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

HUMAN RESOURCES
DIVISION

120174

April 3, 1979

Mr. Leonard Schaeffer, Administrator
Health Care Financing Administration
Department of Health, Education, and
Welfare

AGC 00624

Dear Mr. Schaeffer:

We have recently completed a survey of the implementation of reimbursement procedures for outpatient dialysis treatments under the end stage renal disease program under Medicare.

The Social Security Amendments of 1972 (Public Law 92-603, enacted on October 30, 1972) authorized the program and mandated that it be operational by July 1, 1973. At the time of enactment, little data was available on the cost of providing renal dialysis treatments and, therefore, to have the program operational by July 1, "interim" reimbursement rates were established which are still in effect.

AGC 01482

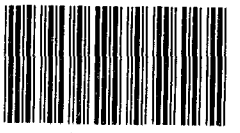
Over the years the Medicare Bureau has made efforts to collect cost data which would serve as a basis for modifying the interim rates, if deemed necessary. The Bureau's efforts, however, have been hampered by court challenges to HEW's authority to collect cost data by the free-standing non-provider renal dialysis facilities.

On June 13, 1978, Public Law 95-292 was enacted and specifically spelled out HEW's authority to collect cost data. The law stated that the Secretary of HEW was to prescribe by regulation the methods and procedures to determine the costs incurred by providers of services and the non-provider renal dialysis facilities. The legislation further provided that the Secretary was to have in place by July 1, 1979, an incentive reimbursement system for such providers and facilities. The reimbursement rate (or rates) developed under the system are to be applied to a facility's or provider's first accounting period which begins on or after the July 1 date.

After the enactment of Public Law 95-292, most renal dialysis facilities have submitted cost data. However, because the Medicare Bureau did not promptly establish cost reporting standards such as the Medicare cost reimbursement principles, for cost reporting, (HIM-15) the validity

~~504870~~

120174



of the current cost data for rate setting purposes is suspect. Facilities were essentially free to report costs as they pleased and at the five facilities we visited as part of our survey, their reported costs were, in fact, inflated based on Medicare cost principles.

In February 1979, the Medicare Bureau asked that the facilities resubmit their cost data in accordance with HIM-15 principles. Further, the facilities were asked to comply by February 28, 1979. As of March 27 only a few of the approximately 240 free-standing renal dialysis facilities had resubmitted cost data.

As mentioned above, as part of our survey, we visited five non-provider renal dialysis facilities and we identified a wide variety of reported costs which would not be allowable under HIM-15 principles.

In terms of the materiality of these overstated costs for rate setting purposes, however, the most significant cost items involved the inclusion of (1) bad debts and charity and courtesy allowances and (2) transactions between related organizations.

Although HIM-15 provides for the reimbursement of bad debts attributable to Medicare's deductible and coinsurance, these amounts, as well as charity and courtesy allowance are not to be reported as allowable program costs. Three of the five facilities we visited included these types of costs in the amounts of $114,000, $98,000, and $69,000. On a reported cost per treatment basis, these unallowable costs amounted to $6, $12.50, and $8, respectively.

In those instances where a provider obtained services, facilities, or supplies from an organization considered to be related by ownership or control, HIM-15 limits the provider's allowable cost to the related organization's costs, exclusive of any profit. Three of the five facilities we visited purchased or leased supplies and equipment from related organizations at prices that included markups which in at least two cases appeared material for rate setting purposes.

At one not-for-profit facility the five physician officers/directors had formed a for-profit organization which provided dialysis equipment, supplies, and space to the dialysis facility. Because of an access to records problem and poor accounting records, we could not establish the cost of the related organization transactions or the profits or markups involved. At another non-profit facility the president/director leased dialysis equipment to the facility at a $17, 284 profit or about $2.20 per treatment.

The third facility was a member of a chain of renal dialysis facilities owned and operated by National Medical Care, Inc. of Boston, Massachusetts. In 1977, this chain operated 85 facilities which provided about 720,000

dialysis treatments. Erika, Inc., which is a wholly-owned subsidiary of the chain, sells dialysis supplies and equipment to the chain members and in 1977 intercompany sales amounted to about $31 million or 60 percent of total sales. Operating profit for the period was about $6.5 million or about 13 percent of total sales, including that profit attributed to unaffiliated customers. For this facility, we estimate the markup on related organization transactions was about $5.60 per treatment.

To the extent that costs reports are resubmitted and time permits, we believe that it would be worthwhile to check--to the extent possible--the facilities' compliance with the bad debt and related organization provisions of HIM-15. In any event, we believe these two areas should receive close scrutiny for rates established in subsequent years.

Sincerely yours,

Robert E. Iffert, Jr.
Assistant Director