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

HUMAN RESOURCES
DIVISION

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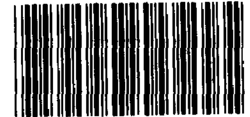
B-210564

FEBRUARY 2, 1983

The Honorable Robert Dole, Chairman
Committee on Finance
United States Senate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The Honorable John Heinz
Chairman, Special Committee
on Aging
United States Senate

Subject: Response to Questions Concerning Percentage Contracts and Limited Service Contracts under Medicare (GAO/HRD-83-30)

Your July 14, 1982, letter asked a number of questions related to contracting by Medicare providers. Since then, changes have been made in the Medicare law regarding percentage-type contracts by the Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97-248, approved Sept. 3, 1982). We agreed with your offices to address the questions related to such contracts in light of those changes. We also agreed to address the questions related to the need for Medicare's procedures for determining the reasonableness of prices under limited service contracts based on our prior report on management service contracts and on the rationale behind the current reimbursement requirements. In addition, we have begun a study designed to address your questions related to the inclusion in full-service management contracts of clauses calling for the contractor to do the purchasing for the provider. We will report to you on the results of that study at a later date.

In summary, we believe that Public Law 97-248 should, when implemented, significantly reduce the use of percentage-type contracts by providers under Medicare. Also, we believe that Medicare's use of reasonableness tests on the amount paid under limited service contracts is justified.

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PUBLIC LAW 97-248 PROHIBITS RECOGNITION OF MOST PERCENTAGE CONTRACTS FOR MEDICARE REIMBURSEMENT

You asked a number of questions about the extent of use by Medicare providers of percentage-type contracts, their effects on Medicare costs, and the reasonableness of this type of contracting. We made recommendations to the Department of Health and Human Services (HHS) in 1978 and 1980[1] that percentage-type contracts should be prohibited. Our concerns which led us to make these recommendations included:

—Paying a percentage of revenue to a contractor is not reasonable because such payments are not necessarily related to the costs of performing the contract.

—The total dollar amount of the contract payment is not known at the onset of the contract.

—There is an incentive for the contractor to maximize provider revenues and thereby maximize contract payments.

Section 109 of Public Law 97-248 prohibits, for a Medicare provider paid on a cost or cost-related basis, recognition of any cost incurred by the provider under a contract where the amount of payment is based on a percentage, or other proportion, of the provider's charges, revenues, or claim for reimbursement-ment. The only exceptions to this rule are (1) services by provider-based physicians,[2] (2) other services where the amount paid is reasonable and where such contracting is a <u>customary commercial</u> business practice, or (3) where the contract provides incentives for the efficient and economical operation of the provider of services and the amount paid is reasonable.

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[1]"Medicaid Insurance Contracts--Problems in Procuring, Administering, and Monitoring" (HRD-77-106, Jan. 23, 1978) and a June 30, 1980, letter report to the Administrator of the Health Care Financing Administration on hospitals' use of management services contracts.

[2]Section 108 of Public Law 97-248 restricts Medicare reimbursement to a provider for its payments to provider-based physicians to the costs, on a reasonable salary equivalent basis, of the services actually provided by the physicians for the general benefit of the provider's patients. This should effectively preclude Medicare recognition of percentage contracts between providers and provider-based physicians.

Regarding the second exemption, we do not believe many percentage-type contracts would be exempted because, while percentage contracting may be a "business practice" in certain segments of the health industry, it is not a "customary commercial business practice" except in a few isolated cases, such as a salesperson's commission. Concerning the third exemption, if, as required to obtain this exemption, the amount paid to the contractor is reasonable and the contract provides incentives for the efficient and economical operation of the provider, our above-listed concerns would be satisfied. However, we do not foresee many percentage-type contracts meeting these conditions for exemption because of the nature of our concerns about percentage contracts.

HHS has not issued regulations implementing section 109. When such regulations are established we expect that the problems associated with percentage-type contracts will be eliminated because such contracts should rarely be accepted for Medicare reimbursement purposes.

PROCEDURES FOR DETERMINING REASONABLENESS OF LIMITED SERVICE CONTRACT PAYMENTS ARE WARRANTED

You asked three questions related to the use of limited service contracts[3] and the procedures prescribed by HHS for determining the reasonableness of amounts paid under such contracts.

Do the concerns expressed in GAO's 1980 report apply to limited services contracts?

Our 1980 report on full-service management contracts[4] listed the following concerns about such contracts:

- The contracts frequently covered excessively long periods.

- The fees for many of the contracts were based on a percentage of gross revenues.

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[3]Limited service contracts are for a particular service or group of services, such as maintenance, laundry, or inhalation therapy.

[4]Full-service management contracts are those in which the contractor is responsible for the day-to-day management of the provider.

—The fees varied widely.

—The documentation of the services actually provided was inadequate.

—The adequacy of controls over payments to the firms was questionable.

—Medicare intermediaries generally were not reviewing the reasonableness of the fees charged.

—The Health Care Financing Administration (HCFA) had not developed adequate standards and instructions governing reimbursement for the costs of the contracts.

Any of these concerns would be applicable to limited service contracts if the same conditions were found to exist. Work we have underway indicates that in at least one type of limited service contract (respiratory therapy) some of the same problems exist.

Since our 1980 report, HCFA has issued guidance governing reimbursement for providers' contracts in the form of revisions to Medicare's Provider Reimbursement Manual, section 2135. We will address section 2135 later in this report in our response to your question about that section.

Are there any Medicare reimbursement mechanisms which dissuade providers from utilizing less costly in-house services?

In our opinion, there are no Medicare reimbursement mechanisms which specifically would dissuade providers from using less costly in-house services. Regardless of whether services are provided in-house or under contract, providers must document their costs to obtain reimbursement under Medicare and all costs are subject to a reasonableness test.

On the other hand, there are a number of Medicare reimbursement mechanisms which provide at least some incentives for choosing lower cost ways of operating whether they be in-house or contracted. For example, one Medicare reimbursement requirement, known as the prudent buyer principle, provides that for the costs of services to be reasonable, the provider cannot pay more than the going rate for the service and must act, like any cost-conscious buyer, to minimize costs. Another example is Medicare's reimbursement limits on the overall amount it will pay providers. These limits should provide incentives to hold

down costs at least below the limits because costs above them are normally not reimbursed. Also, hospitals share in Medicare savings when they hold their cost increases below specified levels.[5] This should also provide incentives for hospitals to select less costly ways of operating.

Is it reasonable to apply section 2135 to limited service contracts?

Section 2135 of Medicare's Provider Reimbursement Manual requires that a provider

—make a prudent decision to contract (that is, assure either that contracting is not more expensive than accomplishing the function in-house or that the function cannot be performed in-house),

—make a prudent purchase (that is, assure that the price of the contract is not excessive), and

—document that these requirements have been met.

All of these requirements, in our opinion, are reasonable. Before a provider contracts for a service currently being performed in-house, it should have analyzed costs to determine whether contracting out is justified. Also, if a provider is adding a new service it is only prudent to determine the most cost beneficial way of doing so, either by in-house or by contract.

The second requirement basically calls for the provider to pay no more than the marketplace price for the contract services and encourages the use of competition to assure this is the case. This is merely a prudent contracting procedure.

The third requirement permits Medicare to determine that the contracting process of the provider resulted in reasonable costs to the program.

Objective, scope, and methodology

We reviewed the provisions of Public Law 97-248 applicable to the questions we were asked, previous GAO reports, and current Medicare regulations and guidelines for determining reasonable costs. Our work was performed at HCFA headquarters and was

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[5]This incentive provision was added by section 101 of Public Law 97-248.

done in accordance with generally accepted government auditing standards.

As requested by your offices, we did not obtain comments from HHS on this report and, unless you publicly announce its contents earlier, no further distribution of this report will be made for 3 days. At that time, we will send copies to interested parties and make copies available to others upon request.

Edward A. Densmore

for Philip A. Bernstein
Director