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REPORT TO THE CHAIRMAN
COMMITTEE ON FINANCE
UNITED STATES SENATE

12-1181



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Evaluation Of Department Of
Health, Education, And Welfare
Proposed Regulation Changes
Affecting Medicare Reimbursements
To Institutions B-164031(4)

BY THE COMPTROLLER GENERAL
OF THE UNITED STATES

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MARCH 24, 1972



COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

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Dear Mr. Chairman:

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The letter of the Senate Committee on Finance, dated October 13, 1971, requested our views on regulation changes under consideration by the Social Security Administration that would modify the use of the combination method of apportioning institutional costs to the Medicare program. Specifically you requested our comments as to whether the changes proposed by the Social Security Administration would result in modification of the reimbursement alternatives along the lines we had recommended in our report to the Congress on lengthy delays in settling the costs of health services furnished under Medicare (B-164031(4), June 23, 1971).

After the receipt of your letter, the Department of Health, Education, and Welfare (HEW) published in the Federal Register on December 2, 1971, a modified version of the regulation changes in the form of a proposed rule pursuant to the Administrative Procedure Act (5 U.S.C. 552 et seq.). Therefore our comments will be directed to the version of the proposed changes as published in the Federal Register.

Essentially the proposed changes would:

- Require the use of a modified version of the combination method of apportionment--excluding delivery-room costs--by hospitals having fewer than 100 beds.
- Require the use of the more accurate departmental method of apportionment by all other hospitals.
- Revise the departmental method to apportion routine services (such as room, board, and nursing services) on the basis of an average per diem cost instead of on the basis of the ratio of routine-service charges for Medicare patients to the routine-service charges for all patients. The average per diem cost basis will continue to be used under the combination method.

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--Provide for separate average per diem cost apportionment for intensive-care, coronary-care, and other special-care inpatient units.

We believe that overall the proposed changes will meet the basic objectives of the recommendation and comments included in our June 1971 report. We still believe, however, that (1) to be consistent with the Medicare law, some recognition should be given to the cost differential between private and semiprivate accommodations and (2) the number of beds in a hospital should not be the sole criterion for determining the method of apportionment to be used. We believe also that the establishment of separate cost centers for intensive-care, coronary-care, and other special-care inpatient units would not simplify cost-finding and apportionment requirements for many smaller hospitals.

SUMMARY OF ISSUES RAISED
IN OUR JUNE 1971 REPORT

Our June 1971 report pointed out that some intermediaries had delayed making final settlements with hospitals because they had questions concerning the hospitals' use of the combination method instead of the departmental method of apportioning costs between Medicare and non-Medicare patients. The use of the combination method resulted in Medicare payments that included certain private-room costs, which are not covered under the program unless medically necessary, and delivery-room costs, which are not applicable to Medicare patients.

We reported that, to determine the significance of the intermediaries' questions, we had analyzed a sample of 239 Medicare cost reports for hospitals in 32 States and Puerto Rico. Medicare's share of the allowable costs had been apportioned by the departmental method in only 12 percent of these cost reports. For 100 of the hospital cost reports in our sample that had been based on the combination method, we were able to compare the amounts of Medicare costs allowed

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with the amounts of Medicare costs that would have been allowed if the departmental method of apportionment had been used.

Our comparison showed that overall the use of the combination method had resulted in reimbursements which were about 4 percent higher than they would have been under the departmental method. Of this 4-percent variance

- about 1 percent was applicable to the differences in computing Medicare's share of routine-service costs and

- about 3 percent was applicable to differences in computing Medicare's share of the ancillary-service costs (such as delivery-room, X-ray, operating-room, and pharmacy costs). About one half of the 3 percent was due to the inclusion of delivery-room costs in the combination method.

Because a 4-percent difference in total Medicare payments for inpatient hospital services represents about \$200 million annually for 1970 and 1971, we concluded that the intermediaries' questions concerning the methods of cost apportionment under Medicare involved an important issue which should be brought to the attention of the Congress. We recommended to HEW that the use of the combination method of apportionment be discontinued or modified.

In responding to our recommendation, HEW stated that, in accordance with an agreement with your Committee, a decision had been made to require larger providers (e.g., those having 100 or more beds) to use the more accurate departmental method to apportion costs to the Medicare program and to require smaller providers (e.g., those having fewer than 100 beds) to use a more simplified method of apportionment.

In commenting on HEW's response to our recommendation, we pointed out that:

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--The departmental method (the use of the ratio of Medicare patient charges to total patient charges) of apportioning the costs of routine services might be inequitable to some hospitals because the differences between hospital charges for private and semiprivate accommodations might not be representative of the differences in costs between such accommodations. Therefore we suggested that some alternative method of recognizing cost differences between various types of accommodations should be developed by the Social Security Administration.

--The number of beds in a hospital should not be the sole criterion for determining which apportionment method should be used for Medicare reimbursement purposes.

Our comments on HEW's December 1971 proposed regulation changes, which refer particularly to the issues raised in our June 1971 report, are as follows.

CHANGES IN METHODS OF APPORTIONING
ANCILLARY-SERVICE COSTS

Generally, about two thirds of Medicare reimbursable costs for inpatient hospital services are for routine services and about one third are for ancillary services. It has been in the apportionment of these ancillary-service costs that most of the differences between the departmental method (the use of ratios of Medicare patient charges to total patient charges for each ancillary department) and the combination method (the use of the ratio of Medicare patient charges to total patient charges for all ancillary departments) seem to have occurred.

For the 100 hospital cost reports included in the sample discussed in our June 1971 report, the ancillary-service costs apportioned to Medicare under the combination method were about \$13.5 million whereas the ancillary-service costs that would have been apportioned to Medicare under the departmental

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method were about \$12.1 million--a difference of about \$1.4 million, or about 10 percent. About half of this difference was due to the inclusion of delivery-room costs under the combination method.

We recognize that the costs of hospital services to Medicare patients are not susceptible to precise determinations. We believe, however, that such a large difference is unreasonable when it (1) results solely from the method of apportionment selected by a hospital and (2) includes the costs of services which are not used by Medicare patients.

Under HEW's December 1971 proposed regulations, the method of apportioning ancillary-service costs to Medicare for hospitals having 100 or more beds would be the departmental method; this is consistent with our recommendation. For hospitals having fewer than 100 beds, Medicare's share of the ancillary-service costs would be determined on the basis of the ratio of Medicare patient charges to all patient charges for all ancillary services exclusive of delivery-room costs and charges. In our opinion, this change would substantially reduce the differences between the two apportionment methods and therefore is in line with the objectives of our recommendation.

CHANGES IN METHODS OF APPORTIONING ROUTINE SERVICE COSTS

Under HEW's proposed regulations the use of hospital charges as a basis for apportioning routine-service costs to Medicare would be discontinued and the average per diem cost method of apportioning such costs would be the method used by all hospitals, regardless of size. If a hospital--regardless of size--has separate and distinct intensive-care, coronary-care, or other special-care inpatient units, then the costs of these units would be determined and apportioned separately to Medicare on an average per diem cost basis.

Private-room cost differential

Under the proposed regulation changes, no distinction would exist between the costs of private and semiprivate accommodations unless such private accommodations could be characterized as luxury items or services. In our opinion, this accounting treatment may not be consistent with the Medicare law.

In defining "reasonable costs," section 1861(v)(2)(A) of the Social Security Act provides that:

"If the bed and board furnished as part of inpatient hospital services *** is in accommodations more expensive than semi-private accommodations, the amount taken into account for purposes of payment under this title with respect to such services may not exceed an amount equal to the reasonable cost of such services if furnished in such semi-private accommodation unless the more expensive accommodations were required for medical reasons."

It appears that this provision indicates that the Congress has presumed that differences in costs existed between semiprivate accommodations and the more expensive institutional accommodations, such as private rooms. The Social Security Administration recognizes that the proposed regulation changes will not differentiate between the costs, but it has concluded that the actual cost differential between such accommodations is far smaller than the charge differential typically imposed.

As indicated in our June 1971 report, we tend to agree with this conclusion. In December 1971 we made a survey of 15 large hospitals (those having 100 to 850 beds) in the Baltimore, Maryland, and Washington, D.C., areas. The survey showed that the daily charges for private rooms generally ranged from \$6 to \$22--or 10 to 30 percent--more than the daily charges for semiprivate rooms. The number of private-room beds ranged from 2 to 33 percent of total beds.

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Under the existing prescribed Medicare cost-finding and cost-reporting procedures, the only costs which can be related measurably to the different accommodations are those costs (depreciation and maintenance or operation of plant) which are allocated to the various activities on the basis of space (square footage). Hospital cost data published by the American Hospital Association in June 1969 indicated that these two cost items represented about 10 percent of total hospital costs.

Under the existing procedures, these depreciation and plant maintenance costs must be allocated--through cost finding--to outpatient services, routine inpatient services, various ancillary inpatient services, the nursery, and any non-patient-care activities. We believe that any further allocations to private and semiprivate accommodations of the portions of these costs distributed to routine services would not be in accordance with the express wishes of your Committee to simplify Medicare cost-finding requirements in order to balance the accuracy of the reimbursable amount to individual hospitals against the cost and difficulty of obtaining it.

Therefore a possible solution to the practical problems of complying with section 1861(v)(2)(A) of the act would be for the Social Security Administration to establish a standard private-room cost differential--based on a study of a random sample of hospitals--which could be applied uniformly by all hospitals on the basis of the number of their private rooms.

For example, consider a hypothetical case using the following assumptions: the standard nationwide cost differential between private and semiprivate accommodations is \$2 a day; a specific hospital has 300 beds, of which 50 are in private rooms; the hospital's allowable inpatient routine services costs are \$3.5 million; and Medicare inpatient days are 30 percent of total patient days. The private-room cost differential and the related adjustment to reimbursable costs in this case would be computed as follows:

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\$2 x 360 days x 50 private rooms	\$36,000
Total allowable routine-service costs	\$3,500,000
Less private-room cost differential	<u>36,000</u>
Adjusted routine-service costs	\$3,464,000
Multiplied by ratio of Medicare inpatient days to total inpatient days	<u>30%</u>
Costs apportioned to Medicare	<u>\$1,039,200</u>

The effect of the foregoing adjustment for the private-room cost differential in the example cited would be about a 1-percent reduction in the routine-service costs reimbursable by Medicare. Although the reduction in reimbursements to individual hospitals may not be significant, the aggregate effect of such reductions of even a fraction of a percent under the multibillion-dollar Medicare program would amount to millions of dollars a year.

If your Committee believes, however, that any cost differential between private and semiprivate accommodations is negligible and would not merit the cost and difficulty of determination, the Committee may wish to consider amending the Medicare law to eliminate any requirement that such cost differentials--except for luxury accommodations--be considered in determining an institution's reimbursable Medicare cost.

Separate apportionment of
routine-service costs for
special-care inpatient units

HEW's proposed regulations provide for separate average per diem cost apportionments for the costs of intensive-care, coronary-care, and other special-care inpatient units, regardless of the size of the hospital. As of June 30, 1971, about 7,000 hospitals were participating in Medicare. According to an August 1971 publication of the American Hospital Association, about 2,750 participating hospitals reported

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having intensive-care units and about 2,300 participating hospitals reported having intensive-cardiac-care units. Our analysis of these data for 12 States showed that about 20 percent of those hospitals having intensive-care and/or coronary-care units had fewer than 100 beds.

Although we have no objection in principle to the proposed refinement to the apportionment methods, it will not simplify the cost-reporting and cost-finding requirements for the small hospitals and it probably will increase the costs to the Medicare program.

Early in the program a special report form--which served the combined cost-reporting requirements of Medicare, Medicaid, and Blue Cross--was approved by the Social Security Administration for use by hospitals in California. On this form, the costs of intensive-care units could be shown separately from other routine-service costs. The statistical data shown in these cost reports were not sufficient to establish the average per diem cost differences between the intensive-care units and general routine services. Our analysis of 35 of these cost reports showed, however, that:

- Intensive-care units accounted for about 7 percent of total routine-service costs.
- Utilization of intensive-care units by Medicare patients averaged about 10 percent more than the utilization by Medicare patients of all routine services, including intensive care. That is, if Medicare patients represented 30 percent of total inpatient days, then Medicare patients would represent about 40 percent of intensive-care inpatient days.

If these data are used as a rough measurement, it appears likely that the proposed refinement in the apportionment methods for intensive-care units would increase Medicare reimbursements to hospitals by less than 1 percent. No similar cost or utilization data were available for coronary-care or other special-care units.

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Although the cost increase to Medicare would appear to be small in relation to total program costs, we believe that the cost increase to the program could be substantial if there were any increases in

- the numbers and types of special-care units for which Medicare's share of costs was determined separately,
- the utilization by Medicare patients of these special-care units in relation to their utilization of other routine inpatient services, or
- the allocation of hospital costs to the special-care units.

CRITERION FOR APPLYING APPORTIONMENT METHODS

We recognize that, to develop regulations involving a subject as complex and far-reaching as Medicare reimbursements to hospitals, some arbitrary judgments have to be made. We recognize also that, to facilitate effective program administration, the apportionment method to be used by each hospital should be set in advance and should not be subject to periodic changes from one method to another.

Nevertheless, as stated in our June 1971 report, it is our opinion that the number of beds in a hospital should not be the sole criterion for determining whether the departmental apportionment method or a simplified and modified version of the combination method should be used for Medicare reimbursement purposes. We believe that total hospital expenses and the previous level of Medicare reimbursement also are important factors to be considered.

Because of the rising costs of hospital care, it is not uncommon for some hospitals having fewer than 100 beds to receive Medicare payments of over \$500,000 a year. Occasionally such hospitals receive Medicare payments of over \$1 million a year. It seems reasonable to us that the more accurate departmental apportionment method should be required in those

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cases in which the amounts of Medicare payments are large enough to warrant the more accurate determinations of reimbursable costs and particularly in those cases in which the hospitals will be further refining their cost-finding and statistical data to identify separately the costs and inpatient days of intensive-care, coronary-care, and other special-care units.

Therefore we believe that the requirement to use the departmental method of apportionment could be extended to those hospitals having fewer than 100 beds where--for two successive preceding Medicare reporting periods--the hospitals' reimbursable Medicare costs were more than \$500,000 a year. We estimate that about 200 hospitals currently would fall into this category.

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So that these views could be considered before the proposed regulation changes were finalized by HEW, we made the contents of this report available to the Social Security Administration for comment.

In commenting on our observation concerning the private-room cost differential, Social Security officials advised us that:

**** we have concluded, after giving full consideration to the views of expert consultants retained to advise SSA in developing the proposed regulations and after researching the literature and studying the issue of alleged cost differential between private and semi-private accommodations, that there is no real evidence of the general existence of such a differential or any administratively feasible method for measuring any such differentials that do, in fact, exist. Although there may be some elements of cost allocated on the basis of space that would suggest a greater cost of furnishing private room accommodations, there are other factors--for example,

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more efficiency in utilization due to the greater flexibility possible in assigning private room beds and certain savings of staff time devoted to meeting 'contagious' patient wants and to assuring privacy of patients in semi-private rooms--that would have the opposite effect on cost. On balance, SSA has concluded that it is reasonable to assume that, for all practical purposes, no measurable differential exists. However, we do not recommend that the law be amended to coincide with our present view on the subject inasmuch as subsequent findings of Government or private research on patient care costs may indicate otherwise and, if so, we would wish to provide for the disallowance of any private-semi-private routine service cost differential that could be identified or assumed on the basis of such studies."

In commenting on our reservations concerning the use of the number of beds as the sole criterion for determining whether the departmental method should be used, the Social Security Administration advised us that:

"*** Although bed size is imprecise as a test of capability for carrying out the Departmental Method, we believe that the 100-bed guideline suggested in the Report of the Committee on Finance (Senate Report No. 91-1431) is reasonable. As the Committee noted, on page 180 of this report, '...there is a correlation between accounting systems and expertise and institution size....' While we are sympathetic to the GAO objective of obtaining the more precise method of apportionment where relatively large amounts of money are involved, we believe that the level of Medicare reimbursement--which is a function of the Medicare proportion of the patient load of an institution as well as of its size--is less reliable than the size of the institution as a test of capability for employing the Departmental Method."

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We appreciate the opportunity to comment on these changes and we hope that the above information will be useful to your Committee.

Sincerely yours,



Comptroller General
of the United States

C ^{*xR*} The Honorable Russell B. Long
Chairman, Committee on Finance *S 4100*
United States Senate