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

FOR RELEASE ON DELIVERY
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STATEMENT OF

THOMAS P. McCORMICK, ASSOCIATE DIRECTOR

HUMAN RESOURCES DIVISION

BEFORE

SUBCOMMITTEE ON HEALTH

SENATE FINANCE COMMITTEE SEN104005

ON

~~THE DEPARTMENT~~ OF HEALTH, EDUCATION, AND WELFARE'S
[HEW's PROPOSED SYSTEM FOR
HOSPITAL UNIFORM REPORTING]

Testimony

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HOUSE WAYS AND MEANS COMMITTEE HSE04101

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THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE'S

PROPOSED SYSTEM FOR

HOSPITAL UNIFORM REPORTING

Mr. Chairman and Members of the Committee, we are pleased to be here today to discuss the results of our work regarding the Department of Health, Education, and Welfare's (HEW's) proposed System for Hospital Uniform Reporting (SHUR).

On February 2, 1979, we were asked by the Senate Finance Committee to assess the proposed system. Our testimony today will address the specific questions the Committee raised in its letter; namely

1. How much additional data is being required under SHUR?
2. What use does HEW intend to make of the data?
3. How do the reporting systems and chart of accounts under SHUR compare to what the American Hospital Association (AHA) has developed?
4. What steps has HEW taken to assess the additional costs to hospitals for SHUR and should Medicare and Medicaid assume a larger-than-normal share of the additional costs?
5. Does GAO have any suggestions for simplifying the proposed system?

BACKGROUND

On January 23, 1979, HEW made available for comment, as a proposed regulation, its proposed SHUR. This proposed reporting system was in response to section 19 of Public Law 95-142--the Medicare and Medicaid Anti-Fraud and Abuse Amendments.

This section requires the Secretary to establish by regulation for each type of health services facility, or organization, a uniform system for the reporting of such matters as costs and volume of services, capital assets, and billing data.

The Act provides that in reporting under such a system, hospitals shall employ such chart of accounts, definitions, principles, and statistics as the Secretary may prescribe to reach a uniform reconciliation of financial and statistical data for specified uniform reports to be provided to the Secretary. The Congress intended that the reconciliation of data be required only at such times as the uniform reports are required and not on a day-to-day basis.

Section 19 was enacted to deal with the problem of variations in the information presented in Medicare and Medicaid cost reports. The Congress also recognized that comparable cost and related data would facilitate effective cost and policy analysis, the assessment of alternative reimbursement mechanisms, and, in certain situations, the identification and control of fraud and abuse.

Before we proceed I should explain that much of our analysis was based on the version of SHUR which was made available for public comment in January 1979. The Health Care Financing Administration (HCFA) is considering modifying SHUR in response to comments it received during the public comment period.

For the sake of clarity we will call the proposed version the "January 1979 version" and the modified version the "current version." The current version is our understanding of the changes HCFA intends to make in SHUR.

As part of our review of SHUR we:

--Obtained and compared AHA's chart of accounts and uniform reporting system to SHUR requirements.

--Reviewed the available information prepared by an HEW contractor to assess the cost of implementing SHUR, however, we did not attempt to judge the reasonableness of the estimated cost.

--Discussed the proposed changes in SHUR and the use of the additional data requirements with HCFA officials.

ADDITIONAL DATA AND ITS USE

The first two questions raised by the Committee pertained to (1) the additional data being required by SHUR over and above that presently required under Medicare's cost reporting system and (2) the use HEW intends to make of such additional data.

Number of forms

SHUR is not only a uniform reporting system but also an instrument for gathering cost reimbursement data, statistics needed for health planning, and health manpower data. As such, it combines the forms of the Medicare cost report and the minimum data set for hospital facilities for the Cooperative Health Statistics System (CHSS), which is authorized by the Health Services Research, Health Statistics, and Medical Libraries Act of 1974 (Public Law 93-353).

When compared to the Medicare cost report--which is a complicated and voluminous reporting system consisting of 43 pages and 35 forms--SHUR as currently envisioned represents a net increase of 10 forms. The following chart shows the number of forms required under the current Medicare cost report, the number of forms added by the January 1979 proposed SHUR, the number of forms HEW has told us will be deleted and the number of forms currently planned.

CHART 1
COMPARISON OF NUMBER OF FORMS
REQUIRED UNDER EXISTING MEDICARE
COST REPORT AND PLANNED UNDER SHUR

Principal use	Existing Medicare cost report	SHUR		
		Originally added (Jan. 1979)	To be dropped	Currently planned
Health planning		1		1
Center for Health Statistics		2		2
Reimbursement	35	7	3	39
Uniform reporting		4	2	2
Capital assets	___	1	___	1
Total	35	15	5	45

Although the chart shows a net increase of 10 new forms, since 2 of the 35 forms now required as part of the Medicare cost report are being dropped under SHUR, there will actually be 12 new forms that will have to be submitted to HEW.

Of the 12 HEW forms, only two principally deal with uniform reporting of hospital operating and nonoperating expenses. These two forms are the heart of the additional SHUR requirements as required by section 19 of Public Law 95-142. To make comparisons among hospitals, HEW has proposed a uniform chart of accounts to be used in the expense reporting part of SHUR.

The purposes of the ten other forms are:

--One form includes information for health planning purposes on the hospitals' post graduate medical education programs (if it has one) by clinical specialty. We were told that this information is needed by planning agencies to develop medical education manpower profiles.

--Two forms replace, in effect, the health facilities minimum data set used by the Cooperative Health Statistics Systems which is a Federal, State, and local data gathering program, operating in 36 States. The program is administered at the Federal level by the National Center of Health Statistics of the Health Resources Administration. One form lists various services

which may be offered at a hospital and requires the hospital to designate how the service is offered at the hospital, if at all. We were told that the health planning agencies need this information to inventory hospital services on an areawide basis. The other form gathers information regarding the number and salary of full-time equivalent hospital workers by 12 employee categories. We were told that the information was needed to compare staffing levels between facilities.

--Six forms are for Medicare reimbursement purposes and are generally designed to make more accurate determinations of unallowable costs and to reconcile the costs and charges of hospital-based physicians.

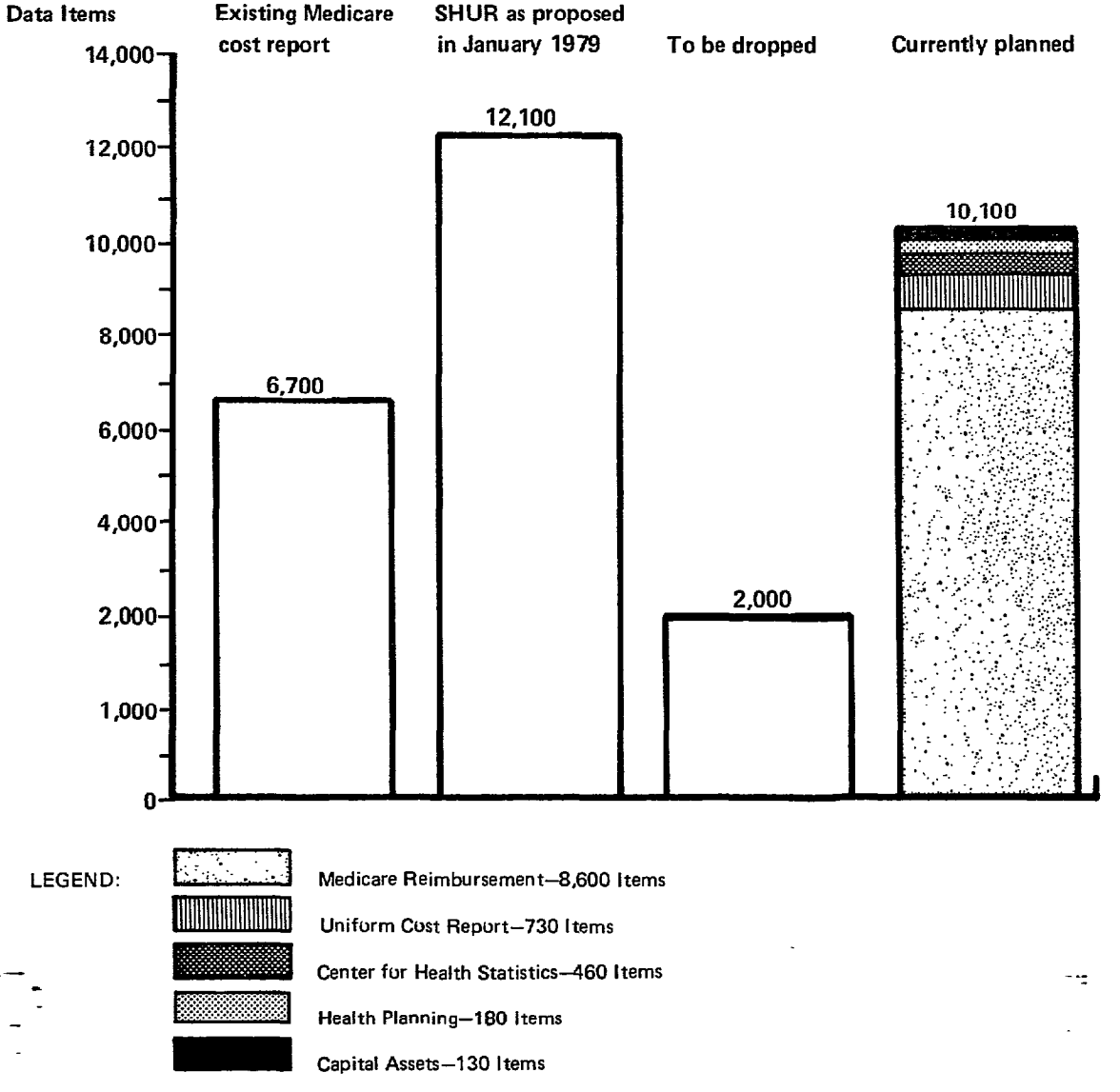
--One form is designed to gather data on capital assets which is required by section 1121(a)(4) of the Social Security Act as amended by section 19 of Public Law 95-142. We were told that the information would be used to compare the historical and replacement costs of a hospital's capital assets. This form also contains information necessary to monitor capital expenditures made by hospitals in accordance with section 1122 of the Social Security Act.

Number of data elements

Although the increase in the number of forms required by SHUR appears to be rather moderate, the increase in the amount of information required to be reported is much more dramatic as shown in the following chart.

CHART 2

COMPARISON OF NUMBER OF DATA ELEMENTS REQUIRED UNDER EXISTING MEDICARE COST REPORT AND CURRENTLY PLANNED UNDER SHUR



We have defined a data element as a blank space to be filled in by a hospital. The last bar on the chart breaks down the required data elements by their primary purpose. Specifically, about 180 are for health planning, about 460 are for the National Center of Health Statistics, about 730 are for uniform cost reporting, about 130 are for capital assets, and about 8,600 are for Medicare reimbursement (some of the Medicare reimbursement data is needed to implement Public Law 95-292 relating to Medicare's end stage renal disease program.) Part of the last number could also be attributed to uniform reporting because much of the net increase results from the increase in the number of cost centers required for uniform reporting which are carried forward to the forms relating to Medicare reimbursement. Also, several of the existing Medicare forms have been expanded to allow for reimbursement settlements for out-patient services under the Medicaid and Maternal-Child Health care programs.

As a practical matter, many hospitals would not have to report the total number of data elements because they do not have all the functions or services included in SHUR. For example, if a hospital did not have a discrete coronary care unit, it would not have to fill in any of the data elements related to it.

Impact of uniform reporting

The two charts discussed before represent an oversimplified view of the additional data being required by SHUR. We believe that, in addition to the new data requirements, another important factor--and probably the biggest burden of SHUR--is the requirement of uniform reporting of cost and cost related data.

As I will discuss later, HCFA commissioned a study to estimate the cost to implement SHUR in a sample of hospitals. This study identified 99 major incompatibilities between the January 1979 SHUR requirements and the hospitals' information systems. About one-third of the incompatibilities (which represented about 18 percent of the cost of correcting all incompatibilities) were related to new data requirements, such as the accumulation of standard units of measurement and new statistics. The remaining incompatibilities pertained to the hospital's problems in accumulating costs in the uniform manner proposed and preparing the SHUR report.

Uniform definitions of cost centers are necessary to obtain comparable cost data. Our review of the legislative history of section 19 of Public Law 95-142 indicates that obtaining comparable cost data was the primary objective of the legislation.

SHUR AND THE AHA SYSTEMS

The third question raised by the Committee pertained to how SHUR's reporting requirements and chart of accounts compare

to the suggested Chart of Accounts for Hospitals published by the AHA in 1976 and the uniform reporting system developed by AHA. We understand that HCFA is reducing the reporting requirements for assets, liabilities, and equity (balance sheet accounts) as originally proposed in the January 1979 version of SHUR; therefore, we will limit our discussion to our analysis of the major revenue and expense accounts required to be reported under SHUR. These accounts form the basis for the SHUR uniform report.

Chart of accounts

We believe that there is a high degree of similarity between SHUR and the AHA chart of accounts.

The January 1979 version of SHUR contained 62 revenue centers and 62 cost centers relating to patient treatment. According to HCFA, the current version of SHUR contains 58 cost centers and hospitals will not have to report revenue for each patient treatment center. Thirty-seven of the 58 SHUR accounts or about two-thirds are similar to AHA's accounts. Eighteen SHUR accounts are not included in AHA's chart of accounts. Most of these involve either ancillary services, intermediate care, or accounts labeled "other***." The remaining 3 SHUR accounts are consolidated under 2 AHA accounts.

Both the January 1979 and current version of SHUR contain 90 accounts for other operating and nonoperating revenues and expenses. These are accounts for such revenues as TV rentals, housing and tuition, and such expense items as administration, maintenance, and laundry. Fifty-eight, or about two-thirds, of these accounts are similar to AHA's accounts and 15 of the SHUR accounts are not in the AHA chart of accounts. The remaining 17 SHUR accounts are consolidated under 9 AHA accounts.

Reporting system

We also believe that there is a high incidence of similarity between the two SHUR forms for reporting of hospital operating and nonoperating expenses, and the AHA uniform reporting system.

The AHA, through its Division of Hospital Administrative Services, has developed a monthly uniform cost reporting system--MONITREND for Hospitals--to which hospitals can subscribe. This new system became effective in April 1979 and replaced a similar system which had been in place for many years. Approximately 2,800 hospitals participate in the system and pay $75 to $150 a month for the service--depending on bed size and whether the hospital is an AHA member.

MONITREND is designed to provide hospital management with important information needed to

--"measure productivity and financial trends;

--assess how policies, procedures, and utilization affect the hospital's operating performance in comparison to other institutions;

--systematize an ongoing monitoring process;

--evaluate budgets; and

--reinforce decisionmaking."

Each month hospitals report information on a two page form. AHA's Guide for Uniform Reporting contains the basic reporting principles hospitals are to follow. The Guide states that:

> "A major feature of MONITREND for Hospitals is the fact that it permits the individual hospital to compare its data with that of similar institutions."
>
> * * *
>
> "In order for the MONITREND for Hospitals monthly report to be of greatest value to the hospital's management, the data submitted by the hospital must be compatible with data submitted by other hospitals in the program."
>
> * * *
>
> "The hospital is not required to maintain its accounts according to the AHA Chart of Accounts for Hospitals or in any other predetermined way; it need only report uniformly."
>
> * * *

Participating hospitals receive monthly reports containing information on utilization, revenue, expense, staffing mix, and productivity. In addition to data relating to the participating hospital, the report provides comparative data on a national and state basis.

Both SHUR and MONITREND require the reporting of information on a functional basis to allow for comparability of data between hospitals. The current version of SHUR includes 58 functional cost centers for hospitals to report their expenses directly related to patient treatment. MONITREND includes 32 functional centers for hospitals to report both revenue and expenses related to patient treatment. Forty-one of the 58 SHUR cost centers or about two-thirds appear on the MONITREND form either as a separate identical center or as part of an aggregated MONITREND center. Two of SHUR's cost centers pertain to nursing home care and are not included in MONITREND because MONITREND has a separate uniform report for such care.

MONITREND is also more aggregated than SHUR in reporting other operating and nonoperating revenue and expenses. MONITREND contains 8 functional centers for reporting other operating and nonoperating revenues. SHUR contains 40 because HCFA and the Blue Cross intermediary wanted these accounts itemized for possible offsets to expense for reimbursement purposes.

MONITREND contains 26 functional centers for reporting other operating and nonoperating expenses. SHUR contains 40 of which 31 are included in MONITREND either as a separate identical center or as part of an aggregated MONITREND center.

For reporting purposes, both MONITREND and SHUR require hospitals to classify expenses. MONITREND requires hospitals to report salaries, other costs, and in some instances, physician remuneration. SHUR requires hospitals to provide a more detailed breakout of cost. The January 1979 version of SHUR required hospitals to report costs by 9 classes. These included salaries and wages, employee benefits, professional fees, medical and surgical supplies, nonmedical and nonsurgical supplies, utilities, purchased services, other direct expenses, and depreciation and rent on moveable equipment. The current version of SHUR combines medical and surgical supplies with the nonmedical and nonsurgical supplies and deletes depreciation and rent on moveable equipment, thus reducing the number of classes to 7.

SHUR as proposed in January 1979 included about 90 standard units of measurement (SUMs), such as number of patient days or number of treatments which were designed to provide a uniform statistic for measuring costs by cost center and to facilitate cost and revenue comparisons among peer group hospitals. The current version of SHUR includes about 60 SUMs designed to facilitate cost comparisons. The monthly MONITREND report includes comparisons of hospitals based on revenue and expense per unit. We compared SHUR's SUMs to MONITREND's statistical units and found that about half were identical

and about one-fourth were different. For the remaining SHUR SUMs, MONITREND did not have either a similar center or a statistic.

ESTIMATED COSTS OF SHUR

The fourth question deals with the steps HEW has taken to assess the additional costs to hospitals of meeting SHUR requirements. The Committee also wanted to know if we felt Medicare and Medicaid should assume a larger-than-normal share of the costs of installing the SHUR system in hospitals.

Assessment of additional costs

HCFA, under a $475,000 contract, had Morris-Davis and Company, a certified public accounting firm in Oakland, California, conduct a study to estimate SHUR implementation costs. Fifty hospitals were selected--using stratified random sampling techniques--from the 1975 universe of 5,870 short-term Medicare hospitals. For each sample hospital, Morris-Davis developed cost estimates for 2 general options for complying with SHUR. The options were:

Option 1--The hospital simply reclassifies its current accounting and statistical information on a once a year basis.

Option 2--The hospital converts its accounting and information systems to collect SHUR data on a routine basis.

HCFA published the Morris-Davis results for 44 of the 50 sample hospitals in April 1979. The average estimated annual cost for option 1 was about $11,500 and ranged from 0 to $53,500. For option 2 the average estimated cost was about $35,000 ($12,700 for one-time system conversion and $22,300 annually for ongoing costs) and ranged from 0 to $195,400. The following chart shows the States where the sampled hospitals were located.

CHART 3
NUMBER OF HOSPITALS BY STATE
IN MORRIS-DAVIS STUDY

	Selected	Included in April report
California*	7	7
New York*	5	5
Minnesota	4	2
Alabama	3	2
Kentucky	3	3
South Carolina	3	3
Pennsylvania	3	2
Illinois	2	2
Maryland*	2	2
Michigan	2	2
Indiana	2	1
Maine	2	2
Florida	1	1
Nevada	1	1
North Carolina	1	1
Tennessee	1	1
Ohio	1	1
Georgia	1	1
Wisconsin	1	0
Rhode Island	1	1
Texas	1	1
Kansas	1	1
Iowa	1	1
Missouri	1	1
Total	50	44

*State Uniform Reporting

HCFA, using the results of the Morris-Davis study, estimated a total option 1 cost of $70.2 million, or an average of $10,200 per hospital, for the 6,848 short-and-long-term hospitals as of December 1978. The HCFA's average cost per hospital of $10,200 differs from the Morris-Davis average cost per hospital because HCFA's estimate was weighted by the hospital's bed size category and whether or not the hospital was located in a State having a uniform cost reporting system. The latter distinction is important because the study showed that the cost for implementing SHUR under option 1 would be about 80 percent lower for hospitals in States with a uniform reporting system.

For a number of reasons, we feel that HCFA's estimate of $70.2 million could be overstated or understated.

First, HCFA's estimate includes 681 long-term hospitals and at least 297 short-term hospitals which were not in the universe from which the sample of 50 hospitals was drawn. We believe that including the additional short-term hospitals in the estimate is probably inconsequential. However, including the long-term hospitals in the estimate assumes that implementation costs for short-term hospitals are representative of the costs for long-term hospitals. We believe that implementation costs in long-term hospitals may be less

than short-term hospitals because, in all probability, their accounting systems would be simpler because of the specialized nature of long-term care hospitals. Thus, the HCFA estimate may be overstated.

Second, the results of 6 hospitals were omitted from the detailed analysis in the Morris-Davis study results because of various problems including unresolved problems with the cost data. The cost results on these hospitals are to be published at a later date. Morris-Davis did, however, provide preliminary estimates for 4 of these hospitals in its report. These hospitals, on the average, had about 70 percent higher costs than the 44 hospitals on which the HCFA estimate was based. In addition, according to a Morris-Davis official, the work-papers applicable to an additional 4 hospitals included in the 44 were returned to the subcontractor because problems were identified with the data after the publication of the report. We do not know the extent to which any of the unresolved problems for these 10 hospitals will affect the contractor's estimated costs and HCFA projections.

Thirdly, Morris-Davis assumed, at HCFA's direction, that when a State's uniform reporting requirement was the same as SHUR's, then the cost to implement that specific requirement under SHUR would be zero. Although we understand HCFA's rationale in making this

assumption, we do not believe it represents a "real world" situation. If a hospital does not comply with a State uniform reporting requirement, it would in fact incur a cost in implementing SHUR. Our review of the Morris-Davis workpapers revealed that none of the 7 hospitals in California complied with all of the State reporting requirements when these requirements were the same as SHUR. For 3 of these hospitals, the working papers included estimates of the costs of implementing SHUR, which totaled about $39,000. The additional costs to the other four hospitals were not estimated. The $39,000, if included in the estimates, would increase the estimated cost of option 1 by almost $1,000 for every hospital in the study.

Finally, although an option 1 approach is all that is technically required, the Morris-Davis study suggests--and we agree--that hospitals will probably adopt a combined option 1 and 2 approach to implement SHUR. So the average cost will probably be somewhere between the option 1 and 2 average costs.

In our view, the biggest benefit of the Morris-Davis study was the identification of those SHUR requirements which impose the largest reporting burden for hospitals. This information has provided HCFA with some rational basis for modifying SHUR before it is issued in final form.

For example, the Morris-Davis study identified 99 major incompatibilities with SHUR and the sampled hospitals' information systems. The study included estimates of the cost of fixing these incompatibilities. Twelve of these incompatibilities affected 40 percent or more of the sampled hospitals. The major incompatibility from a cost standpoint was the actual preparation of the SHUR report which averaged about $4,900 for 93 percent of the sampled hospitals. Other incompatibilities, and the option 1 costs to correct them, which affected 40 percent or more of the sampled hospitals included

--Noncapitalized nonroutine maintenance not charged to specific cost centers which affected about 60 percent of the sampled hospitals and cost an average of $700 to correct.

--Depreciation and lease of moveable equipment not charged to using cost centers which affected 50 percent of the sampled hospital and cost an average of $300 to correct.

--Electronic data processing costs not allocated as required by SHUR which affected 43 percent of the hospital and cost an average of $600 to correct.

All of these requirements have been dropped or modified by HCFA on the apparent assumption that the added

cost of correcting the incompatibilities was not worth the benefits to be obtained by keeping the requirements.

Twenty of the 44 hospitals included in the Morris-Davis study also participate in AHA's MONITREND program. For these hospitals, the average cost of option 1 was about $11,000 annually as compared to the average cost of $12,000 for non-MONITREND hospitals. Under option 2, however, this comparison becomes significant because the average cost for MONITREND hospitals was $25,000 (including one-time systems implementation and ongoing costs) whereas the comparable cost for the non-MONITREND hospitals averaged about $42,000. This indicates that those 2,800 hospitals participating in MONITREND can modify their information systems to accommodate SHUR much easier than those that do not participate.

Who should pay for the added costs of SHUR?

Regarding the Committee's question of who should pay for the added cost of SHUR, we believe that this is basically a policy matter which the Congress should decide. For example, the Congress made this type of decision in December 1975 when it authorized the Federal Medicare and Medicaid programs to pay for 100 percent of the costs of the Professional Standards Review Organization activities in hospitals without the requirement of any apportionment of the review costs among patients of the

hospital for whom such costs had not been incurred. However, since the Committee specifically requested our views on this question, we do believe that the Medicare and Medicaid programs should assume a larger-than-normal share of the cost of SHUR. Presently, the Medicare and Medicaid programs pay about $28 billion or about 40 percent of total hospitals' costs. Thus, these programs would be absorbing a significant amount of the added costs of SHUR in any event.

It is not clear to us how HCFA intends to make comparative cost information available to hospitals in a format beneficial to them. Therefore, we believe that Medicare and Medicaid should pay for the option 1 incremental costs of accumulating data and preparing these forms. In addition, we recognize that many hospitals would opt to make certain conversions in their information systems to accommodate SHUR. We believe Medicare and Medicaid should pay a larger-than-normal share of the one-time system conversion costs--perhaps amortized over a 3-year period--and a proportionate share of the ongoing costs. Our rationale in this regard is that conversion of systems, particularly payroll systems to gather SHUR data, appears to be a reasonable decision for hospital managers to make if they also concluded that such changes could improve their institution's information systems on an ongoing basis.

SUGGESTIONS FOR SIMPLIFYING SYSTEM

The Committee asked for our suggestions for simplifying the proposed reporting system. We believe that HEW needs to have uniformly reported data to improve its administration of Federal health care financing programs. The biggest value of uniformly reported data is that it allows for more accurate comparisons between hospitals. As indicated in the legislative committee reports on Public Law 95-142 explaining the need for section 19, a persistent problem under the program as currently structured is the presence of variations in the information contained in the cost reports.
More accurate comparisons are beneficial for improving health planning and existing reimbursement systems, and for developing alternative reimbursement systems.

As discussed in our comparison between SHUR and AHA's MONITREND system, there were still some differences between the SUMs required by SHUR and those required by MONITREND. One such difference pertains to the Social Services cost center; where MONITREND reports expenses per discharge unit and SHUR uses relative value units as the statistic. According to the Morris-Davis study, 50 percent of the hospitals in the study could not readily develop the Social Service SUM required by the January 1979 version of SHUR

and it would cost--on the average--over $600 a hospital to resolve this incompatibility. We understand that HCFA is considering revising this statistic. We believe that the Social Service SUM should be dropped in SHUR unless a statistic, which is less costly for hospitals to obtain, is found.

We believe that HCFA should reconsider requiring hospitals to report salaries by employee classification in addition to the number of employees by classification. The Morris-Davis study indicates that about 20 percent of the sampled hospitals would have to spend about $1,000 each to comply with this requirement which was one of the more costly incompatibilities identified in the study. In addition, the salary information will be reported by hospitals on one of the forms which previously was part of the CHSS hospital facilities' minimum data set. The predecessor data set did not require data on salaries by employee classification; but only data on the number of full-time equivalent employees. The purpose of the information on numbers of employees was to gather data to make comparisons between hospitals by staffing levels. It is not clear to us how the new data requirements for salaries would improve these comparisons--particularly in view of the added costs of obtaining such data.

Hospitals are required on Schedule F--Reclassification and Adjustment of Trial Balance of Expenses--to consolidate

certain general service cost centers for reimbursement purposes. For example, general accounting, hospital administration, medical staff administration, medical photography and illustration, and insurance are consolidated into one center called "other administrative and general." We were told that this was done because HCFA could not find a logical basis for allocating these costs on an individual cost center basis. We believe hospitals should be allowed to allocate these centers individually if they have a reasonable basis for doing it.

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Mr. Chairman, this concludes our statement. We will be pleased to respond to any questions you or other members of the Committee may have.