12962 COM

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

February 25, 1980

B-197171

+ Sen Long & Russell

The Honorable Harrison A. Williams, Jr.
Chairman, Committee on Labor and
Human Resources
United States Senate

7100

Dear Mr. Chairman:

Your letter of December 3, 1979, requested our comments on H.R. 2626, a bill to establish a National Commission on Hospital Costs, to encourage voluntary efforts to contain hospital costs, to provide for the orderly development of State hospital cost containment programs, to encourage philanthropic support for nonprofit hospitals, and for other purposes. This bill has been passed by the House of Representatives and has been jointly referred to the Committee on Labor and Human Resources and the Committee on Finance. Another bill--H.R. 934--reported to the Senate on December 10, 1979, by the Committee on Finance contains provisions which are similar to many of those in H.R. 2626 and we have considered H.R. 934 in preparing these comments.

Section 3 of H.R. 2626 would establish a program to fund State hospital cost containment programs. In order to receive Federal funding, a State's program would have to disregard any funds derived as a result of donor restricted grants, gifts, or endowment income. 1/ Thus, such revenues would not have to be offset against expenses. Section 5 of H.R. 2626 extends this same principle to the determination of payments under the Medicare, Medicaid, and Maternal and Child Health programs. Current Medicare reimbursement policy generally followed for these three programs provides that funds resulting from unrestricted grants, gifts, and endowments are not to be deducted from operating costs in

---

1/ Donor restricted refers to those grants, gifts, and endowments which the donor has designated for a specific purpose such as construction of a hospital wing or providing a particular type of service.

008783

HRO-BILL-6

computing allowable costs, but funds from donor restricted grants, gifts, and endowments are to be deducted or offset against expenses in determining allowable costs. This policy is based on the rationale that by not offsetting funds derived from donor restricted sources, double payment for services would result. The following example illustrates this rationale.

> Hospital A receives a gift of $100,000 which the donor restricts to use in providing radiological treatment to all patients. During the year involved, Hospital A provides 10,000 such treatments (1,000 to Medicare beneficiaries) at a cost of $1,000,000 or $100 per treatment. If the hospital is paid its costs of $100 per treatment by all payors, it will receive $1,100,000 for the treatments, including the restricted gift. Thus, the hospital would have been reimbursed twice for a portion of the services.
>
> Under current policy, Medicare's reimbursable costs to Hospital A would be $90,000 for radiological treatments, or $90 a treatment. Under the revision proposed by H.R. 2626, Medicare's reimbursable costs would be $100,000.

We question the desirability of changing the reimbursement principle to disregard donor restricted funds as deductions to operating costs because the double payment rationale seems reasonable to us. We also note that H.R. 934, as reported by the Committee on Finance, includes a provision (section 207) which would codify current Medicare reimbursement policy with respect to restricted and unrestricted donations.

Section 7 of H.R. 2626 would establish, under Medicare and Medicaid, a program under which any participating hospital could provide any level of institutional care authorized by the programs; that is, inpatient hospital, skilled nursing facility (SNF), or intermediate care facility (ICF). ICF care is provided under Medicaid only. The net effect of section 7 would be to remove the distinct part requirement for reimbursement under Medicaid and Medicare. The distinct part requirement provides that to receive payment for SNF or ICF services under the programs a hospital must have distinct beds within the overall facility which are dedicated to, and

licensed for, providing SNF or ICF care. Costs must be accumulated separately and/or allocated equitably for the hospital and nursing home parts of the facility.

Removal of the distinct part requirement would permit a hospital to use any of its beds for any level of care and to change the use of a particular bed among the various levels. This would simplify record keeping and cost allocation requirements for the hospital. Under the reimbursement method of section 7, hospitals would be paid on the basis of their total allowable costs of providing all levels of covered care.

Section 221 of H.R. 934 would establish a similar program but would restrict its applicability to rural hospitals with less than 50 beds which have a certificate of need to provide long-term care and, on a demonstration basis, to hospitals of 100 beds or less meeting the other requirements. H.R. 934 includes another provision (section 211) which would establish a program under which all hospitals not covered by section 221 would be paid for days of care provided in the hospital to patients requiring only the SNF or ICF level of care, at the average daily rate for SNF and ICF care under Medicaid. Hospitals in areas without an oversupply of hospital beds and with an undersupply of nursing home beds would be exempted. The purpose of section 211 is to pay hospitals in those areas where there is a surplus of hospital beds only for the level of care needed by Medicare and Medicaid patients and, thereby, reduce the costs of these programs. The Committee on Finance estimated savings of $1 billion during fiscal years 1980 through 1984 if the provision were enacted. The Congressional Budget Office estimated $260 million in savings for the same period.

According to the Finance Committee report on H.R. 934 (S. Rept. No. 96-471) the difference in estimated savings is based on the belief that the magnitude of the inappropriate use of high-cost hospital beds by Medicare and Medicaid is so large that the reductions in cost would be greater than assumed in the Congressional Budget Office estimate.

Because section 7 of H.R. 2626 would result in paying all hospitals on the basis of their allowable costs regardless of the covered level of care needed by Medicare and Medicaid patients, its enactment would tend to negate much of the savings anticipated to be realized from enactment of section 211 of H.R. 934.

We have issued a number of reports which discuss the need to increase the availability of nursing home beds to Medicare and Medicaid patients. 1/ These reports discussed the high costs associated with patients remaining in hospitals when they could be adequately served by nursing homes but were unable to transfer because of the unavailability of nursing home beds. A provision such as section 211 of H.R. 934 could help to increase the availability of nursing home beds by encouraging hospitals to convert unneeded acute care beds to nursing care beds. Also, H.R. 934 includes provisions to promote closing and conversion of underutilized hospitals by helping to pay through Medicare and Medicaid, the costs of conversion or closing (section 203) and to require the Department of Health, Education, and Welfare to study and make recommendations related to the availability of SNF services under Medicare and Medicaid (section 224).

In summary, section 7 of H.R. 2626 would provide little incentive under Medicare and Medicaid to convert or close unneeded acute hospital beds because hospitals would be paid on the basis of their total allowable costs regardless of the covered level of care provided. In fact, it could encourage hospitals to seek nursing-home type patients to fill empty beds without significantly lowering costs.

In this regard, we noted that the Congressional Budget Office estimated that a similar provision in H.R. 4000 as reported to the House by the Committee on Ways and Means would increase Federal Medicare and Medicaid costs by about $91 million for fiscal years 1980 through 1984. Therefore, we suggest that section 7 be deleted. On the other hand, sections 203, 211, and 224 of H.R. 934 address the need to increase the availability of lower cost nursing home services with an overall reduction in costs. Although we do not know

---

1/ "Ohio's Medicaid Program: Problems Identified Can Have National Importance", HRD-78-98A; Oct. 23, 1978, pp. 7-11;
"Potential Effects of a Proposed Amendment to Medicaid's Nursing Home Reimbursement Requirements", HRD-80-1; Oct. 15, 1979, pp. 4-8;
"Health Costs Can Be Reduced by Millions of Dollars if Federal Agencies Fully Carry Out GAO Recommendations", HRD-80-6; Nov. 13, 1979, pp. 19, 71-73 and 76-77.

if these provisions are the best ways to attack the problems, we believe they are preferable to section 7 of H.R. 2626.

TECHNICAL COMMENTS

Although we believe that section 7 of H.R. 2626 should be deleted, if the Committee decides to adopt it, we suggest that the language of that section be revised.

As presently drafted, we are concerned that the language of section 7 could have the effect of nullifying other provisions of the law which limit Medicare and Medicaid hospital reimbursement (1) to the lower of costs or charges and (2) for services which are substantially more expensive than determined to be necessary in the efficient delivery of health services.

Section 1814(b) of the Social Security Act (added by section 233 of the Social Security Amendments of 1972) limits reimbursement to institutional providers under Medicare and Medicaid to the lesser of the reasonable costs of services determined under section 1861(v) or the customary charges to the public for such services. 1/

The second limitation was added to section 1861(v) by section 223 of Public Law 92-603. As section 223 has been historically implemented by HEW, limits have been established annually on the maximum amount reimbursable for hospital inpatient routine service (operating) costs. These limits are set for each standard metropolitan statistical area and for rural areas. HEW estimates that for 1979 application of the section 223 limits will reduce Medicare payments to hospitals by about $160 million.

The proposed language of section 7(a) provides that

> "Notwithstanding any other provision of this title, payment to any hospital for services furnished under an agreement entered into under this section shall be based upon the reasonable costs of the services as determined under subparagraph (B)."

1/ This provision would be repealed by section 17 of H.R. 3990 as reported by the House Committee on Ways and Means in November 1979.

In our view, this language could be interpreted as nullifying the reimbursement limitations imposed by sections 223 and 233 of P.L. 92-603 and if this is not the Committee's intent, we suggest that the language be modified accordingly.

Under the procedures proposed by section 7 of H.R. 2626, in order to allocate routine service costs between hospital and long-term care services for the purposes of determining payment for inpatient hospital services, the total reimbursement received for routine services for all long-term care patients would be subtracted from total routine costs before calculations are made to determine Medicare and Medicaid reimbursement. Although we believe that the reasonable interpretation of this provision would also require that long-term care patient days be subtracted from total inpatient days before calculations are made, we suggest that this be specifically stated. Otherwise, hospitals could be unintentionally underpaid.

I trust that these comments will assist the Committee in its consideration of H.R. 2626.

Because H.R. 2626 was jointly referred to the Committee on Finance, we are sending copies of these comments to that Committee.

Sincerely yours,

R. F. Keller

Deputy Comptroller General
of the United States

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

Info Mgmt & Technology Group

12991

FEB 25 1980

Combined with 12962 (008783)

B-199171

The Honorable Russell B. Long
Chairman, Committee on Finance
United States Senate

Dear Mr. Chairman:

The Chairman, Senate Committee on Labor and Human Resources, requested our comments on H.R. 2626, a bill passed by the House related to hospital cost containment. Because H.R. 2626 was jointly referred to the Committee and the Committee on Finance, we are sending you a copy of our comments. Also, we considered similar provisions contained in H.R. 934 as reported by the Committee on Finance in preparing our comments on H.R. 2626.

I trust that our comments will assist the Committee in its consideration of H.R. 2626.

Sincerely yours

R.F.KELLER

Deputy Comptroller General
of the United States

Enclosure

3/4
Check not attached
letter - if we
have it + it
has been processed
see me. If not -
Just see me -
GPL

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

FEB 25 1980

B-197171

The Honorable Harrison A. Williams, Jr.
Chairman, Committee on Labor and
Human Resources
United States Senate

Dear Mr. Chairman:

Your letter of December 3, 1979, requested our comments on H.R. 2626, a bill to establish a National Commission on Hospital Costs, to encourage voluntary efforts to contain hospital costs, to provide for the orderly development of State hospital cost containment programs, to encourage philanthropic support for nonprofit hospitals, and for other purposes. This bill has been passed by the House of Representatives and has been jointly referred to the Committee on Labor and Human Resources and the Committee on Finance. Another bill--H.R. 934--reported to the Senate on December 10, 1979, by the Committee on Finance contains provisions which are similar to many of those in H.R. 2626 and we have considered H.R. 934 in preparing these comments.

Section 3 of H.R. 2626 would establish a program to fund State hospital cost containment programs. In order to receive Federal funding, a State's program would have to disregard any funds derived as a result of donor restricted grants, gifts, or endowment income. 1/ Thus, such revenues would not have to be offset against expenses. Section 5 of H.R. 2626 extends this same principle to the determination of payments under the Medicare, Medicaid, and Maternal and Child Health programs. Current Medicare reimbursement policy generally followed for these three programs provides that funds resulting from unrestricted grants, gifts, and endowments are not to be deducted from operating costs in

---

1/ Donor restricted refers to those grants, gifts, and endowments which the donor has designated for a specific purpose such as construction of a hospital wing or providing a particular type of service.

computing allowable costs, but funds from donor restricted grants, gifts, and endowments are to be deducted or offset against expenses in determining allowable costs. This policy is based on the rationale that by not offsetting funds derived from donor restricted sources, double payment for services would result. The following example illustrates this rationale.

> Hospital A receives a gift of $100,000 which the donor restricts to use in providing radiological treatment to all patients. During the year involved, Hospital A provides 10,000 such treatments (1,000 to Medicare beneficiaries) at a cost of $1,000,000 or $100 per treatment. If the hospital is paid its costs of $100 per treatment by all payors, it will receive $1,100,000 for the treatments, including the restricted gift. Thus, the hospital would have been reimbursed twice for a portion of the services.
>
> Under current policy, Medicare's reimbursable costs to Hospital A would be $90,000 for radiological treatments, or $90 a treatment. Under the revision proposed by H.R. 2626, Medicare's reimbursable costs would be $100,000.

We question the desirability of changing the reimbursement principle to disregard donor restricted funds as deductions to operating costs because the double payment rationale seems reasonable to us. We also note that H.R. 934, as reported by the Committee on Finance, includes a provision (section 207) which would codify current Medicare reimbursement policy with respect to restricted and unrestricted donations.

Section 7 of H.R. 2626 would establish, under Medicare and Medicaid, a program under which any participating hospital could provide any level of institutional care authorized by the programs; that is, inpatient hospital, skilled nursing facility (SNF), or intermediate care facility (ICF). ICF care is provided under Medicaid only. The net effect of section 7 would be to remove the distinct part requirement for reimbursement under Medicaid and Medicare. The distinct part requirement provides that to receive payment for SNF or ICF services under the programs a hospital must have distinct beds within the overall facility which are dedicated to, and

licensed for, providing SNF or ICF care. Costs must be accumulated separately and/or allocated equitably for the hospital and nursing home parts of the facility.

Removal of the distinct part requirement would permit a hospital to use any of its beds for any level of care and to change the use of a particular bed among the various levels. This would simplify record keeping and cost allocation requirements for the hospital. Under the reimbursement method of section 7, hospitals would be paid on the basis of their total allowable costs of providing all levels of covered care.

Section 221 of H.R. 934 would establish a similar program but would restrict its applicability to rural hospitals with less than 50 beds which have a certificate of need to provide long-term care and, on a demonstration basis, to hospitals of 100 beds or less meeting the other requirements. H.R. 934 includes another provision (section 211) which would establish a program under which all hospitals not covered by section 221 would be paid for days of care provided in the hospital to patients requiring only the SNF or ICF level of care, at the average daily rate for SNF and ICF care under Medicaid. Hospitals in areas without an oversupply of hospital beds and with an undersupply of nursing home beds would be exempted. The purpose of section 211 is to pay hospitals in those areas where there is a surplus of hospital beds only for the level of care needed by Medicare and Medicaid patients and, thereby, reduce the costs of these programs. The Committee on Finance estimated savings of $1 billion during fiscal years 1980 through 1984 if the provision were enacted. The Congressional Budget Office estimated $260 million in savings for the same period.

According to the Finance Committee report on H.R. 934 (S. Rept. No. 96-471) the difference in estimated savings is based on the belief that the magnitude of the inappropriate use of high-cost hospital beds by Medicare and Medicaid is so large that the reductions in cost would be greater than assumed in the Congressional Budget Office estimate.

Because section 7 of H.R. 2626 would result in paying all hospitals on the basis of their allowable costs regardless of the covered level of care needed by Medicare and Medicaid patients, its enactment would tend to negate much of the savings anticipated to be realized from enactment of section 211 of H.R. 934.

We have issued a number of reports which discuss the need to increase the availability of nursing home beds to Medicare and Medicaid patients. 1/ These reports discussed the high costs associated with patients remaining in hospitals when they could be adequately served by nursing homes but were unable to transfer because of the unavailability of nursing home beds. A provision such as section 211 of H.R. 934 could help to increase the availability of nursing home beds by encouraging hospitals to convert unneeded acute care beds to nursing care beds. Also, H.R. 934 includes provisions to promote closing and conversion of underutilized hospitals by helping to pay through Medicare and Medicaid, the costs of conversion or closing (section 203) and to require the Department of Health, Education, and Welfare to study and make recommendations related to the availability of SNF services under Medicare and Medicaid (section 224).

In summary, section 7 of H.R. 2626 would provide little incentive under Medicare and Medicaid to convert or close unneeded acute hospital beds because hospitals would be paid on the basis of their total allowable costs regardless of the covered level of care provided. In fact, it could encourage hospitals to seek nursing-home type patients to fill empty beds without significantly lowering costs.

In this regard, we noted that the Congressional Budget Office estimated that a similar provision in H.R. 4000 as reported to the House by the Committee on Ways and Means would increase Federal Medicare and Medicaid costs by about $91 million for fiscal years 1980 through 1984. Therefore, we suggest that section 7 be deleted. On the other hand, sections 203, 211, and 224 of H.R. 934 address the need to increase the availability of lower cost nursing home services with an overall reduction in costs. Although we do not know

---

1/ "Ohio's Medicaid Program: Problems Identified Can Have National Importance", HRD-78-98A; Oct. 23, 1978, pp. 7-11;
"Potential Effects of a Proposed Amendment to Medicaid's Nursing Home Reimbursement Requirements", HRD-80-1; Oct. 15, 1979, pp. 4-8;
"Health Costs Can Be Reduced by Millions of Dollars if Federal Agencies Fully Carry Out GAO Recommendations", HRD-80-6; Nov. 13, 1979, pp. 19, 71-73 and 76-77.

if these provisions are the best ways to attack the problems, we believe they are preferable to section 7 of H.R. 2626.

TECHNICAL COMMENTS

Although we believe that section 7 of H.R. 2626 should be deleted, if the Committee decides to adopt it, we suggest that the language of that section be revised.

As presently drafted, we are concerned that the language of section 7 could have the effect of nullifying other provisions of the law which limit Medicare and Medicaid hospital reimbursement (1) to the lower of costs or charges and (2) for services which are substantially more expensive than determined to be necessary in the efficient delivery of health services.

Section 1814(b) of the Social Security Act (added by section 233 of the Social Security Amendments of 1972) limits reimbursement to institutional providers under Medicare and Medicaid to the lesser of the reasonable costs of services determined under section 1861(v) or the customary charges to the public for such services. 1/

The second limitation was added to section 1861(v) by section 223 of Public Law 92-603. As section 223 has been historically implemented by HEW, limits have been established annually on the maximum amount reimbursable for hospital inpatient routine service (operating) costs. These limits are set for each standard metropolitan statistical area and for rural areas. HEW estimates that for 1979 application of the section 223 limits will reduce Medicare payments to hospitals by about $160 million.

The proposed language of section 7 provides that

"Notwithstanding any other provision of this title, payment to any hospital for services furnished under an agreement entered into under this section shall be based upon the reasonable costs of the services as determined under subparagraph (B)."

1/ This provision would be repealed by section 17 of H.R. 3990 as reported by the House Committee on Ways and Means in November 1979.

In our view, this language could be interpreted as nullifying the reimbursement limitations imposed by sections 223 and 233 of P.L. 92-603 and if this is not the Committee's intent, we suggest that the language be modified accordingly.

Under the procedures proposed by section 7 of H.R. 2626, in order to allocate routine service costs between hospital and long-term care services for the purposes of determining payment for inpatient hospital services, the total reimbursement received for routine services for all long-term care patients would be subtracted from total routine costs before calculations are made to determine Medicare and Medicaid reimbursement. Although we believe that the reasonable interpretation of this provision would also require that long-term care patient days be subtracted from total inpatient days before calculations are made, we suggest that this be specifically stated. Otherwise, hospitals could be unintentionally underpaid.

I trust that these comments will assist the Committee in its consideration of H.R. 2626.

Because H.R. 2626 was jointly referred to the Committee on Finance, we are sending copies of these comments to that Committee.

Sincerely yours,

R.F.KELLER

Deputy Comptroller General
of the United States