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Double return on volunteer medical services

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by

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The physicians of Chicago's Cook County Hospital are now building a large research and charitable fund that will help improve patient care in the Chicago area. They are using as a foundation a Medicare regulation that allows them to bill Medicare for the fair market value of professional services given by the volunteer medical staff of the hospital.

The doctors' plan was drawn from a preliminary management survey by Touche Ross in October and November 1966. Because of our familiarity with Medicare regulations and appreciation of the potential funds which might be involved, we proposed as one of the survey recommendations that the doctors consider forming an organization to determine the practicability—as well as the feasibility—of attempting to obtain some of the funds apparently available under the Medicare regulations.

The doctors agreed and formed the Associated Physicians of Cook County Hospital, Inc.

The corporation's by-laws described the purpose of the organization: "The corporation is organized to carry on and promote medical and scientific education and research; to educate and train doctors, nurses, technicians and other persons to the extent related to or instant to modern hospital and medical care and services; to promote and improve extended medical treatment and hospital facilities. No part of the income of this corporation shall be distributed to its members, directors or officers and no part of the net earnings of the corporation shall inure to the benefit of any member or individual . . ."

To accomplish this end, the Associated Physicians asked us to:

—Estimate the amount of money that might be collected by billing Medicare and other third parties, such as insurance companies, for the fair market value of volunteer services;

—Recommend an appropriate organizational unit to receive and manage the funds;

—Obtain a ruling from the Internal Revenue Service to protect the participating volunteer physicians from the tax liability for the services to be billed;

—Estimate the cost of operating the billing and collection system;

—Estimate the initial cost of design and implementation of the billing and collection procedures.

The concept we developed for Cook County follows in principle Medicare regulations that are often used when persons, such as nuns, work without monetary compensation as nurses in a hospital.

According to these regulations, volunteers performing professional services for a hospital might, in addition to contributing their time, enable the hospital to benefit financially from their services if the equivalent value of their services were included in the hospital's cost report. In such cases the cost of providing equivalent nursing services is determined and agreed upon by both the hospital and the Medicare intermediary. Then the hospital is entitled to include the nursing cost as part of its operating cost in the Medicare report, which is submitted to the intermediary and ultimately to the Social Security Administration. The nursing cost is established by reviewing the wage rates paid by other hospitals in the immediate area and determining the market value of the nursing services.

One of the central principles of Medicare requires that the hospital be reimbursed for the cost of treating patients. During the year the hospital submits invoices to the Medicare intermediary and is paid on a provisional basis for the patient bills submitted. At the end of the hospital's fiscal year, a final settlement is made.

Because that settlement is based on the actual cost incurred, it can result in the hospital's owing the intermediary money or the intermediary's owing the hospital. The settlement is determined by the cost incurred by the hospital versus the payments received and/or outstanding. Since the federal government is willing to share only the cost applicable for treating Medicare patients, the computation of the amount due requires a number of calculations which, in effect, prorate the elements of cost equitably between the Medicare and the non-Medicare patient services provided by the hospital.

The calculations are summarized on a cost report which is submitted to the government annually. That report is then used as a basis for a final determination of the amount of money, representing Medicare costs, recoverable from the federal government.

The principal point of divergence between these concepts and the plan created for the Chicago hospital is that the Cook County doctors formed an independent professional organization and elected to bill Medicare for the professional services rendered, as they would any private patient. Therefore, the doctors are not required to file a cost

report, nor are their activities considered in the hospital's Medicare cost report. In this way the volunteer doctors can give their time and simultaneously make a financial contribution to better patient care.

A particularly knotty problem that faced the Touche Ross team was obtaining a ruling from the Internal Revenue Service to exempt from payment of federal income taxes the proposed organization and the income generated by the billing. This exemption was based on the charitable uses to which this money would be put.

The team submitted the ruling request to the IRS with the proposed by-laws of the organization. But unfortunately accounts appeared in newspapers and financial publications almost simultaneously—and independently—outlining the abusive practices of private tax-exempt foundations. The most prominent was a Barrington, Illinois, firm, the American Building Constitutionally, which was accused of avoiding the spirit of the regulations and schooling others in how to abuse these regulations.

As Touche Ross submitted the request for exemption, this account was written in the Wall Street Journal:

August 28, 1967.

Foundation Twist

How Families Create Organizations to Cut Their Liability for Tax

Group Gives 30-hour Course that Teaches its Members Way to Revamp Finances

But Prober Doubts Legality

". . . Where did a medical man pick up such sophistication in the nation's complex tax laws? From a nonprofit membership trust called American Building Constitutionally, or ABC. Dr. Saxon paid a $7,000 membership fee to join ABC shortly after it was formed early in 1966. (The fee was raised to $10,500 last May 1.)

An ABC trustee says the organization is "Henry Fordizing"—or mass producing—legal and tax expertise long available only to the wealthy. In little more than a year of existence, this trustee says, ABC has helped more than 800 members in nearly 50 states establish nonprofit foundations and related trusts that lessen the income, property and estate taxes the members pay.

ABC's purpose is to "awaken the average creative person" to the benefits of "restructuring" his business and estate on a not-for-profit basis, says Robert D. Hayes, a Barrington, Illinois, sales training expert and one of ABC's trustees. Wealthy families recognized early in this century, Mr. Hayes says, that the principle of tax exemption for nonprofit endeavors "provides a means of giving people a chance to benefit mankind and have certain advantages." He adds: "If it's legal, moral and ethical for them, it ought to be ethical for everyone else."

At a time when Congress is considering tighter controls over tax-exempt foundations, ABC is attracting the attention of some state and Federal officials. California and Illinois officials and a Congressional subcommittee are known to be poking into ABC's affairs.

Wright Patman, Too

A House of Representatives small business subcommittee, which has been studying private tax-exempt foundations since 1962, is about to reconsider ABC's operations. "I am deeply concerned about it," says Rep. Wright Patman of Texas, who is chairman of the subcommittee. H. A. Olsher, the subcommittee's director of foundation studies, has gone to Illinois to learn about ABC first-hand.

A spokesman for the Internal Revenue Service says the IRS is "apprehensive" about ABC. But the IRS has taken no position toward it. "We expect an investigation of the whole organization by the IRS," says ABC's Mr. Hayes. . . ."

Consequently the publicity delayed an IRS determination until it was entirely satisfied with the merits of the proposed doctors' organization.

The very size of Cook County Hospital presented a number of practical problems. One of the world's three largest hospitals, Cook County treats some 80,000 in-patients annually and provides outpatient care to more than 260,000 a year. The hospital complex covers 21 acres and is served by a professional and administrative staff of over 6,000.

Since the hospital is so large, one of the team's first problems was to determine how much money would be involved. It became apparent that the potential was staggering.

William M. McCoy, the administrator of Chicago's Cook County Hospital, one of the world's three largest hospitals.

The second problem was the development of an appropriate schedule of fee norms. The norms had to be agreed upon by both the doctors and the intermediary—in this case Blue Cross/Blue Shield of Illinois. It was because of the sensitive nature of this information that the doctors asked Touche Ross to gather and tabulate it.

Once Touche Ross developed a set of standard fees, the team sampled the Medicare case records of patients treated in Cook County Hospital and developed a profile of the typical Medicare patient.

With these statistics it was possible to project the gross amount of dollars involved with a high degree of mathematical reliability. After properly structured sampling techniques were employed, mathematical formulas were applied which predicted accurately, in terms of standard deviation, the potential amount of money involved.

The problem of estimating the amount of potential revenue was further complicated by the deductible features included in the provisions of the Medicare Act. According to the Medicare law, in a twelve-month period each individual must have a $50 deductible applied to the billing generated under Part B (the part of Medicare coverage involved in physicians' billings) and a 20 percent co-insurance factor for all charges over the $50 figure. Our estimates, therefore, had to consider the deductible features under the Part B of the Medicare law.

The third problem was far less complicated but nevertheless a real problem. It was to review the county's routing of billing paper work. To insure that the paper work applicable to Medicare patients would enter the special routines demanded by the proposed volunteer physicians' billing cycle, adequate safeguards needed to be designed. Since the entire billing system of Cook County Hospital uses an average daily rate to develop a patient invoice, it was necessary to make a detailed survey of the various departments involved in billing: public aid, admissions, insurance and medical records.

At this point the study team had to unravel and document both the economic benefits and the existing billing paper workflow. Then the proposed system could be defined in enough detail to allow us to prepare a general description of it. This included the design, on a broad level, of the actual system, allowing us to determine the type and number of personnel which would be required for operation. From there we were able to estimate operating costs, both initial and ongoing.

By mid-October 1967 the work was completed and the report made to the physicians' committee. Finding the results encouraging, the committee elected to put the project to work.

They hired an administrative staff, incorporated an organization and began the billing. By April 1968 over $200,000 in billings had been generated and cash collections were coming in. The chairman of the physicians' organization estimated then that by December 1968 over $500,000 will have been collected. He predicted that that sum will represent only the beginning of the estimated $700,000 or more to be realized from the project—and turned ultimately into better patient care in all Chicago area hospitals.