimed by the 14 hospitals for the reporting periods involved and costs of about $19.8 million were allowed by the intermediaries as a result of their audits.

We questioned whether net payments of $447,000 to 12 of the hospitals, as allowed by the intermediaries' audits, should have been made by the Medicare program. The problems leading to these questionable payments are detailed in chapter 2. We questioned also the charges to Medicare for the services of hospital-based physicians at five of the 14 hospitals which, we estimate, were about $175,300 in excess of the hospitals' reimbursable costs for such services. These questionable payments are discussed in chapter 3.

Our findings relating to the 14 hospitals were communicated to HEW, the intermediaries, and the hospitals at various times between November 1969 and March 1971 with our recommendations that the cost reports be adjusted, where appropriate, and the resulting overpayments be recovered.

We considered the replies of SSA and the intermediaries in preparing this overall report. In general, SSA either concurred in our recommendations or stated that it would examine further into the payments questioned by us.

CHAPTER 2

DETERMINING ALLOWABLE MEDICARE COSTS REIMBURSABLE BY INTERMEDIARIES

Our examination of the intermediaries' audits and, where applicable, the related settlements at 14 hospitals for the cost of services furnished to Medicare patients indicated that the intermediaries had made net overpayments to 12 hospitals of about $447,000 The net overpayments resulted from total overcharges of about $560,600 by the 12 hospitals and total undercharges of about $113,600 by eight of the 12 hospitals These erroneous charges resulted primarily because.

--Certain costs were charged to the Medicare program which were not allowed by the Medicare law and/or related HEW regulations.

--Although required by HEW regulations and instructions, nonpatient revenues and other moneys received by the hospitals were not offset against allowable costs.

--The hospitals did not claim reimbursement for all their allowable costs.

--The hospitals overallocated or underallocated costs of certain activities to those hospital services for which Medicare pays a greater share of costs.

--Data used in computing Medicare's share of hospital costs and/or settlements was incomplete or contained errors.

Also about 30 percent of the Medicare program's bad debts tested by us at 19 hospitals (including six of the 14 reviewed in detail) in three States should have been paid by the States under their Medicaid or Old Age Assistance programs rather than by Medicare

We recognize that, because of budget and staffing limitations, it may not have been practicable for the

intermediaries to have explored certain cost-reimbursement matters to the same extent as was done in our reviews at selected hospitals Our reviews were made in considerable detail to identify problems which would require the particular attention of SSA and the intermediaries to insure that Medicare payments were being made in accordance with the law and regulations.

Because our reviews were directed to the larger hospitals (i e , hospitals with 100 or more beds), the reimbursement problems identified might not be representative for all hospitals participating in Medicare. Hospitals with 100 or more beds represent less than half the number of hospitals participating in Medicare, but they accounted for about 80 percent of the $4 5 billion in Medicare payments made to hospitals in fiscal year 1970 Therefore, we believe that the reimbursement problems discussed in this report could have a significant effect on the overall Medicare program.

In reimbursing hospitals it is important, we believe, that intermediaries neither overpay nor underpay these institutions To aid in achieving this objective we have summarized below the problems which, we believe, warrant particular attention in the Medicare audit and settlement processes

INTERMEDIARY PAYMENTS TO HOSPITALS INCLUDED NONALLOWABLE COSTS

Ten hospitals charged Medicare about $238,540 for certain hospital costs not allowable under the Medicare law and/or related HEW regulations.

Hospitals may provide or arrange for services not covered under the hospital insurance (part A) portion of Medicare. Included are (1) physicians' services to individual patients, which are covered under part B, and (2) private-duty nurses and such personal convenience items as television and telephone services, which are not covered at all. Also hospitals may engage in research and educational or commercial activities not directly related to the care of Medicare patients and, therefore, not chargeable to the program.

The allowability of hospital costs under the Medicare law and HEW regulations can involve differences of interpretations. In our opinion, the overcharges resulted principally because the hospitals experienced difficulties in identifying the costs of services and activities not covered under the program and because the intermediaries had not developed sufficient information during their audits so that they or SSA could have made informed judgments as to the allowability of such costs.

Examples of our findings illustrating this problem are discussed below.

Costs of unidentified research

At one hospital the intermediary allowed physicians' salaries of $286,100 which the hospital had allocated to research on the basis of physicians' time reports. Medicare's share of the cost was about $84,500.

The reports of the House Committee on Ways and Means and of the Senate Committee on Finance which accompanied the bill that became the Medicare law stated that a hospital's expenses for medical research, over and above the costs closely related to normal patient care, would not be paid by Medicare because available research funds were generally ample to support important basic research. Therefore, HEW's

reimbursement regulations do not allow hospitals to charge Medicare for research costs, over and above usual patient care. SSA instructions describe usual patient care as those items and services (routine and ancillary) ordinarily provided by hospitals in the treatment of patients under the supervision of physicians.

SSA instructions provide that costs of research involving Medicare patients may be allowed only if records are maintained identifying patients in the research projects, patient charges, and other statistical data necessary for allocating and apportioning the costs. The hospital had not kept such records

The intermediary had allowed the hospital's allocation of the physicians' salaries to research as a reimbursable part A cost because the hospital had maintained that the time charged by physicians to research should have been charged to other activities, such as administration, which were allowable costs under part A of Medicare.

The HEW Audit Agency had completed an audit of HEW research and training grants at this hospital about 1 month before the intermediary started its Medicare audit. The intermediary, however, did not ask for the HEW audit report or working papers. The intermediary apparently was not aware that its conclusions in allowing the research charges were not consistent with those of the HEW Audit Agency.

These same allocations of the physicians' salaries had been given to the HEW auditors by the hospital and had been used by them in evaluating the reasonableness of the hospital's charges of indirect costs to the HEW research and training grants. On the basis of their evaluation, the HEW auditors considered that the $286,100 in physicians' salaries represented the costs of hospital-supported direct research and concluded that it was not reimbursable under the HEW grants.

Private-duty nursing

The Medicare legislation provides that the hospital insurance (part A) portion of the program cover inpatient costs related to patient care; however, certain patient-care costs,

such as private rooms which are not medically necessary and private-duty nursing, are not covered by the program. One hospital was overpaid $74,400 because the intermediary allowed the hospital that portion of its cost of furnishing private-duty nursing which had not been recovered from patients.

According to hospital officials, the hospital obtained special-duty nurses from local nurse registries to care for critically ill patients when their attending physicians considered such care to be medically necessary. The officials stated that these nurses were not part of the regular hospital staff but were obtained on an as-needed basis by the hospital for specific patients and were considered to be a necessary supplement to the full-time staff.

The hospital initially did not consider these nursing services to be covered by Medicare and billed the patients for the services.[1] The intermediary's auditors, however, were of the opinion that the costs should be allowed because the nurses were hired by the hospital, and SSA instructions defined a private-duty nurse as one hired by the patient or his family.

The local Blue Cross plan requested a ruling from BCA. The plan's request, however, contained erroneous information in stating that no additional charges had been made to patients for the private-nursing care. On the basis of incorrect information in the request, BCA's opinion was that the costs of these nursing services were allowable under Medicare. Therefore $360,200 of the hospital's unrecovered costs for private-duty nursing were included in allowable costs, resulting in a $74,400 increase in Medicare payments to the hospital.

At our request, an SSA official reviewed the details of the above case and informed us that the nursing services referred to came within the exclusion of private-duty nurses as stated in section 1861(b)(5) of the Social Security Act. He stated further that:

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[1]According to the hospital's agreement with HEW, it could not charge Medicare patients for covered services, except the deductible and coinsurance amounts.

"The general policy involved is that the exclusion relates to the services of nurses who are not employees of the institution and whose services do not, generally speaking, represent a cost to the institution. This principle applies in situations *** where the hospital arranges to get the services of a nurse for a particular patient, pays the nurse, and charges the patient for the service. The principle applies even where the hospital fails to recover the full amount it had to pay the nurse ***."

In explaining the rationale for the statutory exclusion of private-duty nursing from Medicare coverage, the SSA official pointed out that, if Medicare paid for private-duty nursing, physicians might find it difficult to resist pressures, from the patients and their families and from hospital and nursing administrators anxious to reduce their nursing workload, to authorize private-duty nursing care in cases where it was not medically necessary.

Physicians' services payable under part B of Medicare

At three hospitals, we noted problems in handling the exclusion from part A hospital costs of the portion of physicians' compensation applicable to services to individual patients. Such services to Medicare patients are covered under part B and, in some instances, have been billed to part B by the physicians or the hospitals. As a result, allowable part A costs were overstated by about $56,700.

One hospital charged part A for a portion of the salaries paid to certain staff physicians for services to individual patients. A hospital official stated that the hospital had made the charge to part A because it had not billed the part B carrier for the professional services provided by these physicians to Medicare patients. These costs were not disallowed during the intermediary's audit.

We learned, however, from a number of these staff physicians that, in addition to receiving salary payments for services to patients, they had billed part B of Medicare,

as well as other insurers and individuals, for their professional services to hospital patients. In accordance with our suggestion, the hospital and the intermediary agreed to eliminate these charges for physicians' services to patients from the costs charged under part A.

At another hospital, certain fringe benefit costs applicable to the part B services of its salaried staff radiologists were paid by the intermediary under part A. Under certain circumstances this treatment of fringe benefit costs is permitted by SSA instructions and, therefore, has not been questioned by the intermediary. We noted, however, that the hospital had previously included both the salaries and the fringe benefit costs in developing the part B charges for the radiologists' services (see p. 32) which, in effect, resulted in Medicare's paying twice for the same fringe benefit costs.

After we brought this situation to their attention, SSA and the intermediary agreed to inquire further into the Medicare reimbursements to the hospital, to insure that the payments made under both parts A and B of the program were correct.

HOSPITALS OVERCHARGED OR UNDERCHARGED FOR CERTAIN ALLOWABLE COSTS

At six hospitals Medicare was overcharged a total of $30,840, and at four hospitals Medicare was undercharged a total of $22,760 for certain costs that were allowable under the HEW reimbursement regulations. The overcharges resulted from problems in identifying the offsets against allowable costs for nonpatient revenues and other moneys received by hospitals, as required by HEW regulations and related instructions. The undercharges were apparently caused by oversights and computation errors by hospitals or intermediaries. These problems are summarized below.

Medicare current financing payments not considered in computing interest expenses

Three hospitals overcharged Medicare for the interest expenses on their current indebtedness. The interest expenses were overstated because Medicare current financing payments[1] to the hospitals were not considered as offsets in determining the allowable interest expenses claimed on working capital loans, although such consideration was required by SSA instructions.

Sinking fund income not deducted

Interest expense on a long-term bonded debt claimed by one hospital should have been offset by interest income earned by the bond's sinking fund. Because the interest income was not deducted in determining net allowable expense, Medicare was overcharged.

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[1] In addition to the basic procedure for intermediaries' paying hospitals on an estimated cost basis (interim payments), current financing is available to hospitals to cover the cost of hospital services from the time the hospital provides the service to the time the intermediary makes its interim payment--up to 30 days. SSA procedures require that interest expense on current indebtedness be adjusted to accomodate the effect of current financing payments.

Restricted donations were not deducted from allowable costs

HEW's Medicare regulations provide that grants, gifts, and income from endowment funds designated by a donor for paying specific operating costs should be deducted from the particular operating cost or group of costs claimed for reimbursement. HEW regulations give the following reason for this cost principle.

> "Donor-restricted funds which are designated for paying certain hospital operating expenses should apply and serve to reduce these costs or group of costs and benefit all patients who use services covered by the donation. If such costs are not reduced, the provider would secure reimbursement for the same expense twice, it would be reimbursed through the donor-restricted contributions as well as from patients and third-party payers including the title XVIII health insurance program." [Medicare part A.]

One hospital covered by our review was reimbursed by the State for the net costs of operating alcoholism and venereal disease clinics. The hospital, however, did not reduce the cost of its outpatient clinics by these amounts, and, as a result, the costs charged to Medicare were overstated. The intermediary's auditors advised us that it was an oversight on their part and that the income should have been used to reduce the operating costs of the clinics.

We noted also that, at the same hospital, the costs charged to Medicare were overstated because certain income from donor-restricted funds, which was used for the purpose of training nurses, was not deducted from nursing-school costs.

Cafeteria revenues not deducted

The dietary department of one hospital operated a cafeteria for its employees and the public. Under HEW regulations the expenses attributable to the cafeteria operation, including indirect costs, should have been excluded from the allowable costs of providing care to patients.

The hospital's cost report showed that direct costs of operating the cafeteria had been excluded from Medicare costs but the indirect costs had not. Under the accounting procedures used by the hospital, these indirect costs could not be readily identified. Under these circumstances, SSA instructions provide that the revenues received from cafeteria operations should be used to reduce allowable dietary costs.

Hospitals undercharged for certain allowable costs

Four hospitals did not claim all the costs permitted by HEW regulations or made computation errors on their cost reports that resulted in understatements of certain allowable costs amounting to $22,760.

For example, a city-owned hospital did not include in its cost report the interest expense paid by the city on certain hospital construction bonds. The expense was allowable under HEW's regulations and the intermediary advised us that it would adjust the hospital's claim to include these costs.

At another hospital, certain overhead costs applicable to non-patient-care activities were handled in the intermediary's audit in such a manner that they were deducted from allowable costs twice. We referred this understatement of reimbursable costs to the intermediary for appropriate adjustment.

ALLOCATIONS OF COSTS WERE INCORRECT

Under the various methods available to hospitals for determining the part of costs chargeable to Medicare, we found that, at the hospitals reviewed, generally from 20 to 35 percent of the hospitals' inpatient costs and from 1 to 10 percent of the hospitals' outpatient costs were charged to the Medicare program. Costs of nursery operations[1] and non-patient-care activities may not be charged to Medicare.

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[1]Under a temporary apportionment method authorized by HEW for hospital reporting periods ended before January 1, 1969, the costs of nursery operations could be included in the costs to be apportioned to the Medicare program.

Because Medicare pays a larger share of the hospitals' costs for inpatient services, incorrect allocations of hospital costs to those services--instead of to outpatient and other services--resulted in net overcharges of $135,980 (overcharges of $141,020 less undercharges of $5,040) to the Medicare program at 12 hospitals. Examples of incorrect allocations follow.

--Five hospitals used inaccurate space (square footage) figures to allocate such costs as depreciation, plant maintenance, plant operation, and housekeeping. At four of these hospitals, the errors resulted in costs being overallocated to those departments or activities for which Medicare paid a greater percentage of costs; at the fifth hospital, errors resulted in the costs being underallocated.

--Six hospitals allocated costs entirely to inpatient services when they should have been allocated to both inpatient and outpatient services. For example, one of the six hospitals was overpaid because all nursing supervision and administration costs were allocated to routine inpatient services, although 37 percent of the nurses were assigned to other departments or activities for which Medicare was charged a lesser share of costs. At this hospital, the Medicare program was charged about 25 percent of the inpatient costs, about 10 percent of the outpatient costs, and none of the nursery costs.

--Medicare's share of hospital costs was overstated because two hospitals did not equitably allocate to gift shops and other concession areas such expenses as depreciation, administrative and general, operation of plant, and housekeeping. The hospitals did not receive any incomes from the operation of gift shops and other concession areas. SSA had instructed its intermediaries, as early as December 1967, that, when no income from operations was received by the hospital to offset operating expenses, general expenses should be allocated to the concession areas and must be excluded in determining the costs chargeable to the Medicare program.

INCOMPLETE OR ERRONEOUS DATA WAS USED

Incomplete or erroneous data, involving three of the five intermediaries, was used in computing Medicare's share of hospital costs and/or in computing cost settlements for seven of the 14 hospitals. As a result, Medicare made net overpayments of about $64,200, for overcharges of $150,000 and undercharges of $85,800.

The incomplete and erronous data was principally due to

--errors in the computer programs used by an intermediary to accumulate hospitals' Medicare charge and payment data and

--hospitals' and intermediaries' failure to consider the most up-to-date data available at the time of the audits and settlements.

Examples of incomplete or erroneous data being used follow.

Audit adjustments

Two hospitals were overpaid because required adjustments to cost statements which were noted by the intermediary's auditors were not furnished to the hospitals for incorporation into their revised cost statements. The auditors informed us that adjustments were not included because of oversights.

Interim payments, deductibles, and coinsurance amounts

After the total hospital cost applicable to Medicare patients is computed, the amount due to the hospital from the Medicare program must be reduced by (1) the amounts paid or payable by Medicare patients under the deductible and coinsurance provisions and (2) the amount of interim payments received or due from the intermediary.

Errors in these items--which we noted at five hospitals--affected the determinations of the amounts of the hospitals' final cost settlements. For example, because of an intermediary's computer error at one hospital the amount payable

by Medicare patients for their deductibles was understated. The net effect was that Medicare was overcharged $26,560.

Overstatement or understatement of hospital charges and inpatient days

Medicare's share of the various hospital costs is computed on the basis of (1) the ratio of Medicare inpatient days to total inpatient days or (2) the ratio of Medicare charges to total charges for the various hospital services. At six hospitals we noted errors in either the Medicare or the total inpatient days or charges, resulting in Medicare being charged an incorrect share of hospital costs.

For example, at one hospital a manually prepared list of Medicare patient charges did not agree with a computer printout because the printout did not include bills in process. Instead of reconciling the two listings to determine what charges and what hospital activities were involved, the hospital used the larger dollar amount shown on the manual listing and allocated this amount to the various activities on the basis of the ratio of charges shown on the incomplete computer printout. As a result, the hospital undercharged Medicare by about $8,400.

MEDICARE PAID FOR BAD DEBTS PAYABLE BY STATES

Under title XIX of the Social Security Act--commonly referred to as Medicaid[1]--the States may pay the Medicare deductible and coinsurance amounts for inpatient hospital services for those Medicare patients also eligible for certain benefits under Medicaid. Also, when the States had not yet adopted a Medicaid program but were operating under title I of the Social Security Act (Old Age Assistance and Medical Assistance for the Aged), the States might have paid the

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[1]The Medicaid program, enacted in July 1965, is a grant-in-aid program under which the Federal Government pays from 50 to 83 percent--depending upon the per capita income in each State--of the costs incurred by the States in providing medical assistance to persons unable to pay for such care.

Medicare deductible and coinsurance amounts for certain eligible beneficiaries. When a State's plan for either of these programs covers the Medicare deductible and coinsurance amounts, the HEW reimbursement regulations specifically prohibit hospitals from charging such amounts to Medicare as bad debts.

We examined into Medicare deductible and coinsurance amounts of about $61,000 claimed as bad debts by 19 hospitals (including six of the 14 reviewed in detail) in three States and allowed by the intermediaries. About $19,000, or 30 percent, of the bad debts should have been paid by the States under their Old Age Assistance or Medicaid programs and not by Medicare.

Improved bill review procedures, such as screening of hospital admissions or screening of patients not paying their deductible and coinsurance amounts, are needed to enable the intermediaries and the hospitals to identify those patients eligible to have their Medicare deductible and coinsurance amounts paid by the States.

In commenting on our findings in a prior report to the agency, SSA said it planned to develop improved bill review procedures to insure that Medicare deductible and coinsurance amounts that should be paid by the States under their welfare programs were not charged to Medicare as bad debts.

INTERMEDIARY COMMENTS

BCA, in letters to SSA dated January 24 and February 16, 1972, commented on a draft of this report. (See apps. II and III.) BCA stated that the incorrect charges identified by our reviews resulted because.

"(a) In some instances, the Medicare Regulations and Manuals were not clear and a judgment decision had to be made by the intermediary based upon data available at the time.

"(b) In other instances, the differences arose because GAO's judgment of what was reasonable in the situation differed from the intermediary's.

"(c) GAO audits were conducted in substantially more detail than Medicare audit requirements contemplated.

* * * * *

"(d) In some cases there were oversights by the auditors and/or the intermediaries."

CHAPTER 3

CHARGES FOR SERVICES OF HOSPITAL-BASED RADIOLOGISTS AND PATHOLOGISTS

Five of the 14 hospitals included in our review charged part B of the Medicare program about $175,300 more than their costs for the services of radiologists and pathologists. Because the hospitals' part B charges for the physicians' services were substantially more than the corresponding amounts paid by the hospitals to the physicians for such services, these charges exceeded the amounts intended to be allowed by HEW regulations. These excess charges included the deductible and coinsurance amounts payable by the Medicare patients as well as the amounts payable by the carriers.

SSA instructions accompanying the cost report forms for hospitals did not require that these forms include information on amounts received from part B carriers and from Medicare patients for the professional services of radiologists and pathologists. In making final settlements, two of the five intermediaries did not determine whether the amounts received under part B were greater than the related part B costs reported by the hospitals. As a result, the five hospitals received more than their reimbursable Medicare costs.

BACKGROUND

The Medicare law established two separate trust funds to finance the program. Part A provides hospital insurance protection and has been financed through social security taxes. Part B provides supplementary medical insurance, which primarily covers payments for the services of physicians and has been financed by monthly premiums from eligible enrollees and matching amounts from the Federal Government. Under the Medicare law, benefit payments for the services of physicians (except for hospital residents and interns under professionally approved training programs) furnished to individual patients were to be made under part B. Such payments are generally made to either the patient

or the physician under the patient's assignment of his right to reimbursement.

For those physicians whose practices were largely confined to or concentrated in hospitals (e.g., radiologists and pathologists), certain of their services in the hospitals, such as teaching, administration, and supervision of technical personnel, could not be specifically related to the care of individual patients. To the extent that the cost of such services was borne by the hospital, HEW regulations provided that reimbursement should be made to the hospital under part A. Under certain circumstances, discussed below, the regulations provide that payment for patient care rendered by hospital-based physicians may be made directly to the hospital under part B.

The HEW regulations provide also that the sum of the payments to the hospital under parts A and B for the services of hospital-based physicians should be about equal to the amount of the physicians' compensation allocable to the Medicare program.

HEW regulations required that, when Medicare was billed for the services of radiologists and pathologists, the hospitals

--enter into agreements with these physicians to formalize whatever financial arrangements existed between the hospitals and the physicians and

--distinguish the part of these physicians' compensations directly related to patient care (the part B professional component) from the portion related to the physicians' services to the institutions (the part A hospital component).

This data was to be submitted to the intermediary responsible for reviewing and approving the allocations of the physician's compensation and for transmitting the information to the part B carrier.

Before April 1968 the part B professional component was billed to the Medicare part B carrier, generally as a

percentage of the hospital's charge for a particular service on a patient-by-patient basis. For example:

> Assume that a hospital's charge for a chest X-ray was $20, including the taking of the X-ray by a hospital technician and the interpreting of the X-ray by a radiologist under contract with the hospital. According to the contract the radiologist was paid 60 percent of the charge, or $12. The hospital and its radiologists had agreed, with the intermediary's approval, that one-half of the payment to the radiologist (in this example, $6) was for supervising the X-ray department--reimbursable under part A--and one-half (again $6) was for the professional service of interpreting the patient's X-ray--reimbursable under part B. The billing for part B would therefore be 30 percent of the hospital's total $20 charge--or $6. Assuming that the Medicare patient's deductible had been met, the part B carrier would pay the hospital 80 percent of the $6 charge ($4.80) and the beneficiary would be responsible for paying the remaining 20 percent ($1.20). However, in the absence of SSA requirements, neither the $4.80 nor the $1.20 were included as Medicare payments received on the hospital's annual Medicare cost reports filed with the part A intermediary.

Splitting the Medicare bills for radiology and pathology services into two parts and billing patients for small part B deductible and coinsurance amounts created paperwork problems for the hospitals. To alleviate these problems, the Social Security Amendments of 1967 (81 Stat. 821) authorized--effective April 1, 1968--a simplified reimbursement method whereby there would be no part B deductible and coinsurance for radiologists' and pathologists' services to Medicare hospital inpatients.

This legislative change, in effect, authorized hospitals--at their option and with the authorization of their radiologists and pathologists--to use a single bill--combined-billing method--for both hospital (part A) and physicians' (part B) services. For the hospitals electing to use the combined-billing method, the billings are paid by the intermediary instead of by the carrier and such payments are included in the hospitals' Medicare cost reports and are subject to the same retroactive adjustments on the basis of the

hospitals' actual allowable costs as other intermediary interim payments. Further, under the combined-billing method, the intermediary would make the adjustments between part A and part B funds on an aggregate basis at the end of a hospital's reporting period.

WHY EXCESSIVE REIMBURSEMENTS OCCURRED

Five hospitals received excessive part B reimbursements for the services of radiologists and pathologists principally because the hospitals did not adhere to HEW regulations for establishing the part B percentages of the hospitals' radiology and pathology charges. Under the regulations the part B percentages of the charges should be designed to yield, as nearly as possible, amounts equal to the physicians' compensation allocable to their service to individual patients. Examples of excessive part B reimbursements follow.

1. For the second annual Medicare reporting period, one hospital established the part B percentage of the radiology charges at a level which allowed the hospital about $92,000, or about 72 percent, more than the hospital's costs.

With the inception of Medicare, the hospital's radiologists established a separate organization which gradually assumed the billing for part B services provided to hospital patients by its member radiologists. The hospital, however, continued to pay the radiologists' salaries and, in return, their earnings were assigned to the hospital.

In establishing the part B portion of the radiology charges, the hospital estimated that 33-1/3 percent of charges would be sufficient to recover the portion of the staff radiologists' salaries and other compensation (fringe benefits) allocable to direct patient care. In developing this percentage the hospital assumed that

--only Medicare patients and a certain category of non-Medicare patients would be charged a physician's fee for radiology services and

--no revenues would be generated from another category of non-Medicare patients which represented about 34 percent of the projected radiology workload.

In actual practice, however, all Medicare and non-Medicare patients were routinely billed by the hospital or, subsequently, by the billing organization for radiology services. Therefore the proposed factor of 33-1/3 percent

of charges submitted by the hospital to the intermediary for approval was an overstatement, because all patients were billed and were expected to contribute to the amounts necessary to recover the portion of the staff radiologists' compensation allocable to direct patient care.

2. Another hospital, also for the second reporting period, established the part B percentage of the pathology charges at a level which allowed the hospital about $16,000, or about 79 percent, more than the hospital's costs.

The pathologists at this hospital were compensated on the basis of a guaranteed annual fee and a percentage of the net revenues of the pathology department (laboratory).

The hospital's rate for billing part B was 20 percent of the laboratory charges. Neither the hospital nor the intermediary could produce information to support this 20-percent rate; however, information applicable to the previous reporting period indicated that the part B rate for pathologists was the equivalent of about 11 percent of the hospital's laboratory charges.

3. Another hospital, for the first 3 months[1] of the third reporting period, established the part B percentages of radiology and pathology charges at levels which allowed about $45,700, or about 275 percent, more than the hospital's costs of the physicians' services to Medicare patients.

At this hospital both radiologists and pathologists were compensated on the basis of percentages of charges of their respective departments. The hospital's rate for billing part B of Medicare for the radiologists' and pathologists' services during the 3-month period was 41 and 60 percent of charges, respectively.

Neither the hospital nor the intermediary could provide us with data supporting the rates used. We noted, however, that the 41 percent of charges used to bill the carrier

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[1]For the last 9 months of the reporting period, the hospital used the combined-billing method, and any excess radiology and pathology charges were adjusted to cost.

for the part B services of the radiologists was about the same as the percentage of charges used to compensate the radiologists for all their services, that is, services covered by both part A and part B. The hospital also allocated about one-half of this compensation to part A services on its Medicare cost report, and, as a result, the hospital was paid by the intermediary under part A for part of the costs that had already been paid by the carrier under part B.

The 60 percent of charges used to bill the carrier for the part B services of the pathologists was about three times the percentage (about 20 percent) of charges used to compensate the pathologists for both part A and part B services. Because about 80 percent of the pathologists' compensation was charged to part A and paid by the intermediary, the part B percentage (20 percent) of the physicians' compensation was the equivalent of 4 percent (20 percent of 20 percent) of charges, compared with the 60 percent used to bill the carrier under part B.

CORRECTIVE ACTIONS

By authorizing the combined-billing method for inpatient hospital services, effective April 1, 1968, the Congress took an important step to alleviate a basic cause of the problem of excessive reimbursements to hospitals for the services of hospital-based physicians.

In April 1970, BCA instructed its Blue Cross plans to adjust hospital cost reports, when there had been no final settlements, for overpayments or underpayments for part B physicians' services when they resulted principally from (1) substantial variances from the estimates of the revenues to be realized by the hospital for the physicians' services or (2) mathematical errors in calculating the professional component percentages.

SSA advised its intermediaries in August 1971 and its carriers in September 1971 that the intermediaries, as part of the settlement process, should make retroactive adjustments of the overpayments or underpayments for part B charges of hospital-based physicians, including radiologists and pathologists. Such adjustments were to be made when the hospital had billed the carrier and when the charges were based on the physicians' compensation. These instructions provided that adjustments were to be based on accounting data maintained by the hospitals and were to be implemented for reporting periods starting after June 30, 1971, and for any earlier periods in which the need for retroactive adjustment actions had been identified.

REMAINING POTENTIAL PROBLEM AREAS

The adoption of the combined-billing method for radiology and pathology services by all hospitals would, in our opinion, practically eliminate the problem of excessive part B payments because procedures and accounting controls to adjust excess payments would be built into the cost reporting and settlement process. When the combined-billing method is not used, SSA's August and September 1971 instructions should help to clarify the intermediaries' responsibilities for making adjustments for excessive payments made to hospitals by the SSA carriers.

Notwithstanding the corrective actions taken, we believe that the following conditions may present continuing problems for SSA and the intermediaries.

--The combined-billing method was not authorized for reporting periods covered by many Medicare costs reports not yet settled.

--Many hospitals and their radiologists and pathologists did not elect to use the combined-billing method and continued to bill the carriers for the physicians part B professional component. SSA's September 1971 instructions did not provide that the carriers accumulate pertinent Medicare payment data for these institutions to assist the hospitals and intermediaries during the cost reporting and settlement process.

Combined-billing method not authorized for early reporting periods

Because the combined-billing method was not in effect until April 1, 1968, it was not available to the 6,800 participating hospitals for their first Medicare reporting period or for all or part of their second Medicare reporting periods. For about 65 percent of the hospitals, it was not available for parts of their third Medicare reporting periods.

As of December 31, 1971, about 4 percent of the hospital cost reports had not been settled for the first reporting period; about 11 percent had not been settled for the second reporting period; and about 20 percent had not been settled for the third reporting period. We estimate that, overall, there were about 2,000 unsettled cost reports applicable to periods before the combined-billing method was authorized, and in which the potential for excessive part B payments should be a matter of particular concern to SSA and intermediaries before they make settlements.

Many hospitals elected not to use the combined-billing method

The use of the combined-billing method for radiology and pathology services is optional with the hospitals

and their physicians. At the time of our review, SSA had not compiled reliable data showing how many hospitals had elected to use this method.[1] The American Hospital Association (AHA), however, made a survey of the billing and financial arrangements between hospitals and their radiologists and pathologists as of August 1969.

Data obtained by AHA from the responding hospitals showed that about 3,600 short-term hospitals[2] billed patients for radiologists services and about 4,200 short-term hospitals billed patients for pathologists services. About 1,300 of the hospitals reported listing separately on the patients' bills the radiologists and pathologists services. Although AHA's survey did not establish that the combined-billing method was not used by those hospitals listing the professional component separately, we believe that a strong correlation exists between these two factors. Our analysis of the AHA data indicates that about one-third of the responding hospitals which billed for radiologists and pathologists services were not using the combined-billing method, but, instead, were billing the Medicare carriers separately for the part B amounts applicable to these physicians' services.

According to SSA's August and September 1971 instructions for making retroactive adjustments for excessive part B payments to hospitals by carriers, the intermediary is supposed to make such adjustments solely on the basis of accounting data maintained by the hospitals. The intermediaries were instructed to develop forms to be used by their hospitals in identifying and calculating incorrect payments for hospital-based physicians' services. The carriers were not required, however, to accumulate pertinent Medicare charge and payment data to assist the hospitals and intermediaries

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[1] Hew advised us in March 1972 that SSA was compiling data on hospitals using combined billing and expected to complete it in the near future. (See app. I, p. 57.)

[2] A short-term hospital is described by AHA as a hospital in which over 50 percent of all patients admitted have a stay of less than 30 days.

in determining or verifying the amounts of any overpayments or underpayments. Conversely, for those services paid for by the intermediaries, pertinent Medicare charge and payment data has been accumulated by SSA and, in many instances, by the intermediaries for use by hospitals and intermediaries in the cost reporting and settlement process.

Thus, for hospitals that did not use the combined-billing method, the procedures and related accounting controls for adjusting for overpayments and underpayments would not be the same as for hospitals that did use the combined-billing method. We believe that, without such accounting controls, intermediaries may experience difficulties in implementing SSA's August 1971 instructions.

HEW AND INTERMEDIARY COMMENTS

HEW, in a letter dated March 17, 1972, and BCA, in letters dated January 24 and February 16, 1972, gave us their comments on a draft of this report (See apps I, II, and III.)

HEW stated that:

--It was always the intent of the Medicare program that charges for professional services of hospital-based physicians should generally be designed to allow amounts closely related to the physicians' compensation

--When it came to SSA's attention that errors in developing part B charge schedules resulted in hospitals' receiving reimbursement which exceeded actual compensation paid to physicians for services, new policy instructions were issued for intermediaries to make appropriate adjustments in their final cost settlements with the hospitals On the basis of its experience, SSA would make the modifications needed to carry out retroactive adjustments effectively.

--In cases where hospitals did not use the combined-billing procedures, SSA's September 1971 instructions did not require carriers to provide hospitals and intermediaries with pertinent part B charge and payment data because of administrative and cost considerations.

--Except for the larger organizations with sophisticated computer systems, carriers usually did not accumulate the data necessary for making the retroactive adjustments during the course of their normal operations Requiring intermediaries to obtain this data from the hospitals instead of from the carriers has some disadvantages, but the savings in administrative costs to the carriers would more than compensate for these disadvantages

The lack of carriers' charge and payment data which would enable intermediaries to make comparisons with

corresponding data accumulated by the hospitals could result in increases in the intermediaries' administrative (audit) costs Therefore, we plan to review the intermediaries' experience in implementing SSA's August 1971 instructions to determine whether the accumulation of part B charge and payment data by the carriers should be required to assist the hospitals and the intermediaries in making the proper retroactive adjustments.

BCA stated that:

--HEW's regulations and the congressional intent indicated clearly that hospital reimbursement must be limited in accordance with the arrangement between the hospital and the physician This principle would apply even when the billing mechanism for physicians' services changed. (See example 1 on p. 32)

--It agreed with our conclusion that the adoption of the combined-billing method for the services of all hospital-based radiologists and pathologists would practically eliminate the problem of excessive part B reimbursements for hospital-based physicians because the majority of such physicians are radiologists and pathologists

--Other hospital-based specialists, such as anesthesiologists and physiatrists, perform a significant number of services for Medicare patients Permitting these physicians to use the combined-billing method would further reduce possible overpayment situations

--It recommended that combined billing be instituted as the sole billing method for all hospital-based-physicians' services, except, perhaps, psychiatric outpatient services. Adopting this recommendation would require legislative changes to eliminate the deductible and coinsurance requirements on inpatient physician (part B) services, as they are now eliminated for radiologists and pathologists, but the

savings to the Medicare program resulting from the use of combined billing would appear to offset the additional cost of paying these deductible and coinsurance amounts.[1]

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[1]BCA made a similar recommendation to the Congress in testifying before the House Committee on Ways and Means and the Senate Committee on Finance on the bills (H R 5710 and H R. 12080) which became the Social Security Amendments of 1967 The bills as enacted into law, however, only eliminated the part B deductible and coinsurance provisions for radiology and pathology services provided to Medicare hospital inpatients

CHAPTER 4

CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS

The overpayments and underpayments identified by our reviews do not necessarily mean that the intermediaries or their audit subcontractors have made good or bad audits of the hospitals' Medicare cost reports. Our findings do reflect, however, the complexities of the present Medicare retrospective-cost-reimbursement system, by illustrating the variety of ways that incorrect payments to hospitals by both intermediaries and carriers have occurred even after the payments have been subject to adjustment through an intermediary audit.

The process of making Medicare audits at hospitals has undergone a significant transition during the first 5 years of the program. Early in the program SSA took the position that it was necessary to make full-scope audits of each hospital to insure that these institutions had adequate recordkeeping systems and had accurately reflected Medicare costs in their reports. Of the intermediary audits of the 14 hospitals included in our reviews, 11 were classified by the intermediaries as full-scope audits.

During fiscal year 1970, intermediaries implemented an SSA policy of making limited-scope audits of Medicare cost reports. Under this policy, the scope of the intermediaries' audits at the hospitals was to be determined on the basis of (1) an analytical evaluation of the cost reports at the intermediaries' offices (desk audits) to identify, for further examination at the hospitals, such items as apparent errors or variations from previous years' experience and (2) the intermediaries' knowledge of possible problems at specific hospitals based on their prior experience. In other words the limited-scope audits were designed to be "audits by exception," involving examinations of specific items on a hospital's cost report when the potential for audit ajustments seemed to be the greatest.

We believe that, regardless of how the scope of the individual Medicare hospital audit is determined, there is a need for:

--In-depth reviews, particularly at the larger hospitals, of the types of services and activities to establish that they are covered by the program and are sufficiently related to the care of Medicare patients to be charged to the program under HEW regulations.

--Analyses of non-patient-care revenues and other moneys received by hospitals to establish if--under HEW regulations--such amounts should be offset against allowable costs.

--Evaluations of the bases for allocating costs between inpatient, outpatient, and non-patient-care activities to insure that hospitals are not overallocating their costs to those activities for which Medicare pays the largest share of the costs.

--Tests of the accuracy and completeness of the statistical and payment data used in preparing cost reports and in computing settlements.

--Consideration of Medicare payments to hospitals by the SSA carriers for the services of hospital-based physicians in the intermediaries' audit and settlement process.

RECOMMENDATIONS TO THE SECRETARY OF HEW

We recommend that HEW require SSA to (1) communicate to all intermediaries the problems of hospital reimbursement discussed in this report and (2) emphasize to all intermediaries the need for the above-cited actions aimed at improving their audits to insure that Medicare payments to hospitals are in accordance with the law and regulations.

HEW AND INTERMEDIARY COMMENTS AND GAO EVALUATION

In its March 17, 1972, letter HEW agreed with our first recommendation and stated that SSA would notify all intermediaries of the problems discussed in this report. Such action by SSA is particularly important because we have been finding problems similar to those discussed in chapter 2 during our current reviews of cost reimbursements to nursing

homes (extended-care facilities) and proprietary-type hospitals.

HEW also expressed qualified agreement with our second recommendation and stated that SSA would advise all intermediaries of the importance of considering, on a hospital-by-hospital basis, the types of in-depth reviews and other actions recommended. HEW believed, however, that such actions should be undertaken only at those hospitals where the intermediaries' desk audits of the hospitals' cost reports suggest a need.

HEW pointed out that (1) it would not be feasible or economical to require in-depth reviews, analyses, evaluations, and tests every year at every hospital and (2) a cost-benefit relationship of the potential for audit adjustment should be considered in determining the scope of audit to be undertaken.

In its January 24, 1972, letter to SSA (see app. II), BCA basically agreed with the conclusions contained in this report. According to BCA, under procedures currently in effect in the Medicare program, the extent of audit required is determined on the basis of desk reviews of the cost report and on the intermediary's knowledge of the hospital's operations. BCA believes these procedures are adequate because large hospitals receive additional review and audit when warranted because of their complexity and the materiality of reimbursement involved.

We do not disagree with HEW and BCA that it would be infeasible to require in-depth reviews or full-scope audits every year at every hospital. On the other hand, if some of the problems discussed in this report have not been identified or resolved by intermediaries after a full-scope field audit, it appears unlikely that such problems would be susceptible to identification or resolution by desk audits of the hospitals' cost reports.

At the larger hospitals, where significant amounts of Medicare payments are involved, certain detailed audit work should be done to establish the proper basis for reimbursement for the period under audit as well as for future periods. For example.

--If a hospital provides services not covered by the program (see p. 15), the allowability of the related costs, once determined by the intermediary in a detailed review, need not be redetermined every year.

--If the square-footage figures used to allocate costs between inpatient and outpatient activities were audited in sufficient detail by the intermediary to establish their accuracy (see p. 23), there should be no need to perform the same detailed audit steps every year unless there were changes in the space assigned to the various activities.

--If the provisions of a donation were reviewed in sufficient detail by the intermediary to determine whether it should be classified as restricted (see p 21), there should be no need to review the provisions of the same donation every year.

CHAPTER 5

PROPOSED LEGISLATIVE CHANGES

From 1970 to 1972 the Congress has considered various legislative changes to the Medicare and Medicaid programs, including legislation providing for experimentation involving certain fundamental changes to the present retrospective reasonable-cost method of paying hospitals under Medicare. This legislation would authorize the Secretary of HEW to experiment with various methods and techniques for prospective reimbursement under both the Medicare and Medicaid programs.

Prospective reimbursement differs from the present method in that a rate of payment is set in advance of the period for which the rate is to apply. The advocates of a prospective-reimbursement method generally claim that it should provide incentives for greater efficiency in hospital administration because, once the rates were set, the hospitals would have an incentive to deliver the required care in a manner that would maximize the differences between actual costs and the payments based on prospective rates. If actual costs exceeded the payments based on prospective rates, the hospital would be required to absorb the losses.

The Congress recognized, however, that prospective-reimbursement methods could have certain disadvantages. A typical expression of this congressional concern was included in the May 1971 report of the House Committee on Ways and Means (H. Rept. 92-231) accompanying the Social Security Amendments of 1971 (H.R. 1) which passed the House of Representatives on June 22, 1971.[1] With regard to the subject of prospective reimbursement, the Committee's report stated:

> "However, your committee is well aware that in considering such a fundamental change in the present reimbursement method, possible disadvantages as well as potential advantages must

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[1] As of May 1972, H.R. 1 was being considered by the Senate Committee on Finance.

be taken into account. While it is clear for example, that prospective rate setting will provide incentives for health care institutions to keep costs at a level no higher than the rates set, it is not clear that the rates set would result in government reimbursement at levels lower than, or even as low as, that which would result under the present retroactive cost finding approach. Providers could be expected to press for a rate that would cover all costs, including research costs and bad debts, as well as margins of safety in the prospective rates that might result in reimbursement--if their requests were met--in excess of the costs that would have been reimbursed under the present approach. Moreover, any excess of reimbursement over costs to voluntary providers would probably be used to expand services, and the new level of expenditures might be reflected in setting higher prospective rates for future years.

"Also to be considered is the fact that under prospective reimbursement it will be necessary to take steps to assure that providers do not cut back on services necessary to quality care in order to keep actual costs down and thus increase the difference between costs and the prospective rate established."

Under House bill 1 the Secretary would be required to submit to the Congress by July 1, 1973, a full report of the results of the experiments and an evaluation of the experiences of other non-Government health care programs concerning prospective reimbursement. The Secretary's report would include detailed recommendations for the specific methods that might be used in the full implementation of a prospective-reimbursement system under the Medicare and Medicaid programs.

In developing the specific methods to be used in implementing a prospective-reimbursement system, we believe it is important that HEW provide for appropriate assurances that such prospective rates will be based on the costs for only those services intended to be covered and will be reasonably

related to the care of those patients intended to benefit from the programs.

It should be noted that Medicare charges by hospitals to the SSA carriers for the professional (part B) services of hospital-based physicians have been established on a prospective basis since the inception of the program. As noted on pages 32 to 34 , significant differences existed between amounts paid to the hospitals and the corresponding amounts received by the physicians.

It is important, we believe,that the Secretary's proposed methods for reimbursement for such services be designed to allow amounts closely related to the physicians' compensation allocable to their part B services, to minimize the type of problem previously experienced under Medicare as described in this report.

HEW COMMENTS

In its March 17, 1972, comments (see app. I) HEW stated that, before sanctioning any method of prospective reimbursement, it would make sure that services to be paid for were related to the care of those patients that the Congress intended the programs to benefit. HEW said, however, that it was possible that its experiments with prospective reimbursements could point to the inclusion of services not presently covered by Medicare and Medicaid in the methods which could be used for implementing a prospective-reimbursement system.

With regard to the professional (part B) services of hospital-based physicians, HEW stated that·

> "In developing methods for implementing a prospective reimbursement system, it is likely that these methods would contemplate the required use of a 'combined billing' procedure for billing for radiology and pathology services. This procedure should, as [GAO's] report states in Chapter 3, tend to eliminate any problems of excessive part B payments for these services."

As discussed in chapter 3, the adoption of the combined-billing method practically eliminated the problem of excessive part B payments because procedures and accounting controls for retroactively adjusting for such excess payments were built into the cost reporting and settlement process. A prospective-reimbursement system, however, would not ordinarily provide for such retroactive adjustments on the basis of a hospital's actual costs. Therefore, HEW would need to determine the accuracy of the prospective rates for physicians' services in hospitals at the time such rates were established.

CHAPTER 6

SCOPE OF REVIEW

We examined the intermediary audits and, where applicable, the related settlements of Medicare payments to 14 hospitals served by five Blue Cross plans operating under subcontracts with BCA, the principal Medicare intermediary. The intermediary audits pertained to one Medicare cost reporting period for each of the 14 hospitals and involved claims of about $20 million in Medicare costs by the hospitals. Our principal objective was to find out whether federally prescribed systems and procedures were adequate to insure that Medicare payments to hospitals were in accordance with the law and regulations

Our reviews were made at SSA headquarters in Baltimore, Md ; at Blue Cross plans in Columbus, Ga.; Boston, Mass ; Syracuse, N.Y.; Youngstown, Ohio; and Dallas, Tex ; and at the 14 hospitals serviced by these intermediaries

Our examination included reviews of the intermediaries' or their subcontractors' audit reports and related workpapers pertaining to the hospitals' cost reports. This was followed by detailed reviews of the audited cost reports at the 14 hospitals. In addition to examining Medicare payments by the intermediaries, we reviewed selected hospital records pertaining to Medicare payments by the SSA carriers for the services of hospital-based radiologists and pathologists.

Our selection of hospital cost reports for review was based on such factors as the size of the hospitals, the amounts of Medicare payments involved, and the proximity of the dates of the intermediaries' audits to the dates of our visits

Variations in the sizes of the hospitals included in our reviews are shown below

Size of hospital	Number of hospitals
100 to 199 beds	5
200 to 299 beds	1
300 to 399 beds	1
400 to 499 beds	2
500 to 599 beds	3
over 600 beds	2
Total	14

At the conclusion of our field reviews, we discussed our findings with hospital officials and with officials of the Blue Cross plans and their audit subcontractors. The results of our examinations were communicated in writing to HEW and/or SSA The comments received from the organizations affected were considered in preparing this report.

At 19 hospitals--including six of the 14 where cost reports were reviewed in detail--in Georgia, Massachusetts, and Texas, we examined charges to the Medicare program for the part A coinsurance and deductible amounts not collected from the Medicare patients (Medicare bad debts) to find out whether such amounts should have been paid to the hospitals by the States under their Medicaid or Old Age Assistance programs.

As part of our reviews, we examined the basic legislation authorizing the Medicare program and pertinent HEW regulations and SSA instructions and guidelines.

DEPARTMENT OF HEALTH EDUCATION AND WELFARE
OFFICE OF THE SECRETARY
WASHINGTON D C 20201

MAR 17 1972

Mr. Dean Crowther
Associate Director, Civil Division
U S General Accounting Office
Washington, D C 20548

Dear Mr Crowther

The Secretary has asked that I respond to your letter of December 14 in which you asked for our comments on your draft report entitled, "Problems Associated With Reimbursement to Hospitals for Costs of Health Services Furnished Under Medicare " The Department's comments are enclosed. At your request, we asked the Blue Cross Association for their comments on your report; a copy of their comments are also enclosed.

We appreciate your contributions toward improving this aspect of Medicare administration

Sincerely yours,

James B. Cardwell
Assistant Secretary, Comptroller

Enclosures

PROBLEMS ASSOCIATED WITH REIMBURSEMENT TO HOSPITALS
FOR COSTS OF HEALTH SERVICES FURNISHED UNDER MEDICARE
(GAO Draft Report to the Congress dated December 14, 1971 B-160431-4)

The draft report summarizes previously reported problems associated with reimbursements to hospitals for costs of health services furnished under the Medicare program The report covers GAO's reviews of intermediary audits and where applicable the related settlements of Medicare payments totaling $20 million to 14 hospitals which were serviced by five intermediaries operating under subcontracts with the principal Medicare intermediary, the Blue Cross Association Although GAO found that most of the payments were correct, they noted several problem areas in the hospital reimbursement system and questioned net charges to Medicare of about $622,300 pertaining to payments made by the intermediaries and carriers to 12 of the 14 hospitals. The major problem areas discussed and summarized in the report are (1) difficulties in determining allowable Medicare costs, (2) problems associated with charges for services of hospital-based physicians, and (3) proposed legislative changes to Medicare reimbursement system--with specific reference to the provisions of H. R 1 dealing with prospective reimbursement

We agree with GAO's conclusion that on the whole the over-and under-payments discussed in the report do not necessarily mean that the intermediaries or their audit subcontractors had made "good" audits or "bad" audits, but rather that the findings reflect the complexities of the Medicare cost reimbursement system In this connection, the report points out that because the review was directed to the larger hospitals, the reimbursement problems identified by GAO may not be representative of all hospitals participating in the program.

Our comments which follow are addressed first to the recommendation and then to other specific matters discussed in the report

Recommendation That the Secretary provide for SSA to (1) communicate to the intermediaries the problem areas of hospital reimbursement discussed in the report, and (2) emphasize to the intermediaries the need for the following cited actions aimed at assuring that Medicare payments to hospitals are in accordance with the law and regulations

--In depth reviews, particularly at the larger hospitals, of the nature of the hospitals' services and activities to establish that they are (a) covered by the program and (b) sufficiently related to the care of Medicare patients to be charged to the program under HEW regulations.

--Analysis of non-patient care revenues and other monies received by hospitals to establish if--under HEW regulations--such amounts should be offset against costs

--Evaluations of the bases for allocating costs between inpatient, outpatient, and non-patient care activities to ensure that hospitals are not overallocating their costs to those activities where Medicare pays the largest share of the costs.

GAO note Page references in this appendix are keyed to an earlier draft of this report

--Tests of the accuracy and completeness of the statistical and payment data used in preparing cost reports and in computing settlements

--Consideration of Medicare payments to hospitals by the SSA carriers for the services of hospital-based physicians in the intermediaries' audit and settlement process.

We agree with the first item of the recommendation, and will notify all intermediaries of the problem areas discussed in the report. We agree also with the second item of the recommendation, however, we think that the actions cited by GAO should be undertaken only at those hospitals where they are needed In our opinion, it would not be feasible or economical to require the types of in-depth reviews, analyses, evaluations, and tests, cited by GAO, every year at every hospital. The determination as to whether these reviews and other actions are needed and in what degree, for any given hospital, should be made by the intermediary based on its knowledge of the hospital and the results of its "desk audit" of the hospital's cost report We would like to mention here that in addition to the hospital audits conducted by the intermediaries, special in-depth reviews of selected hospitals are made by SSA's Program Validation Branch and regional office contractor staffs to ensure compliance with HEW regulations and guidelines.

SSA's purpose in developing and encouraging the use of limited-scope audits was to aid in reducing the administrative costs of the program As GAO notes, limited-scope audits involve examinations of those items of hospital cost where the potential for adjustment appears to be the greatest In deciding on the scope of audit, an intermediary is, in a sense, making an informed judgment that the potential for audit adjustment in certain areas equals or exceeds the cost of auditing.

We think that for the most part this cost-benefit relationship has application in considering the need for the actions cited in the recommendation. Accordingly, we will advise all intermediaries of the importance of carefully considering, on a hospital-by-hospital basis, the type of in-depth reviews and other actions cited by GAO.

COMMENTS ON OTHER MATTERS IN THE GAO REPORT

Current Status of Settlements of Hospital Cost Reports (Page 18)

In discussing the status of settlements with hospitals and the percentage of hospitals, nationwide, that had made final settlement at June 30, 1971, the report states that on that date there were about 4,000 unsettled hospital cost reports applicable to the first three years of the Medicare program While the report does not draw any conclusions or make any recommendations with respect to the status of settlements, we would like to mention that there has been a continuing reduction in the backlog of unsettled cost reports In the Department's comments to GAO's June 1971 report--"Lengthy Delays in Settling the Costs of Health Services Furnished Under Medicare"--we described the substantial progress that has

been made as the parties concerned have gained more experience with Medicare requirements, and as systems, procedures, and policies have been refined As of December 31, 1971, settlements had been completed on 96 percent of the hospitals' first-year cost reports, on 89 percent of the second-year reports, and on 80 percent of the third-year reports Overall, there were fewer than 2,500 unsettled hospital cost reports applicable to the first three years of the program

GAO's Views Regarding The Problems Associated With Charges For Professional Services Of Hospital-Based Radiologists And Pathologists (Pages 39-51)

The report discusses various matters relative to GAO's finding that 5 of the 14 hospitals reviewed had charged the program a total of $175,300 in excess of actual costs for the services of hospital-based radiologists and pathologists While acknowledging the corrective actions taken by SSA, GAO believes that the following conditions may present continuing problems for SSA and the intermediaries

1. The combined billing method for hospitals was not authorized for reporting periods covered by many Medicare cost reports for which settlements have not been made, and

2. Many hospitals and their radiologists and pathologists did not elect to use the combined billing method, and for these institutions that continued to bill the carriers for the physicians' Part B professional component--SSA does not require that the carriers accumulate pertinent Medicare payment data to assist the hospitals and intermediaries during the cost reporting and settlement process.

With respect to the first item above, it has always been the intent of the Medicare program that charges for the professional services of hospital-based physicians should generally be designed to yield amounts closely related to the physician's compensation. When it came to our attention that errors in developing the compensation-related charge schedules resulted in hospitals receiving reimbursement which exceeded the actual compensation paid to physicians for their patient care services, new policy instructions (Part A Intermediary Manual, Section 3920) were issued in August 1971, calling for intermediaries to make the appropriate adjustments in their final cost settlements with the hospitals We are watching the implementation of these instructions closely On the basis of our experience, we will make whatever modifications are needed so that retroactive adjustments can be carried out effectively

With respect to the second item above, our August 1971 instructions were developed after careful study of the comments received from intermediaries and carriers Administrative and cost factors were also considered Indications were that except for the larger carriers with sophisticated computer systems, carriers by and large did not accumulate the pertinent data necessary for these retroactive adjustments during the normal course of operations. The carriers' comments indicated that to add this data requirement to their systems

would in many cases result in substantial additional costs We recognize that obtaining such payment data from hospital records instead of from the carriers has some disadvantages, but we think that the savings in administrative costs to the carriers will more than compensate for this

The draft report contains a statement that SSA had not compiled reliable data showing how many hospitals had elected to use the combined billing method We have begun a compilation of hospitals using combined billing and expect to complete it within the very near future

GAO's Views On Proposed Legislative Changes To Reimbursement System (Pages 55-57)

The draft report discusses prospective reimbursement with specific reference to the provisions of the Social Security Amendments of 1971 (H.R.1) requiring the Secretary to report to the Congress by July 1, 1973, on specific methods that might be used in the full implementation of a prospective reimbursement system under the Medicare, Medicaid, and Title V programs Although the report does not make any recommendations, GAO is of the view that

--in developing these specific methods, it is important that the Secretary provide for appropriate assurances that such prospective rates are based on the costs for only those services that are covered by the programs and are reasonably related to the care of those patients intended to benefit from the programs, and

--with respect to the professional (Part B) services of hospital-based physicians, it is important that the proposed method for reimbursement for these services be designed to yield amounts closely related to the physicians' compensation allocable to their Part B services

Section 402(a)(1)(B) of H.R.1 would, in effect, authorize the Secretary to engage in experiments for the purpose of determining whether the inclusion of services not now covered under Titles XVIII, XIX, and V, would have a favorable impact on presently covered services from the standpoint of economy and effective utilization. It is possible that the results of these experiments could point to the inclusion of "non-covered" services in the methods which could be used for implementing a prospective reimbursement system However, before the Department would sanction any such method, it would make sure that the services to be paid for are related to the care of those patients that the Congress intended the programs to benefit

In developing methods for implementing a prospective reimbursement system, it is likely that these methods would contemplate the required use of a "combined billing" procedure for billing for radiology and pathology services. This procedure should, as the report states in Chapter 3, tend to eliminate any problems of excessive Part B payments for these services

[See GAO note.]

GAO note: The deleted material pertains to suggested language changes which have been incorporated into the report.

Page 39, 2nd paragraph, beginning "Under SSA's instructions* ". We think that this is more a matter of the absence of specific instructions and that the finding would be placed in truer perspective if the report pointed out that two of the five intermediaries were involved We suggest the following language

> "SSA instructions accompanying the annual cost reporting forms for hospitals did not provide that these forms would show or include amounts received from Part B carriers and from Medicare patients for the professional services of hospital-based radiologists and pathologists In making final settlement, two of the five intermediaries involved in our reviews did not consider these amounts or determine whether they were greater than the related costs reported by the hospitals As a result, the five hospitals **etc "

Page 45, 4th paragraph beginning "Intermediary officials serving 3 of the 5 hospitals **". We think this presentation may lead the reader to assume that it reflects the views of a number of intermediaries when, in fact, it represents the views of only one intermediary The paragraph adds little, if anything, to the report, however, if it is to be included in the final report, we suggest a language change along these lines

> "Officials of one intermediary--serving 3 of the 5 hospitals where the excessive reimbursements occurred--stated that **etc."

We suggest too that, if the paragraph is to appear in the final report, SSA's comment to GAO's interim report be included, namely, that while the intermediary's views may have been true in the early days of the Medicare program, present instructions spell out with sufficient clarity what is expected of intermediaries in implementing the hospital-based physician reimbursement regulations.

GEORGE N THAJAPI
Vice President
Government Programs Operation

BLUE CROSS ASSOCIATION

840 NORTH LAKE SHORE DRIVE CHICAGO ILLINOIS 60611 (312) 329 5841

January 24, 1972

Mr Raymond A Del Rosso
Assistant Bureau Director
Contractor Operations
Bureau of Health Insurance
Department of Health, Education
and Welfare
Social Security Administration
Baltimore, Maryland 21235

Dear Mr Del Rosso

This is in regard to GAO's report entitled "Problems Associated with Reimbursement to Hospitals for Cost of Health Services Furnished Under Medicare" submitted to us for comment

The General Accounting Office's report is a summary of its findings based upon detailed audits of fourteen hospitals serviced by five intermediaries We offered specific comments on their findings in previous letters written to SSA It should be noted that in many instances, the intermediary and/or Social Security Administration disagreed with the findings reported by GAO We were not able to determine the extent to which these items were included in this summary report

The problem areas and adjustments identified by GAO arose because of many factors

(a) In some instances, the Medicare Regulations and Manuals were not clear, and a judgment decision had to be made by the intermediary based upon data available at that time

(b) In other instances, the differences arose because GAO's judgment of what was reasonable in the situation differed from the intermediary's

(c) GAO audits were conducted in substantially more detail than Medicare audit requirements contemplated

GAO note Page references in this appendix are keyed to an earlier draft of this report

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GAO recognized this fact as indicated on Page 22 of their report in which they state "We recognize that because of budget and staffing limitations, it may not have been practicable for the intermediaries to have explored certain cost reimbursement problems to the same extent as was done in our reviews at selected hospitals Our reviews were made in considerable detail with the objective of identifying any problem areas which would require the particular attention of SSA and the intermediaries in order to assure that Medicare payments are being made in accordance with the Law and Regulations " Had the intermediaries been able to be as thorough as GAO, they would have identified and adjusted many of these problem areas

(d) In some cases there were oversights by the auditors and/or the intermediaries

We wish to point out that, while the problem areas identified by GAO may represent areas which need to be clarified by SSA, they are not necessarily typical of the problems that would be encountered at other providers. GAO's report does not always specify the dollar amount applicable to each hospital or problem area or frequency of encountering the various problem areas identified Therefore, based on this report, we cannot determine whether a problem was unique to one hospital or whether only a few of the problem areas accounted for most of the dollar value of the adjustments GAO partially recognized this in their statement on Page 22 of their report "We also recognize that, because our review was directed to the larger hospitals which receive the vast majority of all Medicare payments to hospitals, the reimbursement problems identified during our review may not be representative for all hospitals participating in Medicare " [See GAO note]

We are in basic agreement with the conclusions reached by GAO Our specific comments on two of their recommendations are as follows

(1) GAO states (on Page 53) that " irrespective of how the scope of the individual Medicare hospital audits are determined, there is a need for . in depth reviews, particularly at the larger hospitals " The report is not clear as to what is meant by an "in depth review " The cost of performing a "full scope audit" in all such larger

GAO note SSA had inadvertently failed to provide BCA with copies of certain workpapers which GAO had furnished to SSA detailing our findings at the individual hospitals These workpapers were later furnished to BCA and considered in BCA s February 16, 1972 letter to SSA (See app III)

institutions would be prohibitive Under procedures currently in effect in the Program, the extent of audit required is determined based on a desk review of the cost report and the intermediaries' knowledge of the providers' operations We believe these procedures are adequate since large hospitals now receive additional review and audit where warranted because of their complexity and the materiality of reimbursement involved

(2) On Page 48, GAO indicates that the adoption of the "combined billing" method for services for all hospital-based radiologists and pathologists would practically eliminate the problem of excessive Part B reimbursement We agree with this conclusion since (1) combined billing does eliminate the problem of Part B overpayments by adjusting the payments to cost at year end through the cost reports and (2) the majority of hospital-based physicians are radiologists and pathologists However, there are other hospital-based physician specialists who perform a significant number of services for Medicare beneficiaries Allowing these physicians to combine bill all services would further reduce possible overpayment situations

We recommend that combined billing be instituted as the only method of billing for all Part B physician services (except, perhaps, psychiatric outpatient services) This would, then, result in all hospital-based physicians billing Medicare in the same manner and would be more efficient and less costly to the Program It would eliminate an extra billing by the hospital and the related processing by the intermediaries and carriers as well as resolving the problems associated with the dual roles of the intermediaries and carriers

This will, of course, require legislative changes to eliminate (as they are now eliminated for radiologists and pathologists) the deductible and coinsurance requirements on inpatient physician (Part B) services The savings to the Program resulting from the use of combined billing would appear to offset the additional cost of these deductible and coinsurance amounts

APPENDIX II

Mr Raymond A Del Rosso January 24, 1972

Thank you for the opportunity to comment on this material

Sincerely,

George N Hasapes

GNH BF bd

cc George Gordon
James Harford

GEORGE N HASAPES
Vice President
Government Programs Operations

BLUE CROSS ASSOCIATION

840 NORTH LAKE SHORE DRIVE CHICAGO ILLINOIS 60611 312 329 5841

February 16, 1972

Mr Raymond A Del Rosso
Assistant Bureau Director
Contractor Operations
Bureau of Health Insurance
Department of Health, Education
and Welfare
Social Security Administration
Baltimore, Maryland 21235

Dear Mr Del Rosso

We wish to make additional comments to GAO's report entitled Problems Associated with Reimbursement to Hospitals for Cost of Health Services Furnished Under Medicare " When we submitted our earlier comments by letter dated January 24, 1972, we did not have the supplemental detailed work sheets available for review

The detailed information highlights the important principle involved with the hospital-based physician adjustment noted on Page 43 of the report We are in complete support of the GAO position that the Medicare Program's total reimbursement to a hospital for physician services should not exceed the costs of the physician's services to that hospital The Regulations, Principles of Reimbursement and Congressional intent are clear that the hospital reimbursement must be limited in accordance with the arrangement between the hospital and the physician

The above principle holds even in situations where the billing mechanism for physician services is changed To permit reimbursement for physician services based on charges when no change has been made in the contractual arrangement between the physician and the hospital would generate amounts for hospital providers of service greatly in excess of costs for providing those services Permitting reimbursement based on charges in cases where only billing arrangements have been changed, would result, as a practical matter, in the elimination of hospital-based physicians' cost reimbursement

GAO note Page reference in this appendix is keyed to an earlier draft of this report

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Mr Raymond Del Rosso February 16, 1972

The detailed information also indicates that the report included all adjustments proposed by GAO whether or not the Intermediary and/or SSA agreed with the adjustments

Further, the detailed information submitted indicates that when the net effect of adjustments is considered (exclusive of hospital-based physician overpayments) three of the fourteen hospitals reviewed account for 97% of the total net adjustment amount Of these three, one hospital accounted for 62% of the total net adjustment

We appreciate the opportunity to furnish these additional comments

Sincerely,

George N. Hasapes

GNH g

GAO notes

1 For about 92 percent of the payments questioned by GAO SSA either concurred in the findings or stated that it would examine further into the matter

2 After considering overcharges and undercharges three of the 14 hospitals accounted for about 85 percent of the total net adjustments (exclusive of hospital-based-physician overpayments) and one hospital accounted for 51 percent of the total net adjustments. In several instances however significant Medicare overcharges at a particular hospital were offset by significant undercharges. At five hospitals GAO identified overcharges ranging from about $34 000 to $228 000 but for three of these five hospitals offsetting undercharges ranged from about $26 000 to $35 000 At seven hospitals GAO identified overcharges ranging from $6 000 to $12 000 but for five of these seven hospitals, the offsetting undercharges ranged from $100 to $7,500 For two hospitals GAO s reviews did not disclose any overcharges or undercharges

PRINCIPAL OFFICIALS OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE RESPONSIBLE FOR ADMINISTRATION OF ACTIVITIES DISCUSSED IN THIS REPORT

	Tenure of office	
	From	To
SECRETARY OF HEALTH, EDUCATION, AND WELFARE:		
Elliot L. Richardson	June 1970	Present
Robert H. Finch	Jan. 1969	June 1970
Wilbur J. Cohen	Mar. 1968	Jan. 1969
John W. Gardner	Aug. 1965	Mar. 1968
COMMISSIONER OF SOCIAL SECURITY:		
Robert M. Ball	Apr. 1962	Present
DIRECTOR, BUREAU OF HEALTH INSURANCE (Note a):		
Thomas M. Tierney	Apr. 1967	Present
Arthur E. Hess	July 1965	Apr. 1967

[a]The Bureau of Health Insurance was part of the Bureau of Disability and Health Insurance until September 1965, when separate bureaus were established to handle the functions of the disability program and the health insurance program.

U.S. GAO Wash D.C.

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