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

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JAN 20 1975

The Honorable Walter F. Mondale
United States Senate

Dear Senator Mondale:

At your request we have examined into the appropriateness and equity of the methods of allocating costs between Holy Trinity Hospital in Graceville, Minnesota, and its attached board and care facility for Medicare reimbursement purposes.

The administrator of the hospital had stated that a change in Medicare cost reporting requirements for small hospitals would reduce its Medicare reimbursement. Holy Trinity Hospital is a combined hospital and nursing home. The nursing home does not participate in Medicare and therefore no portion of the costs allocated to the nursing home would be reimbursed by the program. The administrator stated that, under the new Medicare cost reporting requirements, more costs would be allocated to the nursing home and less to the hospital than would be allocated under the previously authorized allocation methods. Because hospital costs would be less, Medicare's share of the combined hospital and nursing home costs would be less.

We talked with Mr. Patrick Finn, Manager, Third-Party Reimbursement, for Robert G. Engelhart and Company, a firm of certified public accountants which serves Holy Trinity Hospital and other small hospitals in Minnesota and in other States.

Mr. Finn advised us that other hospitals were losing money because of the change in Medicare cost reporting requirements. He noted that the losses were greatest to hospitals, such as Holy Trinity, with nursing homes. Mr. Finn provided us with additional data which is discussed later.

Some background on Medicare reimbursement would be beneficial in understanding the problem.

BACKGROUND

Hospitals participating in Medicare are paid for the cost of their services based on cost reports prepared using cost allocation methods specified by Medicare regulations and instructions.

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Before 1972, hospitals could generally choose between two methods of cost apportionment--the Departmental Method or the Combination Method. Under either method, the provider could choose either Step-down Cost Finding or other more complex methods of cost allocation with the approval of its intermediary.

In 1970, the Senate Committee on Finance and the Department of Health, Education, and Welfare, desiring to simplify recordkeeping and cost reporting requirements and eliminate the option for providers to choose between apportionment methods, agreed that institutions with less than 100 beds would be required to use the Combination Method with simplified cost finding. (Senate Report No. 91-1431 to accompany H.R. 17550, the Social Security Amendments of 1970, pp. 178-180.)

Under Simplified Cost Finding, costs of nonrevenue producing departments are allocated directly to revenue-producing departments. The bases to be used and the centers to be combined for allocation are specified on the cost report forms developed for this method and their use is mandatory unless prior approval for alternatives is obtained from the Social Security Administration (SSA).

Regulations were subsequently issued in May 1972 requiring hospitals with less than 100 beds to use the Combination Method with Simplified Cost Finding for cost reporting periods beginning after December 31, 1971. These regulations can be found in title 20 of the Code of Federal Regulations, part 405.452.

ANALYSIS OF DATA PROVIDED BY ENGELHART AND COMPANY

Engelhart and Company provided us with: (1) detailed information on Holy Trinity Hospital, (2) correspondence from its office to three other hospitals having nursing homes not participating in Medicare which had similar problems with Simplified Cost Finding, and (3) comparisons for six hospitals with nursing homes (including one of the three included in item (2)) and 23 hospitals without nursing homes of the amounts to be received from Medicare using Simplified Cost Finding with amounts that would have been received under previously authorized cost allocation methods.

The estimated net loss for 18 of the 23 hospitals without nursing homes (after excluding four hospitals where Engelhart and Company believed a valid comparison could not be made and one where we believed a valid comparison could not be made) was about 0.5 percent. This is in line with the results of an SSA study, to be discussed later, which estimated an average loss of less than 1 percent of reimbursable costs.

Three of the nursing homes of the six hospitals with nursing homes participated in Medicare, but there was no indication as to the Medicare reimbursement received for skilled nursing services. Without such information, the overall gain or loss resulting from the use of Simplified Cost Finding could not be determined. For the remaining three hospitals, the aggregate net loss was about 1.3 percent of Medicare reimbursement.

The only data we examined in detail was that of Holy Trinity Hospital.

Engelhart and Company's analysis showed that for the year ended December 31, 1972, by using Step-down Cost Finding, costs of $66,629 would be charged to the nursing home whereas, by using Simplified Cost Finding, $97,760 would be charged to the nursing home--a difference of $31,131.

The hospital participates in the Medicare program but the nursing home does not. Over 50 percent of the hospital's costs are apportioned to the Medicare program. Thus, every dollar charged to the nursing home rather than the hospital results in over a 50 cents reduction in Medicare reimbursement.

Engelhart and Company estimated that the additional $31,131 charged to the nursing home would result in about $17,000 less reimbursement from Medicare or a difference of about 6.5 percent of the total Medicare reimbursable costs of about $261,200.

The hospital had previously used multiple bases for allocating some employee health and welfare and administrative costs which resulted in higher Medicare reimbursement. SSA's policy prohibits this, therefore, it might not be allowed in the future even if the Step-down method could be used. Thus, the cost allocated to the nursing home using Step-down Cost Finding could be increased resulting in a lower loss attributable to Simplified Cost Finding. However, we believe this reduction would not be substantial--about $1,000--which would reduce the true loss to perhaps $16,000.

In an October 23, 1973, letter to Holy Trinity Hospital, SSA denied a request by the hospital to use Step-down Cost Finding and suggested that the hospital's problem could be alleviated by directly charging certain costs which could be specifically identifiable to each building or wing of the hospital-nursing home complex.

Consequently, Engelhart and Company prepared a cost allocation using direct costing which showed that direct costing allocated about $10,000 more costs rather than less costs to the nursing home.

In our opinion, however, Engelhart and Company did not use direct costing as contemplated by SSA. It charged certain costs directly to the nursing home but did not charge similar costs directly to various cost centers for the hospital. The effect was that the nursing home bore all the direct costs charged but continued to share in what could have been direct hospital costs.

Using the direct costing method suggested by SSA, we estimated that costs of about $84,000 could have been charged or allocated to the nursing home as compared to $66,629 allocated through Step-down Cost Finding and the $97,760 allocated using Simplified Cost Finding.

The amount of our estimate should not be considered firm because, without a detailed audit, we had to make certain assumptions as to what could be charged as direct costs. Nevertheless, we believe our estimate is sufficiently accurate to conclude that direct costing would reduce the amount of cost charged and allocated to the nursing home but the costs charged would still be more than the costs allocated using Step-down Cost Finding.

GENERAL IMPACT OF SIMPLIFIED COST FINDING ON MEDICARE REIMBURSEMENT

In September and October 1972, SSA made a study to determine the impact of Simplified Cost Finding on Medicare reimbursement. The study covered 80 cost reports for hospitals of less than 100 beds for reporting periods ending in fiscal year 1971. The study showed that by using Simplified Cost Finding, allowable inpatient costs reimbursable by Medicare would average 0.94 percent less than the reports as filed. After eliminating 12 cost reports with extreme deviations from the average, the study showed that allowable inpatient costs averaged 0.65 percent less using Simplified Cost Finding.

The study stated that, "* * * hospitals would receive less reimbursement under * * * [Simplified Cost Finding] because of a significant shift of cost from routine to ancillary service." Because Medicare inpatient hospital stays are longer than non-Medicare patient stays, generally, Medicare patients receive fewer ancillary services per day than non-Medicare patients.

Although none of the hospitals included in the study had attached nursing facilities, some did have nonallowable cost centers. The study noted, "If the provider had significant direct cost in a nonallowable cost center, the * * * calculation resulted in more overhead cost being assigned to these areas with the resultant effect of lower Medicare reimbursement."

The presence of significant costs in a nonallowable cost center was a major reason for the extreme deviations in the 12 hospitals' cost reports eliminated to arrive at the average of 0.65 percent cost variance.

Thus, SSA has recognized that hospitals would generally receive less reimbursement when Simplified Cost Finding was used and the reimbursement could be less than average if a hospital had significant direct costs in a nonallowable cost center.

CONCLUSIONS

Holy Trinity Hospital's Medicare reimbursement is reduced because it is required to use Simplified Cost Finding. Although the reduction is difficult to estimate without a complete audit, it could be about $16,000 or about 6 percent of its Medicare reimbursement.

The use of direct costing as suggested by SSA would not eliminate the loss but could reduce it by about half.

Simplified Cost Finding presents similar problems for other hospitals serviced by Engelhart and Company. The losses generally do not appear as great--about 1 percent overall. This is consistent with SSA's study of 80 hospital cost reports which indicated an average loss of about 1 percent.

Medicare reimbursement to all hospitals in the United States for fiscal year 1975 is estimated to be about $10 billion, of which about 20 percent or $2 billion will go to hospitals with less than 100 beds. A 1 percent loss to these hospitals would be about $20 million.

However, some hospitals with nonparticipating nursing homes are experiencing greater losses. Holy Trinity is losing about 6 percent. The correspondence from Engelhart and Company indicated that three other hospitals with nonparticipating nursing homes were losing 3.7 percent, 7.1 percent, and 4.0 percent.

In our report to the Senate Committee on Finance--Evaluation of Department of Health, Education, and Welfare Proposed Regulation Changes Affecting Medicare Reimbursements to Institutions (B-164031(4), March 24, 1972)--we expressed the opinion that the number of beds in a hospital should not be the sole criteria for determining the method of cost apportionment to be used.

SSA is planning to send a questionnaire to its intermediaries to learn the capability and willingness of providers with less than 100 beds to convert from the Combination Method with Simplified Cost Finding to the Departmental Method with Step-down Cost Finding.

Based on the results of the questionnaire, SSA could change its regulation regarding cost finding methods.

Notwithstanding the outcome of SSA's study, we believe an equitable solution would be to allow those hospitals, particularly those with nursing homes, which have the desire and capability to do so, to use the Departmental Method with Step-down Cost Finding, subject to the approval of their intermediaries.

We believe that an option to change reimbursement methods each year to maximize reimbursement is undesirable. However, this problem could be eliminated by requiring any provider who selects the Departmental Method to continue with it each year.

Sincerely yours,

[Deputy] Comptroller General
of the United States