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UNITED STATES GENERAL ACCOUNTING OFFICE

WASHINGTON, D.C. 20548

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RELEASED

HUMAN RESOURCES DIVISION

SEPTEMBER 10, 1979

B-164031(3)

The Honorable Sam M. Gibbons
Chairman, Subcommittee on Oversight
Committee on Ways and Means
House of Representatives

Dear Mr. Chairman:

Subject: Blue Cross Association Performance as a Medicare Contractor (HRD-79-116)

Your March 1, 1979, letter (and attachments) requested that we examine (1) potential future roles for the Blue Cross Association (BCA) as a Medicare intermediary under contract with the Department of Health, Education, and Welfare (HEW) and (2) certain aspects of BCA's past performance as the prime contractor for the 68 Blue Cross plans acting as Medicare intermediaries.

Because of the particular concern you expressed over the adequacy of BCA's performance, this report deals exclusively with that issue. Alternative roles for BCA as a Medicare intermediary will be discussed in a separate report to you, which we currently expect to complete early in 1980.

The concern over BCA's performance centers on its role in and implementation of Medicare reimbursement policy for the fees charged to Medicare home health agencies by the Unihealth Services Corporation, Inc., of New Orleans. As you know, we testified on Unihealth's activities before your Subcommittee in August 1978, and subsequently, information was developed by the Subcommittee that suggested BCA may have delayed or interfered with the implementation of Medicare's policy on the allowability of Unihealth charges for reimbursement purposes.

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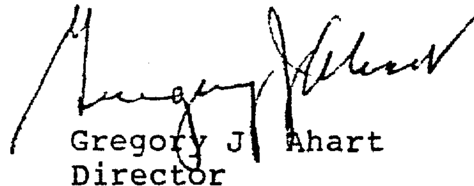
To place BCA's role in perspective, we developed a chronology (see enc. I) of the major events that highlight BCA's involvement in implementing Medicare's reimbursement policy for Unihealth fees. We believe it shows that BCA did not interfere with policy implementation.

Also, in connection with BCA's performance, you asked us to determine if there were other problems over the last few years. According to a Medicare Bureau evaluation covering the period January 1, 1972, to May 31, 1973, the answer is yes. BCA, however, disagreed and said that this assessment was neither accurate nor fair. A copy of this evaluation, as well as BCA's response, was provided to the Subcommittee staff on July 13, 1979. Because of the age of the evaluation, we did not attempt to validate its findings.

At your request, we did not obtain written comments from HEW or BCA. Also, unless you publicly announce the report's contents earlier, no further distribution will be made until 30 days from the date of the report. At that time, we will send copies to interested parties and make copies available to others upon request.

Sincerely yours,



Gregory J. Ahart
Director

Enclosure

CHRONOLOGY OF BLUE CROSS ASSOCIATION (BCA) ACTIONS IN IMPLEMENTING MEDICARE'S REIMBURSEMENT POLICY FOR UNIHEALTH FEES

June 21, 1973--After an inquiry from the North Carolina Blue Cross Plan concerning a contract between the Unihealth Services Corporation, Inc., and a home health agency serviced by the Plan, BCA advised that--for Medicare reimbursement purposes--the arrangement between Unihealth and the agency was a franchise arrangement for management services. Also, BCA said that Unihealth's $30 per hour fee was reasonable. BCA's decision on the fee's reasonableness was based on its knowledge of public accounting rates for similar services.

February 27, 1974--Because of earlier questions and requests for assistance from the New Orleans Plan, BCA contacted the plan for additional information on the relationship between Unihealth and Home Health Services of Louisiana, Inc. From this discussion BCA concluded that the Louisiana agency was related to Unihealth through control.

August 28, 1974--BCA completed research on management contract arrangements and issued a Management Contract Checklist (Administrative Bulletin #707-B, Revision #1) to all of the plans. The checklist was developed because of the growing number of management contracts between hospitals and outside management companies. The checklist applied, however, to any contractual agreement between a provider and a management company which was to perform services in return for a management fee. Key concerns outlined in the checklist were whether the (1) management contract represented an arm's length transaction, (2) parties were related through ownership or control, and (3) fees were reasonable.

September 18, 1974--In response to inquiries from several plans and the Medicare Bureau's Division of Direct Reimbursement 1/ regarding the relationship Unihealth had with the home health agencies it serviced, BCA made an onsite review at Unihealth's corporate headquarters in New Orleans.

1/The Division of Direct Reimbursement acts as an intermediary under Part A of Medicare and performs the same functions as various Blue Cross plans and commercial insurance companies.

<u>November 14, 1974</u>--Based on its site visit and information from the Division of Direct Reimbursement, BCA concluded that Unihealth's relationship with its providers was a management contract arrangement, except for Home Health Services of Louisiana, Inc., which was a related organization. On the basis of this determination BCA asked the Division of Direct Reimbursement and the Blue Cross plans serving Unihealth affiliated providers to review the reasonableness of the Unihealth fees.

We asked BCA's Director of Chain Organizations to explain the inconsistency between BCA's June 21, 1973, determination that Unihealth's relationship with a home health agency was a franchise arrangement for management services and its November 14, 1974, decision that Unihealth's relationship with its providers was a management contract arrangement. The Director explained that the June 21, 1973, decision involved BCA's first contact with Unihealth; the November 14, 1974, decision was determined after a more comprehensive study of Unihealth operations.

<u>March 12, 1976</u>--Prompted by the Colorado Blue Cross Plan's concerns over the unreasonableness of Unihealth's fees for the services it provided, BCA met with the Division of Direct Reimbursement to discuss management services under contractual arrangements. BCA agreed to work on a comprehensive audit program for home health agencies.

<u>September 21, 22, 1976</u>--At the Medicare Bureau's request, representatives from BCA and the Bureau met to standardize their approach to audits of Unihealth contracts.

<u>November 2, 1976</u>--BCA gave the nine plans serving Unihealth affiliated providers information from Unihealth regarding various contract changes (fee structure, contract length, etc.). BCA also stressed that the plans should follow the procedures in Administrative Bulletin #707-B, Revision #1 to evaluate Unihealth contracts.

<u>November 3, 1976</u>--The Medicare Bureau sent BCA a letter to confirm the conclusions reached at the September 21-22, 1976, meeting. Copies were also sent to the Division of Direct Reimbursement and the Travelers Insurance Company, since they too served Unihealth affiliated providers.

According to the letter, the Bureau concluded that the arrangement between Unihealth and its affiliated providers was a franchise. Therefore, the provider payments to Unihealth would have to be reviewed according to the provisions of Provider Reimbursement Manual, section 2133. This section requires that a reasonable value be placed on the individual services provided by Unihealth after eliminating the costs for services not related to patient care, including certain franchise fees. According to the Bureau, the basic difference between a franchise and a management arrangement is that the latter contains no elements of franchise and all services are considered to be related to patient care. The Bureau's letter instructed the intermediaries to use this method to review fees for all previously settled cost reports subject to reopening unless the review cost would exceed the likely recoveries.

February 10, 1977--BCA transmitted the Medicare Bureau's November 3, 1976, instructions to the nine Blue Cross plans which served Unihealth affiliated providers. To determine if the reanalysis would be worth the added costs, in the transmittal letter BCA requested information on the contract terms, services provided by Unihealth, and details on the intermediary's evaluation of reasonableness.

According to the Director for Chain Organizations, several factors contributed to BCA's 2-1/2 month delay in issuing the Bureau's instructions to the plans. First, the Director said that the Medicare Bureau's letter to BCA was not received until late December; it apparently had been misrouted. Second, the instructions came when the group responsible for notifying the plans had only two staff members to handle all chain organization matters. Third, the staff was hesitant about sending the letter because it had not specified how the intermediaries were to identify the franchise fees and it did not know how to instruct the plans.

BCA's Director for Chain Organizations did not believe that the Unihealth arrangement was a franchise. Further, the Director believed that since existing instructions (November 14, 1974) required evaluation of the costs for reasonableness, any residual franchise costs that might be identified were likely to be negligible.

All nine of the plans responded to BCA's request for information--seven in writing and the other two orally. The responses showed that most of the intermediaries serviced only one Unihealth affiliated provider with Blue Cross of Florida serving the most--10. While it was difficult to determine from the responses just what disallowances were made (or might be made), the responses did show that--with the exception of Blue Cross of Florida--the intermediaries had reviewed or were reviewing Unihealth fees. Blue Cross of Florida (response dated April 17, 1977) stated that most of its Unihealth affiliated providers were new and more information would be available after the field audits were completed. Eight of the ten agencies were approved for Medicare participation in June 1975 or later.

February 18, 1977--BCA issued a revised administrative bulletin (#707, 77.02) on management contract arrangements. It expanded the requirements of the previous bulletin (#707-B, Revision #1) by requiring the auditor to compare the fees for individual services to those charged on the open market and to determine if the management fee may be unreasonable in relation to the services provided. The comparisons were to be made for services such as data processing, cost report preparation, budgeting/financial counseling, and recruiting/training of personnel.

May 25, 1977--BCA issued its audit program for home health agencies. The manual was developed by BCA's Chain Organization Task Force to provide procedures for the examination of home health agency accounting and statistical records. It contains a section on purchased services which required evaluation of management service contracts using Administrative Bulletin #707, 77.02. It also contains a section on franchise fees which required the auditor to identify the specific services furnished, to determine whether they were patient related, and to evaluate the reasonableness of the costs in accordance with Medicare principles.

June 17, 1977--BCA met with representatives from the Division of Direct Reimbursement and the plans to discuss componentizing management charges to home health agencies, that is, identifying and placing a value on the individual services provided.

July 27, 1977--As a further result of its componentization effort, BCA sent eight plans copies of its management contract cost analysis for two home health agencies. Although the componentization was not complete, this information was furnished for use in evaluating cost reports already audited as well as for future audits. Basically, the analysis showed detailed examples of how the componentization approach could be applied to management fees.

October 6, 1977--Unihealth sued HEW over its decision to analyze Unihealth costs as if it were a franchise operation. From this point on, BCA's involvement with Unihealth reimbursement issues was essentially an assist role, that is, helping HEW prepare its case for the suit. BCA's future initiatives--as they relate to home health reimbursement--were concerned for the most part with developing cost per visit guidelines.

January 11-12, 1978--BCA's Ad Hoc Committee on Reasonable Costs for Home Health Agencies met to plan its research on home health agency costs. According to BCA, this research was necessary because the Medicare Bureau and its regional offices had not provided cost guidelines that were adequate to withstand appeal.

March 30, 1978--BCA requested audited home health agency cost report data from all of the Blue Cross plans. These data were to be analyzed and processed by computer to arrive at statistically reliable cost per visit guidelines.

August 10, 1978--BCA testified before the Subcommittee on Oversight, House Committee on Ways and Means on its efforts and recommendations to develop a comprehensive, national approach to home health agency reimbursement.

February 14, 1979--The court handling Unihealth's suit against HEW ruled that it did not have jurisdiction over the matter.

March 6, 1979--BCA issued to all of its plans the reasonable cost guidelines it had developed for home health agencies (exclusive of facility-based home health agencies such as those affiliated with hospitals and government-sponsored home health agencies). The guidelines provide ranges of per visit costs by type of visit (home health aide, skilled nurse, etc.) and by size of agency as measured by the number of visits made annually.

BCA instructed the plans to incorporate these guidelines into their desk review programs and the procedures used for determining the scope of their audits. It required that all home health agency Medicare provider cost reports for fiscal periods ended on or after July 1, 1974, which had not passed the 3-year limitation on reopening, be reanalyzed using these data to determine reasonable costs.

April 25, 1979--BCA issued to all of its plans reasonable cost guidelines for government-sponsored and facility-based home health agencies. The guidelines are identical to the March 6, 1979, guidelines in format and the types of information provided.