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STATEMENT OF

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SPECIAL ASSISTANT TO THE COMPTROLLER GENERAL

BEFORE THE

SUBCOMMITTEE ON CIVIL SERVICE

COMMITTEE ON POST OFFICE AND CIVIL SERVICE

HOUSE OF REPRESENTATIVES

ON

OFFICE OF THE SPECIAL COUNSEL,

MERIT SYSTEMS PROTECTION BOARD

032044/ 126944

Madam Chairwoman and Members of the Subcommittee:

I am pleased to appear before you to discuss our review, made at your request, of the Office of the Special Counsel of the Merit Systems Protection Board and to provide our views on operations of the Special Counsel under the Civil Service Reform Act. My testimony, like our report, will concentrate on the protections against reprisal available to government whistleblowers.

Of about 3,500 prohibited personnel action complaints filed with the Special Counsel in the past two years, some 400 involved allegations of reprisal for whistleblowing. Nearly all 400 sought relief from some adverse agency action taken allegedly without cause other than in reprisal against legitimate whistleblowing activity. Few of these complainants will ever receive the relief they seek through the Office of the Special Counsel, particularly as the Special Counsel does not emphasize the pursuit of corrective action on behalf of aggrieved whistleblowers. During the two years prior to August 1984, the Special Counsel obtained redress for a total of but three whistleblowers--redress in the form of canceled transfers. On the other hand the Special Counsel, in emphasizing disciplinary measures to punish perpetrators of prohibited personnel practices, last year for the first time did win several disciplinary action cases before the MSPB; and he was able to work out four other disciplinary action settlements with agencies.

Why has the Office of the Special Counsel been instrumental in directly helping so few individuals in recent years, despite its improved record in disciplinary prosecutions? At the outset, let me specify some possibilities which come to mind that our review shows not to be the reasons.

First, administrative disarray is no longer a serious problem. The incumbent Special Counsel has centralized his operations and eliminated the most serious internal organizational problems that plagued the agency in its first years.

Second, inadequate investigation does not appear to be a problem. While only eight percent of all complaints receive an in-depth field investigation, nearly half of these are whistleblower reprisal cases. We concluded that all of 76 randomly selected whistleblower cases we examined were closed only after development of a critical litigative defect. As far as we are aware, no meritorious complaint has been abandoned in recent years because of lack of staff to investigate or prosecute.

Third, there is no indication that lack of access to the courts prevents the Special Counsel from prosecuting more corrective action complaints. He has not found it necessary to take a corrective action complaint even as far as the MSPB for several years.

And finally, our analysis of cases did not reveal any specific legal or definitional technicality that is systematically obstructing the prosecution of otherwise meritorious cases.

What factors, then, do account for the infrequency of tangible assistance to the 11,000 federal employees who have

brought complaints to the Office of the Special Counsel since the agency was established in 1979? Mainly, they relate to the limited role assumed by the Special Counsel, to difficulties of proof, and to lack of litigative merit.

During the past 2-1/2 years the incumbent Special Counsel has stressed the use of his prosecutorial powers for protection of the merit system itself rather than the individual interests of federal employees. Like a prosecutor before a court, the Special Counsel represents the overall public interest before the Merit Systems Protection Board rather than seeking remedies in the personal interest of individual victims. While the Special Counsel may seek corrective action for those injured as well as disciplinary action against managers who break the law, the incumbent Special Counsel regards corrective action for individual complainants as incidental to his primary responsibility for disciplinary prosecutions. A significant Federal appellate court decision--Frazier v. MSPB--provides support for the view that the role of the Special Counsel is not as an advocate for individual employees.

A second reason why corrective action for individuals is infrequently pursued lies in the standard of proof required by the MSPB in such cases. It is not enough to show that there was a connection between an employee's protected disclosure, or blowing the whistle, and an adverse personnel action against the employee. Even when the Special Counsel establishes that whistleblowing was a significant factor leading to reprisal, the agency can avoid having to take corrective action by

establishing that there were other legitimate reasons for disciplining an employee. The Special Counsel was recently successful in obtaining an MSPB ruling which distinguished corrective from disciplinary cases in this regard by holding that disciplinary action may be imposed on a supervisor if a prohibited motive plays any part at all in a personnel decision. But the more stringent standard still applies to corrective action cases and makes them difficult to win.

A third and perhaps the most fundamental reason why few complaints requesting corrective action are pursued is that few of them have sufficient merit. Each of the 76 whistleblower reprisal cases in our sample had a defect when viewed from a litigative perspective. For example, some disclosures did not fall within the definition of whistleblowing, in other cases whistleblowing took place after the employee had already suffered an adverse personnel action, and in still other cases a whistleblower was only one of several employees affected by transfer or reduction in force actions . Our report lists nine broad categories of such factors surrounding complaints of reprisal brought by whistleblowers. And even though the Special Counsel closes a case as soon as such a defect is apparent, many of the cases contained more than one. While Office of the Special Counsel files document only technical legal determinations of litigative potential, applying less formal standards of merit would not, in our opinion, have led to substantially different results.

Although we noted several whistleblowing disclosures of seemingly significant operational or policy problems, most of the cases involved accounts of minor disputes with supervisors or purely personal objections to agency policy, under the guise of whistleblowing. And although some employees who claimed whistleblower protection were clearly assets to the workforce, many more had well-documented performance or disciplinary problems. The conclusion is inescapable that a substantial proportion of the individuals who appeal to the Special Counsel for protection under the whistleblower reprisal provisions of the law do not fit the ideal pattern of legitimate whistleblowers whose experiences were cited in the original congressional debate on the Civil Service Reform Act. Having said that, however, I hasten to add that there still is an obvious need for effective protections for those federal employees who take career risks to expose genuine waste, mismanagement, threats to public safety, or abuse of authority.

This is the basic dilemma that must be faced in determining whether, or how, to strengthen protections against prohibited personnel practices. A balance must be struck between the objective of encouraging legitimate disclosures of waste, mismanagement, and abuse of authority and that of maintaining management authority and accountability. While there is a legitimate need for efforts directed toward deterrence and systemic improvements, provision must also be made for meeting the legitimate need of individuals to have an effective avenue of relief for wrongs affecting them alone. Yet in striking the proper

balance we should not overlook the fact that the President, the MSPB, the media, the courts, responsible agency heads, inspectors general, and of course the Congress itself all contribute in some measure to the protections available to legitimate whistleblowers.

Recognizing that the Office of the Special Counsel got off to an inauspicious start, with its budget, organizational, and management problems in the early years after its establishment in 1979, and recognizing that real progress has been made in correcting those problems in recent years, it is my opinion that we need a little more time before making a judgment as to whether any change in the statutory underpinning of the Office is necessary.

There are other aspects of our review that I have not mentioned, and I will be glad to respond to your questions on those matters as well as on what I have covered in this brief statement.

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United States General Accounting Office

Washington, D.C.

FOR RELEASE ON DELIVERY
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STATEMENT OF

MICHAEL ZIMMERMAN, ASSOCIATE DIRECTOR

HUMAN RESOURCES DIVISION

BEFORE THE

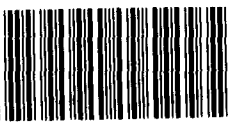
COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

UNITED STATES HOUSE OF REPRESENTATIVES

ON

MEDICARE PAYMENTS TO HOSPITALS



Mr. Chairman and members of the Committee:

We are pleased to be here today to discuss two issues related to Medicare reimbursement to hospitals:

(1) The impact of the Health Care Financing Administration's (HCFA's) use of unaudited hospital cost reports in establishing the Prospective Payment System (PPS) payment rates.

(2) The Return on Equity payments to proprietary hospitals.

The information presented in this testimony is a composite of information from our past reports and testimony, as well as from our ongoing assignments. The specific scope of our work, as it relates to the two major issues, will be detailed further as we discuss each issue.

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PPS PAYMENT RATES ARE OVERSTATED

Using unaudited and otherwise incorrect data in calculating the standardized payment rates has substantially inflated the Medicare reimbursements that are, and will be made to hospitals under PPS. In calculating the national PPS rates, HCFA

--used unaudited hospital cost data to develop the cost per discharge,

--included capital costs that should have been excluded, and

--made coding and computation errors.

If no adjustments are made to the current rates to correct these problems, Medicare could overpay inpatient hospital services by about 4.3 percent, or about $940 million in fiscal year 1986. Based on these preliminary estimates, Medicare overpayments could total over $8 billion during the next 5 years.[1]

The Prospective Payment System

Concerned about growing health care costs, the Congress established a Medicare prospective payment system for hospitals

[1]These estimates are conservative in that they exclude the four states--Maryland, Massachusetts, New York, and New Jersey--that operate their own hospital reimbursement systems under waivers granted by the Department of Health and Human Services (HHS). Congressional Budget Office (CBO) staff advised us to include these states in our analysis because any reduction in PPS rates would also require a reduction in these states rates since the states' system can be no more costly than PPS. Including the waiver states would increase our estimates presented in this testimony by about $2 billion over 5 years. We summarize how we computed our estimates excluding the waiver states in attachment I and including them in attachment II.

in the Social Security Amendments of 1983 (Public Law 98-21). PPS was designed to cover hospital operating costs for routine, ancillary, and intensive care inpatient services. In contrast to the cost reimbursement system that it replaced, PPS pays a predetermined rate for each hospital discharge, regardless of the number of services provided or the length of the patient's hospital stay.

The PPS payment rate is generally calculated based on two key factors. First, HCFA established a weighting factor for each of 468 diagnosis related groups (DRGs)--diagnoses that are homogeneous with respect to beneficiary profiles and resource usage. The DRG-weighting factor is multiplied by a second factor known as the standardized amount, which generaly reflects base-year hospital operating costs.[2]

Where the DRG weighting factor determines how Medicare reimbursements are distributed, the standardized amount determines the total amounts to be distributed. Accordingly, the validity of the base year cost data used to calculate the standardized amount has been the focus of our past and current audit work.

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[2]In fiscal years 1984-86, the second factor is a blend of hospital-specific, regional, and national rates. Payment amounts are adjusted annually to reflect an increase in market basket (the price of goods and services purchased by hospitals), and for such changes as hospital productivity and technology advances.

Unaudited Cost Reports Used To Determine PPS Payment Rates

To compute the PPS payment rates, the Social Security Amendments of 1983 directed HHS to use hospital cost data from the most recent cost reporting period for which data were available. To meet this requirement, HCFA used the Medicare hospital cost reports for reporting periods ended in 1981.

Normally, these yearly hospital cost reports are desk reviewed by insurance companies, called intermediaries, to assess their completeness and accuracy. Unallowable costs are disallowed. Each year a percentage of the cost reports are field audited, which can identify additional unallowable costs. Our analysis of reports submitted by intermediaries in fiscal years 1981 and 1982 shows that for those cost reports that were desk reviewed only, an average of 5.3 percent and 6.9 percent of the costs, respectivly, were disallowed.

Of the 5,501 hospital cost reports used to develop the PPS rates, however, only 62--about 1 percent--had been reviewed or audited at the time the rates were developed. Since then, HCFA has audited the 1981 reports but has not adjusted the PPS rates to reflect audit results.

As part of an ongoing assignment, we have attempted to determine the full impact of using the unaudited cost reports in establishing the PPS payment rates. To do this, we took a random sample of 418 field-audited cost reports from the original 5,501 cost reports, and compared the pre-audit cost data used by HCFA with HCFA's audited cost data.[3]

[3]Our sample is projectable to the universe at the 95-percent confidence level ± 0.76 percent.

The comparision showed that substantial dollar adjustments were made to the 1981 cost reports for unallowable costs as a result of the audits. Adjustments were made for unallowable costs, such as federal income taxes, Hill-Burton free care costs, and directorship fees. One cost report, for example, was adjusted by about $1.3 million because federal income taxes, an unallowable cost, were claimed.

HCFA officials said that unaudited data rather than audited data were used because of the short time frame available in which to develop and implement PPS. They also said that they normally use unaudited data in making studies.

If audited cost data were used, we estimate that the fiscal year 1986 payments to hospitals could be reduced by about 3 percent or about $657 million.

Some Unallowable Capital Costs Are Included in the Rates

Our analysis of the data from the sampled cost reports also showed that some capital costs were inappropriately included in the PPS rate. All capital costs should have been excluded from the base year data because capital is paid for separately as a pass-through.

Capital costs include those facility costs associated with the buildings, furnishings, and equipment necessary to provide patient care. Depreciation for these assets and interest paid on funds borrowed to acquire them are also capital costs allowable under Medicare.

Our review of HCFA's methodology for developing the PPS rates showed that the national and regional hospital cost data include some capital costs related to the ancillary and special care units. In extracting data from hospital cost reports, HCFA did not identify capital costs allocated to the ancillary departments and the special care units from the general service departments, such as administrative, pharmacy, and laundry. Consequently, these capital costs had been erroneously included in the development of the rates, and hospitals are being doubly reimbursed for these costs.

HCFA officials agreed that these capital costs were included in the rates. An agency official said it would have taken a lot of time to identify these costs and they had a very short time frame to compute the rates.

Based on our analysis, we estimate that these unallowable capital costs have inflated the PPS payment rates by 1.3 percent. This would amount to $285 million in fiscal year 1986 Medicare expenditures.

There is some question, which we are still investigating, as to whether the adjustments HHS made to maintain budget neutrality corrected the problem of including these capital costs in the base year data. The Social Security Amendments of 1983 require that HHS adjust payment rates for 1984 and 1985 so aggregate payments for operating costs of inpatient hospital services are neither more nor less than HHS estimates would have been paid under prior legislation for the same services. This concept was called budget neutrality.

In response to an HHS Office of Inspector General draft report addressing the issue of inappropriately including capital in base year costs, HCFA's position was that the budget neutrality adjustments compensated for these costs. Our reading of the public record on this matter, however, indicates that no such adjustments were made. Nevertheless, we are continuing to investigate this matter.

Other Errors in Calculating PPS Rates

As part of our review of the 418 cost reports, we also found that HCFA made errors in coding and computing the information from the base year cost reports and in programming the computations using these data. In four cases, for example, HCFA understated the hospital's cost per discharge from $307 to $1,011. At this time, we are not sure of the exact extent or impact of these problems, but are continuing to address this question as part of our ongoing work.

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As a final note on the accuracy of HCFA's calculation of the standardized payment rates, we would like to point out that the information presented in this statement is from an ongoing assignment and it has not been finalized. However, this information is consistent with conclusions from several of our previous reports dealing with the reasonableness of PPS rates

for individual services. For example, in a February 26, 1985, report on cardiac pacemaker surgeries,[4] we stated that the use of unaudited hospital cost reports for 12 hospitals reviewed resulted in medical supplies and laboratory services costs being overstated by about 5 percent. Until these problems are corrected, the Medicare program will continue to overpay for inpatient hospital services.

We believe an adjustment to the standardized amount to compensate for inflated base year costs would be appropriate, but at this time our data are still too preliminary for us to suggest a precise amount. We believe, however, that HHS, using our data as well as other information, such as the historic differences it has noted between audited and unaudited cost reports, could develop a rate to adjust base year costs. We would be pleased to work with HHS to help facilitate the development of such an adjustment factor.

As a longer term strategy, however, we believe HCFA should recompute the base rate using more current audited data reflecting hospitals' operating experiences under PPS.

RETURN ON EQUITY

The second issue we are discussing relates to Medicare payments to proprietary hospitals for return on equity. Medicare allows proprietary hospitals a return on equity capital invested and used in the providing patient care. Equity capital

[4]Medicare's Policies and Prospective Payment Rates for Cardiac Pacemaker Surgeries Need Review and Revision (GAO/HRD-85-39, Feb. 26, 1985).

refers to the provider's investment in plant, property, and equipment related to patient care plus net working capital--the funds for necessary for day-to-day operation of patient care activities.

In 1983, the Congress reduced the allowable rate of return on equity capital. Before that time, Medicare paid proprietary providers a rate of return on all their hospital related equity capital equal to 1-1/2 times the rate earned on funds invested by Medicare's Hospital Insurance Trust Fund. The Social Security Amendments of 1983 reduced the rate of return for hospitals equity invested in providing inpatient hospital services to equal that earned by the Trust Fund--a reduction of one-third--but continued to allow the higher rate for hospitals' equity invested in providing outpatient services.

As with capital costs, return on equity is treated separately under Medicare's prospective payment system and continues to be passed through for reimbursement of reasonable costs. About $200 million, or 0.5 percent, of Medicare's total 1984 hospital reimbursement, was for return on equity payments.

We have a review underway to assess what happens to hospital costs and services when nonprofit hospitals are purchased by private sector businesses. In a review of 30 hospitals that have undergone such a change in ownership since 1980, we have found the added return on equity claimed by the hospitals averaged about $143 per Medicare discharge. The 30 hospitals claimed about $4.3 million annually for return on equity.

Proprietary institutions historically have financed capital expenditures through funds invested by owners in expectation of earning a return on their investment. Therefore, the return is needed to avoid the withdrawal of capital and to attract additional capital for expansion. At issue here is whether a return allowance should be explicitly provided for by Medicare, as under the present system, or whether proprietary hospitals' return should be obtained exclusively from their ability to provide services at a profit.

On March 21, 1984, we testified before this Committee on the effects of changes in provider ownership on capital costs. We pointed out that under Medicare's prospective payment system, hospitals can now realize a profit by holding their operating costs below the prospective payment level. In addition, we noted that some questions have been raised about whether there is a need to guarantee a return on equity in addition to the profits that can be earned by efficient management practices under PPS.

Under prospective payments, not-for-profit hospitals gain or lose on the basis of whether their costs are lower or higher than the prospective payments because currently Medicare does not provide them any specific return on equity allowance. Eliminating the return on equity allowance would therefore place proprietary and not-for-profit hospitals on the same footing in terms of Medicare's payment rules. This would be comparable to the situation for Medicare's end stage renal disease program, where there is no distinction between payment rates for proprietary and not-for-profit hospitals.

In addition, there is precedent for not explicitly reimbursing providers for a return on equity. Under Medicaid a number of states do not include a return allowance in computing their payment rates for nursing homes.

The Social Security Admendments of 1983 required HHS to study and report to Congress by October 20, 1984, on proposals for inclusions of all capital-related costs in PPS. As of May 8, 1985, this study had not been released, and therefore, we have not had the opportunity to review the proposals.

We believe the question of whether to continue explicitly providing proprietary hospitals a return on equity allowance is one that merits congressional attention. PPS is designed to reward efficient hospitals. As with not-for-profit hospitals, proprietary hospitals that cannot provide services at Medicare rates should be expected to economize or absorb their losses. On the other hand, eliminating the explicit return provisions will, by definition, reduce profitability, which may have an impact on the availability of investor capital to the hospital industry. Both issues have to be considered in developing policies on this matter.

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This concludes my prepared statement. We will be happy to address any questions you may have.

ATTACHMENT I

COMPUTATION OF
ESTIMATED SAVINGS (EXCLUDING WAIVER STATES) ACHIEVABLE
BY USING CORRECTED COST DATA

	Fiscal year					5-Year
	1986	1987	1988	1989	1990	total
	(Billions)					
Estimated Medicare Hospital Payments Under PPS[1]	$48.142	53.357	59.107	65.609	72.826	299.041
Less Estimated Payments to Waiver States - 17.5%[2] Capital Costs - 7%[1] Direct Med. Ed. - 3%[1] Exempt Hospitals - 2%[1] Total - 29.5%	$14.202	15.740	17.437	19.355	21.484	88.217
Total Related to PPS Hospitals	$33.940	37.617	41.670	46.254	51.342	210.824
Hospital Specific Portion[3]						
Less 35% - 1986	$11.879					11.879
Less 10% - 1987		3.762				3.762
Total	$22.061	33.855	41.670	46.254	51.342	195.183
Savings to Medicare (Based on 4.27% Overstatement of PPS Rates)	$ .94	1.45	1.78	1.98	2.19	8.33

[1]Estimated Medicare Hospital Payments are based on CBO staff estimates which include projections of future market basket plus 0.25 percent, and increases in both admissions and in the Medicare population.

[2]The estimated Medicare hospital payments were reduced to eliminate estimated payments for the hospitals in the four waiver states. A 17.5-percent reduction was computed by the HHS Office of Inspector General based on the ratio of total costs of hospitals in waiver states to total costs for all 5,631 hospitals in the fiscal year 1981 cost data.

[3]During fiscal years 1986 and 1987, PPS will continue to be phased in, and payment rates will be calculated by blending hospital-specific rates (based on hospital cost experience) and the federal PPS rate. The amounts shown represent the CBO's estimate of that portion of total PPS payments in fiscal years 1986 and 1987, which are hospital specific.

NOTE: Numbers do not add across due to rounding.

ATTACHMENT II

COMPUTATION OF
ESTIMATED SAVINGS (INCLUDING WAIVER STATES) ACHIEVABLE
BY USING CORRECTED COST DATA

	Fiscal year					5-Year
	1986	1987	1988	1989	1990	total
	(Billions)					
Estimated Medicare Hospital Payments Under PPS[1]	$48.142	53.357	59.107	65.609	72.826	299.041
Less Estimated Payments to Capital Costs - 7%[1] Direct Med. Ed. - 3%[1] Exempt Hospitals - 2%[1] Total - 12%	$ 5.777	6.403	7.093	7.873	8.739	35.885
Total Related to PPS Hospitals	$42.365	46.954	52.014	57.736	64.087	263.156
Hospital Specific Portion[2]						
Less 35% - 1986	$14.828					14.828
Less 10% - 1987		4.695				4.695
Total	$27.537	42.259	52.014	57.736	64.087	243.633
Savings to Medicare (Based on 4.27% Overstatement of PPS Rates)	$ 1.18	1.80	2.22	2.47	2.74	10.40

[1]Estimated Medicare Hospital Payments are based on CBO staff estimates which include projections of future market basket plus 0.25 percent, and increases in both admissions and the Medicare population.

[2]During fiscal years 1986 and 1987, PPS will continue to be phased in, and payment rates will be calculated by blending hospital-specific rates (based on hospital cost experience) and the federal PPS rate. The amounts shown represent the CBO's estimate of that portion of total PPS payments in fiscal years 1986 and 1987, which are hospital specific.

NOTE: Numbers do not add across due to rounding.