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BY THE U.S. GENERAL ACCOUNTING OFFICE

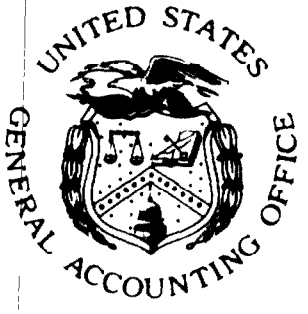
# Report To The Honorable Harry N. Walters Administrator Of Veterans Affairs

# Opportunities To Increase VA's Medical Care Cost Recoveries

The Veterans Administration (VA) generally provides free medical care to eligible veterans. However, when a veteran requires treatment because of injuries suffered on the job or because of another person's negligent actions, VA can recover the cost of the medical care provided from the responsible third party. VA can also recover the cost of care provided to nonveterans in an emergency and to patients later found to be ineligible for VA care.

However, VA did not charge enough to recover the full costs of care provided to most such patients. VA prepares bills on the basis of two national average per diem rates--one for medical/surgical patients and one for psychiatric patients Had the changes in methods of computing billing rates GAO is recommending in this report been in effect during fiscal year 1982, VA could have increased its billngs by over $10 million.

Delays in revising VA billing rates have significantly reduced potential recoveries over the years. In a companion report (GAO/HRD-84-32), GAO recommends steps the Office of Management and Budget should take to improve future recoveries





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

HUMAN RESOURCES
DIVISION

B-211058

The Honorable Harry N. Walters
Administrator of Veterans Affairs

Dear Mr. Walters:

This report summarizes the results of our review of VA's methods for establishing medical care cost recovery rates. It suggests ways to increase medical care recoveries while providing a more equitable basis for billings. The issues in this report were discussed with VA officials, and their comments have been included where appropriate.

Our review was made because we had noted in a similar review at the Department of Defense that the government was not recovering the full cost of care provided for high-cost medical services. Because VA's cost data on high-cost medical services, such as cardiac surgery, were not sufficiently reliable to compute the costs of specific types of medical care, we limited our review to the adequacy of per diem and sharing agreement rates.

This report contains recommendations to you on pages 8 and 15. As you know, 31 U.S.C. 720 requires that the head of a federal agency submit a written statement on actions taken on our recommendations to the House Committee on Government Operations and the Senate Committee on Governmental Affairs not later than 60 days after the date of the report and to the House and Senate Committees on Appropriations with the agency's first request for appropriations made more than 60 days after the date of the report.

We are sending copies of this report to the Director, Office of Management and Budget, and the Chairmen of the four above-mentioned Committees and the House and Senate Committees on Veterans' Affairs.

Sincerely yours,

Richard L. Fogel
Director

GENERAL ACCOUNTING OFFICE
REPORT TO THE ADMINISTRATOR
OF VETERANS AFFAIRS

# OPPORTUNITIES TO INCREASE VA'S MEDICAL CARE COST RECOVERIES

## D I G E S T


The Veterans Administration (VA) can charge for care provided to patients (1) injured on the job or because of another person's negligent actions, (2) in an emergency, or (3) later found to be ineligible for VA care.

VA prepares bills for such patients on the basis of two national average per diem rates--one for medical/surgical patients and one for psychiatric patients--which are intended to cover all related costs of care, including room and board, physicians' costs, ancillary services, and all indirect and support costs. For fiscal year 1982, VA collected $13.8 million for medical services out of $48.1 million billed.

However, VA billing rates are not high enough to recover the full costs of medical services provided to most billable patients and result in overcharges to other patients.


### SEPARATE RATES FOR ACUTE AND NONACUTE CARE COULD INCREASE RECOVERIES

For example, VA combines the per diem costs attributable to nonacute and acute care medical and surgical patients when developing the national per diem rates. As a result, acute medical/surgical patients were undercharged about $4.4 million in fiscal year 1982 because nonacute care costs were included in the billing rates.

The fiscal year 1983 per diem rates were $42 too low to recover the reasonable value of care provided to acute care patients. About 98 percent of the medical/surgical patients billed in fiscal years 1981 and 1982 were acute care patients.

### FACILITY PER DIEM RATES WOULD BE MORE EQUITABLE AND SAVE MONEY

Similarly, patients at high-cost VA facilities were undercharged for the care they received, while patients at low-cost facilities were overcharged because VA uses national rather than facility billing rates.

In fiscal year 1982, VA charged medical/surgical patients $285 a day regardless of which VA facility provided the care. However, the fiscal year 1982 per diem costs at VA medical centers ranged from about $172 to $529 for surgical care and from $82 to $501 for medical care.

The practice of using a national rate does not allow VA to bill on the basis of costs incurred at the facility where the patient received care. Use of the national rate may have reduced 1982 billing amounts by about $6.2 million.

## DELAYS IN REVISING RATES ARE COSTLY

Federal agencies' (VA, the Department of Defense (DOD), and the Department of Health and Human Services (HHS)) billing rates should go into effect at the beginning of the fiscal year because they are based on that year's estimated costs for providing care. As a matter of policy, the Office of Management and Budget (OMB) does not approve and publish any agency's billing rates until all agencies have submitted their proposed rates.

Although VA has submitted its proposed rates to OMB on time, DOD and HHS have not. For example, DOD did not submit its proposed rates for fiscal year 1984 until October 7, 1983.

As a result, for the last 4 years, VA's revised per diem rates have not gone into effect until after the start of the fiscal year, reducing VA billing amounts. The 7-month delay in setting fiscal year 1981 rates reduced VA billing amounts by about $9 million.

VA and OMB need to work together to ensure that billing rates are established in a timely manner.

## SHARING AGREEMENTS MAY NOT RECOVER FULL COSTS

VA medical centers may enter into sharing agreements with non-VA hospitals to buy or sell medical services under prenegotiated rates and conditions. By law, VA must recover the full costs of services provided to nonfederal hospitals under such agreements. Because VA has provided only general guidance to its medical centers on costs to include and methods to use in developing sharing agreement rates:

--VA medical centers used various methods to develop sharing agreement rates, some of which appear to measure costs better than others.

--Some standard indirect costs included in VA's national per diem rates were not included in any of the sharing agreement rates.

In addition, sharing agreements were not always renewed in a timely manner. Because health care costs have generally been increasing, delays in revising sharing agreement rates reduce VA recoveries. (See p. 14.)

Although we could not readily quantify the lost revenues, the revenues lost by not including all personnel fringe benefits in sharing agreement rates exceeded $1 million in fiscal year 1981.

RECOMMENDATIONS

GAO recommends that the Administrator of Veterans Affairs, through the Chief Medical Director:

--Develop separate medical care recovery per diem rates for acute and nonacute medical/surgical and psychiatric care on a facility-by-facility basis.

--Provide more specific guidance on costs to be included in private sector sharing agreement rates to ensure that they are consistent with factors used in developing VA per diem rates.

--Direct VA medical centers to renegotiate sharing agreements before they expire.

In a report to the Director of OMB (GAO/HRD-84-32, Feb. 13, 1984), we recommended that he take steps to ensure that the per diem rates are implemented at the beginning of the fiscal year to which they apply.

Tear Sheet

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## ABBREVIATIONS

| | |
|---|---|
| GAO | General Accounting Office |
| OMB | Office of Management and Budget |
| VA | Veterans Administration |

# CHAPTER 1

## INTRODUCTION

The Veterans Administration (VA) is authorized to recover the "reasonable" value of medical services provided to certain patients provided care at VA facilities and to recover the actual cost of services provided to patients under sharing agreements (see p. 2) with non-VA hospitals. Specifically:

--The Federal Medical Care Recovery Act (42 U.S.C. 2651) authorizes recovery of the "reasonable value"[1] of care provided to eligible patients needing medical treatment for injuries which resulted from the negligent or other wrongful actions of a third party (tort-feasor).

--The Veterans' Health Care, Training, and Small Business Loan Act of 1981 (38 U.S.C. 629) extended VA's recovery authority to include veterans' injuries or illnesses stemming from (1) employment and covered by a workers' compensation law or plan, (2) a motor vehicle accident for which the veteran had uninsured motorist coverage, and (3) a violent crime occurring in a jurisdiction that reimburses for such victims' medical care.

--The Veterans Omnibus Health Care Act of 1976 (38 U.S.C. 611) authorizes recovery of the costs of emergency care provided to persons otherwise ineligible for VA care.

In addition, VA attempts to recover the cost of medical care provided to persons presumed to be eligible for care at the time of admission, but later found to be ineligible. For fiscal year 1982, VA collected $13.8 million for medical services subject to reimbursement out of $48.1 million billed.

Under Executive Order 11060, the Office of Management and Budget (OMB) is responsible for setting the rates used by VA in billing liable third parties. The order states that

> "The Director of the Bureau of the Budget [now OMB] shall, for the purposes of the Act of September 25, 1962, from time to time, determine and establish rates that represent the reasonable value of hospital,

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[1]The term "reasonable value" is neither defined in the act nor discussed in its legislative history.

medical, surgical, or dental care and treatment (including prostheses and medical appliances) furnished or to be furnished."[2]

OMB has generally[3] accepted the national per diem rates developed by VA for use at all VA facilities. VA also uses these rates in billing the other categories of patients described above.

VA sets two national rates--one for medical/surgical patients and one for psychiatric patients. The rates cover all related costs of care, including room and board, physicians' costs, ancillary services, and all indirect and support costs. VA does not accumulate actual cost data by patient or by treatment provided or procedure performed.

In addition to treating nonveterans in need of emergency care and veterans presumed to be eligible at time of admission but later found ineligible, VA has entered into sharing agreements with non-VA hospitals, medical schools, and research centers to buy or sell specialized types of care at prenegotiated rates. Sharing agreement rates are set at the local medical facility level and do not need OMB approval. However, under the law (38 U.S.C. 5051-5053), sharing agreement rates for services sold to non-VA facilities are to cover the full cost of services rendered, supplies used, and normal depreciation and amortization costs of equipment. In fiscal year 1981, 96 VA medical facilities provided about $12 million of medical services (excluding such things as training and library support costs) to non-VA hospitals, of which about $8.5 million was provided to nonfederal hospitals.

## OBJECTIVES, SCOPE, AND METHODOLOGY

Our original survey objectives were to determine whether the per diem and sharing agreement rates VA charged liable third parties and others were sufficient to recover the costs of care provided. We intended to collect and analyze data on (1) VA's costs of providing various types of high-cost care, including spinal cord injury, cardiac surgery, and renal transplants; (2) the extent such services were used by patients from whom VA could seek

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[2]The act of September 25, 1962, refers to the Federal Medical Care Recovery Act (42 U.S.C. 2651), which concerns third-party liability for tort-feasor cases.

[3]From June 1979 to May 1981, OMB set rates independent of VA's recommended rates to conform to former President Carter's cost containment guidelines.

reimbursement; and (3) the reasonableness of sharing agreement rates with non-VA hospitals.

However, VA's cost distribution data on specific medical services, such as cardiac surgery and electron microscopy procedures, were not sufficiently reliable to compute the costs of specific types of medical care at individual facilities, and no data on services provided to billed patients, other than the number of inpatient days or outpatient visits they utilized, were available.

Therefore, we limited our work to determining whether VA's per diem rates recover the full cost of an "average" day of VA care and whether VA's sharing agreements were based on all appropriate VA costs. Specifically, we sought to determine whether (1) VA's medical/surgical per diem rate was adequate to recover the cost of care provided to acute care patients, (2) the national average per diem rate generated the same total charges as would individual facility rates, and (3) rates were revised in a timely manner. We limited our analysis of the impact of adopting individual facility rates to medical/surgical, rather than psychiatric, billings because they accounted for the preponderance of billings.

To identify data on costs of care and numbers of billable patients, we obtained data from officials in VA's Finance and Medical Administration Services and examined VA's quarterly reports on collections of reimbursable insurance benefits (RCS 10-90) and medical centers' fiscal years 1981 and 1982 cost distribution reports (RCS 14-4).

We discussed the reliability of VA's cost distribution data with VA central office officials and officials at three VA medical centers--San Francisco and Palo Alto, California, and West Roxbury, Massachusetts. According to the VA officials, the cost distribution data are reliable for estimating per diem costs, but are not accurate enough to be used for determining the costs of specific treatment programs. VA is working to improve the validity and reliability of the cost distribution reports.

We discussed with the OMB officials responsible for approving VA billing rates the feasibility of using alternative methods of computing per diem rates for billing liable third parties and the reasons for delays in approving the rates.

To determine the percentages of billed patients in each VA category of care (including medicine, neurology, psychiatry, surgery, intermediate medicine, and rehabilitation medicine), we obtained data on fiscal years 1981 and 1982 billings from the

Lyons, East Orange, and Philadelphia VA medical centers. Although the locations were selected judgmentally, the mix of patients in the three medical centers was comparable to VA patients nationwide.

To determine whether the methods used and costs included in developing sharing agreement rates were appropriate, we

- --interviewed VA central office officials to (1) identify costs included in VA's national per diem rates, (2) identify costs that should be included in sharing agreement rates, and (3) determine the extent of central office monitoring of sharing agreement rates;

- --reviewed VA Inspector General reports relating to sharing agreements;

- --examined sharing agreements at 11 VA medical centers and discussed the methods used and costs included in developing the rates with medical center staff; and

- --examined data submitted to the central office by each VA medical center on the type and cost of medical services provided to or received from non-VA facilities during fiscal year 1981 to compare the rates charged by medical centers for similar services.

We did not evaluate the appropriateness of the rates VA pays for services it receives under sharing agreements with non-VA hospitals.

We also attempted to evaluate the potential effect on VA billings of using an alternative billing system based on diagnosis related groups. The Congress recently enacted legislation (Public Law 98-21) directing the Department of Health and Human Services to adopt such a system for the Medicare program. Hospitals in a few states, including New Jersey, already prepare bills based on diagnosis related groups. However, we did not pursue this alternative because, according to VA officials, VA's automated cost distribution and patient treatment data are not accurate enough to provide a reliable basis for diagnosis related billings. As noted earlier, VA is working to improve the data's reliability.

In April 1983, we briefed VA Department of Medicine and Surgery officials, including the Assistant Chief Medical Director for Administration, on the results of our preliminary work. Because they agreed with our tentative findings, conclusions, and recommendations, we did not expand the scope of our audit work. Our review was performed in accordance with generally accepted government auditing standards.

## CHAPTER 2

## CHANGES IN METHODS FOR ESTABLISHING PER DIEM RATES COULD INCREASE RECOVERIES

VA develops separate nationwide per diem rates for billing medical/surgical and psychiatric patients. These rates are used regardless of diagnosis, intensity of care, or actual per diem costs at the facility that provided the care. VA could increase medical care cost recoveries, and bill on a more equitable basis, by establishing individual facility per diem rates for acute and nonacute care patients. Prompt OMB approval and publication of per diem rates at the beginning of the fiscal year could further increase recoveries.

### SEPARATE RATES FOR ACUTE AND NONACUTE CARE COULD INCREASE RECOVERIES

In developing the nationwide per diem rates, VA includes both nonacute (rehabilitation[1] and intermediate[2] medicine) and acute (medicine, neurology, and surgical) care costs. Because nonacute care is less costly, VA's fiscal year 1983 per diem rates are about $42 too low to recover the reasonable value of care provided to acute care patients. Such patients represented approximately 98 percent of billed medical/surgical patients in fiscal years 1981 and 1982.

If the less costly intermediate and rehabilitation medicine units had not been included in computing the fiscal year 1982 medical/surgical per diem rate, the acute medical/surgical billing rate ($285) would have been increased by $30 (10.8 percent) to $315. Similarly, if intermediate and rehabilitation medicine costs had not been included in the 1983 medical/surgical rate, the rate would have been $42 (13.5 percent) higher ($357 versus

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[1]According to a VA official, rehabilitation medicine care is provided to patients with stabilized, nonacute medical conditions. It is not designed to "cure" a condition but helps the patient obtain maximum use of residual functions through physical, occupational, speech, and educational therapy and vocational rehabilitation.

[2]According to a VA official, intermediate medicine patients are medical or surgical patients who are not acutely ill but require daily physician visits; frequent use of ancillary services, such as radiology and laboratory; and rehabilitation services.

$315). Although 21.9 percent of the patient days used in computing the medical/surgical per diem were for intermediate and rehabilitation care, less than 2 percent of the billed medical/surgical patients received those less costly levels of care. Thus, by including the per diem costs for intermediate and rehabilitation care in the overall medical/surgical per diem costs, the rate charged to most billed medical/surgical patients did not cover the reasonable value of care.

Over 84 percent of all billed patients at the Lyons, East Orange, and Philadelphia VA medical centers during 1981 and 1982 were acute medical or surgical patients. The other patients were psychiatric patients (14 percent) or intermediate or rehabilitation medicine patients (2 percent). Because the mix of total patients in the three medical centers was comparable to VA patients nationwide, VA officials agreed that the mix of billed patients at these facilities is probably representative of billed patients nationwide. Based on that assumption, acute medical/surgical patients would represent about $40.4 million of the $48.1 million in fiscal year 1982 VA billings, and using only acute care costs in the billing rate would have increased VA billings by $4.4 million. VA's Financial Reports Division staff agreed with our estimate of the effect of excluding intermediate and rehabilitation care costs from the medical/surgical per diem rate.

The psychiatry per diem rate also combines costs associated with acute and nonacute patients. However, we were unable to estimate the impact of setting separate rates for psychiatric patients because VA's cost distribution report does not distinguish between acute and nonacute patients. According to the Assistant Chief Medical Director for Administration, VA is considering separating acute and nonacute psychiatric costs on future cost distribution reports.

## FACILITY PER DIEM RATES WOULD BE MORE EQUITABLE AND INCREASE BILLING AMOUNTS

Although per diem costs vary significantly from one VA facility to another, VA charges patients the national average per diem rate regardless of where they were treated. As a result, some bills overcharge for care while others undercharge. Computing individual facility per diem rates would, in our opinion, be more equitable than the nationwide per diem rate. In addition, our limited analysis indicates that using individual facility rates would increase VA billing amounts.

VA medical centers' fiscal year 1982 per diem costs, based on the cost distribution report (exclusive of overhead costs), ranged from about $172 to $529 for surgical care and from about

$82 to $501 for medical care. This compared with the nationwide average of $271 for surgical and $199 for medical. Rates vary among VA facilities because of variations in the types and complexity of services provided, geographic differences in wages paid to VA employees, and differences in charges for contracted services.

Because VA did not have data on the number of billed patient days by facility, we used data on fiscal year 1982 workers' compensation and tort-feasor cases[3] to determine the potential effect of using local facility per diem rates on billings. We estimate that in fiscal year 1982 VA could have charged about 15.3 percent more ($6.2 million) by using local facility medical/surgical per diem rates rather than the national per diem rate. Our analysis is discussed in greater detail on pages 17 and 18 of appendix I.

To develop individual facility per diem rates, medical centers could make the same adjustments to the individual facilities' per diem costs that are made to the national average per diem costs to arrive at the national per diem rate. Specifically, they would adjust prior years' actual facility costs to include overhead costs (e.g., depreciation of buildings and equipment), fringe benefit factors (e.g., retirement, health and life insurance), and anticipated budgetary increases.

According to the OMB official responsible for VA's budget, no statutes or regulations prevent VA from billing using local per diem rates. VA officials told us that they believe the per diem cost data at the individual facility level are generally accurate. VA's Chief, Medical Administration Service, agreed that VA should establish individual facility per diem rates and said that VA would work with OMB to establish such rates.

## DELAYS IN OMB APPROVAL OF PER DIEM RATES REDUCE RECOVERIES

Although VA has, for the last 3 years, submitted proposed reimbursement rates to OMB in April, OMB has taken as long as a year to approve and publish the new rates. The delays in implementing revised billing rates have reduced VA billing amounts by

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[3]The reliability of data in VA's "Quarterly Report on Collections of Reimbursable Insurance Benefits" is questionable. For example, we obtained copies of fiscal year 1982 billings for 26, 5, and 5 workers' compensation and tort-feasor patients from East Orange, Lyons, and Philadelphia VA medical centers, respectively. VA's report, however, reported 4, 0, and 17, respectively. However, VA's data were the only such data available.

millions of dollars. For example, the fiscal year 1981 rates took effect 9 months into the fiscal year, reducing VA billing amounts by almost $9 million. OMB, however, has made significant progress in reducing the delays, and the fiscal year 1984 rates took effect November 2, 1983.

In addition to VA's rates, OMB must approve rates for care provided by the Department of Defense and the Department of Health and Human Services. According to an OMB official, OMB has a policy of approving all three agencies' billing rates before any are published. He said new rates should go into effect on October 1 of each year because they are based on that fiscal year's anticipated budget.

A 1973 OMB directive required that federal agencies submit their proposed reimbursement rates in March so that the new reimbursement rates could take effect at the beginning of the fiscal year. When the directive was issued, the fiscal year began July 1. According to an OMB official, the submission deadlines were not revised in 1976, when the start of the fiscal year was changed to October 1. However, the OMB official said that only VA has been submitting the proposed rates in accordance with the 1973 directive. VA, the Departments of Health and Human Services, and Defense submitted their proposed rates for fiscal year 1984 on April 4, August 17, and October 7, 1983, respectively. The OMB official said that the rates could be published to take effect October 1, if OMB receives the proposed rates by mid-August. She said that Defense was late in submitting its rates for fiscal year 1984 because it was implementing new procedures for calculating the rates.

VA and OMB officials agreed that they need to work together to ensure that per diem rates are established in a timely manner.

## CONCLUSIONS

VA should bill for care using individual facility per diem rates. They more accurately reflect the cost of the care provided and are more equitable to the patients billed. Individual facility per diem rates for acute and nonacute care should be revised at the beginning of each fiscal year to reflect that year's projected costs and to recover the full amount owed.

## RECOMMENDATION TO THE ADMINISTRATOR OF VETERANS AFFAIRS

We recommend that the Administrator, through the Chief Medical Director, develop separate medical care recovery rates for acute and nonacute medical/surgical and psychiatric care on a facility-by-facility basis.

In a separate report (GAO/HRD-84-32, Feb. 13, 1984) to the Director of OMB, we recommended that he take steps to ensure that the rates are implemented at the beginning of the fiscal year to which they apply.

## CHAPTER 3

## ADDITIONAL GUIDANCE NEEDED TO ENSURE THAT SHARING AGREEMENTS RECOVER FULL COSTS

By law (38 U.S.C. 5051-5053), VA must recover the full costs of services provided to non-VA hospitals under sharing agreements.[1] Although VA has provided general guidance to its medical centers on costs to include in developing sharing agreement rates, the guidance does not (1) specify the method to be used to develop the rates or (2) direct the medical centers to include certain indirect costs used in computing national per diem rates.

VA medical centers used several methods for developing sharing agreement rates, and some medical centers have not recovered the full cost of services provided. Although we could not quantify the lost revenues for each sharing agreement, the revenue lost by not including all personnel fringe benefits in sharing agreement rates exceeded $1 million in fiscal year 1981. In addition, sharing agreements were not always renegotiated in a timely manner. Because health care costs have generally been increasing, delays in revising sharing agreement rates reduce VA recoveries.

VA's guidance (VA Manual MP-4 Part V) requires that sharing agreement rates cover all costs, including administrative, engineering, and building management support costs; building and equipment depreciation; central office medical administration expenses; and interest on net capital investment. The manual also requires that the actual time spent and supplies consumed be used to establish the charges when the rate cannot be developed directly from VA's medical cost distribution (RCS 14-4) report.

### SOME MEDICAL CENTERS' METHODOLOGIES CAPTURE COSTS BETTER THAN OTHERS

Because VA's guidance on sharing agreements does not specify the methodology to be used in computing direct and indirect costs associated with providing a given service or procedure, VA medical centers used various methods to develop sharing agreement rates. Some appeared to measure costs better than others.

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[1]In negotiating sharing agreements with Department of Defense hospitals, VA must consider actual costs of the services to be provided, but under recent legislation (Public Law 97-174), it can negotiate a sharing agreement rate less than actual cost.

The methods used by three VA medical centers appeared to be more effective than others in computing medical center costs. These medical centers computed costs using each cost center's (e.g., radiology and laboratory) total projected costs and overall workload. The Columbia, Missouri, VA medical center used this method for a wide variety of services, including pulmonary, cardiology, gastrointestinal, renal, and nuclear medicine procedures. Each test or procedure was assigned a relative weight (based on the total resources consumed), which was then multiplied by the projected annual workload for that service (e.g., number of procedures and tests) to arrive at the weighted number of work-load units. The total weighted number of work-load units for the cost center was divided into the cost center's total projected direct and indirect costs to produce an average unit dollar value. The average unit dollar value was multiplied by the relative value for a given procedure to determine the sharing agreement rate for that procedure.

Using the Columbia medical center's 1980 nuclear medicine in vitro laboratory costs as an example:

> If a certain nuclear medicine procedure is given a relative weighted value of 50 and the medical center expected to perform 46 of those procedures during the year, the weighted work-load units for that procedure would be 2,300. These would be added to the weighted work-load units for all the other nuclear medicine procedures, producing a total of 218,976 weighted work-load units.
>
> The laboratory's total costs of $401,793 would be divided by the 218,976 weighted work-load units, producing a $1.84 unit dollar value. This would be multiplied by the procedure's relative weighted value of 50 to give a rate of $92 for that procedure.

Methods used by other VA facilities did not capture all costs related to performing a given service. For example, the Albany, New York, and Martinez, California, medical centers identified the direct personnel costs, equipment, and supplies spent in performing a given procedure or service and added the overhead and support factors (e.g., depreciation on buildings and equipment, and costs allocated from support cost centers, such as building management). This method may not capture all costs, however, because it does not include the cost centers' indirect costs, such as equipment quality control and on-the-job training.

Similarly, facilities that relied totally on the cost distribution report (RCS 14-4, section III) in setting sharing agreement rates did not recover the actual value of the services

provided because the section of the report used for specialized services was unreliable and did not always reflect the costs of performing the specific service or procedure covered by the sharing agreement.

According to several VA officials, including the Director of VA's Resource Allocation Development Service and the Staff Assistant to the Director of Resource Management for the Department of Medicine and Surgery, the specialized medical services section of the cost distribution report is unreliable and should only be used as a starting point for setting sharing rates. They said that medical centers should develop confirmatory evidence to support or build onto the cost distribution report costs.

In addition, because the cost distribution report rate reflects an average unit cost for all patients--not just those treated under the sharing agreements--for a given category of service or procedure, it may understate the costs of services provided under the sharing agreement. For example, the West Roxbury VA medical center's sharing agreement for spinal cord injury patients is based on the report's per diem costs for all spinal cord injury patients. However, the sharing agreement covers only the initial, most intensive period of treatment, which is the most costly. VA officials at West Roxbury agreed that basing the sharing agreement rates on the average costs significantly understated the costs of services provided to patients under the sharing agreement.

## SHARING AGREEMENT RATES SHOULD INCLUDE SAME INDIRECT COSTS INCLUDED IN PER DIEM RATES

Some indirect costs included in VA's national per diem rates were not included in local sharing agreement rates for specific procedures or services. VA's manual containing sharing agreement guidance directs facilities to include the costs of administration, engineering, and building management; depreciation of equipment and buildings; central office medical administration expenses; and interest on net capital investment. However, some cost factors that the VA central office used in developing national per diem rates were not used by medical centers in developing sharing agreements. Specifically, sharing agreement rates did not include

- --most personnel fringe benefits, such as retirement and disability programs;
- --the same costs for depreciation of buildings used in developing the national per diem rates; and

--costs of services provided to the Department of Medicine and Surgery from other VA departments.

In addition, malpractice costs are not included in either the national per diem rate or sharing agreements.

Personnel fringe benefit factors, such as the retirement factors prescribed by OMB Circular A-76, are included by the VA central office in the nationwide per diem rates. The OMB circular states that costs related to federal employee retirement amount to 20.4 percent of personal services costs. A VA central office official told us that facilities using the cost distribution report to develop sharing agreement rates included the 7-percent direct federal retirement contribution included in the personal services costs in the cost distribution report but did not include the remaining 13.4-percent unfunded liability.

Other personnel benefit costs not included in sharing agreement rates were employee health and life insurance benefits, workers' compensation, bonuses and awards, and unemployment programs. According to the circular, these fringe benefits added an additional 5.6 percent to personal services costs. Adding the 19-percent fringe benefit factor to personal services costs would increase total sharing agreement rates by at least 13 percent. In fiscal year 1981, this would have increased sharing agreement charges to nonfederal facilities by about $1.1 million.

The medical centers we visited depreciated buildings over a longer period than did VA's central office when it developed national per diem rates. As a result, the medical centers understated costs in sharing agreements. VA's central office reduced the period over which it depreciates buildings from 67 to 48 years but had not updated the manual used by the facilities, which still depreciated buildings over 67 years.

According to a VA Resource Management official, VA's central office added a factor to the national per diem costs for "common services" that VA facilities did not add to sharing agreements. Common services are services provided to one department, such as the Department of Medicine and Surgery (both central office and medical centers) by other VA departments. Common services costs added to the national per diem rate are for data processing services from the Office of Data Management and Telecommunications and VA regional office services under the Department of Veterans Benefits. Although these factors would not significantly increase sharing agreement rates, we believe that they should be included in sharing agreement rates.

According to a VA official, other common services costs are not included in either the national per diem rates or sharing agreement rates. These include services from

--the Procurement and Supply Division, which approves sharing agreements and develops supply policy;

--the General Counsel and District Counsels, which provide legal assistance;

--Budget and Finance, which provides fiscal policy and financial reports; and

--Personnel and Labor Relations, which provides policy guidance on personnel matters.

Another cost related to VA medical care, but not included in computing either the national per diem rates or sharing agreement rates, is the cost of settling malpractice claims. In fiscal year 1982 the government paid $17.2 million for VA malpractice settlements. This figure does not include any adjudication costs, such as attorney or support staff time spent in processing and resolving these cases.

VA may want to revise its guidance on depreciation and add factors for personnel fringe benefits, common services, and malpractice to ensure that (1) sharing agreements are developed consistently and (2) all costs are captured in both nationwide per diem rates and local sharing agreements.

Although VA adjusts the national per diem rate for anticipated increased budgetary costs, some VA medical centers, such as West Roxbury, Massachusetts, did not. It based sharing agreement rates solely on past costs, thus overcharging or undercharging for the year to which they applied. VA's central office set the fiscal year 1983 per diem rates about 8 percent above 1982 costs to provide for increased salary costs. VA's guidance on sharing agreements, however, does not direct VA medical centers to make similar adjustments in sharing agreement rates.

## SHARING AGREEMENTS SHOULD BE RENEGOTIATED IN A TIMELY MANNER

Delays in renewing sharing agreements prevent VA from recovering the full cost of services provided. Sharing agreements are typically for a 1-year period with many rates increasing annually. However, not all agreements are renegotiated before the prior agreement expires. For example, West Roxbury's 1980 spinal cord injury sharing agreement with the state of Massachusetts, with a per diem charge of $289, expired in December 1980, but a new agreement, with a $334 per diem rate, did not go into effect until January 1983. During the interim the 1980 rates were used. Similarly, the Columbia, Missouri, VA medical center's

agreement[2] with the University of Missouri's Columbia Medical Center was scheduled to expire on April 30, 1979, but was extended in 3-month increments until a new agreement became effective on April 4, 1982. Examples of how much the Columbia VA medical center's sharing agreement costs increased during this period include

--pulmonary intensive care increased from $290 to $457 per day,

--gastrointestinal gastroscopy with biopsy increased from $72 to $118, and

--total colon colonoscopy increased from $103 to $154.

During this period the rates the university charged VA for most services also remained unchanged.

## CONCLUSIONS

VA should ensure that sharing agreement rates result in the recovery of the full costs of services provided to nonfederal hospitals. Additional guidance is needed on the methods medical centers should use to establish and update sharing agreement rates.

## RECOMMENDATIONS TO THE ADMINISTRATOR OF VETERANS AFFAIRS

We recommend that the Administrator, through the Chief Medical Director:

--provide more specific guidance on costs to be included in private sector sharing agreement rates to ensure that they are consistent with factors used in developing per diem rates and

--direct VA medical centers to renegotiate sharing agreements before they expire.

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[2]The Columbia, Missouri, sharing agreement was VA's largest. In 1981, VA sold about $1.6 million and bought another $2.1 million in services.

## EXPLANATIONS OF

## POTENTIAL INCREASED BILLING AMOUNTS

According to VA's "Quarterly Report on Collections of Reimbursable Insurance Benefits," VA charged liable third parties and others $48.1 million in fiscal year 1982. This figure was the basis for projecting potential increased billing amounts that would result from changes in how the per diem rates are developed and when they are put into effect. Each change and related dollar impact is independent of other proposed changes. Thus, the total financial impact of all our recommendations would be the cumulative dollars projected from each.

### EXCLUDING INTERMEDIATE AND REHABILITATION CARE FROM MEDICAL/SURGICAL RATE

VA's fiscal year 1982 reimbursement rates were based on the 1980 actual per diem costs, adjusted for projected increases in VA's 1981 and 1982 budgets. We added to the direct medicine (excluding intermediate and rehabilitation care), neurology, and surgical per diem costs from VA's September 30, 1980, RCS 14-4 nationwide cost distribution report, the related support costs (administration, engineering and building management, research, education and training), overhead costs (depreciation on buildings and equipment, central office overhead, and interest on net capital investment), and fringe benefit factors (e.g., retirement, health and life insurance). The nationwide cost distribution report combines all direct cost and patient day data from the 172 VA medical centers. The total of these costs was divided by the number of patient days attributable to medicine (excluding intermediate and rehabilitation care), neurology, and surgery. The resulting per diem cost of $246.33 was 10.75 percent higher than the $222.42 medical/surgical figure that was used as the 1980 base for 1982 reimbursement rates. The $222.42 was developed using the same process but included intermediate and rehabilitation medicine costs and patient days. Staff from VA's Financial Reports Division agreed with our methodology.

Of fiscal year 1981 and 1982 billings from the Lyons, East Orange, and Philadelphia medical centers, 84.3 percent were for acute medicine, neurology, or surgery patients, 14.2 percent were for psychiatric patients, and 1.5 percent were for intermediate or rehabilitation medicine patients. If these percentages are representative of billed patients nationwide, the fiscal year 1982 billings of medical/surgical patients were about $40.6 million. Increasing the billings by 10.75 percent would mean an additional $4.4 million in billings. Although billing rates for

intermediate and rehabilitation medicine patients would decrease if they were separated out from the medical/surgical per diem rate, there were so few billable patients in these categories that the effect on total billings would be minimal.

## USING INDIVIDUAL FACILITY PER DIEM RATES

VA currently bills all medical/surgical patients using the same national average per diem rate regardless of the costs at the facilities where they were actually treated. To determine whether a national average per diem rate enabled VA to bill the full cost of care provided to billed patients, we analyzed the effect of charging each patient a per diem rate based on where his or her care was provided versus using the national average per diem.

The figures we used for both individual facilities' and VA nationwide per diem costs were those shown in Table XV "Costs Per Diem" in VA's Summary of Medical Programs, September 1982. The costs are based on VA's RCS 14-4 report of medical cost distributions.

The rates we used did not include indirect costs, such as depreciation, central office overhead, interest on net capital investment, and fringe benefit factors (e.g., retirement and health and life insurance). However, because neither the individual facilities' per diem costs nor the national average per diem costs included these indirect cost factors, there should be no effect on computing the relative impact of using individual versus national average per diem figures.

The figures in the "Costs Per Diem" table separated medical and surgical costs even though VA combines them on a weighted basis in computing reimbursement rates. We therefore developed combined medical/surgical per diem cost figures for each facility and nationwide, based on the relative numbers of medical and surgical patient days at each facility and nationwide. We obtained this information from Table IV "VA Hospital Care" in VA's Summary of Medical Programs, September 1982, which shows the average daily census for medical and surgical patients. The individual medical/surgical per diem costs at facilities for which we had billing data ranged from $92.53 at Battle Creek, Michigan, to $382.41 at Los Angeles, California.

We then multiplied both the individual facilities' medical/surgical per diem costs and the weighted national average per diem cost ($218.52) by the number of patients billed under workers' compensation and liable third-party (tort-feasor)

categories at each facility, according to VA's "Quarterly Report on Collections of Reimbursable Insurance Benefits" for fiscal year 1982. Although it would have been preferable to use figures on billed patient days rather than numbers of billed patients, such figures were not available. We did not use the numbers from the two other categories on the report on billings and collections of reimbursable insurance benefits ("all types disclaiming responsibility" and "other") because both relate to insurance, most of which disclaim responsibility for payment of hospitalization costs at tax-supported institutions. In addition, workers' compensation and tort-feasor cases account for most billed costs.

Although VA's report probably does not account for all billed patients, it provided a basis for identifying the allocation of patients among VA facilities and computing the relative impact of billing with individual facility rates rather than a national average rate. The result, based on medical/surgical per diem costs, was a 15.3-percent increase. Appendix II shows the computations discussed above. Only facilities that showed billings for workers' compensation or tort-feasor cases in VA's 1982 report of collections and had local facility cost figures appear in the appendix.

If the 15.3-percent increase were multiplied by the share of 1982 billings attributable to billed medical/surgical patients ($40,583,537), it would mean $6,209,281 in increased billings. We did not analyze the impact of individual versus nationwide per diem rates on the 15.7 percent of billable patients that are not medical or surgical, but if the same relative effect occurred, it would have meant another $1,156,414 in 1982 ($7,558,262 x 15.3 percent).

## DELAYS IN REVISING PER DIEM RATES

According to the OMB official responsible for VA's budget, VA's reimbursement rates should go into effect October 1 of each year because they are based on that fiscal year's anticipated budget. However, for fiscal years 1981, 1982, and 1983, they went into effect on May 11, 1981; January 4, 1982; and December 15, 1982, respectively. In computing the impact of these delays, we had to develop a formula that recognized the percentages of patients billed at the medical/surgical per diem rate (85.8 percent) versus the psychiatric per diem rate (14.2 percent), the old and new billing rates for both of those categories each year, and how far into the year the new rates went into effect. The formulas we developed to estimate the dollars lost by delays in implementing new per diem rates were:

APPENDIX I

$$(1) \qquad S = \frac{X\ T\ \left(\frac{R2}{R1} - 1\right)}{X + \frac{R2}{R1}\ (12 - X)}$$

$$(2) \qquad \frac{R2}{R1} = \frac{A2}{A1}\left[\frac{1 + \frac{(P2)(B2)}{(P1)(A2)}}{1 + \frac{(P2)(B1)}{(P1)(A1)}}\right]$$

in which:

S = Potential additional billings if VA used new rates the entire fiscal year.

T = Total actual annual billings.

X = Time delay (in terms of months) between start of fiscal year and effective date of new rates.

R1 = Prior year's weighted billing rate to account for percentages of medical/surgical patients and psychiatric patients.

R2 = Revised weighted billing rate to account for percentages of medical/surgical patients and psychiatric patients.

A1 = Prior year's billing rate for medical/surgical patients.

A2 = Revised billing rate for medical/surgical patients.

B1 = Prior year's billing rate for psychiatric patients.

B2 = Revised billing rate for psychiatric patients.

P1* = Percentage of patients billed as medical/surgical.

P2* = Percentage of patients billed as psychiatric.

*Based on billings from Lyons, East Orange, and Philadelphia VA medical centers.

Our formula was based on the following assumptions:

--Billings are evenly distributed throughout the year.

--VA would use the revised rates beginning October 1 if they were approved by that date.

--The proportion of medical/surgical patients (A) to psychiatric patients (B) is constant during the year.

--The billings are proportional to the percentage of patients in categories A and B.

The impact of the delays in implementing revised billing rates was almost $9 million in 1981 and almost $2 million in 1982.

## COMPARISON OF 1982 FACILITY AND NATIONAL PER DIEM COSTS

| Facility | Surgical | | | Medical | | | Facility | | Billing amounts using | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | ADC[a] | Cost[b] | Total | ADC[a] | Cost[b] | Total | costs[c] | Billings[d] | Facility costs | National costs | Total difference |
| | (1) | (2) | (3) | (4) | (5) | (6) | (7) | (8) | (9) | (10) | (11) |
| Albany | 139 | 208.71 | 29,010.69 | 317 | 167.13 | 52,980.21 | 179.80 | 40 | 7,192.00 | 8,740.80 | (1,548.80) |
| Albuquerque | 104 | 258.64 | 26,898.56 | 115 | 360.54 | 41,462.10 | 312.15 | 80 | 24,972.00 | 17,481.60 | 7,490.40 |
| Alexandria | 60 | 267.56 | 16,053.60 | 191 | 131.74 | 25,162.34 | 164.21 | 2 | 328.42 | 437.04 | (108.62) |
| Allen Park | 113 | 250.46 | 28,301.98 | 217 | 226.05 | 49,052.85 | 234.41 | 98 | 22,972.18 | 21,414.96 | 1,557.22 |
| Amarillo | 48 | 200.48 | 9,623.04 | 54 | 218.71 | 11,810.34 | 210.13 | 38 | 7,984.94 | 8,303.76 | (318.82) |
| Asheville | 113 | 225.66 | 25,499.58 | 311 | 126.44 | 39,322.84 | 152.88 | 33 | 5,045.04 | 7,211.16 | (2,166.12) |
| Atlanta | 149 | 263.99 | 39,334.51 | 155 | 280.28 | 43,443.40 | 272.30 | 31 | 8,441.30 | 6,774.12 | 1,667.18 |
| Augusta | 103 | 334.73 | 34,477.19 | 331 | 191.96 | 63,538.76 | 225.84 | 54 | 12,195.36 | 11,800.08 | 395.28 |
| Batavia | 24 | 202.59 | 4,862.16 | 176 | 127.57 | 22,452.32 | 136.57 | 29 | 3,960.53 | 6,337.08 | (2,376.55) |
| Battle Creek | 0 | 0.0 | 0.00 | 318 | 92.53 | 29,424.54 | 92.53 | 20 | 1,850.60 | 4,370.40 | (2,519.80) |
| Bay Pines | 110 | 213.81 | 23,519.10 | 329 | 129.16 | 42,493.64 | 150.37 | 117 | 17,593.29 | 25,566.84 | (7,973.55) |
| Beckley | 42 | 224.76 | 9,439.92 | 87 | 167.36 | 14,560.32 | 186.05 | 5 | 930.25 | 1,092.60 | (162.35) |
| Boise | 30 | 318.23 | 9,546.90 | 55 | 337.97 | 18,588.35 | 331.00 | 4 | 1,324.00 | 874.08 | 449.92 |
| Boston | 199 | 239.80 | 47,720.20 | 282 | 236.93 | 66,814.26 | 238.12 | 151 | 35,956.12 | 32,996.52 | 2,959.60 |
| Bronx | 183 | 282.39 | 51,677.37 | 281 | 304.96 | 85,693.76 | 296.06 | 89 | 26,349.34 | 19,448.28 | 6,901.06 |
| Brooklyn | 180 | 223.87 | 40,296.60 | 502 | 164.81 | 82,734.62 | 180.40 | 24 | 4,329.60 | 5,244.48 | (914.88) |
| Buffalo | 161 | 234.78 | 37,799.58 | 383 | 177.02 | 67,798.66 | 194.11 | 58 | 11,258.38 | 12,674.16 | (1,415.78) |
| Charleston | 69 | 345.59 | 23,845.71 | 79 | 346.91 | 27,405.89 | 346.29 | 66 | 22,855.14 | 14,422.32 | 8,432.82 |
| Cheyenne | 18 | 251.26 | 4,522.68 | 73 | 167.95 | 12,260.35 | 184.43 | 32 | 5,901.76 | 6,992.64 | (1,090.88) |
| Chicago (Lk) | 113 | 268.80 | 30,374.40 | 226 | 228.71 | 51,688.46 | 242.07 | 171 | 41,393.97 | 37,366.92 | 4,027.05 |
| Cleveland | 170 | 246.44 | 41,894.80 | 322 | 281.69 | 90,704.18 | 269.51 | 177 | 47,703.27 | 38,678.04 | 9,025.23 |
| Columbia | 88 | 311.40 | 27,403.20 | 114 | 254.53 | 29,016.42 | 279.31 | 67 | 18,713.77 | 14,640.84 | 4,072.93 |
| Dallas | 190 | 260.57 | 49,508.30 | 220 | 261.56 | 57,543.20 | 261.10 | 51 | 13,316.10 | 11,144.52 | 2,171.58 |
| Denver | 130 | 231.02 | 30,032.60 | 86 | 427.40 | 36,756.40 | 309.21 | 41 | 12,677.61 | 8,959.32 | 3,718.29 |
| Des Moines | 100 | 250.73 | 25,073.00 | 98 | 237.43 | 23,268.14 | 244.15 | 109 | 26,612.35 | 23,818.68 | 2,793.67 |
| Dublin | 29 | 271.11 | 7,862.19 | 231 | 141.84 | 32,765.04 | 156.26 | 3 | 468.78 | 655.56 | (186.78) |
| Durham | 157 | 254.85 | 40,011.45 | 140 | 286.51 | 40,111.40 | 269.77 | 194 | 52,335.38 | 42,392.88 | 9,942.50 |
| East Orange | 177 | 272.65 | 48,259.05 | 448 | 193.99 | 86,907.52 | 216.27 | 4 | 865.08 | 874.08 | (9.00) |
| Fargo | 31 | 253.90 | 7,870.90 | 109 | 231.37 | 25,219.33 | 236.36 | 136 | 32,144.96 | 29,718.72 | 2,426.24 |
| Fayetteville | 49 | 217.55 | 10,659.95 | 102 | 187.80 | 19,155.60 | 197.45 | 33 | 6,515.85 | 7,211.16 | (695.31) |
| Fort Harrison | 40 | 216.31 | 8,652.40 | 77 | 183.62 | 14,138.74 | 194.80 | 8 | 1,558.40 | 1,748.16 | (189.76) |
| Fort Meade | 20 | 241.41 | 4,828.20 | 179 | 110.27 | 19,738.33 | 123.45 | 9 | 1,111.05 | 1,966.68 | (855.63) |



APPENDIX II

| Facility | Surgical ADC[a] (1) | Surgical Cost[b] (2) | Surgical Total (3) | Medical ADC[a] (4) | Medical Cost[b] (5) | Medical Total (6) | Facility costs[c] (7) | Billings[d] (8) | Billing amounts using Facility costs (9) | Billing amounts using National costs (10) | Total difference (11) |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Gainesville | 148 | 296.23 | 43,842.04 | 130 | 280.00 | 36,400.00 | 288.64 | 169 | 48,780.16 | 36,929.88 | 11,850.28 |
| Grand Junction | 19 | 239.82 | 4,556.58 | 46 | 171.03 | 7,867.38 | 191.14 | 16 | 3,058.24 | 3,496.32 | (438.08) |
| Hot Springs | 25 | 196.91 | 4,922.75 | 120 | 155.34 | 18,640.80 | 162.51 | 3 | 487.53 | 655.56 | (168.03) |
| Houston | 179 | 302.86 | 54,211.94 | 368 | 232.29 | 85,482.72 | 255.38 | 31 | 7,916.78 | 6,774.12 | 1,142.66 |
| Indianapolis | 118 | 347.38 | 40,990.84 | 162 | 272.08 | 44,076.96 | 303.81 | 73 | 22,178.13 | 15,951.96 | 6,226.17 |
| Iowa City | 105 | 246.33 | 25,864.65 | 96 | 350.68 | 33,665.28 | 296.17 | 180 | 53,310.60 | 39,333.60 | 13,977.00 |
| Jackson | 116 | 230.62 | 26,751.92 | 195 | 199.29 | 38,861.55 | 210.98 | 112 | 23,629.76 | 24,474.24 | (844.48) |
| Lake City | 66 | 192.67 | 12,716.22 | 211 | 134.71 | 28,423.81 | 148.52 | 58 | 8,614.16 | 12,674.16 | (4,060.00) |
| Lexington | 95 | 342.14 | 32,503.30 | 427 | 147.18 | 62,845.86 | 182.66 | 21 | 3,835.86 | 4,588.92 | (753.06) |
| Little Rock | 239 | 223.15 | 53,332.85 | 325 | 219.76 | 71,422.00 | 221.20 | 118 | 26,101.60 | 25,785.36 | 316.24 |
| Loma Linda | 119 | 243.20 | 28,940.80 | 171 | 254.52 | 43,522.92 | 249.87 | 60 | 14,992.20 | 13,111.20 | 1,881.00 |
| Long Beach | 187 | 287.11 | 53,689.57 | 563 | 263.07 | 148,108.41 | 269.06 | 139 | 37,399.34 | 30,374.28 | 7,025.06 |
| Los Angeles | 145 | 418.80 | 60,726.00 | 351 | 367.38 | 128,950.38 | 382.41 | 117 | 44,741.97 | 25,566.84 | 19,175.13 |
| Louisville | 112 | 229.59 | 25,714.08 | 123 | 236.09 | 29,039.07 | 232.99 | 29 | 6,756.71 | 6,337.08 | 419.63 |
| Madison | 96 | 270.51 | 25,968.96 | 114 | 302.64 | 34,500.96 | 287.95 | 25 | 7,198.75 | 5,463.00 | 1,735.75 |
| Manchester | 34 | 267.79 | 9,104.86 | 97 | 176.97 | 17,166.09 | 200.54 | 44 | 8,823.76 | 9,614.88 | (791.12) |
| Marlin | 0 | 0.0 | 0.00 | 174 | 130.67 | 22,736.58 | 130.67 | 17 | 2,221.39 | 3,714.84 | (1,493.45) |
| Martinsburg | 49 | 220.30 | 10,794.70 | 289 | 148.20 | 42,829.80 | 158.65 | 20 | 3,173.00 | 4,370.40 | (1,197.40) |
| Memphis | 159 | 206.14 | 32,776.26 | 373 | 207.60 | 77,434.80 | 207.16 | 76 | 15,744.16 | 16,607.52 | (863.36) |
| Miami | 135 | 271.39 | 36,637.65 | 294 | 227.54 | 66,896.76 | 241.34 | 55 | 13,273.70 | 12,018.60 | 1,255.10 |
| Minneapolis | 217 | 289.47 | 62,814.99 | 264 | 282.62 | 74,611.68 | 285.71 | 244 | 69,713.24 | 53,318.88 | 16,394.36 |
| Mountain Home | 104 | 197.87 | 20,578.48 | 241 | 148.81 | 35,863.21 | 163.60 | 5 | 818.00 | 1,092.60 | (274.60) |
| Nashville | 134 | 331.33 | 44,398.22 | 190 | 197.89 | 37,599.10 | 253.08 | 25 | 6,327.00 | 5,463.00 | 864.00 |
| New Orleans | 150 | 255.12 | 38,268.00 | 171 | 281.48 | 48,133.08 | 269.16 | 194 | 52,217.04 | 42,392.88 | 9,824.16 |
| New York | 231 | 262.87 | 60,722.97 | 305 | 274.46 | 83,710.30 | 269.47 | 93 | 25,060.71 | 20,322.36 | 4,738.35 |
| Northport | 136 | 235.93 | 32,086.48 | 300 | 206.67 | 62,001.00 | 215.80 | 140 | 30,212.00 | 30,592.80 | (380.80) |
| Oklahoma City | 94 | 278.42 | 26,171.48 | 127 | 330.75 | 42,005.25 | 308.49 | 55 | 16,966.95 | 12,018.60 | 4,948.35 |
| Perry Point | 0 | 0.0 | 0.00 | 367 | 120.85 | 44,351.95 | 120.85 | 13 | 1,571.05 | 2,840.76 | (1,269.71) |
| Philadelphia | 155 | 228.43 | 35,406.65 | 152 | 310.21 | 47,151.92 | 268.92 | 17 | 4,571.64 | 3,714.84 | 856.80 |
| Phoenix | 105 | 230.38 | 24,189.90 | 166 | 208.17 | 34,556.22 | 216.78 | 183 | 39,670.74 | 39,989.16 | (318.42) |
| Prescott | 28 | 241.64 | 6,765.92 | 91 | 197.96 | 18,014.36 | 208.24 | 5 | 1,041.20 | 1,092.60 | (51.40) |
| Providence | 59 | 318.01 | 18,762.59 | 145 | 260.87 | 37,826.15 | 277.40 | 49 | 13,592.60 | 10,707.48 | 2,885.12 |
| Richmond | 140 | 260.20 | 36,428.00 | 362 | 216.05 | 78,210.10 | 228.36 | 90 | 20,552.40 | 19,666.80 | 885.60 |
| Roseburg | 17 | 256.92 | 4,367.64 | 112 | 173.08 | 19,384.96 | 184.13 | 13 | 2,393.69 | 2,840.76 | (447.07) |



APPENDIX II

| Facility | Surgical ADC[a] (1) | Surgical Cost[b] (2) | Surgical Total (3) | Medical ADC[a] (4) | Medical Cost[b] (5) | Medical Total (6) | Facility costs[c] (7) | Billings[d] (8) | Billing amounts using Facility costs (9) | Billing amounts using National costs (10) | Total difference (11) |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Saginaw | 31 | 243.03 | 7,533.93 | 90 | 158.73 | 14,285.70 | 180.33 | 4 | 721.32 | 874.08 | (152.76) |
| Salisbury | 33 | 197.12 | 6,504.96 | 317 | 93.61 | 29,674.37 | 103.37 | 1 | 103.37 | 218.52 | (115.15) |
| San Diego | 120 | 383.18 | 45,981.60 | 171 | 326.76 | 55,875.96 | 350.03 | 75 | 26,252.25 | 16,389.00 | 9,863.25 |
| Sepulveda | 66 | 353.44 | 23,327.04 | 215 | 297.88 | 64,044.20 | 310.93 | 93 | 28,916.49 | 20,322.36 | 8,594.13 |
| Sheridan | 0 | 0.0 | 0.00 | 103 | 146.39 | 15,078.17 | 146.39 | 8 | 1,171.12 | 1,748.16 | (577.04) |
| Shreveport | 89 | 248.02 | 22,073.78 | 150 | 205.12 | 30,768.00 | 221.10 | 27 | 5,969.70 | 5,900.04 | 69.66 |
| Sioux Falls | 59 | 241.52 | 14,249.68 | 92 | 180.40 | 16,596.80 | 204.28 | 5 | 1,021.40 | 1,092.60 | (71.20) |
| St. Louis | 141 | 249.51 | 35,180.91 | 330 | 230.78 | 76,157.40 | 236.39 | 2 | 472.78 | 437.04 | 35.74 |
| Syracuse | 92 | 239.70 | 22,052.40 | 102 | 276.66 | 28,219.32 | 259.13 | 227 | 58,822.51 | 49,604.04 | 9,218.47 |
| Tampa | 178 | 235.97 | 42,002.66 | 229 | 260.95 | 59,757.55 | 250.03 | 133 | 33,253.99 | 29,063.16 | 4,190.83 |
| Temple | 133 | 206.30 | 27,437.90 | 233 | 179.12 | 41,734.96 | 189.00 | 98 | 18,522.00 | 21,414.96 | (2,892.96) |
| West Roxbury | 62 | 421.90 | 26,157.80 | 137 | 314.75 | 43,120.75 | 348.13 | 156 | 54,308.28 | 34,089.12 | 20,219.16 |
| Wilkes Barre | 87 | 173.03 | 15,053.61 | 211 | 153.42 | 32,371.62 | 159.15 | 16 | 2,546.40 | 3,496.32 | (949.92) |
| Wood | 201 | 235.14 | 47,263.14 | 288 | 214.49 | 61,773.12 | 222.98 | 247 | 55,076.06 | 53,974.44 | 1,101.62 |
| Total | | | | | | | | | 1,404,039.42 | 1,217,593.44 | 186,445.98[e] |

Column 3 = Column 1 x Column 2
Column 6 = Column 4 x Column 5
Column 7 = (Column 3 + Column 6) - (Column 1 + Column 4)
Column 9 = Column 7 x Column 8.
Column 10 = Column 8 x $218.52
Column 11 = Column 9 - Column 10

[a]Average daily census.

[b]Facility's per diem costs.

[c]Weighted medical/surgical per diem costs.

[d]Number of workers' compensation and tort-feasor patients billed.

[e]$186,446 represents a 15.3-percent increase over the billings based on the national average per diem.



APPENDIX II

| Facility | Surgical ADC[a] (1) | Surgical Cost[b] (2) | Surgical Total (3) | Medical ADC[a] (4) | Medical Cost[b] (5) | Medical Total (6) | Facility costs[c] (7) | Billings[d] (8) | Billing amounts using Facility costs (9) | Billing amounts using National costs (10) | Total difference (11) |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Saginaw | 31 | 243.03 | 7,533.93 | 90 | 158.73 | 14,285.70 | 180.33 | 4 | 721.32 | 874.08 | (152.76) |
| Salisbury | 33 | 197.12 | 6,504.96 | 317 | 93.61 | 29,674.37 | 103.37 | 1 | 103.37 | 218.52 | (115.15) |
| San Diego | 120 | 383.18 | 45,981.60 | 171 | 326.76 | 55,875.96 | 350.03 | 75 | 26,252.25 | 16,389.00 | 9,863.25 |
| Sepulveda | 66 | 353.44 | 23,327.04 | 215 | 297.88 | 64,044.20 | 310.93 | 93 | 28,916.49 | 20,322.36 | 8,594.13 |
| Sheridan | 0 | 0.0 | 0.00 | 103 | 146.39 | 15,078.17 | 146.39 | 8 | 1,171.12 | 1,748.16 | (577.04) |
| Shreveport | 89 | 248.02 | 22,073.78 | 150 | 205.12 | 30,768.00 | 221.10 | 27 | 5,969.70 | 5,900.04 | 69.66 |
| Sioux Falls | 59 | 241.52 | 14,249.68 | 92 | 180.40 | 16,596.80 | 204.28 | 5 | 1,021.40 | 1,092.60 | (71.20) |
| St. Louis | 141 | 249.51 | 35,180.91 | 330 | 230.78 | 76,157.40 | 236.39 | 2 | 472.78 | 437.04 | 35.74 |
| Syracuse | 92 | 239.70 | 22,052.40 | 102 | 276.66 | 28,219.32 | 259.13 | 227 | 58,822.51 | 49,604.04 | 9,218.47 |
| Tampa | 178 | 235.97 | 42,002.66 | 229 | 260.95 | 59,757.55 | 250.03 | 133 | 33,253.99 | 29,063.16 | 4,190.83 |
| Temple | 133 | 206.30 | 27,437.90 | 233 | 179.12 | 41,734.96 | 189.00 | 98 | 18,522.00 | 21,414.96 | (2,892.96) |
| West Roxbury | 62 | 421.90 | 26,157.80 | 137 | 314.75 | 43,120.75 | 348.13 | 156 | 54,308.28 | 34,089.12 | 20,219.16 |
| Wilkes Barre | 87 | 173.03 | 15,053.61 | 211 | 153.42 | 32,371.62 | 159.15 | 16 | 2,546.40 | 3,496.32 | (949.92) |
| Wood | 201 | 235.14 | 47,263.14 | 288 | 214.49 | 61,773.12 | 222.98 | 247 | 55,076.06 | 53,974.44 | 1,101.62 |
| Total | | | | | | | | | 1,404,039.42 | 1,217,593.44 | 186,445.98[e] |

Column 3 = Column 1 x Column 2
Column 6 = Column 4 x Column 5
Column 7 = (Column 3 + Column 6) - (Column 1 + Column 4)
Column 9 = Column 7 x Column 8.
Column 10 = Column 8 x $218.52
Column 11 = Column 9 - Column 10

[a]Average daily census.

[b]Facility's per diem costs.

[c]Weighted medical/surgical per diem costs.

[d]Number of workers' compensation and tort-feasor patients billed.

[e]$186,446 represents a 15.3-percent increase over the billings based on the national average per diem.



APPENDIX II

24311

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