SYSTEM FOR HOSPITAL UNIFORM REPORTING (SHUR)

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

NINETY-SIXTH CONGRESS

FIRST SESSION

JULY 26, 1979

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE

80-821 O WASHINGTON : 1979 HG 96-36

COMMITTEE ON FINANCE

RUSSELL B. LONG, Louisiana, *Chairman*

HERMAN E. TALMADGE, Georgia
ABRAHAM RIBICOFF, Connecticut
HARRY F. BYRD, JR., Virginia
GAYLORD NELSON, Wisconsin
MIKE GRAVEL, Alaska
LLOYD BENTSEN, Texas
SPARK M. MATSUNAGA, Hawaii
DANIEL PATRICK MOYNIHAN, New York
MAX BAUCUS, Montana
DAVID L. BOREN, Oklahoma
BILL BRADLEY, New Jersey

ROBERT DOLE, Kansas
BOB PACKWOOD, Oregon
WILLIAM V. ROTH, JR., Delaware
JOHN C. DANFORTH, Missouri
JOHN H. CHAFEE, Rhode Island
JOHN HEINZ, Pennsylvania
MALCOLM WALLOP, Wyoming
DAVID DURENBERGER, Minnesota

MICHAEL STERN, *Staff Director*
ROBERT E. LIGHTHIZER, *Chief Minority Counsel*

SUBCOMMITTEE ON HEALTH

HERMAN E. TALMADGE, Georgia, *Chairman*

ABRAHAM RIBICOFF, Connecticut
GAYLORD NELSON, Wisconsin
SPARK M. MATSUNAGA, Hawaii

ROBERT DOLE, Kansas
DAVID DURENBERGER, Minnesota
WILLIAM V. ROTH, JR., Delaware

CONTENTS

SYSTEM FOR HOSPITAL UNIFORM REPORTING (SHUR)

THURSDAY, JULY 26, 1979

U.S. SENATE,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON FINANCE,
Washington, D.C.

The subcommittee met, pursuant to notice, at 3 p.m., in room 324, Russell Senate Office Building, Hon. Herman E. Talmadge (chairman of the subcommittee) presiding.

Present: Senator Talmadge.

[The press release announcing this hearing follows:]

[Press release, July 13, 1979]

SUBCOMMITTEE ON HEALTH SCHEDULES HEARING ON SYSTEM FOR HOSPITAL UNIFORM REPORTING (SHUR)

The Honorable Herman E. Talmadge (D., Ga.), Chairman of the Subcommittee on Health of the Committee on Finance, announced today that the Subcommittee will meet on Thursday *afternoon,* July 26, 1979 to receive a report from the General Accounting Office concerning the implementation of section 19 of Public Law 95-142, which requires the Secretary to establish a uniform system of reporting for hospitals.

The hearing will begin at 3:00 P.M., Thursday, July 26, 1979 in Room 324 Russell Senate Office Building.

Senator Talmadge said that, "Section 19 was enacted to deal with the problem of the variations in the information contained in Medicare and Medicaid cost reports, and the need for comparable cost and related data essential for reimbursement purposes, policy analysis and control of fraud and abuse.

"It appears that the Department's proposed system has gone considerably beyond the Congressional intent and we asked GAO to undertake a review of their proposal.

"We will hear GAO's evaluation as to whether SHUR is in keeping with the law and whether there is any unnecessary or overly burdensome detailed information required which could be reduced or eliminated.

"Once we have GAO's findings, we will assess the need for further hearings. In the interim we would be pleased to receive written statements from those with an interest in this matter."

Written statements.—Statements submitted for inclusion in the record should be typewritten, not more than 25 double-spaced pages in length and mailed with five (5) copies not later than August 9, 1979, to Michael Stern, Staff Director, Committee on Finance, Room 2227 Dirksen Senate Office Building, Washington, D.C. 20510.

Senator TALMADGE. The subcommittee will please come to order.

Today, we will hear from the General Accounting Office as to their findings concerning the implementation of section 19 of Public Law 95-142. That section requires the Secretary of Health, Education, and Welfare to establish a uniform system of costs reporting for hospitals. Last February, at my request, the staff of the committee asked the General Accounting Office for an assessment of the HEW's proposed system for uniform reporting, known as SHUR.

There has been and continues to be considerable controversy over the proposed SHUR system.

So much so that the House recently voted not to allow HEW to use appropriated funds to issue regulations on SHUR. The Senate Appropriations Committee stated in their report that HEW should proceed to revise the SHUR proposal and that no 1980 funds could be used for data collection under SHUR.

I understand that House-Senate differences are to be worked out next week.

Thus, the GAO evaluation we will hear today should assist not only the legislative committees but also the appropriating committees.

Section 19 of Public Law 95-142 was enacted to deal with the problem of the variations in the information contained in medicare and medicaid cost reports, and the need for comparable cost and related data essential for reimbursement purposes, policy analysis and control of fraud and abuse.

It appears that the Department's proposed system has gone considerably beyond the congressional intent.

We will hear GAO's evaluation as to whether SHUR is in keeping with the law and whether there is any unnecessary or overly burdensome detailed information required which could be reduced or eliminated.

In view of the hearings being held tomorrow by the Ways and Means Committee on this subject, we have not schedule public witnesses to appear at this time, although we have asked for written statements from those with an interest in this matter.

In addition, I would invite interested parties to include in their testimony any comments in connection with GAO's statement or matters discussed here today.

It would also be appropriate for me at this time to commend Comptroller General Staats and his fine staff.

The Subcommittee on Health has always found GAO responsive to our requests for assistance. In particular, Mr. Iffert and Mr. Dowdal deserve particular commendation.

Senator TALMADGE. Before you proceed with your testimony, I believe that there is a statement submitted by Senator Dole. Without objection, that will be inserted in the record at this point.

[The statement of Hon. Bob Dole follows:]

STATEMENT OF SENATOR BOB DOLE

Mr. Chairman, I am pleased to join with you today in welcoming our witness, Mr. McCormick of the General Accounting Office. I am eager to hear the results of their study of the Department of Health, Education and Welfare's proposed system for hospital uniform reporting, commonly known as SHUR.

As you know, I was a supporter of the original medicare/medicaid antifraud and abuse amendments, which require the development of a system for hospitals to report certain cost and statistical information in a uniform manner and I strongly endorse the concept of methods to control fraud and abuse. Because it is clear a loss of funds due to fraud and abuse results in fewer dollars being made available of health care services for the poor, the elderly, and the disabled, all of whom look to these programs for help.

However, in our efforts to protect the programs and their recipients, we must avoid adding an unreasonable burden to that already borne by our hospitals. The system to strive for is one which obtains the needed information in a uniform manner without adding substantial costs to institutions, especially, at a time when we are encouraging them to decrease their costs.

Serious concerns have been raised about the complexity and costs of implementing the regulations as originally proposed. I believe the system may prove to be an excessive and costly encumbrance.

The Department of Health, Education and Welfare estimates that SHUR will cost $65.6 million to adopt—the American Hospital Association's figures are about three times that, or $180 million. This is a discrepancy of well over $100 million.

This discrepancy seems to be based on several factors. First, many of the costs that hospitals would incur to implement the system have not been included in the HEW estimate. Secondly, they included in the sample a disproportionately large number of hospitals in States with existing mandatory reporting systems. They would incur fewer costs to implement the system. This lower cost estimate is of particular concern for those hospitals located in rural States.

Kansas is a State with a large number of small, rural hospitals. Of the 143 community hospitals in the State, 75 percent are under 100 beds and 44 percent are under 50 beds. I am, therefore, most concerned with the impact on these small rural hospitals. Even though there are provisions for hospitals with a limited number of admissions to report in less detail, they will still be required to collect all the information necessary to support the direct recording of costs, standard units of measure, and medicare statistical basis.

This is of particular concern for hospitals that are still operating on hand-posting accounting systems, which are used in about ¼ of the Kansas hospitals. If SHUR were implemented, these hospitals would be forced to acquire some form of automated data processing capability—a most expensive proposition.

I am also concerned about the effect of the proposed rule which would require all medicare and medicaid hospitals to report on the cost of their operation and the volume of their services, both in the aggregate and by functional accounts. If, in order to comply with the detailed reporting requirements under the SHUR proposal, hospitals are forced to convert their internal accounting systems, effective and efficient management of those hospitals will be severely reduced. This would be the result because functional accounting does not provide the information necessary for the successful management of a hospital; costs are assigned to cost centers based on prescribed definitions of functional activities and not on the basis of a particular department's responsibility for incurring and controlling its costs. This is contrary to the main purpose of the hospital accounting system which is the development of management information. The hospital administrative team is, and must remain, the most important user of the information generated by the accounting system.

I am pleased that Senator Talmadge has scheduled today's hearing to review the GAO report. I look forward to Mr. McCormick's testimony and am hopeful that we will develop a better understanding of (1) how much additional data is being required by SHUR above that presently required by medicare, (2) how HEW plans to use the additional data obtained, (3) how the reporting requirements and chart of accounts of SHUR and the American Hospital Association compare, (4) steps the Department has taken to assess the additional costs to hospitals in establishing the system, and, (5) suggestions of the General Accounting Office for simplifying the proposed reporting system.

It is crucial that before the system is finalized there be evidence the additional expense and effort required produce some data which is of value. We must guard against Federal regulation which is not necessary.

I am hopeful we may all work together with the Department to produce regulations which meet the intent of the law without placing undue burden on the hospitals.

Senator TALMADGE. Now, Mr. McCormick, if you and your associates are prepared to proceed, we would be pleased to hear your testimony.

STATEMENT OF THOMAS P. McCORMICK, ASSOCIATE DIRECTOR, HUMAN RESOURCES DIVISION, GENERAL ACCOUNTING OFFICE

Mr. McCORMICK. Thank you, Mr. Chairman.

I would like to introduce my associates: Mr. Robert Iffert on my left, Assistant Director of the Human Resources Division; on my right, Mr. Bob DeRoy.

If it is all right with you, Mr. Chairman, I would like to summarize my statement. I have a rather lengthy statement and I would like to highlight it.

Senator TALMADGE. Your entire statement will be inserted in the record and if you will summarize it, the Senate is in session and we are having votes periodically, so we would like to complete the hearing before the next vote if we can.

Proceed, sir.

Mr. MCCORMICK. We are pleased to be here today to discuss the results of our work regarding HEW's proposed system for hospital uniform reporting, commonly referred to as 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 antifraud 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 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; and 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—January 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 2 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 10 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 twelve 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.

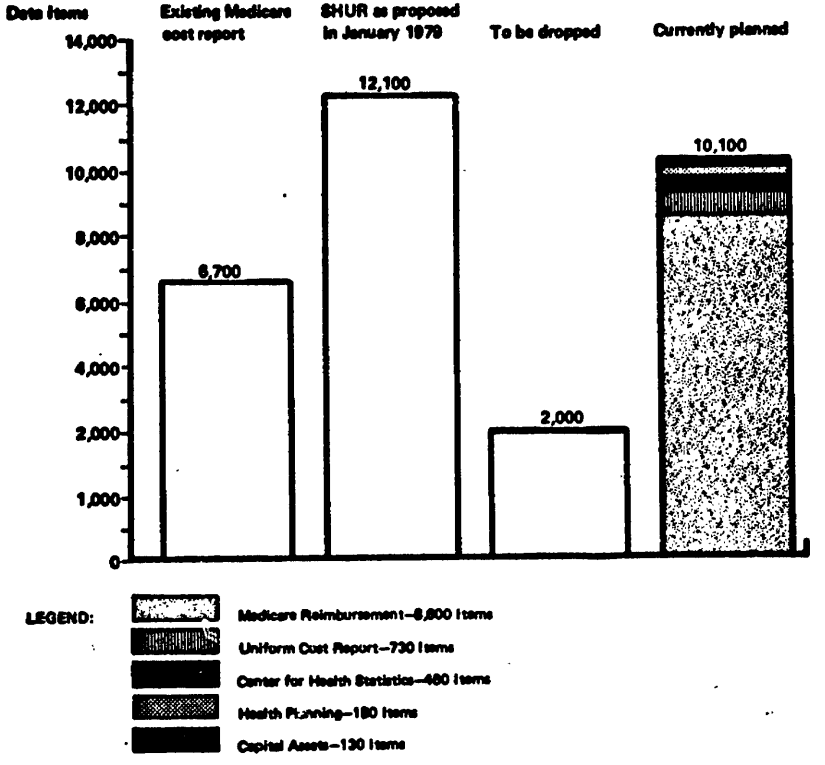
One form is designed to gather data on capital assets which is required by Section 1121(a)(4) of the Social Security Act as amended by section 19 of Public Law 95-142. We were told that the information would be used to compare the historical and replacement costs of a hospital's capital assets. This 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 outpatient 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 fifty-eight 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 three SHUR accounts are consolidated under two 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, hous-

ing, 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 fifty-eight 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 eight 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 nine 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 movable equipment. The current version of SHUR combines medical and surgical supplies with the nonmedical and nonsurgical supplies and deletes depreciation and rent on movable equipment, thus reducing the number of classes to seven.

SHUR, as proposed in January 1979, included about 90 standard units of measurement (SUM's), 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 SUM's designed to facilitate cost comparisons. The monthly Monitrend report includes comparisons of hospitals based on revenue and expense per unit. We compared SHUR SUM's to Monitrend's statistical units and found that about half were identical and about one-fourth were different. For the remaining SHUR SUM's, 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 & Co., a certified public accounting firm in Oakland, Calif., 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 two 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 one 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 [1]	7	7
New York [1]	5	5
Minnesota	4	2
Alabama	3	2
Kentucky	3	3
South Carolina	3	3
Pennsylvania	3	2
Illinois	2	2
Maryland [1]	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

[1] 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 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 six 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 four 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 workpapers applicable to an additional 4 hospitals included in the 44 were returned to the subcontractor because the 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.

Third, 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 seven hospitals in California complied with all of the State reporting requirements when these requirements were the same as SHUR. For three 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 sys-

tems. 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 movable equipment not charged to using cost centers which affected 50 percent of the sampled hospitals and cost an average of $300 to correct; and electronic data processing costs not allocated as required by SHUR which affected 43 percent of the hospitals 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 forty-four 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 for 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 SUM's 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.

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

Senator TALMADGE. Thank you very much, Mr. McCormick for a very comprehensive and thorough response to the subcommittee request. I understand that one of the principal items of difference between HEW and the hospital industry is the linkage between the uniform reporting requirements and the medicare cost reporting system for reimbursement.

I understand that the industry maintains that this linkage is not authorized by section 19 of Public Law 95-142.

What are GAO's views on this issue?

Mr. MCCORMICK. Specifically, Mr. Chairman, the simple answer to that question is, Yes, we believe there is definitely a linkage between the uniform reporting requirement and medicare cost reimbursement. One of the reasons is that section 19 specifically amended the reasonable cost provisions of title 18. Therefore, we think, by making that amendment, the Congress was saying that there definitely was a linkage between the two.

Senator TALMADGE. Without uniform cost reporting, would hospitals be able to evade limitations and inappropriately maximized Federal reimbursement?

Mr. MCCORMICK. I think I will ask Mr. Iffert to answer that question.

Mr. IFFERT. There is some evidence that that has occurred. We have obtained the results of a HCFA study in January 1977 regarding the provider cost shifts from routine services to special care and ancillary service areas. This study concluded that the hospitals were able to maximize reimbursement or avoid section 223 limits on general routine care by such methods as changing their accounting methods, changing statistical bases or changing beds from general routine to special care units.

The study also indicated that the changes would generally conform to medicare reimbursement principles. It is relatively short, and it would be helpful to include it in the record.

Senator TALMADGE. Would you submit for the record your study of that, please?

Mr. IFFERT. Yes, sir.

[The material referred to follows:]

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL SECURITY ADMINISTRATION,
January 31, 1977.

Memorandum to: Division of Provider Reimbursement, and Accounting Policy, Program Policy, BHI.
From: John W. Jansak, Division of Contractor Operations, Program Operations, BHI.
Subject: Study of Provider Cost Shifts from Routine Services to Special Care Units and Ancillaries—Information.

Per your request, we have conducted a limited study to determine if providers were shifting costs from the general routine area to special care units in order to avoid Section 223 limits. However, the study was expanded to include all shifts from general routine to other areas (ancillary, outpatient, etc.) since Section 223 avoidance can also be accomplished by these means.

We used two types of samples. The first sample consisted of 20 providers selected at random. The second limited sample consisted of 14 providers who were approaching or exceeding the general routine cost limit. Eight of the 34 providers reviewed appear to be shifting costs primarily to the ancillary areas.

The cost shifts away from the general routine occurred generally in fiscal year 1975 and were accomplished by changes in the following:

1. Direct Cost Distributions, i.e., salaries and other direct costs. Increases in these costs resulted in corresponding increases in A&G and Employee Health and Welfare cost allocations.
2. Direct Cost Distributions of General Service Costs on the books of the provider.
3. Changes in Accounting Methods.
4. Changes in Statistical Bases.
5. Significant Increases or Decreases in Statistics.
6. Changes in the number of beds—A couple of providers in our study transferred beds and the related square feet statistics from general routine to a special care unit. The need for the transfer of additional beds was questionable since the number of SCU inpatient days declined in the later year.

Attached for your information are schedules of six providers in which we have explained some of the more significant cost shifts. The changes in the accounting methods or bases in 1975 generally conformed to Medicare principles and resulted in a more accurate allocation of cost to general routine when compared to prior years' methods which were highly questionable and generally shifted excessive cost to general routine. Prior to fiscal year 1975, it was usually to the provider's advantage to load the routine cost center. With the advent of the general routine cost limitation in fiscal year 1975, some providers, particularly those approaching the cost limits, attempted to do everything legally possible to shift more costs into the ancillary and SCU cost centers.

In conclusion, it is our opinion that cost shifts will become more prevalent as providers strive to maximize Medicare reimbursement and/or avoid the Section 223 limits. We believe that as long as Medicare instructions allow providers to direct cost general service costs and to otherwise circumvent cost finding under the guise of more sophisticated methods, the conditions enumerated above will continue to exist.

Attachments.

PROVIDER A

	1973-74—December		1974-75—December	
	Cost increase	Percent of increase	Cost increase	Percent of increase
Ancillary	$521,489	9	$2,077,972	32
General routine	1,205,965	15	826,126	9
Intensive coronary	66,543	15	74,740	14
ICU neonatal	66,636	27	198,993	63
Nursery	13,777	7	28,805	14
Emergency (includes emergency room phys. comp.)	64,385	14	59,968	11
Nonallowable	59,450	33	39,562	17
Total	1,998,245	13	3,306,166	19
Total I/P days including general routine days	6,831	4	9,770	5

PROVIDER A—Continued

	1973-74—December		1974-75—December	
	Cost increase	Percent of increase	Cost increase	Percent of increase
General routine I/P days	6,826	4	7,744	4
ICU	(110)	(3)	220	6
Intensive care nursery	115	3	1,806	46
Ancillary per diem	$1.60	5	$9.02	26
General routine per diem	$5.07	11	$2.33	5
ICU	$21.34	18	$11.23	8

CONCLUSION

The increase in ancillary costs as compared to general routine costs (32 percent versus 9 percent) appears excessive in 1974-1975 and suggests an apparent shifting of costs from routine to ancillary cost centers. This difference is even wider on a per diem basis (26 percent versus 5 percent). Note that this same situation did not exist in the 1973-1974 comparison where the general routine exceeded the increse in ancillaries (15 percent versus 9 percent).

Most of the 1975 ancillary cost increases occurred in direct costs (salary and other), and in those overhead cost centers that are allocated based on direct cost dollars, i.e., A&G and EH&W. We found that the allocation bases of three overhead cost centers were changed in 1975 causing a shift of costs from general routine to ancillary. In a fourth overhead cost center, interns and residents, the same effect is obtained due to a change in the allocation statistics. Statistics, which were properly allocated to nursery in 1975, were apparently included in the statistics allocated to routine in previous years.

PROVIDER B

	1973-74—December		1974-75—December	
	Cost increase	Percent of increase	Cost increase	Percent of increase
Ancillary	$703,519	11	$1,939,016	27
General routine	284,509	5	60,571	1
SCU	219,312	10	143,040	6
SNF (certified)	(1,337)	.....	131,234	10
SNF (ATU)	.....	.....	425,126	100
Nonallowables	(46,786)	.....	114,397	100
Total	1,159,217	7	2,813,384	16
Total I/P days including SCU	(4,104)	(5)	(6,205)	(8)
General routine I/P days only	(3,876)	(5)	(7,032)	(10)
Ancillary cost per diem	$12.96	17	$34.36	38
General routine cost per diem	$8.37	10	$10.75	12

CONCLUSION

A redistribution or shifting of the total cost in 1975 from routine to ancillary appears to have occurred. Routine costs rose only 1 percent in 1975 while ancillary costs increased 27 percent. The disparity is not as wide on a per diem basis with 12 and 38 percent increases being registered for routine and ancillaries respectively.

Additional analysis revealed that the bulk of the dollars involved in the 1975 ancillary increase was in direct costs (salaries and other). However, the increase in ancillary costs attributable to overhead allocations in 1975 represents a 49 percent increase over the 1974 comparable period. We noted several instances in which statistical bases were changed in 1975 which contributed to this large increase.

PROVIDER C

	1973-74—December		1974-75—December	
	Cost increase	Percent of increase	Cost increase	Percent of increase
Ancillary	$1,157,579	14	$2,209,203	24
General routine	973,396	6	2,578,141	16
ICU	(26,633)	(2)	288,964	27
CCU	22,094	14	75,136	41
Burn unit	49,588	17	70,576	21
Nursery	108,460	19	256,549	38
Outpatient	134,799	17	223,238	23
Total	2,419,283	9	5,701,807	20
I/P Days including SCU	9,090	1	(6,115)	(3)
General routine I/P days only	8,584	5	(6,667)	(3)
ICU I/P days	23	0	474	10
CCU I/P days	(31)	0	(52)	0
Burn unit	514	49	130	8
Nursery days	(947)	(9)	3,087	33
Ancillary cost per diem	$3.82	9	$12.80	27
General routine cost per diem	$1.38	2	$16.78	20
ICU per diem	($6.63)	(3)	$34.77	16
CCU per diem	$25.07	17	$83.17	48
Burn unit per diem	($58.42)	(21)	$24.97	12

CONCLUSION

Some shifting of costs into the CCU from other areas may have occurred. Cost of the CCU in 1975 increased significantly (41 percent or 48 percent on a per diem basis) while the inpatient days in that unit remained somewhat constant. The CCU 1975 cost increases were also disproportionate to increases incurred in other patient care areas.

Most of the CCU 1975 cost increase can be traced to direct costs (salary and other) and in those overhead cost centers that are allocated based on direct cost dollars. Other overhead distributions to CCU increased due to the higher proportion of statistics assigned to the CCU in relation to those assigned to other cost centers.

PROVIDER D

	1973-74—December		1974-75—December	
	Cost increase	Percent of increase	Cost increase	Percent of increase
Ancillary	$217,106	13	$546,108	29
General routine	97,251	5	296,491	15
ICU	12,350)	12	32,208	30
CCU	(13,770)	(9)	22,400	16
Nursery	(3,148)	(5)	2,806	4
Outpatient	52,690	47	43,454	27
Nonreimbursable	3,063	42	3,377	33
ECF	22,789	9	76,841	28
I. & R. nonapproved	34,984	39	16,382	13
HHA	18,837	100	61,757	328
Total	442,152	10	1,101,824	23
I/P days including SCU	2,370	5	641	1
General routine I/P days	2,310	5	764	2

PROVIDER D—Continued

	1973-74—December		1974-75—December	
	Cost increase	Percent of increase	Cost increase	Percent of increase
ICU I/P days	0	.....	(75)	(6)
CCU I/P days	60	5	(48)	(4)
Ancillary per diem	$2.67	7	$10.42	27
General routine per diem	$0.01	0	$5.55	13
ICU per diem	$9.82	12	$33.03	36
CCU per diem	($18.01)	(14)	$24.09	21

CONCLUSION

Ancillary costs increased at approximately twice the rate of general routine in 1975 which suggests some cost shifting from routine to ancillary cost centers. Most of the ancillary increases in 1975 occurred in direct costs (salary and other), and the resultant increases in overhead allocations based on these increases.

PROVIDER E

	1973-74—December		1974-75—December	
	Cost increase	Percent of increase	Cost increase	Percent of increase
Ancillary	$290,836	34	$60,431	5
General routine	137,952	10	(198,964)	(14)
SCU	4,542	3	9,363	6
Outpatient cost centers	(55,463)	(63)	(15,984)	(50)
I. & R. nonapproved	0	0	114,310	100
Total	377,867	16	(30,844)	(1)
I/P days including SCU	(1,038)	(5)	(2,753)	(13)
General routine I/P days	(1,000)	(5)	(2,723)	(14)
SCU I/P days	(38)	(3)	(30)	(3)
Ancillary cost per diem	$15.53	40	$11.28	21
General routine cost per diem	$9.94	16	($0.14)	0

CONCLUSION

There appears to be some cost shifts from routine to ancillary. In the 1974-1975 periods, on a per diem basis, ancillary costs increased 21% while general routine costs showed no increase.

These differences appear to be primarily related to the provider's treatment of intern and resident and employee health and welfare costs. Intern and resident costs of a nonapproved teaching program were apparently direct costed to general routine and/or emergency cost centers in 1973 and 1974. In 1975 these costs were properly reimbursed through Exhibit J.

Employee health and welfare costs were treated differently in each of the 3 years reviewed. In 1973 a hybrid method of direct costing and overhead allocation was used. In 1974 regular cost finding methods were employed while in 1975 direct costing was used in its entirety.

PROVIDER F

	1973-74—December		1974-75—December	
	Cost increase	Percent of increase	Cost increase	Percent of increase
Ancillary	$527,292	12	$1,608,852	33
General routine	417,199	10	(56,512)	(1)
SCU	63,358	8	109,256	12
Nursery	147,545	25	50,764	7
Outpatient clinic	500,834	36	481,802	26
Nonallowable	(60,189)	(14)	(9,245)	(2)
Nonhospital	(88,183)	(9)	196,423	22
Total	1,507,856	12	2,381,340	17
I/P days including SCU	3,676	6	(4,136)	(6)
General routine days only	3,211	6	(3,960)	(7)
Ancillary cost per diem	$4.14	6	$31.65	43
General routine cost per diem	$2.95	4	$4.48	6

CONCLUSION

The significant shift of costs in 1975 from routine to ancillary services was due, in part, to a change in the accounting treatment of cost of drugs sold and cost of medical supplies sold. These costs were properly handled in 1975; however, the allocations in prior years are questionable. In 1973 and 1974 it appears that most of these costs were charged directly to routine services.

Senator TALMADGE. In your testimony you indicate that only 2 of the 12 forms proposed under SHUR, and some 730 data items, deal with uniform reporting of hospital operating and nonoperating expenses. If this is true, how did we end up with a manual that appears to be between 500 and 600 pages?

Mr. MCCORMICK. That is what the AHA would like to know, too. I think in part there are a couple of answers to that question. I think one relates to the fact that SHUR was modeled after some State uniform reporting systems namely California, Washington, and Arizona. If you look at the size of those manuals, they are just about as thick as SHUR. But these systems also call for uniform accounting as well as uniform reporting.

I think there is another part of that that relates to the genesis of the SHUR requirement. I will have Mr. Iffert go back through some of the background. Even before the antifraud and abuse amendments, there was some legislation passed relating to the national health planning. That was the genesis of SHUR. Let Mr. Iffert speak specifically to that.

Mr. IFFERT. I think that is true that SHUR was first developed to try to implement a provision in Public Law 93-641, the National Health Planning and Resource Development Act of 1974. What this act did was direct the Secretary of HEW to establish a uniform system of cost accounting, which is entirely different than the uniform system of reporting, and to develop a system for calculating the volume of services provided by health services institutions.

Since this particular section came under the heading of technical assistance, there was no clear mandate in the law to impose the cost accounting system upon the industry, but merely to develop it.

Anyway, HEW's efforts to implement this particular section of the law which called for a cost accounting system was really the genesis of SHUR, and we think part of that was carried forward and probably explained why HCFA developed such a comprehensive document as ultimately came out in January.

Mr. McCORMICK. In addition, I believe the Blue Cross Association in commenting on the proposed SHUR system was able to almost revise the 500- or 600-page manual to 108 pages. We have not looked at it or reviewed it, but I understand they were able to do that, which would indicate that maybe we can reduce the size of that manual.

Senator TALMADGE. You indicate that two of the additional forms and 460 of the additional data items in effect replace the health facilities minimal data set used for the cooperative health statistics program for the National Center for Health Statistics. Apparently HEW is attempting to coordinate and consolidate some of its data gathering requirements, an objective that I certainly would not want to discourage.

However, I am not certain that hospitals understand the objective. Would you agree with that assessment?

Mr. McCORMICK. Mr. DeRoy?

Mr. DEROY. I think we would have to agree. During our review, we met with hospital officials to discuss SHUR. When we told them it was our understanding that some of the SHUR data was for health statistics and planning, it was news to them.

I do not think that the notice of proposed rulemaking made it clear that HCFA was, in fact, coordinating the SHUR system with other reporting systems already in existence and authorized by previous legislation.

Senator TALMADGE. The bell has rung for a vote and I regret I will have to go to the floor to cast my vote. I have only a few more questions. The staff will submit those to you and will you please respond in writing for inclusion in the record.

[The material referred to follows:]

Question 1. In response to the committee's third question regarding the comparison between SHUR's chart of accounts and uniform reporting system and AHA's, you testified that there seems to be a high degree of similarity. How similar are these systems, and does the SHUR system go significantly beyond AHA's own system?

Answer. Both Monitrend And SHUR are designed to gather uniform cost data on a functional basis to facilitate comparisons between hospitals. Most of the SHUR cost centers appear on Monitrend either as a separate identical center or as part of an aggregated Monitrend center. Most of the SHUR statistical units of measure, which are used to facilitate comparisons between hospitals, are identical to those used on Monitrend. We were told that all existing uniform reporting systems, including SHUR, California, Washington, and Arizona have their bases in AHA's chart of accounts.

We believe there are 3 major differences between the 2 systems which prevent HCFA from simply adopting the Monitrend system. First, SHUR requires hospitals to provide a more detailed breakout of costs than Monitrend. We were told that HCFA needs this data to obtain a better understanding of the differences between costs at similar facilities. Second, SHUR contains certain centers which are required for Medicare and/or Medicaid reimbursement, while Monitrend does not contain these centers. Examples include those centers related to blood, end stage renal disease, and intermediate care. Finally, many SHUR centers are aggregated under one Monitrend center. For example, medical/surgical intensive care, pediatric intensive care, coronary care, burn care, and psychiatric intensive care are grouped into one center under Monitrend. We were told that HCFA needs the information reported separately for these centers to make more accurate comparisons between

hospitals or that the information has to be reported separately for reimbursement purposes.

Question II. There have been charges by the hospital industry that the Morris-Davis study did not in some cases accurately reflect the sample hospitals' best estimates of implementing SHUR. Since you testified that you reviewed the working papers supporting the study, would you comment on this?

Answer. We were able to review workpapers for only 38 of the 50 sampled hospitals. The remaining workpapers had been returned to the subcontractors. It is our understanding that the auditors worked with hospital personnel to develop the estimates. Yet, we were unable to find any evidence of the hospitals' concurrence with the estimates for 17 of the hospitals. We found that 15 hospitals agreed with the estimate and 6 disagreed. Generally the hospital administrators disagreed because no estimates were made for incompatibilities they believed to be SHUR requirements or the incremental cost approach to the study was wrong. For example, if a hospital required 1,000 hours to prepare the SHUR report, the auditors estimated the cost based on a fraction of a full-time equivalent employee and not the cost of hiring a new employee. Also, no overhead costs were included in the estimates because the auditors assumed that these costs would not change due to the relatively small number of additional full-time equivalent employees required to implement SHUR.

Question III. Does the SHUR system impose less burdensome reporting requirements on the small rural hospitals and, if not, should it?

Answer. The current version of SHUR allows small hospitals (under 4,000 admissions) to combine certain overhead cost centers. In addition, certain other reporting principles, which are applicable to all hospitals, should reduce the reporting burden for small hospitals. These include the use of statistical sampling to gather cost and statistical information and a higher threshold level for having to transfer misplaced costs from one center to another.

We share your concern about minimizing the regulatory burden for small hospitals. However, when this was done in 1972 by simplifying Medicare cost reporting, the results tended to hurt rather than help these small hospitals by reducing their Medicare reimbursements. This was not corrected until January 1979.

In May 1972, HEW issued regulations which required hospitals with less then 100 beds to use simplified cost allocating methods for reporting periods beginning after December 31, 1971. This method was less sophisticated and less accurate than the method required for larger institutions. However, for those small hospitals, which also had nursing homes, the result was to allocate more costs to the nursing homes than would otherwise be allocated using the more accurate method. This resulted in less costs being allocated to the hospital and, thus, lower Medicare reimbursement. We are aware of situations where this lower reimbursement amounted to as much as 6 or 7 percent which can be significant for small rural hospitals with higher Medicare utilization. Because of this inequity, HEW has issued new regulations in 1979, which equalized the cost allocation requirements for all hospitals.

Question IV. Why couldn't the Health Care Financing Administration merely take the AHA Monitrend system and use it as the basis for establishing a system for uniform reporting?

Answer. Despite the high degree of similarity between Monitrend and SHUR, we believe that HCFA cannot simply adopt the Monitrend system for several reasons. First, and foremost, the Monitrend system does not contain those cost centers needed for Medicare reimbursement. These include those centers related to Medicare's end stage renal disease program and Medicaid's coverage of intermediate care. Second, Monitrend breaks out costs by salaries and other costs only. HCFA has told us that they need costs broken out further to compare hospitals fairly. Finally, many SHUR cost centers related to patient care are combined under the Monitrend system. HCFA wants these centers separately identified to make more accurate comparisons between facilities.

Question V. In view of the voluminous reporting requirements proposed by HEW and the confusion over the SHUR system, it seems to me that the appropriate action for the Department is to come forth with a revised proposal for additional public comment. Would you agree with that assessment?

Answer. We understand that the Department intends to come forth with a revised proposal for additional public comment. We believe that this would be appropriate due to the number of changes to SHUR as proposed in January 1979 being contemplated by the Department.

Senator TALMADGE. Are there any other statements to be inserted in the record?

I am told that Senator Dole also has a series of questions which will be submitted for response in writing for the record.

[The material referred to follows:]

Question I. Did you study the HCFA cost study on the implementation of SHUR? Were there any weaknesses in the study?

Answer. We reviewed the workpapers for 38 of the 50 sampled hospitals. The remaining workpapers had been returned to the subcontractor either to finalize the estimate or to prepare for exit conferences. We did not attempt to validate the study's results because of the subjective nature of the estimates. We believe that a major weakness in the study was the failure of the auditors to obtain hospital concurrence with their cost estimates. It is our understanding that the auditors worked with hospital personnel to develop the cost estimates. Yet we were unable to find any evidence in the workpapers of the hospital's concurrence with the estimate for 17 of the 38 hospitals. We found evidence that 15 hospitals agreed with the estimate and 6 disagreed. We also understand that the estimates went through several levels of review after the auditors left each hospital. In some instances, it appears that an estimate was revised without the hospitals being advised of the change.

Question II. Has there been any valid estimation of the total system cost of SHUR. That is, increased costs to HCFA, intermediaries, and hospitals? If so, what are the estimated costs?

Answer. We were told that HCFA estimated that it would cost hospitals $70.2 million to implement SHUR. This estimate, however, does not include any possible increases in costs to HCFA or to intermediaries. We were told that no estimates were prepared for these possible increases.

Question III. On page 10, you indicated that 20 percent of the cost of correcting incompatibilities between SHUR requirements and the hospital's information systems was related to new data requirements. How important are these new areas of data?

Answer. Most of these new data items relate to standard units of measure which were designed to provide a uniform statistic for measuring costs by cost center and to facilitate comparisons among peer group hospitals. Without a uniform statistic it could be impossible to make meaningful comparisons between hospitals or comparisons over time at one hospital.

One new data area relates to the reporting of employees' salaries by 12 employee classifications. Examples of these classifications include dentists, nurses, management and supervision, and physicians. As discussed in our testimony, we do not believe that this new data would improve comparisons between hospitals.

Question IV. Would SHUR be a more effective data source if it were to collect only direct Department costs? It seems that indirect costs or overhead, such as fuel and depreciation on obsolete equipment, would distort comparability between institutions.

Answer. We believe that HCFA has to collect both direct departmental costs and overhead costs because our review of the legislative history of P.L. 95-142 indicates that the uniform cost reporting system was supposed to be linked to Medicare reimbursement. Thus, HCFA needs to obtain information on total costs. We do believe, however, that HCFA could compare patient care costs centers based on direct departmental costs. Allocating overhead would tend to add more variables to the comparisons. We also believe that HCFA can make meaningful comparisons of individual overhead cost centers between hospitals.

Question V. Would you please comment on the effect that the proposed regulations will have on small rural hospitals? What would you suggest to alleviate some of these problems?

Answer. We cannot answer this question fully because our review did not attempt to analyze the effect of the proposed SHUR on small rural hospitals. We do believe, however, that the revisions being contemplated by HCFA should reduce the burden on both small and large hospitals.

We share your concern regarding alleviating the reporting burden for small hospitals. However, as discussed previously in our answer to Senator Talmadge's question, when this was done before, the results tended to hurt rather than help these small hospitals by reducing Medicare reimbursement.

Question VI. On page 6, you mention that one new form would be used to compare the historical and replacement costs of a hospital's capital assets. What is the value of this?

Answer. We believe that this comparison is of little value. First, we have been told that the information is of no use for reimbursement purposes. Second, we do

not see how such a comparison would benefit health planners in evaluating certificate of need requests or in performing their other functions.

Question VII. You mention on page 12, that there is similarity between the SHUR forms for reporting the operating and non-operating expenses, and the AHA's system (known as Monitrend). It would seem to me to be less complicated and less expensive to expand a system which is presently in place. This is an area where the private sector has begun to establish its own system to provide for comparisions between hospitals. Would you comment on the merits of expanding the present AHA system vs. developing an entirely new system?

Answer. It is our understanding that SHUR was developed from the existing uniform reporting and accounting systems used in California, Washington, and Arizona. We believe the current version of SHUR closely resembles Monitrend. As discussed previously in our answer to Senator Talmadge's question, we believe there are 3 major differences between the 2 systems. First, SHUR requires hospitals to provide a more detailed breakout of costs that Monitrend does. Second, SHUR contains certain centers which include those centers related to blood, end state renal disease, and intermediate care. Finally, as previously stated, many SHUR centers are grouped into a single Monitrend center. We were told that HCFA needs this additional information to make more accurate comparisions between hospitals.

In addition, Monitrend is strictly a voluntary system aimed at helping hospital management and the extent of participating hospitals' compliance is not known, whereas SHUR is mandatory and presumably there will be audits to assure compliance with the reporting requirements and penalties may be levied against noncomplying institutions.

Question VIII. Many small rural hospitals are still utilizing hand-posted accounting systems. If SHUR were implemented, it has been suggested that such hospitals would be forced to acquire automated-data-processing capabilities. Do you feel this is a correct assessment?

Answer. We did not analyze SHUR to identify the impact of the reporting system on small rural hospitals. However, based on our reading of the January 1979 version of SHUR, we understand how some hospitals believe that they would have to either obtain automated data processing capability or expand existing systems. For example, the January 1979 version of SHUR required that salary costs be assigned to the functional cost center based on actual hours worked in that cost center. Such a requirement seems to indicate that hospitals would have to account for every minute of an employee's working day to assure that costs were assigned to the proper cost center. Some hospitals have suggested that they would have to install time clocks at each department and connect these to a central computer to comply with the requirements. The current version of SHUR drops this requirement and allows hospitals to assign costs and gather statistics on a statistical basis. We believe this should reduce the burden for hospitals and alleviate the need for drastic system revisions.

Senator TALMADGE. I want to thank you and Mr. Staats and your associates for your splendid cooperation in this endeavor and I hope that we can reduce this paperwork. I do not know of anything that the American people are madder about now than excess Government regulation.

We have got an agricultural census that is mandated by law, and yet the Senate voted yesterday, or the day before, 90 to 4 to prohibit its enforcement, so that gives you some idea of how upset the American people are on excess reports and excess regulation.

Thank you very much.

[The prepared statement of Mr. McCormick follows:]

STATEMENT OF THOMAS P. MCCORMICK, ASSOCIATE DIRECTOR, HUMAN RESOURCES DIVISION, GENERAL ACCOUNTING OFFICE

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 antifraud 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 commnt 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 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; and 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—January 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 hospital's 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.

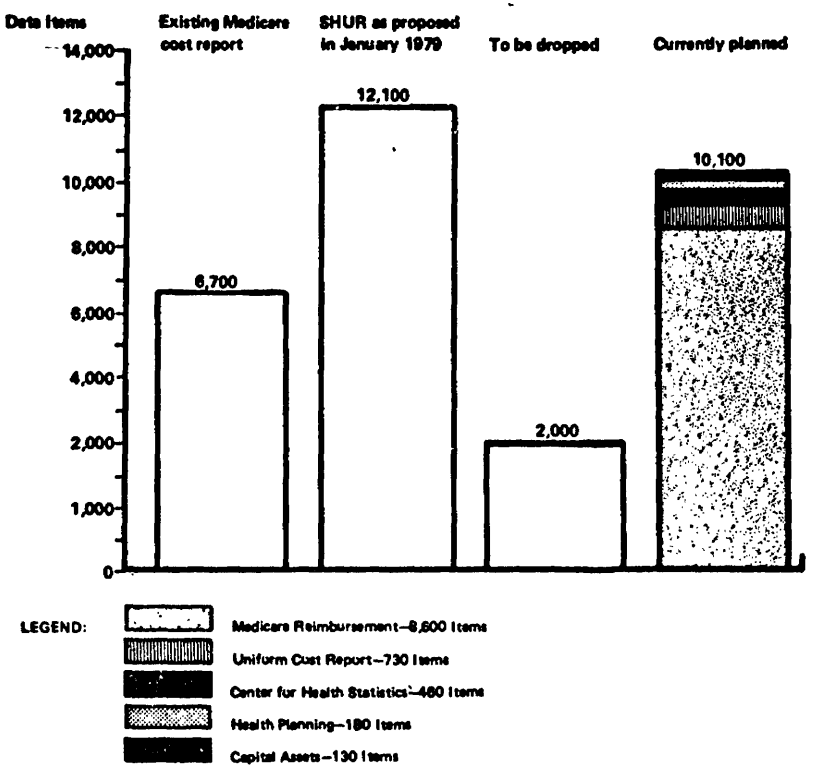
One form is designed to gather data on capital assets which is required by section 1121(a)(4) of the Social Security Act as amended by section 19 of Public Law 95-142. We were told that the information would be used to compare the historical and replacement costs of a hospital's capital assets. This 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 outpatient 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 Montitrend 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[1]	7	7
New York[1]	5	5
Minnesota	4	2
Alabama	3	2
Kentucky	3	3
South Carolina	3	3
Pennsylvania	3	2
Illinois	2	2
Maryland[1]	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

[1] 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 workpapers 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.

Third, 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 indentified 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 woud 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.

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

Senator TALMADGE. The subcommittee will now stand in recess subject to the call of the Chair.

[Thereupon, at 3:30 p.m., the subcommittee recessed, to reconvene at the call of the Chair.]

[By direction of the chairman, the following communications were made a part of the hearing record:]

STATEMENT OF THE FEDERATION OF AMERICAN HOSPITALS

On behalf of the members of the Federation of American Hospitals, the national trade association of investor-owned hospitals and hospital management companies, we appreciate this opportunity to present our views on the Department of Health, Education and Welfare's proposed regulations, manual, and forms to establish a System for Hospital Uniform Reporting (SHUR) under authority of Section 19, Public Law 95-142.

The Federation represents the nation's 1,000 investor-owned hospitals and hospital management companies with over 110,000 beds, encompassing small rural hospitals as well as large urban and suburban medical centers. These facilities were all built or acquired with private capital. In addition, our member hospital management companies now manage under contract over 250 additional hospitals, including teaching hospitals, public institutions, religious and other community non-profit hospitals.

Because of the investment of private risk capital and management of other hospitals under contract, our members are very conscious of cost effectiveness. We are familiar with uniform reporting systems because many of our members are multi-facility hospital management companies which have established uniform reporting to accumulate financial and operating information. Each has uniform accounting, management information, and reporting systems that are designed for its own needs. These systems are designed to satisfy a wide variety of needs which they do very well: (1) SEC quarterly and annual reports; (2) IRS requirements for corporate income taxes as well as separate state income tax reports; (3) Medicare reimbursement; and (4) management information to enable the companies and their hospitals to be cost effective through the periodic monitoring of budget and control standards of operating results, both financial and utilization, (some daily, some weekly, some monthly, some quarterly, and some annually) to determine deviation from norms and the reasons therefore.

Most important, Mr. Chairman—these systems provide for the hospital and corporate managers, information in the way that they have determined it to be the most effective—from both cost and quality of patient care aspects. After all they have several constituencies to serve: stockholders who demand that we manage efficiently; patients and their physicians who demand that we provide quality facilities and services; and the payors—government, insurers, and others who require a variety of financial and utilization data.

Mr. Chairman, the Federation has been following HEW's attempt to impose a uniform accounting system on the hospital industry since 1975 when Sec. 1533(d) of the Health Planning Law, Public Law 93-641 gave HEW the authority to establish—but not implement—a number of uniform systems: measuring the aggregate operational costs and aggregate volume of services rendered by providers; cost accounting; calculating appropriate rates; a system to classify various providers quantitatively; a system for reporting costs, volumes, rates, and classification information. The purposes of these uniform systems were to assist health planners, not change the Medicare reimbursement system. Nevertheless, the first draft document produced by HEW in 1975 to implement that section of the health planning law, and every subsequent revision (including authority allegedly eminating from Sec. 19, Public Law 95-142, the Medicare/Medicaid Fraud and Abuse Bill, signed into law October 26, 1977) and—there have been at least six draft revisions—have all been nothing more than a ploy to foist on the hospital industry a costly, complex, duplicative, and unnecessary uniform accounting system.

There is little conceptual differences between the first draft manual produced in 1975 under a health planning law to that we are considering today in 1979 under a Fraud and Abuse Law, except that this most recent proposal; goes even one more unnecessary step farther. It now has not only mandated its uniform accounting system but also now is requiring that Medicare reimbursement payments be inflexibly linked to this uniform accounting/reporting system, and its definitions, chart of accounts, principles, and statistical units. The concept, manual, forms, and indeed total SHUR system before us today is essentially that developed before the present HCFA Administrator or his predecessor and at least three HEW Secretaries ago—ever heard of SHUR. They began this bureaucratic project even before the Health Planning Law in the Health Insurance Studies Division, Office of Research and Statistics, Social Security Administration—a Division and Office that no longer exist—and they are still marketing essentially the same product begun more than four years ago.

Mr. Chairman, the Federation has consistently supported and recognized the need for uniform reporting of hospital financial and utilization data to assist health planners, prospective payment demonstrations and experiments, and peer review. But, we cannot support such a reporting system that links Medicare reimbursement

to it—the objectives and principles of reporting and reimbursement are so different that equitable treatment of both providers and government would be distorted and ultimately destroyed. This would lead inevitably toward some of the largest, lengthy, most expensive, numerous, and complex disputes and law suits ever confronting the Federal government. And for what purpose? Will the proposed SHUR system so refine and purify reporting and payment systems to enable the Federal government to avoid, save, or recover millions of dollars by new comparisons it would produce? We think not.

The present Medicare Reimbursement Mechanism with its own regulations, forms, intermediary and provider manuals, administrative and judicial review systems and thirteen years of coordinated experience can move in the direction that SHUR is heading. It can do so in an orderly manner through revision of present regulations, manuals, and forms, leaving intact the present basis of reimbursement principles that recognize differences among hospitals and are designed to treat such differences in size, location, age, ownership, complexity, occupancy, patient mix, and other variances including alternative management philosophies as valid and legal reasons for rates not being comparable nor an indication, per se, of inefficiency.

The Federation has at every opportunity provided advisory as well as technical input to HEW over the past four years as they have been developing and exposing to the industry their uniform accounting/reporting system.

Let me illustrate how HEW's proposed system would force hospitals into reorganizing its management structure to a functionally oriented based. Every housekeeping duty whether performed by the general housekeeping staff, or by nurses or aides in emptying trash receptacles or cleaning up after a sick patient or by food service personnel in cleaning the kitchen would have to be time charged and accounted for as "housekeeping". On the other hand, the dietary department that prepares food for patients may serve the food to patients but in other hospitals because of the architectural design or other reasons, management may choose to have the food served by nurses or aides. In this latter case, the time a nurse or aide is involved in serving or assisting patients with their meals under SHUR is a "dietary" function. Hospitals should not be forced into managing—accounting for nurses, or aides, or housekeepers, or dietary personnel—in that way to satisfy a whim of HEW as to the preciseness of comparing the cost of housekeeping or food service or nursing from one hospital to another. It's a costly process for those that want to continue to manage on a responsibility basis—the way most of our hospitals do. We would have to establish a second subsystem of time-keeping and fringe benefit allocation on a quarter or half hour basis to track such changes in functional duties performed by hospital personnel.

And evern if the Federal government agreed to pick up the total cost of such duplicative, redundant systems—which they have not yet indicated they would—how much does the Medicare program expect to save in payments to hospitals by such comparisons. Operating costs are incurred by the hospital for x-ray services, for food, for housekeeping, and many other services. Present HCFA regulations, cost reporting policies and forms, audits by intermediaries, HEW, GAO, and public accountants, "prudent buyer" rules; routine cost limits, and many other existing regulatory powers protect the Federal dollar. Let me illustrate how HEW is already construing statutory language prior to Sec. 19, Public Law 95-142 as authority to reduce its costs in fiscal year 1980 by almost a half a billion dollars through amending two Medicare reimbursement regulations: effective July 1, 1979, HCFA revised its method of paying for malpractice premiums by changing the apportionment methodology—estimated fiscal year 1980 savings $310,000,000. Also effective July 1, 1979, HCFA tightened its reimbursement regulations on routine in-patient operating costs for Medicare services to produce an estimated fiscal year 1980 savings of $100,000,000.

The issues involved in the controversy surrounding the SHUR manual and regulations include these basic questions:

(1) What is the purpose of the legislation?

(2) What is the cost of compliance?

(3) What part of that cost will be reimbursed by the Medicare program and what part will be passed on to other third party payors and consumers?

(4) Is there a less costly, less burdensome way to achieve that purpose?

(5) Should Section 19 be repealed or modified?

PURPOSE OF UNIFORM REPORTING

The Senate Finance Committee Report (95-453) which accompanied the legislation authorizing uniform reporting as part of the Anti-Fraud and Abuse Amendments of 1977 states in part:

"Since it is generally agreed that the existence of comparable cost and related data is essential for effective cost and policy analysis, the assessment of alternative reimbursement mechanisms and, in certain situations, the identification and control of fraud and abuse, the committee believes it is necessary to correct the deficiencies in the present reporting system under these programs."

The House-Senate Conference Report (95-673) notes, in accepting the Senate amendment:

"It is the intent of the conferees in agreeing to the Senate amendment that the reconciliation of data not be required on a day-to-day basis but only at such times as the uniform reports are required, and only for purposes of such reports."

In reading this legislative history, it is clear that uniform reporting was intended by Congress for the purposes of cost and policy analysis, assessment of alternative reimbursement mechanisms, and identification of fraud and abuse. It is also clear that administrative costs were not intended to soar and that application of the system "should not prove unduly onerous". (Senate Report 95-453) Further, Mr. Chairman, we have been unable to find anything in Section 19 of Public Law 95-142 or in the legislative history which indicates that Congress intended either to combine the uniform reporting system with the Medicare cost report or to alter the current reimbursement payment system. To the contrary, in interrupting testimony given by the American Hospital Association (AHA) on March 3 and 7, 1977, before a joint hearing of the Subcommittee on Health of the Ways and Means Committee and the Subcommittee on Health and Environment of the Committee on Interstate and Foreign Commerce, Representative Rogers indicated that there wasn't any authority in the bill for the Secretary to change reimbursement. The HEW SHUR proposal combines reimbursement with uniform reporting and changes the current reimbursement payment mechanism.

The objectives of uniform reporting and Medicare cost reporting are significantly different.

The proposed system could lead to a redetermination of Medicare reimbursement that is neither authorized nor intended by Section 19(a) of Public Law 95-142. The principal objective of uniform reporting is comparability of reported data, and attainment of this goal would prohibit hospital managers from using alternative accounting methods of assigning costs for purposes of Medicare remibursement, a practice now authorized under Medicare regulations and generally accepted accounting principles. On the other hand, the principal objective of reimbursement is equity for both the purchaser and provider of care, and equity requires a recognition of the unique cost characteristics of hospitals. To combine these two very different objectives in the same reporting mechanism will hamper attainment of the goals of both reimbursement and uniform reporting.

To achieve the reimbursement objective of an equitable payment system, there must be flexibility in the system to account for the differences between hospitals and the services they render. This has been recognized in the very regulations and policy directives which the Department of HEW has promulgated. Regulation Section 405.401 in discussing principles of reimbursement indicates that the principles should be flexible on many points to take into consideration the wide variations in size, scope of services, and regional differences. Regulation Section 405.402 mentions that one of the objectives or tests that should be satisfied is that the division of allowable costs is fair to each provider individually. In addressing apportionment, Regulation Section 405.403 states that:

"* * * Consideration of equity among institutions are involved in accomplishing the objectives of paying each provider fully, but only, for services to beneficiaries."

Regulation Section 405.405 in addressing financial data and reports states in part:

"* * * Standardized definitions, accounting, statistics, and reporting practices which are widely accepted in the hospital and related fields are followed. Changes in these practices and systems will not be required in order to determine costs payable under the principles of reimbursement. Essentially, the methods of determining costs payable under title XVIII involve making use of data available from the institution's basic accounts, as usually maintained, to arrive at equitable and proper payment for services to beneficiaries * * *"

The SHUR proposed by HEW establishes a uniform reporting system which impact on a reimbursement system that has evolved over a period of 13 years. SHUR eliminates all cost-finding and allocation options which have been previously granted providers to achieve more accurate and equitable reimbursement. Another example, is that SHUR's consolidation of general and administrative reporting centers eliminates the provider's ability to perform more sophisticated cost allocations which are allowed under existing Medicare instructions in the Provider Reimbursement Manual (HIM-15).

On the other hand, the opposite is also true. A change in reimbursement through a change in the Medicare Law, regulations, policies, or a judicial decision may impact the uniform reporting. For example, after publication of the proposed SHUR, HCFA issued a regulation which requires that malpractice costs be directly apportioned to Medicare based on a provider's Medicare malpractice loss experience. This regulation, which has been strongly opposed by the industry, necessitates a modification of the Medicare cost reporting forms to discretely cost find a cost which has always been considered a component of administrative and general expenses. SHUR presently considers malpractice insurance as an element of general and administrative cost. (A position with which we agree.) Will HCFA now revise the SHUR package to reflect the new Medicare regulation?

The two objectives—the reporting of uniform data and the calculation of reimbursable costs—are very different and subject to their own rules. While Medicare reimbursement reporting requires flexibility, uniform reporting does not. The SHUR proposed by HEW establishes uniform reporting which impacts on reimbursement and visa versa; reimbursement changes can potentially influence uniform reporting.

Mr. Chairman, the Senate Appropriations Committee, in its very recent report (No. 96-247) on Department of Labor/HEW appropriations for fiscal year 1980, states:

"The Committee is greatly disturbed by the scope of the proposed regulations implementing the System for Hospital Uniform Reporting (SHUR), and overwhelmed by the sheer volume of more than 500 pages of proposed manual provisions and forms. The Committee emphasizes that the authority to implement such a system called for a uniform reporting system, not a uniform accounting system. In light of these concerns, the Committee intends that the Department of HEW be prohibited from using any funds appropriated under this act for data collection pursuant to SHUR during fiscal year 1980."

The Senate Finance Committee was cognizant of the full House of Representatives action on June 28, 1979, in adopting by a vote of 306 to 101, prohibiting the use of any HEW fiscal year 1980 appropriated funds to implement SHUR. The real point at issue here is what did the Congress intend a uniform reporting system to be when it enacted Section 19, Public Law 95-142? We believe it was intended to be a system for comparing hospital costs, services, and utilization on a uniform basis for health planning, prospective payment demonstrations, peer review activities, etc. and not a system with wholly different objectives of determining allowable costs to be reimbursed to hospitals on behalf of Medicare and other federal patients where law, both statutory and judicial, has always recognized differences in hospitals for payment purposes.

The cost estimates of implementing SHUR are varied. The range is anywhere from a low of $75 million to a high in excess of $200 million. While a promised revision of the proposed regulations could reduce somewhat those estimates, the costs are still staggering and at least raise the important question of benefits in program administration. The level of detail of SHUR is analogous to a full IRS audit of every tax return filed. The benefits in terms of identifying fraud and abuse are also analagous—SHUR will be just as wasteful and unproductive as IRS audits of all taxpayers would be.

Hospitals which need a management based accounting system will now be required to maintain an additional functional system for the Medicare-Medicaid programs at significant additional cost.

And these costs do not include, nor as far as we know have they ever been estimated, the cost of processing, analysis, evaluation, and ultimate use by the government, its intermediaries, and to all of the private and government including GAO augmented audits that will be required to verify such exhorbitant amounts of data. A ball park figure of two to three times the estimated hospital implementation costs would not be far out of line—or another $150 million to $600 million.

PAYMENT FOR SHUR

The question of who will pay for the cost of implementing SHUR has not been adequately addressed. As a mandated regulatory cost, it seems equitable to expect government reimbursement for the total cost of implementing SHUR, but no such acknowledgement has come from HEW. If Medicare and Medicaid reimburse only a portion of these costs, as is likely, then the major portion of those costs will be passed on to other third party payors and consumers. However, the recently adopted final regulation changing the Medicare policy on reimbursing malpractice premium expenses from a utilization of days basis to a ratio of malpractice dollar claims paid to Medicare beneficiaries to all beneficiaries lends support to our contention that the federal program should underwrite the entire cost.

In addition, the total costs of SHUR will be added to total hospital expenditures, and these amount to a significant roadblock to the industry's Voluntary Effort to contain expenditures.

Finally, the existing ceilings on cost reimbursement under Section 223 regulations make no provision for recognizing these new costs.

A LESS COSTLY UNIFORM REPORTING SYSTEM

Is there a less costly, less burdensome uniform reporting system that meets Congressional intent and HEW data needs that is feasible? We think so. The Federation, through its SHUR Ad Hoc Committee, has been working on such a system, not linked to Medicare cost reimbursement. It is still in draft form and is expected to be completed by July 31, 1979. It will comprise about 20 pages in total, including reporting principles, concepts, and forms.

Compare this to the 400 page proposed SHUR manual and additional implementing regulations and forms.

We think it will satisfy currently identified reporting requirements for hospital data when used in conjunction with the separate and existing, but always changing, Medicare cost reimbursement system. It will provide in a simpler, more aggregated—and thus easier to evaluate and compare—form the essence of information needed by HEW to compare hospital financial and utilization data among and between hospitals for planning, peer review, prospective payment experiments, and other perceived needs. And, will, so far as we can ascertain, satisfy Congressional intent and at a fraction of the cost. Copies of our recommended system will be forwarded to the Subcommittee for its review when completed.

REPEAL OR MODIFY SECTION 19

The Subcommittee should consider repealing Section 19, Public Law 95-142 and then recommend new legislation under an amendment to the Health Planning Law or other Public Health statute to require uniform reporting only. Alternatively, Section 19, Public Law 95-142 could be substantially modified by amendment to prohibit the level of detail proposed in the SHUR regulation and explicit language incorporated into the statute to clarify its purposes.

SUMMARY AND RECOMMENDATIONS

Mr. Chairman, let me conclude by summarizing our major objections to the proposed SHUR system:

1. It would require hospitals either to change their current management philosophy from a responsibility oriented structure to a functional base or to establish costly, unnecessary, additional procedures, accounts, and other records to provide functional cost data.
2. It would link the Medicare cost reimbursement system to the uniform reporting system, each with different objectives and principles: the cost reimbursement system is designed to recognize and account for the differences between hospitals; whereas, the objective of uniform reporting is to achieve comparability of data.
3. It would be extremely costly to implement SHUR as proposed not only for hospitals but for the government to make use of the data. And, HEW as not yet determined how or who will use the information so they can make no reliable estimate of potential cost savings to the government.

Finally, we offer the following recommendations for your consideration:

(A) The entire cost of SHUR, in whatever final form it may emerge, be paid for by the federal government.

(B) A less costly uniform reporting system be considered that is simpler, less burdensome, provides data in a more aggregated level, and that is separate from Medicare reimbursement.

(C) Section 19, Public Law 95-142 be rescinded entirely and a new amendment developed for inclusion in the Health Planning or other Public Health Service law addressing uniform reporting requirements only. Alternatively, amend Section 19, Public Law 95-142 to clarify Congressional intent, and state objectives more specifically.

Thank you for this opportunity to share our views.

TEXAS HOSPITAL ASSOCIATION,
Austin, Tex., July 31, 1979.

MICHAEL STERN,
Staff Director, Committee on Finance,
Washington, D.C.

DEAR MR. STERN: This letter, together with its attachments, is submitted for the record in conjunction with the Subcommittee on Health of the Committee on Finance hearing, Thursday, July 26, 1979, concerning the implementation of Section 19 of Public Law 95-142.

The Texas Hospital Association, representing 550 affected hospital members, is unalterably opposed to the System for Hospital Uniform Reporting (SHUR) as proposed in the Federal Register of January 23, 1979, by the Health Care Financing Administration to implement Section 19 of Public Law 95-142. Attachment 1 to this letter outlines four distinct issues relating to SHUR that should be brought to the attention of Congress. Attachment 2 highlights requirements within the SHUR manual that reveal the unnecessary cost of implementing and maintaining SHUR, its over-emphasis on accounting detail that is undocumented as to need, benefit or usefulness, and the obvious result of such detail that SHUR becomes an accounting system contrary to Congressional intent to develop a uniform reporting system.

The Texas Hospital Association supports the recent action of Congress to prohibit implementation of SHUR in fiscal year 1980. In addition, we strongly support and encourage the continuation of Congressional inquiry into the proposed SHUR and particularly support the action of the Senate Appropriations Committee in its position that SHUR not be implemented without Congressional approval. It is our position, however, that SHUR not just be modified, but that Section 19 of Public Law 95-142 be repealed.

The Subcommittee's consideration of these comments is appreciated.

Sincerely,

O. RAY HURST, CAE, *President.*

Attachments 1 and 2.

POSITION PAPER OF THE TEXAS HOSPITAL ASSOCIATION—SYSTEM FOR HOSPITAL UNIFORM REPORTING (SHUR)

A Notice of Proposed Rulemaking (NPRM) has been published in the Federal Register of January 23, 1979, regarding the System for Hospital Uniform Reporting (SHUR). The SHUR manual is being proposed to implement Section 19 of Public Law 95-142, the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977.

There are at a minimum, four distinct issues relating to SHUR that should be brought to the attention of the Congress:

1. Cost implications of adopting and maintaining the system;
2. Requirement of Functional vs. Responsibility reporting;
3. Documentation of Need for, Use of, and Cost/Benefit of SHUR data;
4. The linkage of Medicare/Medicaid reimbursement to SHUR and the intent of Congress is passing Section 19 of Public Law 95-142.

COST IMPLICATIONS

The cost of implementing and maintaining the system will be substantial. The Health Care Financing Administration (HCFA) contends that the cost of implementing and maintaining SHUR will average $3,000 to $10,000 per hospital. Industry estimates place the cost as high as $100,000 per hospital. Actually, smaller hospitals might incur cost of $10,000 to $50,000 with larger hospitals experiencing cost well in excess of $100,000. If the average cost is $100,000, then the cost to patients of SHUR will be $700,000,000.

FUNCTIONAL VERSUS RESPONSIBILITY REPORTING

The SHUR manual requires functional reporting whereby expenses and revenues are reported in cost centers as defined by the Health Care Financing Administration. This is contrary to the responsibility basis accounting systems common to the hospital industry. Only by assigning responsibility for monitoring and controlling costs to designated individuals or departments, and then only by accounting for costs along these responsibility or organizational lines, can hospitals effectively control their costs. Thus, few hospitals will want to use SHUR as their primary accounting system. With the massive amount of statistics required by SHUR to convert from the hospital's responsibility accounting system to the functional reports, SHUR will virtually require hospitals to run concurrent accounting systems.

DOCUMENTATION OF NEED FOR, USE OF, AND COST/BENEFIT OF SHUR DATA

Public Law 95-142 states, "The Secretary shall provide information obtained through use of the uniform reporting systems * * * in a useful manner and format to appropriate agencies and organizations, including health systems agencies * * * and State health planning and development agencies * * *, as may be necessary to carry out such agencies' and organizations' functions."

If a study of the need for, use of, and cost/benefit of SHUR data has been made, the results of the study should be made public for the purpose of comment by concerned organizations. If a study of this nature has not been made, the advisability of imposing a new Federal regulation as burdensome and costly as SHUR without clearly establishing the real need for and benefit of the data generated must be questioned.

COMBINING OF UNIFORM REPORTING WITH MEDICARE COST REPORTING AND THE INTENT OF CONGRESS

The SHUR manual combines the uniform reporting system with the Medicare cost reporting system. Examination of the legislative history of Section 19 of Public Law 95-142 does not reveal legislative intent to develop a uniform reporting system to reform the Medicare reimbursement system. As stated in Public Law 95-142, "For the purpose of reporting the cost of services provided by, of planning, and of measuring and comparing the efficiency of and effective use of services in hospitals, * * *, the Secretary shall establish by regulation * * * a uniform system for reporting * * *". These stated purposes of Section 19 do not indicate Congressional intent to use the uniform reporting system as an adjunct to the Medicare/Medicaid Reimbursement System. In addition, the stated purposes do not require that hospitals be reimbursed through the uniform reporting system.

The SHUR manual as currently drafted appears to be contradictory to Congressional intent and in excess of the legislative authority granted in section 19 of Public Law 95-142.

SUMMARY COMMENTS

Any regulatory measure dealing with hospitals should be implemented only if it provides a tangible benefit of better health care of lower cost—to the public, that uses hospital services, or to the taxpayers, who pay for hospital services through Medicare and Medicaid. The implementation of SHUR will not ead to better health care or lower cost. Quite the opposite, SHUR imposes additional costly reporting requirements on hospitals without first clearly defining the objectives of the system in terms of the users of SHUR data, the needs of these users for data, and the cost of compiling the data versus the benefit of having the data.

The cost of implementing SHUR and the cost of maintaining the System will simply be an additional inflationary factor introduced into the hospital environment. With a national goal of cost containment, both on the part of the Federal Government and the health care industry, the imposition of such new costly government regulation is contrary to the interest of the public in general and the interest of health care patients in particular.

The primary purpose of passage of Public Law 95-142 was the detection of fraud and abuse. Even though Section 19 to Public Law 95-142 is law, it must be questioned whether uniform reporting, as a means of detecting fraud and abuse, will be effective. Statistics generated by a particular hospital, either in comparison to the same statistics from a prior period or in comparison to statistics from other hospitals, would not provide an indication of fraud except in the rarest of circumstances. It is unlikley that fraud detected through the use of such analysis would go undetected by a particular hospital's existing system of internal control and/or audit by fiscal intermiediaries (and independent accountants in many cases).

Certainly there is no relationship between detection of fraud and abuse and the reimbursement system for services provided Medicare and Medicaid recipients.

RECOMMENDED ACTION

Considering the significant cost implications of implemenation of a uniform reporting system as contained in SHUR, the contradiction of such a system to the national goal of cost containment; the absence of documentation of the need for and benefits to be derived; and the lack of significant contribution of uniform reporting to the detection of fraud and abuse, the primary purpose of Public Law 95-142, it is recommended that Section 19 of Public Law 95-142 be repealed.

COMMENTS OF THE TEXAS HOSPITAL ASSOCIATION REGARDING SYSTEM FOR HOSPITAL UNIFORM REPORTING (SHUR)

In the Position Paper of the Texas Hospital Association, four distinct issues relating to SHUR are addressed:

1. Cost implications of adopting and maintaining the system;
2. Requirement of functional vs. Responsibility reporting;
3. Documentation of Need for, Use, of, and Cost/Benefit of SHUR data;
4. The linkage of Medicare/Medicaid reimbursement to SHUR and the intent of Congress in passing Section 19 of Public Law 95-142.

The comments in this paper highlight requirements within the SHUR manual that reveal the unnecessary cost of implementing and maintaining SHUR, its over-emphasis on accounting detail that is undocumented as to need, benefit or usefulness, and the obvious result of such detail that SHUR becomes an accounting system contrary to Congressional intent to develop a uniform reporting system.

FUNCTIONAL VERSUS RESPONSIBILITY REPORTING

Responsibility basis accounting systems are common to the hospital industry. SHUR, with a basis of functional reporting (with functional cost centers defined by HCFA), is simply incompatible with present systems. Effective management of hospital operations requires accounting and statistical data that reflect results from operations as the hospital is organized. The prescribed and inflexible reporting required by SHUR will simply not provide a reasonable basis for evaluation of management effectiveness, since required data will cover various responsibility areas. The conversion of responsibility based data to functional cost centers on other than a daily or monthly basis will be impractical due to the excessive detail required by the SHUR reports. This excessive detail makes SHUR an accounting system rather than a reporting system and will result in many hospitals being forced to maintain two sets of financial records.

An example of the problems inherent in accounting for data on other than a responsibility basis is the method prescribed by SHUR to account for the time of a nurse. The functional reporting guidelines require that salary and benefit costs be charged to various cost centers depending on the function the nurse is performing. Time spent in the operating room is charged to the operating room cost center. Delivery of laboratory specimens to the laboratory is charged to the laboratory cost center. Time spent cleaning the operating room floor is charged to the housekeeping cost center. It is obvious that effective monitoring of cost relating to the nursing staff assigned to the operating room will be difficult for the hospital due to the spreading of the total nursing costs to numerous cost centers. In addition, the benefit of such cost allocation is questionable, and the expense of doing so on an on-going basis will be significant.

REQUIREMENT OF BALANCE SHEET INFORMATION

The basic concept of the SHUR manual, and the justifications for its existence, are premised on the need for comparable data related to expenses and revenues. The requirement for presentation of balance sheet information, therefore, is unnecessary.

SHUR is presented as a uniform reporting system, not a uniform accounting system. The inclusion of balance sheet data, however, is evidence of the true nature of SHUR—a uniform accounting system. This is contrary to the legislative intent of Section 19 of Public Law 95-142. The requirements for balance sheet information should be eliminated.

DIRECT CHARGES TO FUNCTIONAL COST CENTERS

The SHUR manual states, "The salary cost must be assigned directly to the functional cost center to which the employee is assigned * * *" and "It may not be based on the average hours worked or by any other such basis". This requirement is simply not reasonable. Nursing staff will be required to account for their time, by cost center, on a daily basis. Aside from the obvious problem of accurately recording this information, the additional accounting burden will be extensive. Using the example of nursing salaries discussed previously, the implications of accounting for direct time charged to numerous cost centers is obvious. The number of possible cost centers to be charged is extensive. Accumulation of such data in the precise manner prescribed by SHUR will require a wasteful, inefficient and costly use of hospital resources.

Similar to the requirements for charging salaries, the SHUR manual states, "Where the cost of depreciation or rent/lease of the movable equipment is utilized

by two or more functional cost centers, the depreciation or rent/lease applicable to such movable equipment must be directly assigned to such functional cost centers based upon cost center usage". For certain types of equipment, such as a portable copier, this requirement will necessitate extensive record-keeping. This method of accounting for depreciation also leads to inconsistent distribution of expenses. For example, when portable EKG or EEG machines are used in other departments such as Emergency Room, the SHUR manual requires revenue and corresponding costs (technician, etc.) to be charged to the EKG or EEG departments, while depreciation and maintenance expenses on the machine are charged to the using departments.

In addition to the direct reporting of specific costs of salary and payroll related employee benefits and depreciation expense on major movable equipment, the value of directly accumulating costs in the detailed manner prescribed by SHUR for non-payroll employee benefits, medical supplies, drugs, maintenance of plan, data processing, and central patient transportation is questionable, especially in view of the cost to the hospital in doing so.

The comparability between individual hospitals of costs directly recorded to prescribed cost centers is subject to question, because such accumulations of cost completely ignore basic differences in hospitals that only nonfinanical information can fully explain.

STANDARD UNITS OF MEASURE

Each functional cost center as outlined in the SHUR manual includes a standard unit of measure (SUM), the product of which supposedly will be used by some agency or agencies (unspecified) for evaluating relative efficiency between hospitals. The comparability of relative efficiency based on these SUMs is an illusion. Such factors as age distribution of the service area and mix or intensity of services provided must be considered in measuring relative efficiency among hospitals.

Regardless of any possible merits of attempting to measure relative efficiency, the accumulation of the data required for a number of the Standard Units of Measure will be costly due to the additional record-keeping and analysis required by the degree of precision and level of detail mandated.

ACCOUNTING FOR FIXED ASSETS

The SHUR manual imposes guidelines for capitalization of fixed assets. A depreciable asset costing $300 or more with a useful life of at least three years must be capitalized and depreciated over its useful life. Even though the SHUR guidelines allow a hospital to set lower limits on its capitalization policies, it is obvious that the existing policies of many hospitals will not comply with the SHUR guidelines. SHUR will necessitate either a change in individual hospital policy or an additional set of fixed asset records. The imposition of these guidelines, particularly in light of differing guidelines for Medicare reporting (cost of $150 and a useful life of at least two years), is unnecessary. Capitalization guidelines that comply with generally accepted accounting principles are completely adequate for reporting purposes. Imposition of guidelines as outlined in the SHUR manual will cause hospitals to incur additional cost in computing data that is not significantly better than data already available.

GUIDELINES FOR MATERIALITY

The SHUR manual provides specific guidelines for determining what cost or accumulation of costs is material for purposes of complying with SHUR. Materiality is defined as misplaced cost of an aggregate amount of at least $1,000 and greater than the lesser of: 1. 3 percent of the direct costs of the functional cost center transferred to or from, or 2. one-quarter of 1 percent of the total annual operating expenses.

Although guidelines of this nature are relatively easy to interpret, they are impractical for daily use. To verify compliance with the guidelines, a hospital would need to make a complete analysis of each cost center at the end of each reporting period. Only by such analysis after all costs are recorded could a judgement be made regarding compliance or non-compliance. This analysis would require a considerable amount of additional time at the end of each reporting period. Here, as with the capitalization guidelines, decisions on materiality that follow generally accepted accounting principles are completely adequate for reporting purposes. Materiality must be determined during the year, on a case by case basis, not at year end. Materiality, determined on any other basis, is simply impractical.

The guidelines for materiality prescribed by SHUR are completely arbitrary and should be eliminated.

CONFLICTS WITH GENERALLY ACCEPTED ACCOUNTING PRINCIPLES (GAAP)

Although reporting requirements under SHUR are generally in agreement with GAAP, certain inconsistencies still exist in the latest version of the manual. For example, malpractice losses paid in excess of amounts covered by a self-insurance fund are not considered insurance expense according to the SHUR manual. This requirement is certainly not in agreement with GAAP.

There is no reason for any requirement to be in conflict with GAAP. Such inconsistencies should be eliminated.

COMPARABILITY OF STATISTICAL INFORMATION

One of the purposes of SHUR data, as stated in the introduction to the manual, is to provide information for "measuring and comparing the efficiency of and effective use of services in hospitals, skilled nursing facilities, * * *". The entire concept of the SHUR manual is geared toward the objective of providing information in as consistent a manner as possible, so that similar information obtained from different hospitals can be compared. Costs and revenues are required to be separated by functional cost centers as defined by HCFA. The methods of calculating and directly charging costs to the cost centers are specified. Standard units of measure are specified for determining the cost of a unit of service.

The objective of obtaining comparable information for purposes of comparison is not without merit. Whether the data as provided by SHUR will truly accomplish that objective is doubtful. Between any two "similar" hospitals, an almost infinite number of differences could exist that would make comparison of specific types of statistics meaningless. Differences in characteristics of the patient population served, intensity and mix of services provided, age and condition of hopsital facilities, and an almost infinite range of other factors will not be eliminated by the reporting requirements of SHUR. Dissimilar data, recorded in a prescribed manner, is not rendered comparable by the recording process. The degree of precision HCFA attempts to impose on the reporting of hospital data is flawed because of the non-recognition of basic differences in hospitals.

AMERICAN MEDICAL ASSOCIATION,
Chicago, Ill., July 27, 1979.

Hon. HERMAN E. TALMADGE,
Chairman, Subcommittee on Health, Committee on Finance, U.S. Senate, Washington, D.C.

DEAR CHAIRMAN TALMADGE: The American Medical Association takes this opportunity to comment on the System for Hospital Uniform reporting (SHUR) proposed by the Health Care Financing Administration (HCFA) to implement Section 19 of Public Law 95-142. This provision requires the HEW Secretary to establish a uniform system of reporting for providers participating in Medicare and Medicaid.

Instead of preparing a reporting system, however, HCFA has drafted a massive, costly and burdensome proposal to establish a new hospital accounting system. An accounting system is not sanctioned in the law. The massiveness of the proposal would impose a crushing regulatory burden on hospitals.

HCFA's SHUR proposal has generated much controversy. Many organizations have voiced strong objections to the proposal. In the enclosed copy of our statement to HCFA we raised serious objections to SHUR. These include: (1) failure to adequately substantiate the costs for implementation and operation of the SHUR system; (2) failure to follow Executive Order 12044; (3) improper creation of an accounting system as part of the proposed reporting system; (4) failure to state the intended use of the accumlated data; and (5) publishing a manual of over 600 pages, thereby ignoring the President's concerns to streamline and simplify the federal regulatory process.

The House of Representatives has also strongly reacted to the SHUR proposal and has approved the Bereuter Amendment to H.R. 4389. Under that amendment to the HEW appropriations bill, funding for implementation of the SHUR system would be withheld.

As we indicated in our comments to HCFA, we believe that implementation of SHUR is inappropriate and should be withdrawn. We believe Congressional scrutiny of the SHUR proposal will bear out our findings.

We urge that our comments and suggestions be carefully considered as your Subcommittee holds hearings on the SHUR proposal.

Sincerely,

JAMES H. SAMMONS, M.D.

Enclosure.

AMERICAN MEDICAL ASSOCIATION,
Chicago, Ill., April 20, 1979.

Mr. LEONARD D. SCHAEFFER,
Administrator, Health Care Financing Administration,
Department of Health, Education, and Welfare, Washington, D.C.

DEAR MR. SCHAEFFER: Enclosed please find the comments of the American Medical Association on the above captioned proposed rule.

Sincerely,

JAMES H. SAMMONS, M.D.

Enclosure.

STATEMENT OF THE AMERICAN MEDICAL ASSOCIATION TO THE HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

The American Medical Association submits the following comments in response to the above captioned notice as well as to the draft manual issued by the Health Care Financing Administration (HCFA) entitled System for Hospital Uniform Reporting (SHUR) dated September 29, 1978.

This proposal cited Section 19 of PL 95-142, the Medicare and Medicaid Anti-Fraud and Abuse Amendments of 1977, as authority for its issuance. Section 19 requires the establishment of uniform reporting systems for providers participating in Medicare and Medicaid. The first system to be established is for hospitals. Later reporting systems will be established for skilled nursing facilities, intermediate care facilities, home health agencies, Health Maintenance Organizations, and other types of health services facilities and organizations. The uniform reporting systems would be required to provide information on (1) cost and volume of services, (2) rates, (3) capital assets, (4) discharge data, and (5) billing data.

In addition to other requirements, Section 19 authorizes the monitoring of the report systems and the release of information obtained from the reports to appropriate agencies and organizations including health planning agencies. Section 19 also allows consideration of appropriate variations in applying the uniform systems to different classes of facilities. Further, the reporting system must be as consistent as possible with systems already in effect pursuant to Section 306(e)(1) of the Public Health Service Act.

The published notice states that the reporting system proposed is only a partial one. It concerns only those portions of hospital reporting dealing with cost and volume of services and with capital assets. The remainder of the system dealing with rates, discharge data and billing data will be covered by a subsequent notice of proposed rulemaking (NPRM). The actual reporting requirements for hospitals would begin six months after the effective date of the regulation.

COMMENTS

The American Medical Association has major objections to the SHUR proposal. We believe that in publishing this proposal HCFA has: (1) failed to state its intended use of the accumulated data; (2) failed to substantiate cost for implementation and operation of the SHUR system; (3) failed to follow Executive Order 12044 concerning this significant proposal; (4) improperly required an accounting system as a part of the proposed reporting system; and (5) through the sheer massiveness of the draft manual, ignored President Carter's concerns to streamline and simplify the federal regulatory process. These concerns raise serious questions as to the appropriateness of implementation of the SHUR system on a nationwide scale at this time.

HCFA GOALS AND OBJECTIVES

We are concerned with HCFA's failure to state clearly anywhere in the proposal its intended use of the data to be collected. The proposal only states that the purpose for collecting the data is "to obtain comparable cost and related data on all participating hospitals for reimbursement, effective cost and policy analysis, assessment of alternative reimbursement mechanisms and health planning." Nowhere does the proposal explain what use will be made of the purported "comparable cost and related data." Intended purposes should be clearly stated for evaluation and public comment.

COST OF IMPLEMENTATION

In the commentary accompanying this proposal, HCFA estimates that the portion of implementation costs to be borne by hospitals will be between $21 million and

$45 million. It further states that total implementation costs will range between $35 million and $75 million. However, estimates prepared by the American Hospital Association indicate that the cost of implementation could be in excess of $300 million. Their figure is based on implementation costs on the average of $50,000 per hospital for the 6,000 hospitals that participate in Medicare and Medicaid. In the commentary HCFA admits it is now conducting a study to establish more precisely implementation costs because the possibility exists that their estimates are low. We must question the accuracy of HCFA's original estimate and the appropriateness of publishing the proposal without accurate cost estimates supported by sufficient data. This large disparity in cost estimates should be resolved before requiring implementation of the SHUR reporting system for hospitals on a nationwide basis.

We also raise the question as to the benefit these reports will bring to HCFA in the administration of the Medicare and Medicaid programs. Does the alleged benefit justify even the more conservative cost estimate of $45 million? If actual costs range upwards to $300 million or more, can there be a corresponding real benefit to the patients, the physicians, the hospitals, the government, and the general public concerned with the delivery of health care services and their costs?

To impose a new, extensive system, which is of questionable benefit and where the full costs are uncertain, is unjustifiable in this period when hospital costs are already under attack by the Administration and when government regulation is already identified as a substantial cause of such increasing costs.

EXECUTIVE ORDER 12044

The publication of this proposal by HCFA has not conformed with Executive Order 12044. This Executive Order, published in the *Federal Register* on March 23, 1978, has as its stated policy that "regulations shall be as simple and clear as possible. They shall achieve legislative goals effectively and efficiently. They shall not impose unnecessary burdens on the economy, on individuals, on public or private organizations, or on state and local governments."

To achieve these objectives, the Executive Order requires regulations to be developed through a process ensuring that: (a) the need for and purposes of regulation are clearly established; (b) the heads of agencies and policy officials exercise effective oversight; (c) the opportunity exists for early participation by concerned individuals as well as governmental agencies and organizations; (d) meaningful alternatives be considered and analyzed before the regulation is issued; and (e) compliance costs, paperwork and other burdens on the public are minimized.

This proposal, with its 600-page manual for implementation, violates criteria established in the Executive Order. The compliance costs and burdens are significant. There has been no information published indicating that any meaningful alternatives have been considered and analyzed before the publication of the proposal. The proposal, and especially the SHUR manual, is anything but clear and simple.

We further find that in the publication of this proposal HCFA has not prepared a regulatory analysis that meets the requirements of Section 3 of Executive Order 12044. One of the criteria to be employed by a governmental agency in determining whether a regulatory analysis should be performed is that the regulations would result in (a) an annual effect on the economy of $100 million or more, or (b) a major increase in costs or prices for individual industries, levels of government or geographic regions. We believe HCFA's proposal falls within both of these categories. While we note that in the commentary accompanying the proposal there is a section headed "Regulatory Analysis", the explanation contained does not meet the procedures outlined in the Executive Order. Each "regulatory analysis" must contain a succinct statement of the problem, a description of the major alternative ways of dealing with the problem that were considered by the agency, an analysis of the economic consequences of each of these alternatives, and finally a detailed explanation of the reasons for choosing one alternative over the others. Further, agencies must include in their public notice of proposed rules how they have met the above requirements.

HCFA has not followed the procedures established. It is imperative because of the significance of this proposal, that the procedures be complied with.

Another point must be raised. We note in the commentary that the cost of implementation and operational costs of the SHUR reporting system will be considered allowable costs and subject to reimbursement by all third-party payors including Medicare and Medicaid. We question not only the legal basis but the propriety of requiring third-party payors to reimburse hospitals for implementation costs associated with the SHUR system. We do not think it proper to impose these costs on payors other than Medicare and Medicaid.

We note that Medicare and Medicaid reimbursement, in connection with the imposition of the SHUR system, will be for administrative services. In this era of cost consciousness, with increasing costs acting to curtail availability of benefits, we do not believe that a new costly administrative program would be the best use of already scarce Medicare and Medicaid funds. We do not expect that hospitals can or should absorb these tremendous administrative costs. However, our concern is that needed funds will be diverted from patient care services in order to pay for the implementation of this reporting system which is of unproven value. Such a diversion of funds in this manner could have an adverse effect on the quality of patient care and the availability of patient care services provided in a hospital setting. We do not believe this is what Congress intended when passing PL 95-142.

Establishment of a new accounting system

As noted earlier in our statement, the alleged purpose of the SHUR proposal is limited to cost reporting for hospitals participating in the Medicare or Medicaid programs. However, the avowed purpose is in conflict with the language contained in the draft SHUR manual. In its introduction, the manual explicitly states that the purpose of the manual is to provide a uniform accounting system. The purpose of the uniform accounting system, according to this introduction, is to provide a common standard of measurement and communication for the use of uniform (1) reporting principles, (2) classification system which identifies cost by cost center by the nature of cost incurred and revenues by revenue center by patients and payor subclassifications, and (3) statistical and service data definitions. The material contained in the 600-page manual leaves no doubt that an accounting system is contemplated. As a result, hospitals would be forced to convert entirely to this accounting system or to maintain two separate systems. Moreover, it seems inescapable that the new accounting system would, for most hospitals, require an enormous expenditure of time, effort and money.

The imposition of a uniform system of accounting is not supported by Congressional sanction. Section 19 of Public Law 95-142 merely authorizes the use of uniform reporting systems. Congressional intent, as indicated by the legislative history of Public Law 95-142, reveals clearly that a uniform accounting system was not intended. Being contrary to Congressional intent and not in conformance with the statute, the SHUR manual should be withdrawn.

Operational massiveness

We are very concerned with the massiveness of this enterprise. We note that the proposal covers only hospitals—leaving other facilities to subsequent proposed rules—and even as to hospitals covers only two out of the five elements to be covered when fully implemented. If 600 pages is now required for only partial compliance by hospitals already burdened by government regulation, we wonder at the amount of paper that will be generated for complete "uniform reporting systems" by hospitals. The paper tonnage will become even more crushing when the system is further applied to skilled nursing facilities, home health agencies, or Health Maintenance Organizations. Based upon the example of the presently proposed SHUR manual for hospitals, we can only expect more massive and burdensome reporting systems to follow.

President Carter has recently indicated his intention to streamline the federal regulatory process and reduce the burdens that regulations cause through legislation. The SHUR regulatory proposal is the antithesis of President Carter's directive. If less than one page of law can result in 600 pages of rules—and this being admittedly only a beginning—the need for the President's initiative is again underscored. We recommend that HCFA bring its regulatory schemes into conformance with the President's goals and initiatives.

CONCLUSION

As noted above, the publication of this proposal and its planned implementation are inappropriate and the proposal should be withdrawn. Any promulgation of a proposal of this magnitude should follow the procedures outlined in Executive Order 12044. It would be well for HCFA to conduct a demonstration project within a limited geographic area, including a limited number of hospitals, so as to determine the actual benefits and costs of implementation of an appropriate proposed reporting system. After assessment of information received from an experimental project, an appropriate system can be formed for broader implementation. In this way the interests of the public would be better served.

NEW JERSEY LABORATORY WORKLOAD REPORTING SERVICE,
July 20, 1979.

Re File code PCO-185-P.

MICHAEL STERN,
Staff Director, Committee on Finance,
Washington, D.C.

DEAR MR. STERN: This letter is in response to Federal Register, Vol. 44, No. 16—Tuesday, January 23, 1979, page 4741, Department of Health, Education, and Welfare Uniform Reporting Systems for Health Service Facilities and Organizations (SHUR) as it relates to hospital laboratory statistical reporting (Chapter III, pp. 3.82-3.85 & Appendix C).

The New Jersey Laboratory Workload Reporting Service (NJLWRS) has identified a number of problems with the present SHUR system in its modifications of the CAP workload reporting methodology.

NJLWRS is a program developed by the New Jersey Hospital Association with the New Jersey Society of Pathologists for the purpose of providing uniform productivity data for hospital laboratories in the state of New Jersey. The modality employed is the Workload Recording Method for Clinical Laboratories developed by the College of American Pathologists (CAP). NJLWRS has been in existence seven years, is presently serving 51 hospitals (18,000 beds) in the state of New Jersey, and has previously advised the New Jersey Department of Health in the development of their guidelines for submitting laboratory data under rate reimbursement regulations.

The CAP workload reporting methodology was designed for the purpose of productivity comparisons and is presently the most sophisticated method for this purpose. There are many problems in adopting a system designed for productivity for fiscal utilization. Since the CAP system was designed for productivity it really only addresses itself to the labor element of the laboratory. Any competent fiscal analysis should include labor, equipment, reagents and overhead. These other factors besides labor can represent substantial costs (e.g., a new twenty channel analyzer costs $250,000.00) and have no relative correlation with labor. SHUR may be attempting to modify workload methodology for fiscal use, but because these modifications were executed without a full understanding of the CAP system, they have distorted the data for no meaningful purpose. By deleting quality control, standards, repeats, some clerical and some specimen collection, SHUR will significantly change the CAP data by artifically creating variances. NJLWRS study of 51 hospitals indicates that SHUR's modification of CAP excludes 21 percent to 56 percent of the laboratories' CAP hours. This is a thirty-five percent variance. With such a large variance in the data, the value of its use for meaningful comparisons is debatable. SHUR's changes will distort the labor component of laboratory cost and not succeed in addressing any of the missing costs, i.e., equipment, reagents and overhead. SHUR's modifications negate any comparative value the data might have had and are not rational for the following reasons.

It is unreasonable to delete quality control, standards and repeats for they represent a real cost to the laboratory. It takes just as much manpower and just as large a quantity of reagents to test a control as to test a patient's serum. Quality control and standards are required by federal regulations but no defined standard is mandated. The number of quality controls, standards and repeats are affected by many variables, such as test mix, equipment design, batch size, technician experience, and reagent reliability, that the laboratory has no control over. Although quality control, standards and repeats are not charged for separately, their costs are included in the charge for doing the patient's test.

It is unreasonable to delete nonchargeable CAP hours, for this will result in inconsistencies in the data. It is hard to give an unambiguous definition of nonchargeables since different institutions may follow different procedures. For example, does "specimen collection for which a patient is not charged are not to be counted" mean that hospitals that charge for specimen collection can include these CAP hours? If some hospitals are including these CAP hours and other hospitals are not including these hours, the data is useless for comparative purposes. NJLWRS studies show that specimen collection and dispatch alone can cause an 18 percent variance in data submission.

An article published in November 1978 Laboratory Management interprets nonchargeables to include clerical. Deletion of clerical would cause inconsistencies from one area of the laboratory to another. Under the CAP methodology the clerical value in chemistry, hematology and serology is included in the tests' CAP value. Therefore, it is impossible under the present CAP system to delete the clerical value from these tests. In other sections of the laboratory, clerical is given a separate CAP weight and counted like a test. In these areas one could exclude the clerical value. If

clerical is to be excluded, it should be excluded in all sections of the laboratory or none of the sections of the laboratory. Since it is impossible to determine the clerical value for the entire laboratory, it should not be excluded from the CAP hours. Furthermore, NJLWRS studies indicate that excluding clerical from a portion of the laboratory adds an additional 16 percent variance to the data.

Another problem is encountered in attempting to relate CP units to units for charge, since the unit for charge and the CAP unit of count differ. For example, most hospitals charge for one would culture, not for the number of plates, tubes, slides, tests and organisms. To complicate the matter further, all wound cultures vary in the number of plates, tubes, slides, tests and organisms depending on the type and number of bacteria cultured.

Including CAP workload units for work done outside the laboratory further confuses the data. The addition of outside CAP units will increase the number of CAP units of hospitals which use outside laboratories, adding additional variance to the data. Since the cost or profit of such tests has no relationship to other testing done by the hospital, it seems inappropriate to include such CAP units. It may also be difficult for the hospital to accurately determine a CAP weight for procedures like cultures or for unlisted procedures that the laboratory is unfamiliar with.

It should be pointed out that the CAP weight and charge have no relationship to each other. CAP weights have been found to be unsuitable as a basis for a charging system for two reasons. The first reason is that for a charging system to be comprehensive and consistent, it must include reagent, equipment, overhead, quality control, standards and repeat cost, which cannot be determined from the CAP weight. The second reason is the variance in weights for the same test. In the CAP workload reporting system, the CAP value for a bilirubin done manually is thirty times the CAP value of a bilirubin done on an SMA 12. The same is true of the other manual procedures when compared to the same procedures automated. These different weights for the same test result in up to 3000 percent variances in CAP weight for the same procedure. The state of New Jersey has tried to adjust for these differences while equalizing equipment and some reagent cost by collecting only manual CAP values. While this may improve the fiscal applicability of such data, it necessitates two reporting systems if the data is to be used for productivity analysis.

The CAP workload reporting methodology gives the laboratory data for reliable productivity comparisons. The proposed SHUR system makes modifications to the CAP workload reporting methodology that distorts its value for productivity comparisons while failing to improve on its fiscal applicability. Therefore, it seems reasonable to adopt the CAP methodology in its present form and save burdening hospitals with dual data collection systems to no purpose.

Thank you very much for this opportunity to comment on the proposed rules.

Sincerely,

RICHARD C. JAMIESON,
Secretary,
Laboratory Statistics Advisory Committee.

BETHESDA HOSPITAL & DEACONESS ASSOCIATION,
Cincinnati, Ohio, July 17, 1979.

Mr. MICHAEL STERN,
Staff Director, Senate Finance Committee,
Washington, D.C.

DEAR MR. STERN: This letter is in regard to Press Release #H-46 of the Senate Finance Committee which announced a scheduled hearing on the System for Hospital Uniform Reporting (SHUR).

As a response to Senator Talmadge's stated intent to "hear GAO's evaluation as to whether SHUR is in keeping with the law and whether there is any unnecessary or overly burdensome detailed information required which could be reduced or eliminated", I am submitting the enclosed letter to be used for informational purposes by members of the Senate Finance Committee.

I hope that these comments will prove helpful to the work of the Committee.

Respectfully submitted.

MARYANN BRECHT POLIDOROFF,
Manager, Government Relations.

Enclosure.

BETHESDA HOSPITAL & DEACONESS ASSOCIATION,
Cincinnati, Ohio, April 19, 1979.

ADMINISTRATOR,
Health Care Financing Administration,
Department of Health, Education, and Welfare, Washington, D.C.

DEAR SIR: I submit to you the following comments in response to the Notice of Proposed Rulemaking for Uniform Reporting for Health Services Facilities and Organizations which was published January 23, 1979 in the *Federal Register.* These comments also pertain to the draft manual issued by the Health Care Financing Administration which is entitled SHUR, or System for Hospital Uniform Reporting.

Is clear that the regulation and draft manual violate the Congressional intent of the law (Section 19a of Public Law 95-142), which mandates the establishment of a uniform reporting system. In the enabling legislation, it is stated that uniform reporting is to be "for the purposes of reporting the costs of services provided by, of planning, and of measuring and comparing the efficiency of and effective use of services in hospitals . . .". SHUR exceeds this mandate, however, in that its implementation would result in a uniform accounting system.

The SHUR draft manual itself states that the proposed system is to "provide uniform, comparable information for purposes of management, reimbursement and planning". The invasion of the Health Care Financing Administration (via SHUR) into the arena of hospital management is clearly inappropriate. Further, the implications of combining aspects of a hospital's reimbursement system with a standardized reporting form are clearly a violation of congressional intent.

There is not sufficient definition with regard to the use and users of reported data elements. The fact that the proposed regulations do not specify the actual purposes of reported data affirms that the burdensome and costly process is without justification. The functional accounting, detailed breakout of expenses, and massive amount of statistical information required dictate and will require extensive conversion of financial reporting systems in all hospitals; however, the benefits of such mammoth efforts are neither specified nor assured. The necessity to undertake the study which the U.S. Department of Health, Education, and Welfare is now performing regarding the cost of SHUR's implementation further indicates that the government has "put the cart before the horse". The proper approach would have been to define what is to be accomplished, to determine the cost benefit of accomplishing specified objectives, and then designing an appropriate system for accomplishing such objectives.

Given the current environment of hospital cost containment, the implementation of SHUR would represent a highly irresponsible and counterproductive action on the part of our government. We at Bethesda have estimated that it will cost between $150,000 and $200,000 just to implement SHUR for our hospitals. We also estimate the ongoing cost to be approximately $50,000 per year in the gathering of statistics, the administrative time involved in adequately overseeing this massive process, and the cost of maintaining two sets of financial records which will be necessary if the hospital still desires to maintain responsible budgeting reporting systems.

I hope that the above comments have been helpful and will be given thoughtful consideration regarding your assessment of the recently proposed rules as well as the draft manual for SHUR.

Respectfully,

BARRY D. BROOKS.

STATEMENT OF THE BLUE CROSS AND BLUE SHIELD ASSOCIATIONS BY MERRITT W. JACOBY, ACTING SENIOR VICE PRESIDENT, GOVERNMENT PROGRAMS

On behalf of the Blue Cross and Blue Shield Associations I, Merritt W. Jacoby, Acting Senior Vice President for Government Programs, submit the following statement for the record of the subcommittee hearing on the SHUR system. The Blue Cross & Blue Shield Associations are pleased to have the opportunity to comment on the proposed implementation of the System for Hospital Uniform Reporting as part of the reporting requirements of Section 19 of Public Law 95-142.

The Blue Cross & Blue Shield Associations are the national coordinating agencies for the 69 Blue Cross and 70 Blue Shield Plans in this country. These Plans provide privately underwritten health care coverage to about 85 million Americans, and serve almost another 20 million as fiscal agents or intermediaries for the Medicare, Medicaid and CHAMPUS programs. Thus, the Plans serve about half the U.S. population.

The Blue Cross Association serves as a nationwide prime contractor to the Department of Health, Education and Welfare for Administration of Part A of the Medicare Program. Sixty-eight Blue Cross Plans are Part A subcontractors of the Association. These Plans are directly affected by the notice of proposed rulemaking which make the Medicare intermediaries responsible for receiving the SHUR report.

We have carefully reviewed the System for Hospital Uniform Reporting (SHUR) announced in the Federal Register of January 23, 1979. We have presented comments on behalf of all Blue Cross Plans participating in the Medicare Part A Program to Mr. Leonard Schaeffer, Administrator of the Health Care Financing Administration (HCFA). We produced and submitted to HCFA a rewritten version of SHUR and we have commented on the proposed Medicare reimbursement changes introduced by certain SHUR forms and their instructions. These documents are available and we will be happy to provide them to the subcommittee at your request.

We support the development of a uniform reporting system. The need for uniform financial, service and statistical data is clear because information is constantly sought by a multitude of governmental agencies and groups, often requiring repetitive and conflicting reports.

The Blue Cross Association has watched the SHUR manual evolve over the past four years and we have participated, at HEW's invitation, in its evolution. During this period HCFA has made constructive and responsive efforts to accommodate industry concerns. The level of detail required in the report has been drastically reduced at the request of industry representatives. The proposed manual contains a logical and well developed structure which will continue to serve as a basis for the uniform report in its final form.

Our testimony is based on this longstanding involvement with HCFA in the development of a uniform reporting system. We are continuing to work with HCFA and have recently attended a meeting at which we received verbal assurances that many of our concerns have been heard and are being incorporated into the final product.

While we support the basic principle of a uniform reporting system, we cannot support SHUR as it was proposed with the accompanying form, HCFA-142 Test, and its instructions. We would recommend the following:

1. A UNIFORM REPORT SHOULD BE ACCOMPANIED BY A CLEAR STATEMENT OF THE USES TO WHICH THE DATA WILL BE PUT

There has never been a clear statement of the uses for the data requested on the uniform report. The uses should be announced by the government before implementation of SHUR and should include—

(a) Those which motivated legislators to pass the law requiring the uniform report;

(b) Those which the uniform report will immediately and obviously serve;

(c) those which are currently met through other data requests of the industry by government; and

(d) Those which the uniform report could ultimately serve, especially when integrated with uniform bill and discharge data.

Clear enunciation of the uses will also serve to focus Government attention on tasks which need to be achieved before implementation of SHUR.

2. THE EXPECTED BENEFITS OF THE REPORT SHOULD EXCEED THE COSTS OF ITS IMPLEMENTATION

It is difficult to evaluate the application of this criterion to the proposal since neither anticipated benefits nor the cost of implementation has been disclosed. The anticipated benefits of the report should be disclosed in terms of (1) the government's need to establish national goals, determine important resource priorities, monitor, regulate and ensure access to needed hospital care for all citizens; and (2) the government's ability to reduce other requirements for hospital reporting. Both the cost and the benefits should be clearly understood by those who have to comply with the reporting requirements.

A cost study was prepared by Morris Davis Co. for HCFA. When this study is completed, it should provide one part of the information needed to evaluate the proposed system. However, estimated benefits of SHUR are equally important since the cost, no matter how great or little, can only be evaluated by a comparision to the benefits. A clear and accurate cost/benefit analysis must precede the implementation of the reporting system.

3. THE REPORTING REQUIREMENTS SHOULD BE EASY TO ACCOMPLISH BY THOSE REPORTING

In introducing a uniform reporting system, presentation is of paramount importance. A 600 page document is simply too large. There are many misstatements regarding SHUR, its contents and objectives that occur because the proposed 600 pages contain a mixture of accounting principles, terminology, reporting requirements and instructions. It is difficult to get a clear idea of exactly what is being requested. The BCA rewritten version of SHUR is an attempt to eliminate the accounting terminology and the confusing and duplicative instructions from the document.

In imposing uniform reporting requirements on the health care industry, the Government should request data which is readily available in the industry, in formats usually maintained. Data requested in the report should not require extraordinary collection efforts by hospitals. Most of the data requested in SHUR is available in hospital records. The need for requested data which is not available should be carefully reviewed and its need justified in comparison with the cost of the hospital's effort to produce it.

4. THE INDUSTRY MUST BE ADEQUATELY PREPARED FOR IMPLEMENTATION OF SHUR

Uniform reporting will take substantial preparation by the hospital industry. Each hospital will need to be educated about the federal government's expectations of its performance under SHUR. The essential elements for hospitals include a well written, easily read and understood uniform reporting manual; adequate lead time between determination of reporting requirements and implementation, to establish whatever additional data gathering capabilities would be needed; and a uniform educational program presented by those generally familiar with specific hospitals.

5. THE IMPLEMENTATION OF THE NEW REPORTING REQUIREMENTS OF SHUR MUST NOT BE USED AS A MEANS TO PROMULGATE NEW MEDICARE REIMBURSEMENT POLICY WITHOUT SPECIFIC IDENTIFICATION OF THE POLICY CHANGES BEING MADE

The manner in which changes in the Medicare reimbursement principles and requirements were introduced in the proposed instructions to form HCFA-142 Test has created confusion about the relationship between the uniform reporting requirements and the method for determining Medicare reimbursement. Substantial changes have been proposed; yet these changes have not been clearly identified, nor have they been submitted to the normal review process through proposed revisions to the Provider Reimbursement Manual (HIM-15). It is important that any changes in Medicare reimbursement incorporated in SHUR are the result of the Health Care Financing Administration's policy decision-making process and include specific industry consultation.

The proposed changes will have a major impact on reimbursement of providers. An example of a change which was not highlighted concerns the standard procedure through which providers request, and receive from their intermediaries, approval to change the order of cost centers for purposes of cost allocation and/or to use different bases for cost allocation.

This procedure is governed by Section 2313 of the Provider Reimbursement Manual and responds to the different situation of providers and the varied levels of sophistication in their record keeping systems. This section allows a written request for a change if the provider believes more appropriate and more accurate allocations will occur. The provider must submit "reasonable justification for the change." The intermediary's written approval will be applicable to all future cost reporting periods unless a subsequent request for change is approved.

A major policy change was proposed through a note on page 4.62 of the SHUR manual. The procedure for requesting a change was stated. The note reads (emphasis added):

"A provider that received approval from its fiscal intermediary for the use of any alternative basis or sequence of allocation prior to the effective date for the use of form HCFA-142 *must reapply* before using any basis or sequence different from that indicated on form HCFA-142. In reapplying, the provider must *establish that the alternate basis or sequence of allocation is more accurate* than that indicated on the official form. A mere demonstration that a cost allocation is different is not adequate to establish that it is more accurate."

To find this policy change required a verbatim reading of the instructions published as part of the SHUR manual, part of a 600 page document. No change is evident in the form and no revision to the Provider Reimbursement Manual was proposed. This extraordinary way of seeking comment on Medicare policy changes

does not comply with the current practice of government consultation with the industry regarding policy changes.

We have commented to HCIA regarding other policy changes proposed in the SHUR manual. These changes included an expanded number of overhead and patient care cost centers and adjustments to cost before, during and after stepdown cost allocation, with specification of the use of either cost or revenue for each adjustment. We are concerned that there may be more changes in the proposed instructions which readers have not discovered and commented upon.

The confusion resulting from the proposed changes in Medicare reimbursement policy has led to a demand that the uniform report and the reimbursement report be separate documents. Whether the reimbursement report and the uniform report are included in one set of forms is not important. What is important is that requirements for uniform reporting not effect new principles and methods for developing Medicare reimbursement. If HCFA does not specifically identify policy changes and issue them for separate prior consultation, we would support the separation of the reimbursement report from the uniform report as the only means available to control these changes.

6. MEDICARE REIMBURSEMENT PRINICIPLES MUST REMAIN INDEPENDENT FROM THE REPORTING REQUIREMENTS

It is desirable that the uniform report and the Medicare cost report be submitted as a single document. However, at the initial stage of implementation and subsequent to the introduction of HCFA-142, the reporting requirements and the reimbursement principles should remain separate. This can be accomplished in the following manner.

(a) The HCFA-142 should include both the uniform reporting data and the computation of Medicare and Medicaid reimbursement costs. This will mean that the forms will be distributed as a single reporting requirement, subject to a single set of filing requirements, subject to the same penalties (regarding fraud, timeframes for filing, failure to file), subject to the same audit and disclosure provisions. These administrative rules can be controlled by a single set of Federal Regulations.

(b) The uniform reporting elements could be specifically identified in the report, currently HCFA-142 Test, Worksheets A through E-4-4; and governed by their own set of instructions, currently SHUR, Chapters 1, 2, and 3, and Chapter 4, pages 4-1 through 4-38.

(c) The computation of Medicare and Medicaid reimbursable costs could be specifically identified in the report, currently HCFA-142 Test, Worksheets F through J, Part III, and governed by their own set of instructions, currently SHUR, Chapter 4, page 4-39 through 4-172, as well as other relevant regulations and general Program instructions (e.g. Reg. 405-451 ff and HIM-15, Parts I and II).

(d) The forms should be structured in the manner to allow the total revenue and expenses and balance sheet items used for the computation of Medicare and Medicaid reimbursable costs to be traced to the uniform reporting data. The manner in which these items are used to determine reimbursable costs should be governed solely by reimbursement policy instructions.

This course of action allows HCFA to revise its uniform data reporting requirements without impacting provider reimbursement. This will benefit the Administration as well as providers, since HCFA will not need to engage in reimbursement-policy consultation each time HCFA needs to modify its data gathering activity. Also, HCFA will be able to revise reimbursement policy without disturbing data gathering activity.

7. REPORTING REQUIREMENTS MUST BE INDEPENDENT FROM ACCOUNTING PRINCIPLES

The association has long supported responsibility accounting by hospitals. Through cooperative ventures with the hospitals they serve, Blue Cross Plans have been in the forefront of efforts to help control cost by providing to hospitals the tools and techniques to improve management efficiency and productivity.

Example of programs include California's Commission for Administrative Service for Hospital (CASH), the Tennessee Effective Management Program (TEMP), Performance Analysis and Review (PAR) developed in Pittsburgh and the System Program for Hospitals in Oregon, Washington and Idaho. More than 20 Plans are engaged in such activities.

The suggestion has been made (and is, in fact, being implemented) that a hospital can most easily comply with SHUR requirements by adopting the chart of accounts detailed in it. We would not recommend that a hospital adopt SHUR's chart of accounts for two reasons:

First, the evolution of SHUR is and will continue to be different from that which will affect changes in a hospital's accounting needs. Time, changes in institutional practices and changes in the government's need for data will gradually erode the apparent similarities between a hospital's accounting system and a nationally maintained chart of accounts.

Second, adoption of the SHUR chart of accounts would not ensure automatic compliance with SHUR requirements. Completion of SHUR would still require analysis of hospital records, reclassification and reformatting of expenses and revenues.

To issue a uniform report, it is necessary to establish a level of reporting detail, describe the various financial and statistical elements to be reported; and provide a format for reporting them. That should be done by defining data elements to be reported, not by requiring conformity to an accounting system.

8. ELIMINATION OF DUPLICATIVE REPORTING

SHUR, as proposed, represents the most massive request for hospital data in history. It has, or should have, the potential to eliminate many other existing data requests of the federal government. In September 1978, Congressman McGuire (New Jersey) stated in the House debate on the "Health Services, Research and Technology Act of 1978" that "There are currently 282 separate programs in HEW alone which have the responsibility for the collection of health statistics." Hospitals should not be required to supply additional reports which would no longer be necessary because of the availability of SHUR data.

We recommend that HCFA establish a data clearinghouse where the availability of hospital data from SHUR could be catalogued and inventoried. Any data requests from the Federal Government should be passed to this clearinghouse so the request could first draw upon available SHUR data.

The elimination of duplicative or excessive data reporting should be pursued not only at the Federal but also at state and local levels. SHUR assures extensive data, uniform in content and format, and reasonably accurate. Resources currently devoted to data gathering could thus be diverted to more productive data analysis and industry understanding.

9. THE COST OF SHUR MUST BE BORNE BY THE FEDERAL GOVERNMENT

The implementation of SHUR will add a significant overhead cost to all hospitals. Since this cost results solely from a Federal requirement, the cost should be borne by the Federal Government.

The principal of provider cost sharing enunciated in Section 1861(v)1(A) of the Social Security Act directs the Secretary of HEW to establish regulations which ensure that: "the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this title will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs."

Precedent for direct assignment of costs has been set by the Secretary in the final regulations governing the cost of Malpractice insurance. HCFA states in the preamble to the final regulations that malpractice costs are "so significant and the disproportionate allocation of malpractice costs to Medicare is so great" that a "unique exception" is warranted to deal with these costs. The cost of SHUR should be treated in the same manner.

Thank you for the opportunity to comment on the proposed SHUR system.

STATEMENT OF THE HOSPITAL FINANCIAL MANAGEMENT ASSOCIATION

The Hospital Financial Management Association is an organization of over 17,000 individuals employed in financial management positions in hospitals and other health service provider organizations or are closely allied to these activities. These are the individuals who will be intimately involved in maintaining the records and completing the forms necessary to comply with SHUR. HFMA members have provided extensive time and effort to the review of various documents which led to the draft of SHUR which was released for comment. The significant concern expressed by these individuals is based on thorough analysis of the proposal.

We would like to comment first on the questions the Subcommittee asked the General Accounting Office and the information supplied by the GAO. Then we would like to review other matters which we believe the Subcommittee should consider in regard to SHUR. We also have specific recommendations for correcting concerns with SHUR.

A. THE SUBCOMMITTEE QUESTIONS

1. How much additional data does SHUR require

While the GAO quantified the significant increase in forms and data elements, the GAO report does not address the appropriateness to Congressional intent of the data presently provided or the proposed additional data to be collected. We see little use being made of the 6,700 data elements already provided by every hospital every year (over 35,000,000 data elements already available annually) and are concerned with the cost benefit of providing additional data.

Interesting versus useful data.—Our discussion of the cost and benefits of implementing SHUR have reinforced our concern that much of the data requirements are based on an assumption that certain items might possibly be interesting. Experienced financial managers can attest to the fact that information needs are limitless if the only concern is whether or not the data may be interesting. Careful consideration of the cost to collect and manage data is significant to wise decisions about what data to collect and report. This is especially true when designing federal systems because once the system is in place, the tendency will be to leave it intact regardless of the actual cost or benefits of the system.

Aggregate versus detailed data.—Authorizing legislation refers to "aggregate costs" but SHUR is designed to identify costs in minute detail. Federal and state decisions are made based on a broad array of information but do not customarily deal with the level of detail which SHUR seeks to identify. Defining users and their needs is a first step in designing a reporting system. We have interpreted the law's reference to "aggregate costs" as a measure of the level of detail which Congress requires. SHUR's excessive detail ignores this direction.

The desire to compare the cost of an X-ray is frequently cited as a need to be satisfied by this system. This may appear to be a simple request, but is fraught with complex issues involving volume, scope of services, Medicare reimbursement issues, and the like. A comparison of published prices for specific services can be easily made. A comparison of costs on the other hand, may be as difficult as comparing the cost of units of energy produced from coal or oil, with unit costs of nuclear or solar energy. Decisions about purchases of an X-ray can be made using information about what providers of this service are charging.

2. What use does HEW intend to make of the additional data

On numerous occasions, HFMA and others have asked the Health Care Financing Administration for a clear statement of the objectives of the system but only generalities have been provided—generalities which are, in our opinion, totally insufficient for purposes of designing a financial reporting system. We fear the GAO has also failed to be sufficiently specific with respect to intended use.

We believe Sections 1533(d) and 19 can be satisfied with a system which is consistent with legislative wording which specifies attention to "aggregate costs." Such data can meet the needs for legislative decision making about present health expenditures and can provide guidance for incentive or competitive arrangements.

We are confident that a detailed statement of objectives would indicate that SHUR is not consistent with Congressional intent, and that it would not meet specifically developed objectives in a thorough and efficient way.

Fraud and abuse detection.—While Section 19 was part of a law dealing with detection of fraud and abuse, SHUR will be of little value in accomplishing the objectives of that law. IRS procedures disclose that comparing detailed unit costs is of little value in fraud detection. The recently completed Congressional debate on the Foreign Corrupt Practices Act focused attention on internal control procedures and monitoring as a more appropriate means for detecting fraud in a corporate setting. Therefore, there seems little relevance of SHUR to detection of fraud and abuse. SHUR's massive and conflicting detail will not facilitate legitimate investigatory efforts but may be inappropriately used to entrap well intentioned efforts to comply with the law and make these efforts appear to be fraudulent or abusive.

Interinstitutional comparability.—SHUR was designed on the faulty assumption that detailed functional reporting, uniform cost allocation and arbitrary productivity units could be used to achieve meaningful comparability on a nationwide scale. This assumption fails to recognize the many valid reasons for differences in unit costs between various efficiently operating providers. For example, the cost of an automated blood test is not comparable to the cost of the same test processed in another way. Both tests may be appropriate and reasonable alternative means of processing may not be possible. Each may be performed in an efficient manner yet with significant differences in unit cost. Comparing unit costs is of very limited value without additional knowledge of the institutions and could significantly confuse the understanding of hospital costs, operations and achievements.

Relevance to decisions.—We also question whether unit costs is the data needed for governmental decision making. Such information may be relevant to decision about programs of service or even cure results, but other approaches may even be more useful for those type analyses. The unit cost approach has no relevance to decisions about competitive arrangements which requirement information about marginal cost. A focus on unit costs ignores care alternatives involving a different mix of services. Incentive payment arrangements will be supported by this system only if the incentive is based on units; of output; yet other bases of incentives may be more consistent with the public, payer and the provider goals. There is serious danger that decisions will be oversimplified if based on the superficial understanding of unit costs this proposed approach will foster.

Use in present Medicare arrangements.—Discussion with HCFA officials regarding intended uses of SHUR indicates that prime use may be to modify the Medicare payment system to further reduce its payment toward the cost of providing services to Medicare beneficiaries.

We believe SHUR is being linked to the Medicare payment system without a clear understanding of payment objectives under the existing Medicare statute. While uniform reporting may be useful in developing certain new approaches to Medicare payment, the narrowness of the SHUR system makes this use very limited. The use of SHUR to determine payments will increase the difficulty of developing alternatives to reimbursement based on "reasonable cost" because it fosters the erroneous impression that a retrospective calculation based on detailed functional reporting solves the basic problems of the current Medicare payment system. We strongly urge that any uniform report be separate from Medicare.

To the extent newly available data indicates the need to modify Medicare payments the data should first be collected and analyzed and the proposed change disclosed and discussed. A massive change in Medicare payment disguised as implementation of a reporting system is inappropriate.

While data collected from SHUR may lead to changes in Medicare payment procedures, we feel it is premature to apply an untested and extremely complex set of new rules on a process that has developed gradually over 12 years. This total change in the basis of calculating payments will cause serious confusion and delay which could cause disasterous financial difficulty to the entire system. Principles of payment which have been in existence for long periods should not be discarded precipitously but only after appropriate discussion and study.

SHUR as proposed is inconsistent with both generally accepted accounting principles and established Medicare payment rules. For example, SHUR would limit the way depreciation is recorded or the way inventory is valued regardless of the appropriateness of the method used for general financial report purposes and regardless of its conformity with generally accepted accounting principles. SHUR would also revise the method of apportioning "administrative and general" costs even though the method devised by Medicare was considered to be most accurate for payment purposes.

The Medicare statute requires precise apportionment of cost between Medicare and non-Medicare patients. Methods which enhance precision have been developed for individual institutions. All of these arrangements would be terminated by SHUR with no opportunity to examine whether new rules comply with the requirement of accurate cost apportionment.

3. How does SHUR compare with AHA's recommended Chart of Accounts and the Hospital Administrative Services (HAS) program (now called Monitrend)

The GAO has described AHA's Monitrend system which is a valuable tool of hospitals in monitoring and controlling costs. HCFA personnel have said they intend to provide information of use to internal institutional management. Use of the SHUR system to generate comparative management reports, however, is of questionable feasibility and of dubious value. An annual report tied to the Medicare payment system will produce little if any information of use to hospital management, which cannot be obtained more easily in other ways. The industry has already developed a comparative reporting system that accomplishes this objective more effectively and at considerably lower cost than that of the SHUR system.

Interference of SHUR with management informational needs has been a significant basis for criticism. While the law says that SHUR should not be an accounting system, the massive detail of the reporting requirements will have a pervasive influence on internal accounting systems.

Management accounting systems are generally organized into responsibility or control centers. The SHUR system requires rearranging data according to function. Normally responsibility and functional reports can be produced from the same records however, the detail required by SHUR is so extensive that most basic

recordkeeping systems would need to be modified. Many fear that managements informational needs would be adversely affected in the process.

Hospital management is striving quite successfully to reduce the rate of cost increase. This is a very inopportune time to risk confusing management's information systems or adding extra recordkeeping requirements at high cost.

4. What has HEW done to assess the cost of SHUR and should medicare and medicaid assume a larger than normal share of the cost

HFMA has long advocated that Medicare pay the full cost of SHUR because we do not feel the costs will be of any benefit to anyone and no one other than the Federal government should be asked to bear these costs. We are pleased that the GAO holds a similar view.

HCFA's effort to measure the proposal's cost effect has generated about as much controversy as the proposal itself. While the results of that study are not applicable if there is a major revision in design of the system, a discussion of the study and its use is presented here to offer guidance to a study of costs of a new system.

Narrow definition of cost.—The costs to be measured were defined very narrowly. Some financial managers involved in the study have expressed their concern that cost to their hospitals were not fully identified.

The study estimated there would be no cost in many hospitals because state reporting requirements similar to those of SHUR are already in place or planned. One of these states where the study indicated no costs would be incurred is Maryland, yet the Maryland Hospital Association has identified differences between the state system and SHUR which would result in cost being incurred if SHUR were implemented in Maryland hospitals.

Only costs in hospitals were studied. The system will also cause other organizations to incur added costs, such as auditing firms, intermediaries and user groups. These costs should not have been ignored by HCFA in evaluating the cost impact of the study.

Cost omitted from the study.—The study originally identified 50 hospitals for study. The report included data from only 44. Verified reports indicate the study results would have been significantly higher had certain of the remaining 6 hospitals been included. Also some of the amounts for hospitals included in the study were erroneously included in the report at less than the correct amount.

The time allowed for the study was exceedingly short. Errors and omissions may have been inevitable because of the timing deadline. Nonetheless we have become aware only of errors and omissions that, if corrected, would have raised the reported results.

Verification of study results.—Even though urged to do so by several authorities HCFA has not verified the study results by an actual application of the SHUR system in any hospital, using more scientific measurement methods. This leaves many unresolved questions about the study results.

Unrepresentative selections of hospitals.—The study was not representative of all hospitals either by size or location. Fourteen of the test hospitals (32 percent) are in states with uniform reporting systems while only 22 percent of the nation's hospitals are in such states. Costs in states with existing reporting requirements are understandably lower than in other states. The study also included more than a proportional share of large hospitals.

Applying study results to the industry.—The measured costs have been inappropriately described as being representative of costs in all hospitals. Due to the study's small sample size and unusual composition, the results cannot properly be considered representative of cost in all hospitals. Due to the size and nature of the sample, the estimate of total cost to all hospitals can only be judged as unreliable. All evidence seems to indicate however, that the reported results minimize the cost impact. Nonetheless this unreliable data has been used by HCFA to avoid regulatory review.

5. Does GAO have suggestions for simplifying SHUR

GAO offered very few substantive suggestions which we interpret as a recognition that superficial modifications of SHUR will not provide an adequate remedy. We continue to feel that SHUR's focus on detail is inappropriate and cannot be rectified by shortening and simplifying.

B. OTHER MATTERS FOR CONSIDERATION

1. A new approach to payment is needed

There is increasing recognition that the cost-based approach to paying for Medicare services is costly and complex, and produces undesirable side effects such as failing to reward efficiency. It is time to correct these deficiencies rather than to

add additional confusion through an enormously complex and costly new system to an already discredited approach. As was pointed our earlier, SHUR supports only those payment arrangements which are based on unit of output measures and is not relevant to incentive systems or competitive approaches.

HFMA has urged HCFA to begin immediately to devise a new approach to paying for Medicare services, seeking appropriate authority with the same zeal which has marked the effort to introduce SHUR.

SHUR, as a uniform reporting proposal, is really a separate issue from Medicare reimbursement, but is apparently being designed for reimbursement minimization rather than to address the many important issues related to objective and equitable reporting practices. We urge the Congress to turn its attention to development of Medicare payment methods which are equitable to other purchasers and which assure the fiscal ability of health care providers to continue meeting community health service needs.

2. Hospitals must still seek full allowable payment under whatever rules are established

Hospitals must claim the maximum allowable payment from Medicare and should be encouraged to do so. Means to control abuse by hospitals are already available and SHUR's detail will probably confuse rather than clarify such control.

In HFMA's view, a hospital's claim for full allowable payment from Medicare is consistent with the law's provision that non-Medicare patients should not bear any share of the cost of serving Medicare patients. Seeking full allowable payment for the services rendered is necessary and proper. SHUR will change some of the techniques for accomplishing that goal—new articles will be written, new computer programs will be prepared and new consultant contracts will be signed—but efforts to receive full allowable payment will continue under any rules. Seeking full payment should not be confused with illegal efforts to receive more than the law allows. Procedures for detecting fraud and abuse are available and being used. Efforts to receive full payment must not be confused with inappropriate manipulation. We believe the SHUR proposal gives evidence that such confusion presently exists.

3. Hospitals must be fully paid for services rendered

In HFMA's view, there is substantial evidence that the government is in many cases avoiding payments to which providers are properly entitled, and is thus jeopardizing hospital fiscal stability. A recent GAO report listed reimbursement limitation mandated by Medicare, Medicaid and State regulatory agencies as a principal cause for the severe hospital financial problems that are jeopardizing the Hill-Burton and HUD loan guarantee programs. The government has inappropriately defined allowable costs too restrictively, possibly to secure preferential treatment and has failed to recognize many financial needs. For example the GAO report included "bad debts and uncompensated care" and "unreimbursed inflation costs" in their list of deficiencies in government payment. There is evidence that much governmental effort is spent in designing ways to manipulate formulas to deny payment to hospitals. A recent example of such manipulation is the shift in rules to determine the government's share of malpractice insurance cost. By violating rules applied to almost all other types of cost, the government has shifted $310 million in legitimate costs to other payers of health care services. Attention should be given to paying hospitals fully for services rendered, rather than designing a system that fosters further preferential treatment to the federal government and jeopardizes hospital fiscal viability.

4. A new comment period and evaluation is required

HCFA has promised extensive revision of SHUR. We feel the revision should be made after certain preliminary steps, such as definition of objectives is complete. We believe that these preliminary steps will lead to a different type revision than HCFA contemplates. We would like to suggest specific ways in which the SHUR proposal may be improved with the goal of properly meeting stated objectives, but in the absence of defined uses such a response is obviously not possible.

Regardless of the type of revision, any extensive revision should be available for public comment. As in the past, HFMA task forces are ready and willing to provide technical review of proposed reporting forms. Adequate review is, of course, not possible until the contemplated revisions are in a form that permits detailed technical review. We expect to continue to cooperate with this project and are pleased that Congressional attention is being give to this matter.

C. RECOMMENDATIONS

The objective of the program should be to collect the data necessary and appropriate for future legislative decisions about payment for health care services. Authoriz-

ing legislation calls for a system to provide "aggregate" data. We believe that provision continues to be appropriate and should be followed. New data should facilitate evaluation of alternative payment arrangements which are presently under Congressional consideration, including use of incentives and competition. Data needed by management must continue to be available in a form which encourages responsible, innovative approaches to cost effective provider operations.

The system must be designed to achieve its objectives at minimum cost to all parties affected by the system—provider organizations and related groups who report data, intermediaries and third party payers who process data, auditors and others who verify data and the various users of data including the government.

Medicare payment provisions should not be modified without legislative authority. Rather than collecting massive additional detail to change the existing Medicare program with all of its recognized weaknesses we urge that the Health Care Financing Administration cooperate with the industry in identifying new relationships between payers and providers which contribute to cost control and evaluation. Data should be designed to facilitate these types of decisions.

Any new proposals should be evaluated in relation to the above recommendations, so a period of public comment is needed, and regulatory impact should be measured.

STATEMENT OF THE NATIONAL ASSOCIATION OF PRIVATE PSYCHIATRIC HOSPITALS

The National Association of Private Psychiatric Hospitals would like to take this opportunity to submit its views on SHUR, System for Hospital Uniform Reporting.

The National Association of Private Psychiatric Hospitals is a private non-profit organization, representing over 180 free-standing (non-governmental) psychiatric hospitals providing multiple levels of care to children, adolescents, adults, geriatrics, alcohol and substance abusers in need of active psychiatric care and treatment. Our member hospitals include services such as mental health centers, residential treatment centers for children, short and long term care hospitals, university affiliated programs, and psychiatric units in general hospitals which have been separately accredited under the standards for psychiatric programs of the Joint Commission on Accreditation of Hospitals. All of our member hospitals are accredited as hospitals under the Accreditation Program for Psychiatric Facilities of the Joint Commission on Accreditation of Hospitals.

More than half (96) of our member hospitals have fewer than 100 beds and all have fewer than 2,000 annual admissions. It is particularly for this reason that we object strongly to the proposed implementation of SHUR and take extreme exception to the entire concept of a federally mandated, highly costly, and unworkable system of uniform accounting which would treat all hospitals alike regardless of special function and mission. We are, therefore, pleased that you have taken the initiative to hold hearings on SHUR prior to HEW's impending publication of final regulations.

As part of the health care delivery system we are extremely disturbed by any attempt of the government to serve as both judge and jury. The system as proposed would do just that. It would give carte blanche to HEW to amass data, use the data, provide payment, and dictate treatment modality, place of treatment, and provider of treatment. Public Law 95-142, the Medicare and Medicaid Fraud and Abuse Act, Section 19, suggested a uniform reporting system from which data could be aggregated, patterns of care delineated, cost of services established. It called for a system from which cost comparisons could be meaningful. The proposed SHUR methodology would be irresponsible bureaucracy since there has been no validation of the actual costs of implementation. Costs which have been estimated to be well over $100 million, the amount that the Administration said it would consider prohibitive. In this day of cost containment it is ludicrous for the government to be pushing, planning and promoting a program whose cost would have to be passed on directly to patients.

We, the NAPPH, believe that HEW has seriously misinterpreted Congressional intent regarding section 19 of the Medicare/Medicaid Fraud and Abuse Act, and the Congress should, therefore, take action to repeal it. Our reasons are as follows:

(1) The legislation states that a system of reporting be established. It further states that such a system reflect the "variations" of the different classes of facilities and organizations. Upon passage of this legislation this association inquired of the Department as to how to proceed and assist in the accumulation of the data needed to develop a system for uniform reporting, which would be useful and applicable to the small specialty hospital and to the Department as well. It was, and still is, the desire of this association to draft a system applicable to our specific needs which would truly measure services, costs, and efficiencies. To date, and now months past the initial "mandatory" date of implementation, the Department has not yet even

acknowledged our request. Neither has the Department made any gestures to deal appropriately with the small specialty hospital to develop a system which would provide for the "variations in the obligation of the system to different classes of facilities or organizations" as called for P.L. 95-142. Furthermore, in the Department's small pilot project with 50 hospitals, designed to measure the financial impact of implementing the SHUR program, not one hospital in the pilot project was a psychiatric hospital. We feel, therefore, that if the SHUR program is implemented without determining the cost and feasibility of compliance by the psychiatric hospitals, the program would be in clear violation of the intent and explicit working of the law.

(2) Nowhere is it stated either in statute or accompanying report language, that this piece of legislation is designed to bring about the creation of a uniform accounting system for all hospitals. Quite the contrary. The House committee report, House Report 95-393, part 1, page 75, specifically states that this legislation establishes a uniform reporting system with no uniform accounting system envisioned. While SHUR as proposed does not call for a uniform accounting system, it mandates such a detailed, complex, lengthy reporting system that small hospitals would have little choice but to convert their accounting systems to comply with the requirements of SHUR.

(3) SHUR, as proposed, is intended to collect all baseline data and information on hospital costs and then relay such information equally to all interested government agencies dealing with reimbursement, planning diagnostic classifications, manpower needs, etc. This plan is Orwellian at best and would at worse mediocratize the health care delivery system. The intent of the law had no mention of changing or revamping the reimbursement system under Medicare or Medicaid. It was designed to detect fraud and abuse. Such widespread distribution of meaningless data is costly and of questionable value to program management since it will be a distortion of facts. Furthermore, the eventuality that programs will be chose, decided upon, and developed based upon fiscal and financial constraints alone, is frightening. The promotion and sharing of information with multiple government agencies using bottom line figures to determine the appropriateness of services is in direct conflict with any methods of improving quality and patient care.

(4) The manner in which the system is proposed and designed to work would preclude any positive effects. If the intent was the immediate detection of fraud and abuse then the time lapse necessary to amass, assimilate, and distribute the information would render the information useless.

If the intent, as Mr. Schaeffer has said, is to detect waste in government, then penalizing the health care delivery system for mismanagement of the government is heinous.

(5) The system called for by law was not meant to have any impact upon the reimbursement. It was meant purely as a disclosure system. However, the proposed SHUR methodology with its rigid formats would impact upon reimbursement by directing the provider to rearrange his data in a way which curiously tends to reduce current period costs at the expense of future years. This most seriously impacts upon the reimbursement system. For example, the system mandates the capitalization of construction loans interest and demands straight line depreciation as opposed to accelerated methods. It would also cause changes in cost reporting as a direct result of the methods of data gathering. Lastly, functional accounting is not the acceptable method of accounting in the health care industry. The government through the proposed SHUR methodology would change the system from its widely practiced departmental method to functional accounting. The government does not set or establish acceptable accounting standards and should not attempt to do so through the subterfuge of "data gathering".

(6) Lastly, but of no less importance is the effect such a system would have on the small hospital, the small specialty hospital in particular. It has been estimated that the SHUR program would cost 25 to 100 thousand dollars per hospital per conversion. In addition, the cost of monitoring the system gathering the additional information and data will add upwards of $2.00 per patient per day. These are very large numbers to small hospitals.

Futhermore, the regulations as proposed in January, 1979, specified that "we (D-HEW) would allow a less detailed reported to be submitted by hospitals, that, for 3 accounting periods preceeding the reporting period, have had average annual admissions of less than 4,000." To date, we, the small specialty hospitals have neither been consulted nor have we seen any format resembling a less detailed form. Yet, the Department is proceeding with planned implementation.

In recent weeks, the House of Representatives saw fit to overwhelmingly vote to delete any funds within the Labor-HEW Appropriations Bill for the implementation of SHUR. The vote was 306-101 in favor of the amendment. We hope that this

committee through its deliberations will follow through on the intent of Congress as expressed by the vote recently taken.

We thank you for the opportunity to present our views.

UNIVERSITY OF CALIFORNIA SYSTEMWIDE ADMINISTRATION,
OFFICE OF THE PRESIDENT,
Berkeley, Calif., August 15, 1979.

MICHAEL STERN,
Staff Director, Committee on Finance,
Washington, D.C.

DEAR MR. STERN: In April, the University of California reviewed the draft of the manual, System for Hospital Uniform Reporting (SHUR). At that time we stated to HCFA that we were concerned with the impact it would have on our hospital operations. Specifically, we expressed concern with its ability to detect fraud and abuse, the cost of implementation, and the combination of a uniform method of reporting with a uniform method of reimbursement.

The excessive detail required by the SHUR program would have little effect in detecting fraud and abuse, the stated purpose of section 19 of the Medicare-Medicaid Anti-Fraud and Abuse Amendments. Comparative analysis of data accumulated will only identify those significant areas of variation. It will not take into account the differences in operation that exist in each hospital that may contribute to those variations. In addition, fraud and abuse usually result from the concealment of data and comparative data accumulated would do little to detect them.

The implementation of a uniform accounting system as proposed in the SHUR manual would be very costly. The University Hospital system has been actively involved in a program to reduce the rate of inflation in hospital expenditures. The University Hospital accounting system, as now defined, provides management with the necessary information to carry out its tasks that are unique within a teaching hospital. An additional accounting system would have to be developed to meet the requirements of SHUR. The costs involved in developing and maintaining an additional accounting system would greatly increase our costs of operation. The costs of additional staffing and the modification of our data processing system are estimated to exceed $2.5 million during the first year of implementation with annual costs of $1.0 million thereafter. This would be in direct conflict with the President's efforts to curb the rate of inflation within the hospital industry.

The University of California stated to HCFA that it strongly opposes the intended use of the SHUR system to uniform reporting for the purpose of reimbursement under the Medicare-Medicaid programs. Present regulations concerning the delivery of care to the aged recognize the different methods used by each hospital to accurately report its costs. The unique characteristics of each hospital determines the proper method of reporting.

The principles of uniform reporting are not compatiable with those of Medicare-Medicaid reimbursement. Responsibility accounting is the most accurate method of reporting cost of service provided to the aged and comes into direct conflict with the SHUR manual statement that responsibility reporting does not allow for comparability. While we recognize the desire for uniform reporting, we recommended to HCFA a system similar to that of the State of California which acknowledges this distinction and separates a uniform reporting system from a cost reporting system for reimbursement purposes.

We are pleased that the implementation date has been set aside, allowing for a comprehensive analysis. We appreciate this opportunity to state our views.

Sincerely yours,

GEOFFREY V. HELLER,
University Coordinator,
Health Care Legislation.

STATEMENT OF JOHN J. KAVANAGH, M.D. ON THE SYSTEM FOR HOSPITAL UNIFORM REPORTING (SHUR) AS IT WOULD APPEAR TO AFFECT THE TEXAS DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

The implementation cost of SHUR was estimated at between $35 million and $75 million as published in the Federal Register, Vol. 44, No. 16, dated January 23, 1979. This does not seem to recognize the real impact of implementation costs in converting those Medicare Providers which are authorized to apportion costs by the method of "Percentage of Per Diem—Method E" for inpatient services such as the Texas Department of Mental Health and Mental Retardation's nine Medicare pro-

viders. In addition, it appears that unique State entities, such as the Department's 25 State facilities that offer inpatient services for the mentally ill and mentally retarded, and which bill clients on a daily per-diem basis for charges not to exceed cost, also are not recognized in projecting the national estimated implementation costs of SHUR.

The implementation cost for the Texas Department of Mental Health and Mental Retardation and its 25 State facilities is estimated at $8.6 million, or 11.4% of the upper limit of $75 million that has been estimated nationally. Implementation of SHUR would necessitate the following major revisions to the Department's 25 State facilities.

A. Establish a modified patient accounting system to convert billing of charges from a daily per diem basis to SHUR's requirements	$7,280,000
B. Modify existing statistical and accounting systems	1,275,000
Estimated implementation cost	8,555,000

The estimated yearly maintenance cost to maintain SHUR would require an additional 600 employees or $6.5 million annually to provide monitoring of the detail required by SHUR.

As stated in my letter of April 20, 1979, submitted to the Administrator of Health Care Finance Administration, the State budget for fiscal years 1980 and 1981 cannot support the above estimated implementation cost of SHUR or the estimated yearly maintenance cost to maintain SHUR since the Department's 23 State facilities are limited to those expenditures that are authorized in the State budget.

If SHUR is enacted, consideration of various types of cost apportionment and billing procedures similar to those now available under Title XVIII of the Social Security Act—Medicare, Method E, should be allowed, especially for those hospitals (facilities) that are organized by State statues and administered by State funding. This would prevent an additional system from being forced on the taxpayers because of the implementation of a System for Hospital Uniform Reporting (SHUR) which would not improve the care and treatment of the mentally ill or mentally retarded clients or assist in preparing some of them to return to the community.

AMERICAN HOSPITAL ASSOCIATION,
Washington, D.C., August 9, 1979.

Hon. HERMAN E. TALMADGE,
Chairman, Subcommittee on Health, Committee on Finance, U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: The American Hospital Association (AHA) is pleased to submit the following information on the proposed System for Hospital Uniform Reporting (SHUR), pursuant to your request for our comments on the testimony of the General Accounting Office (GAO) on July 26, 1979 before the Subcommittee. These comments supplement our detailed statement on the SHUR, which is enclosed along with our comments to HEW on the SHUR and our anaylsis of the study conducted by Morris, Davis and Company.

AHA is aware that GAO was asked to respond only to specific questions concerning the SHUR rather than to provide a comprehensive analysis of the proposed system. We believe that, because a complete analysis was not undertaken, some of the GAO statements are inaccurate and may lead to erroneous conclusions such as: (1) the proposed SHUR is compatible with the AHA's Monitrend for Hospitals system and the AHA's chart of accounts for hospitals; and (2) implementation of the SHUR would not be costly and burdensome for the nation's hospitals. We believe that these conclusions result from inaccurate assumptions about the nature of the SHUR and the AHA Monitrend system.

THE PROPOSED SHUR AND MONITREND FOR HOSPITALS ARE BASED ON DIFFERENT OBJECTIVES AND ARE QUALITATIVELY DIFFERENT.

GAO implies that there is a great deal of similarity between Monitrend and the proposed SHUR. Although the GAO statement provides a quantitative analysis of the differences and similarities between the two systems (e.g., with respect to the statistical requirements and the numbers of reporting centers), it fails entirely to address two important substantive issues:

1. The purpose and intended uses of each system; and
2. The level of reporting required by each system.

PURPOSE AND USES OF DATA

The major unresolved issue regarding HEW's use of the proposed SHUR is the intent of the Congress in enacting Section 19 of Public Law 95-142. GAO has commented that Section 19 "was enacted to deal with the problem of variations in the information presented in Medicare and Medicaid cost reports" and 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." GAO further recognizes that the SHUR as proposed "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 we have made clear in our full statement, it is AHA's understanding that the SHUR was intended to be a system to identify certain cost related information and other statistical data in order that the Congress could develop effective cost and policy analysis, the assessment of alternative reimbursement mechanisms, and to evaluate, in certain situations, efforts to control fraud and abuse. It is apparent that the major difference between the view of HEW and GAO and that of the industry pertains to the use of a Section 19 as a basis for drastically modifying Medicare reimbursement based upon information reported by the SHUR.

It is this difference that GAO fails to appreciate in comparing the SHUR to the AHA's Monitrend for Hospitals system. Monitrend is a form of uniform reporting designed to accomplish certain limited and specific purposes. These purposes, as correctly identified by GAO in its statement, are: measurement of productivity and financial trends; assessment of policies, procedures, and utilization with respect to operating performance; establishment of an ongoing monitoring mechanism, evaluation of budgets; and reinforcement of decision-making. It should be noted that this list does not suggest that the data are useful for reimbursement activities, which indeed they are not. In no way can information provided by the program be used to establish cost bases for reimbursement, which is the function of cost finding. Cost finding considers each institution's configuration of services, community needs, environmental constraints, and economic circumstances. Because Monitrend is designed as an internal management tool, the criteria for data collection and the methodology for presenting the data to client hospitals are tailored to the objectives of the program.

For example, Monitrend uses the median as a measure of central tendency rather than the mean or the mode because the median is less affected by extremes of data. For some indicators, the monthly report shows the difference between an individual hospital's performance and a selected median in order to provide a quantitative estimate of what it means to be significantly different from the median. These calculations provide hospital management with a meaningful way of identifying areas which may need further evaluation. They do not provide a definitive basis for specific management decisions. Monitrend seeks to ensure that the information collected is used properly by hospital management. Various Monitrend reports and publications repeatedly stress two basic principles:

1. As a measurement tool, the Monitrend report should be used as a yardstick rather than a micrometer. This principle is incompatible with the use of such data for reimbursement and financial purposes.

2. The median data provided by the Monitrend report are reference points, not standards or goals. Again, the emphasis is on management guidance rather financial decision-making.

Because the purpose and uses of data for Monitrend are substantially different from those of the SHUR as proposed, the data collection burden and the required level of reporting for the two system are substantially different as well.

DATA COLLECTION AND THE REQUIRED LEVEL OF REPORTING

GAO, in comparing the proposed SHUR to the existing Medicare cost reporting system, notes that the SHUR will impose only 12 new forms. In making this comparison and in comparing SHUR to Monitrend, GAO has failed to consider the detail required by these forms and the burden they will impose on hospitals to reclassify their data according to the extensive and restrictive chart of accounts which accompanies the SHUR forms.

GAO states: "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." In so stating, GAO fails to recognize that, based upon instructions contained within the proposed SHUR, a hospital without a discrete coronary care unit would have to

reclassify costs which are not maintained on a discrete basis into the discrete cost centers of SHUR. Hospitals which would not so reclassify such information would skew the SHUR reports, thereby diminishing the comparability of the data. This reclassification, dictated by the level of reporting under the SHUR would be both time consuming and costly. GAO is, therefore, incorrect in stating that these circumstances would diminish the burden of the proposed system.

By contrast, data collection for Monitrend is closely linked to the purposes of the program. Reporting center categories are kept as broad as is consistent with the provision of meaningful overall management information. The AHA's 20-year experience with management information systems has demonstrated that the fragmentation of reporting centers, and the concomitant reclassification of expenses this entails, increases disproportionately the cost of participation in the system with respect to any benefits to be derived from greater detail. The GAO statement notes that the SHUR includes 58 functional centers related to patient services. Monitrend uses only 32 centers for this activity. In this single area, the SHUR proposes 81 percent more reporting centers.

Monitrend collects 44 different activity statistics, three of which are considered unsuitable for comparative purposes and two of which are alternative statistics for the same centers. The statistics are designed to provide broad activity measurement for purposes of overall assessment and monitoring trends within discrete centers. Although AHA chose its statistics very carefully over a period of years, the statistics vary in the degree to which they adequately measure departmental activity. This requires the user of Monitrend data to be knowledgeable about their limitations when performing an analysis. It should be noted, too, that AHA has examined many other statistical bases, some of which are now proposed in the SHUR, and rejected them for purposes of uniform reporting as invalid, unrealistic or too costly to collect.

To date, HEW has not demonstrated the benefits that will be derived from the detailed level of reporting required by the SHUR. By contrast, Monitrend places very strict and limited criteria on the data it collects and then cautions users against attempting to apply them too narrowly. Clearly, Monitrend and the SHUR contemplate different purposes and uses of the data, given this difference in the level of reporting. The two systems are different in kind and not simply in degree.

AHA'S CHART OF ACCOUNTS DIFFERS IN PURPOSE FROM THE SHUR CHART OF ACCOUNTS

In comparing the AHA chart of accounts to that mandated by the SHUR, GAO has failed to examine the fact that the AHA chart is only a suggested structure for hospital accounting. It is not an integral part of Monitrend or any other management information system, nor is it the basis for Medicare cost reporting. It serves only to assist hospital management in designing an accounting system to meet the particular needs of each institution. By contrast, the SHUR chart of accounts would be mandated and therefore restrictive of management discretion. It would be intended to serve the broad and detailed requirements of the proposed SHUR. GOA's suggestion of similarity between the two charts is incorrect and misleading.

GAO DID NOT CONSIDER THE FULL IMPLEMENTATION COSTS OF THE SHUR

Finally, while the GAO review of the cost of implementing the SHUR notes that there may be some problems with the Morris, Davis cost estimate study, GAO did not identify or comment on the fact that the study failed to consider the cost of government processing, storage, retrieval, analysis, and sharing of the SHUR reported data. Obviously, the handling of this information would be costly, and we believe that GAO should have considered these cost factors in its report.

Mr. Chairman, this concludes or comments. We appreciate this opportunity to present our views on the GAO testimony, the proposed System for Hospital Uniform Reporting and the Morris, Davis report.

Sincerely

LEO J. GEHRIG, M.D.,
Senior Vice President.

[The GAO response to the AHA letter above appears as an appendix on p. 157.]

STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION

The American Hospital Association (AHA) is pleased to present its views with respect to the proposed implementation of the System for Hospital Uniform Reporting (SHUR). The AHA represents over 6,100 member hospitals and health care institutions, as well as more than 30,000 personal members.

The AHA has major objections to the SHUR. Most of the Association's members participate in the Medicare and/or Medicaid program of the federal government.

Therefore, they are subject to the rules and regulations of the agencies administering these programs, and would be subject to the SHUR requirements. On behalf of the institutions which must bear the burdens of the SHUR program, AHA has participated in the development process of the SHUR by presenting the recommendations, concerns, and objections of the hospital industry to HEW.

Recently, AHA staff had discussions with representatives of the Health Care Financing Administration (HCFA) to review our specific recommendations for modifying the SHUR that are intended to reduce its burden and cost and to resolve other serious problems. At this meeting, HCFA staff indicated a willingness to make minor revisions in the proposed manual, but we have not received a reply to our subsequent written request for the details of the planned changes.

Thus, we are not in a position to evaluate the changes that may be made, but we are concerned that many of the problems specified in our statement today have not been satisfactorily dealt with. A prime example—and an area of continuing disagreement with the Department—is the fact that this proposal would make major changes in the Medicare hospital reimbursement system. We would be pleased, of course, to provide the Subcommittee with our analysis of a revised SHUR manual when it is available. We would now like to review for you the problems we anticipate the proposed program would create for hospitals throughout the country and for Medicare.

AHA's objections are not aimed against the development of a system for hospital uniform reporting. In fact, AHA has supported, and continues to support, the concept of uniform reporting by health care facilities. However, the HEW proposal goes far beyond the concept of a uniform reporting system. As a regulatory change that would impose sweeping modifications and duplications on existing hospital accounting practices, the SHUR would force the use of uniform accounting systems for thousands of hospitals, regardless of their individual management needs. HEW does not disguise this intention—the SHUR manual explicitly states that the system is: "*a uniform accounting* system incorporating the chart of accounts, definitions, principles and statistics required by the Secretary to be used by hospitals to reach the uniform reconciliation of financial and statistical data necessary for uniform reporting under this act." [Italic added.]

The proposal is particularly inappropriate because it is ill-conceived and impractical, and because it is inconsistent with Congressional intent. In addition, the SHUR would impose tremendous and unwarranted costs upon the hospital industry.

Our principal objejections to the SHUR, which were presented to HEW in our detailed comments of April 20, 1979, are summarized below. (A copy of our complete regulatory comments accompanies this statement.)

SHUR WOULD IMPOSE TREMENDOUS COSTS

While estimates on cost of implementation of the proposed system vary, there is no doubt that those costs would be well in excess of $100 million on an industrywide basis.

A demonstration project contracted for by HCFA with a private accounting firm was conducted in 50 hospitals to estimate the cost of compliance with the SHUR. The project was seriously flawed in its methodology, resulting in unreliable conclusions. For example, in no case was the proposed SHUR system installed in a test hospital and the actual cost to the hospital determined. While HCFA's extrapolated cost from the study is $65.6 million, the accounting firm which undertook the project admitted in the study report that its figures could be understated by as much as 50 percent. Our analysis of the cost of implementing the SHUR, a copy of which is enclosed, concludes that the cost would be approximately $180 million, or three times HCFA's estimate. Despite these indications of economic costs in excess of $100 million, HCFA has failed to perform the full economic impact analysis required by Executive Order 12044.

Presently, the results of the HCFA study have been compiled for only 44 of 50 study hospitals. AHA has, in discussions with the remaining six hospitals, ascertained that the cost of implementing the SHUR in these facilities is considerable. One has estimated costs in excess of $300,000. The omission of these hospitals from the results reported by HCFA appears to be highly prejudicial to the accuracy of these results.

SHUR WOULD FAIL TO DEFINE THE USE AND USERS OF DATA

The extensiveness of the information requirements of the SHUR manual has been of great concern to the hospital industry. The reporting system, as developed at this time, is designed to assemble an enormous amount of data for purposes yet to be defined—apparently with the expectation that when the data needs are eventually

defined the requisite information will be available. We believe this is an extremely wasteful approach. It is important that the purposes to be served by the reporting system be decided before selection of the data elements.

AHA also objects to implementing the SHUR proposal because of the failure of the Medicare Bureau and HCFA to develop adequate information systems to use existing information in cost reports filed by all providers participating in Medicare. For example, the Medicare Bureau was asked by AHA in 1977 to provide the Association with information concerning the components of each hospital's inpatient routine service costs. The Medicare Bureau advised AHA that it was unable to do so. While the Medicare Bureau had the information in the form of hard copy (i.e., complete cost reports), the information had not been entered into a management information system. There is no value to be gained by reporting information that would merely be buried in the files unused.

Before any attempt is made to implement the SHUR, HCFA should first develop the necessary systems to capture and utilize existing Medicare cost report information, then develop systems for additional SHUR data. We believe that a substantial amount of valuable information is presently contained in the Medicare cost reports. If HCFA would develop this source of information, many of the SHUR requirements would be unnecessary.

SHUR WOULD RESULT IN A REQUIREMENT OF UNIFORM ACCOUNTING

The Medicare/Medicaid Anti-Fraud and Abuse Amendments of 1977 provide no statutory basis for HEW to require the imposition of a uniform hospital accounting system.

The legislative history of P.L. 95-142 further demonstrates that Section 19 was not intended to provide for such a system. The report of the House Committee on Ways and Means on that legislation does not mandate a uniform accounting system, but instead, states the following:

"Although proposals have been made to require uniform accounting as well as uniform reporting, *the bill does not mandate a uniform accounting system.* Your Committee was not prepared to conclude that a uniform accounting system is necessary in order to generate the required comparable data. Your Committee is inclined to believe at this time that the uniform reporting system, with specific documentation for the reported costs as part of the organization's accounting system is sufficient * * *."[1] [*Italic* added.]

In direct contravention of legislative authority, the SHUR manual makes it clear that what is intended is a uniform system of accounting. It states that, "in developing a uniform accounting system, it was recognized that the system must provide the data necessary to support management and the different regulatory system, cost allocation systems, disclosure requirements and state reporting requirements which exist." The manual further states that the purpose of the uniform accounting system is to "provide a common standard of measurement and communication through the use of uniform (accounting) principles.[2] The implication of these references to accounting is, of course, that a uniform accounting system is necessary in order that uniform reporting be achieved. AHA believes, to the contrary, that a uniform accounting system is not necessary and should not be required as a basis of uniform reporting.

SHUR WOULD RESULT IN INEQUITABLE MEDICARE REIMBURSEMENT

Our most serious objection to the proposed SHUR is HEW's intent to base provider reimbursement on the SHUR. The objection to requiring that the Medicare payment system be based upon the uniform reporting system stems from the fact that the key principles of one are different and incompatible with those of the other. Medicare's basic reimbursement requirement is to pay reasonable costs for program beneficiaries. The basic reporting principle being pursued is uniformity. If uniformity becomes the determining factor, equity and accuracy in reimbursement would be sacrificed.

Medicare reimbursement: Medicare was enacted in 1965 to meet the growing problem of providing services to the aged. A fundemental principle of the program is that Medicare should pay all costs of program beneficiaries and none of non-beneficiaries. To determine such costs, HEW, over the last fifteen years, has developed and is continuously refining (often with solicitation of industry comment), a system of cost accounting and reporting for payment purposes which recognizes differences among hospitals and their approach to delivery of care. This approach

[1] H.R. Rep. No. 95-393, Part 1, 95th Congress, 1st Session 75 (1977).
[2] Draft SHUR Manual, p. 0.2.

has two benefits. First, it is generally consistent with the internal accounting performed by hospitals to manage, control, and report hospital operations. Second, and most important, it is designed to assure that the costs of services provided are fairly and accurately determined.

Uniform reporting system: A uniform reporting system implies by its very name that reports are, or should be, standardized. The primary purpose of the SHUR as conceived by Congress, is to achieve comparability of defined data elements relating to defined functional activities. In the process, differences between hospitals and their operations would be ignored.

Therefore, the flexibility and accuracy of the Medicare cost reporting system is not compatible with the standardization and rigidity of any uniform reporting system. Better comparability of data through uniform reporting does not in all cases result in a more accurate determination of the cost of services provided to program beneficiaries. Thus, in combining a reporting and a reimbursement system, the objectives of one or both must, of necessity, be compromised in the system design.

An important discussion of these issues in the context of Section 19 took place during the 1977 joint hearing in the House of Representatives before the Subcommittee on Health of the Committee on Ways and Means and the Subcommittee on Health and The Environment of the Committee on Interstate and Foreign Commerce. In presenting testimony at those hearings on H.R. 3, we voiced concern that: "the proposed amendments * * * suggest that the Secretary of Health, Education and Welfare could change [such] reimbursement in any way he chooses, and then require all hospitals to enter into arrangements with Blue Cross and private insurers, as well as with Medicare and Medicaid, that adhere to the reimbursement approaches designed by the Secretary."

At this point in the testimony, Representatives Paul Rogers (then Chairman of the Subcommittee on Health and The Environment, the cosponsor of H.R. 3) interrupted to say:

"May I point out here that you have misread the bill. I don't think there is any authority to have the Secretary back that up, either to change reimbursement * * * [sic][3]

It is evident that the cosponsor of H.R. 3 did not intend that the implementation of a uniform reporting system would result in reimbursement policies and procedures.

THE SHUR REIMBURSEMENT ISSUE

The American Hospital Association is opposed to HEW's proposed use of the SHUR to redetermine Medicare reimbursement. Medicare has allowed hospitals to use either the basic suggested method or alternative methods of cost finding if the alternatives yield more equitable and accurate determination of Medicare and non-Medicare costs. This flexibility to use alternative methods recognizes legitimate differences between institutions. In order for Medicare to ensure that such alternative mechanisms actually result in a more accurate determination of Medicare costs, HEW requires each hospital to demonstrate to the satisfaction of its fiscal intermediary the purpose and result of its alternative system prior to its usage. If an intermediary is not satisfied with the hospital's methodology, acceptance and approval will not be granted.

We were recently informed by the staff of HCFA that the proposed SHUR would nullify all existing alternative mechanisms of determining Medicare cost. We believe serious inaccuracies of payment will occur if such policy is adopted and the procedures that have been carefully developed and approved since 1965 are arbitrarily discarded.

There is precedent for recognizing the legitimate differences between the information requirements presented in financial reports and determination of costs for reimbursement purposes. This is reflected in a letter dated May 1, 1979, which we received from Mildred Tyssowski, acting director of the Medicare Bureau, in answer to a letter the American Hospital Association submitted in response to a notice of final rulemaking concerning Medicare's treatment of gains and losses or disposal of depreciable assets. To quote:

"Your key comment that portions of our amendments conflicted with generally accepted accounting principles (GAAP) arises from a divergence of objectives that should be identified. *The purpose of GAAP is to present financial statements in a manner consistent with standards and principles generally accepted by the accounting community as presented by the American Institute of Certified Public Account-*

[3] Joint Hearings before the Subcommittee on Health of the House Committee on Ways and Means and the Subcommittee on Health and The Environment of the House Interstate and Foreign Commerce Committee, 95th Congress, 1st Session, 226 (1977).

ants and its associated organizations. They were not developed with the objective of serving as a basis for third-party reimbursement. Medicare reimbursement principles, on the other hand, were developed to reimburse providers for the reasonable cost of services covered under Title XVIII of the Social Security Act which are related to the care of Medicare beneficiaries. The timing of this reimbursement and the determination of cost are not necessarily consistent with GAAP.

"Since the basic objectives are different, many costs correctly presented on certified financial statements may not be allowable as costs under the Medicare program if they are determined to be not reasonable or not related to patient care. Other costs such as demolition and abandonment losses are reimbursed by Medicare over a time frame different than that which may be used under GAAP in order to prevent possible reimbursement abuses." [Italic added.]

It is clearly evident from this correspondence that reimbursement principles for the determination of Medicare payment can be and are different from information requirements presented to certified financial reports. We believe this philosophy must be carried forward into the SHUR.

We would like to emphasize further the reasons that the SHUR should not be used for reimbursement purposes. The SHUR would force a restriction and/or compression of approved hospital cost centers to a very rigid and prescribed set. This action would result in a loss of data elements for many institutions and create a payment system that would not accurately reflect the true nature and scope of services being provided to Medicare and non-Medicare patients.

For example, the SHUR would require hospitals to report all laboratory services in only two cost centers, clinical laboratory and other laboratory. This would distort activities of teaching and tertiary care facilities which may be accumulating costs and statistics for different types of laboratory services (i.e., anatomical pathology, hematology, cardiology, pulmonary, clinical, and general laboratory). These facilities are presently collecting cost and statistical data which permit a greater level of detail and accuracy for distributing the cost of these services to the users than would be permitted by the SHUR. The SHUR would result in a serious loss of accuracy in determining Medicare payments to such institutions.

Similarly, the SHUR would restrict the allocation of hospital administrative and general expenses to four cost centers. Medicare currently permits hospitals to recognize six cost centers in determining their administrative and general expenses. They are: admitting; electronic data processing; accounting; nonpatient telephone; purchasing, receiving, and stores; and all others. The SHUR report would compress these cost centers into admitting, accounting, insurance, and all others. In the accounting center, for example, the SHUR would combine costs of patient accounting, crediting and collections, cashier and admitting, emergency room registration, clinic registration, etc., into one cost center and would allocate the total based on gross patient revenues. Why should such a method of allocation be required if an institution knows the actual direct cost of each of the components and can allocate them on the basis of actual cost rather than the surrogate gross patient revenues? A required change from six to four cost centers would mean there would be less sensitivity to important differences in local conditions and thus result in less accurate and equitable payment.

Another reason that the SHUR should not be used for reimbursement purposes is that comparability of SHUR data would be impaired. Comparability of financial information generally depends on like events being accounted for in the same manner both between periods for a single enterprise and between two or more enterprises. The proposed SHUR system would permit comparability between years for a single hospital only if the definitions of data elements remain unchanged from year to year. Recent Medicare reimbursement changes related to renal dialysis, malpractice, and other items have altered the data required for payment purposes. Further, HCFA recently indicated that, as a result of a reimbursement change, malpractice insurance expense will no longer be reported in the administrative and general cost center, but rather, in accordance with a reimbursement procedure. In this instance, and in others cited previously, linkage of the SHUR and Medicare reimbursement system would require that every time Medicare changes its payment policy or its regulations, a similar change to the SHUR would have to be made. Such changes would make it practically impossible for the SHUR to gather comparable data between years without adjusting prior years' data—a very costly process. Thus, the principle of the SHUR—comparability of hospital reported elements for different periods—would be thwarted.

CONCLUSION

In summary, the development of the SHUR to date has involved very serious problems and has produced a proposed system that would be unnecessarily burden-

some and costly. Despite discussions with representatives of HCFA, critical issues of concern to hospitals have not been resolved. Therefore, we wish to recommend a series of steps we believe to be necessary in the further development of the SHUR during Fiscal Year 1980, in line with the actions taken by the House and Senate during consideration of the Labor/HEW appropriations bill for that year. They are:

(1) The proposed SHUR manual should be revised and published for additional public comment through another notice of proposed rulemaking;

(2) HCFA should undertake a cost analysis of the revised manual, including an evaluation of the actual costs of implementing the reporting system in selected hospitals;

(3) Provision should be made for separate publication and evaluation of any proposed changes to Medicare reimbursement policies or procedures in a manner consistent with past practices for making such payment changes; and

(4) Continuing authority should be provided to Medicare fiscal intermediaries to grant flexibility in cost reporting determined to result in more accurate and equitable identification of the reasonable costs of services to Medicare beneficiaries.

We wish to commend the Subcommittee for initiating this inquiry into the implementation of the SHUR system, and appreciate this opportunity to present our views.

Statement of the American Hospital Association

To the
Department of Health, Education
and Welfare

on

Proposed Uniform Reporting
Systems for Health Services
Facilities and Organizations

April 20, 1979

Headquarters
American Hospital Association
840 N. Lake Shore Drive
Chicago, Illinois 60611

Washington Office
444 N. Capitol Street N.W.
Suite 500
Washington, D. C. 20001

For Further Information Contact:

Robert J. Flanagan(312)280-6626/Richard L. Epstein 280-6641
Lawrence S. Goldberg 280-6170/Lawrence A. Manson 280-6670
Lee J. Epstein 280-6168/Laurie A. Bookstein 280-6659

AMERICAN HOSPITAL ASSOCIATION
840 NORTH LAKE SHORE DRIVE CHICAGO, ILLINOIS 60611 TELEPHONE 312-280-6000

April 20, 1979

Mr. Leonard Schaeffer
Administrator
Health Care Financing Administration
Department of Health, Education and Welfare
P.O. Box 2382
Washington, D.C. 20013

Reference: HEW Proposed Uniform Reporting Systems for Health Services Facilities and Organizations, January 23, 1979 (44 FR 4742).

Dear Mr. Schaeffer

The American Hospital Association (AHA) appreciates the opportunity to submit the enclosed comments on the Proposed Uniform Reporting Systems for Health Services Facilities and Organizations (SHUR) regulations. In view of the position taken, both formally and informally, by the Health Care Financing Administration (HCFA) on the desire of HCFA to receive helpful and thorough comments on the proposed SHUR, AHA's comments reflect the concerns and the specific objections and recommendations of the hospital field with respect to the SHUR proposal.

The hospital field objects to the SHUR as proposed in several major ways. First, the SHUR proposal has been improperly developed. That is, the purposes and objectives of HEW in establishing SHUR are not at all clear. The Notice of Proposed Rulemaking describes the objective of SHUR as a uniform system of cost reporting while, in contrast, the SHUR manual provides for a uniform accounting system. Over the years, through many discussions with HCFA and other agencies, AHA was given to understand that a system was being established for health care institutions to report certain information in a uniform manner and not for the imposition of uniform accounting. Requiring hospitals to adopt a uniform system of accounting is inappropriate and beyond the law. Moreover, its implementation would impose enormous additional costs for the industry and for the government, both of which are already unreasonably burdened.

CABLE ADDRESS AMHOSP

Further, because of HCFA's failure either to identify who will use the information sought by the proposed SHUR, or the uses to which such information might be applied, there has been no attempt to demonstrate what benefit will be provided by such a costly undertaking.

In addition, HEW's failure to determine such costs and benefits prior to issuing the proposed SHUR contravenes the important requirement for a regulatory analysis provided in Executive Order 12044. These concerns, and others discussed more extensively in our comments, are not only those of the hospital industry; several members of the Congress are equally concerned with the effect, propriety and usefulness of this 600-page manual.

The attached comments were developed prior to AHA's receipt of the cost study conducted by an accounting firm through the award of an RFP. Our staff is now analyzing the results and findings of the study. We do, however, have several preliminary observations:

- There is a substantial flaw in the method by which the total cost of implementing the SHUR as proposed was measured. The total implementation cost cannot be measured (as some persons, including a member of your staff, have suggested) by multiplying the reclassification average by the total number of health care institutions to which the SHUR as proposed would apply. To do so is statistically invalid. For instance, it would not give appropriate treatment to the number of hospitals contained in the study which are at present already subject to uniform reporting in their respective states. Of the hospitals included in the study, 32 percent are located in states requiring uniform reporting, while only 20 percent of the hospitals nationally are located in states which require uniform reporting. Therefore, the average results with respect to total implementation costs reflect a significantly lower and therefore inaccurate dollar amount.

- The results of the study also reveal a tremendous range of costs in implementing SHUR as proposed. The reported size of the standard deviation further supports that a simple average is not a valid determinant of the total cost of implementing SHUR.

- The report also indicates that hospitals will most likely use a combination of simple reclassification entries and a partial conversion to certain SHUR requirements on a day-to-day basis. Using such an approach, according to the report of the study, suggests an average cost of $17,500 per hospital. As stated

above, this simple average cannot and should not be used alone as a basis for determining total compliance with SHUR in its proposed form, as it is not a statistically valid base for extrapolation of the universe total cost.

- The report also notes that the accounting firm's contract did not include the costs to government and fiscal intermediaries and others in its determination of the cost of implementing SHUR. It would appear, therefore, that the total cost of implementing SHUR as proposed is greatly in excess of that which is implied by the study.

AHA recognizes that the study report may offer a basis by which some of the problems of incompatability between the proposed SHUR and present accounting systems may be mitigated, and perhaps that the suggestions made could provide a new starting point for the hospital field and HCFA to resolve our major differences concerning the SHUR proposal.

In the past, you and other representatives of HCFA have indicated to AHA and other organizations what appeared to be a genuine willingness to modify the system as proposed, and to do so in a manner that would take into account and indeed reflect the results of the study, the comments of the hospital industry and those of other interested groups. AHA looks forward to meeting with you and your staff to begin this new process. Accordingly, we would urge you to postpone any final rulemaking until thorough discussions have been conducted and full reconsideration is given to the entire proposal.

Very truly yours

Robert J. Flanagan, Jr., D.B.A.
Vice President

Richard L. Epstein, Esq.
Vice President

TABLE OF CONTENTS

AMERICAN HOSPITAL ASSOCIATION COMMENTS ON DHEW PROPOSED UNIFORM REPORTING SYSTEMS FOR HEALTH SERVICES FACILITIES AND ORGANIZATIONS

I. INTRODUCTION

The American Hospital Association (AHA) submits these comments in response to the HEW Notice of Proposed Rulemaking (NPRM) for Uniform Reporting Systems for Health Services Facilities and Organizations, published January 23, 1979 at 44 FR 4742, as well as the latest draft manual issued by the Health Care Financing Administration (HCFA) entitled System for Hospital Uniform Reporting (SHUR) dated September 29, 1978.

The proposed rules, intended to implement certain provisions of Section 19 of P.L. 95-142, the Medicare and Medicaid Anti-Fraud and Abuse Amendments of 1977, would govern the reporting of cost-related information by hospitals participating in the Medicare or Medicaid programs. These rules purport to prescribe a uniform manner by which the information is to be reported. It is the SHUR manual which sets forth the details of the system being proposed.

The American Hospital Association has major objections to the SHUR proposal. Most of AHA's 6,400 member institutions parti-

cipate in the Medicare and/or Medicaid programs of the federal government. As such, they are subject to the rules and regulations of the agencies administering these programs, and would be subject to the SHUR requirements. On behalf of the institutions which must bear the unsupportable and unnecessary burdens of the SHUR program, AHA has participated in the development of the SHUR program by presenting the concerns, objections, and recommendations of the hospital industry to HEW. Unfortunately, HEW has not accepted the position of the hospital industry in developing SHUR, and AHA will continue to oppose the direction HEW has taken on this issue.

AHA's objections are not with regard to development of a system for hospital uniform reporting. In fact, AHA has supported, and will continue to support, the concept of uniform reporting by health care facilities. But the HEW proposal goes far beyond the concept of a uniform reporting system. In a regulatory change that would impose the sweeping replacement of existing hospital accounting practices, SHUR would result in uniform accounting procedures for thousands of hospitals. HEW makes no attempt to disguise this intention--the SHUR manual explicitly admits that it provides:

> a uniform accounting system incorporating the chart of accounts, definitions, principles and statistics required by the Secretary to be used by hospitals to reach the uniform reconciliation of

> financial and statistical data necessary for uniform reporting under this act.[1] [Emphasis added.]

Through this proposal, HEW would impose tremendous and unwarranted costs upon the hospital industry. The proposal is particularly inappropriate because it is ill-conceived and impractical, because its impact has not been properly investigated as required by Executive Order 12044, and because it is inconsistent with Congressional directives. For these and other reasons which are discussed below, AHA objects to the SHUR as proposed and urges that the NPRM be withdrawn. No new proposal incorporating a uniform accounting system should be issued. Moreover, the entire reporting system needs much further study and development before uniform reporting is implemented in the over 6,000 hospitals to which such a system would apply.

AHA comments on the proposal are grouped into four major sections. Section II discusses the development of the SHUR proposal; Section III presents AHA's major objections to SHUR as presently proposed; Section IV addresses technical aspects of the proposal; and Section V describes an alternative approach to a uniform reporting system that would embody the statutory requirements of Section 19.

---

[1] The HEW draft manual entitled System for Hospital Uniform Reporting, dated September 29, 1978, page 0.2.

II. HEW'S PURPOSE: SHUR AS A UNIFORM SYSTEM OF ACCOUNTING

A. Conflicting Statements of HEW Objectives

The fundamental disagreement between HEW and the hospital industry concerning the 600-page SHUR manual is the purpose of this massive undertaking. Hospital industry representatives have asserted that practical considerations and statutory authority provide only for the development of uniform reporting--yet actions by HEW reveal that, as a prerequisite to implementing a system of uniform reporting, HEW is imposing uniform cost accounting on hospitals. While HEW statements conflict on the objectives of the proposal, these inconsistencies do not obscure HEW's intention to implement uniform accounting.

The preamble to the SHUR NPRM describes SHUR's intentions as limited to uniform cost reporting:

> The proposal requires all hospitals participating in the Medicare or Medicaid program to report cost-related information in a prescribed uniform manner. It implements certain provisions of Section 19 of the Medicare/Medicaid Anti-Fraud and Abuse Amendments (P.L. 95-142). The purpose is to obtain comparable cost and related data on all participating hospitals

> for reimbursement, effective cost and policy analysis, assessment of alternative reimbursement mechanisms and health planning.[2]

The NPRM preamble also states that the SHUR manual "also contains a detailed, functional chart of accounts which must be used to reconcile a hospital's internal books and records in order to file the SHUR report."[3] However, according to the preamble, "the chart of accounts would not be required as the hospital's day-to-day accounting system. In order to avoid duplication, and to be consistent with Section 1861(v)(1)(F), this draft manual would incorporate the current federal cost report required for Medicare and Medicaid."[4] [Emphasis added.] Thus, according to the quoted HEW statements of purpose in the NPRM, the proposal would appear to require simply a detailed uniform reporting system.

In conflict with the NPRM language, however, the SHUR manual makes it clear that what is intended is a uniform system of accounting.[5] The introduction to the manual explicitly admits

---

[2] 44 FR 4742. The proposed rule would require all Medicare and Medicaid hospitals to report on the costs of their operation and the volume of their services, both in the aggregate and by functional accounts. It would also require hospitals to report their capital assets. The draft SHUR manual sets forth the definitions, principles, and statistics to be used in preparing and submitting the reports.

[3] 44 FR 4742.

[4] 44 FR 4742.

[5] The NPRM preamble states that the proposed regulation does not set forth the details of the SHUR but that these are contained in the SHUR manual: "It merely sets forth the basic reporting requirements and the provisions for public disclosure of SHUR information. The details of the reporting requirements, including forms and instructions, are contained in the SHUR manual which is also available for public comment." 44 FR 4742.

that the manual provides a uniform accounting system.[6] The manual states that:

> the purpose of the uniform accounting system is to provide a common standard of measurement and communication through the use of uniform: (1) reporting principles, (2) classification system which identifies costs by cost center by the nature of costs incurred and revenues by revenue center by patients and payor sub-classifications, and (3) statistical and service data definitions.[7] [Emphasis added.]

While the manual's introduction states that the SHUR accounting system has been developed for use by hospitals either as their day-to-day accounting systems or to reconcile their internal accounting systems with the uniform reporting requirements, the foregoing demonstrates that hospitals will have to convert their systems to the "recommended" accounting system or support the cost of two entirely separate systems. In practice, hospitals would be forced to convert to an entirely different accounting system at enormous cost.

AHA objects to this HEW objective of imposing a uniform system of accounting on the hospital industry. AHA's objections are based both on practical considerations and the belief that HEW is exceeding statutory authority as provided in Section 19 of P.L. 95-142. Another major objection to the proposal is the tremendous costs involved in implementing the SHUR as proposed, particularly when the intended countervailing benefits are unproven

---

[6] Refer to discussion in Section III D.

[7] Draft SHUR manual, p. 0.2.

and even undisclosed. AHA also opposes the SHUR proposal in that it would combine uniform reporting with Medicare or Medicaid reimbursement. That objection is based upon the practical problem that the two systems, uniform reporting and reimbursement, present incompatible principles.[8]

B. HEW's Purpose Demonstrated in the Proposal's Development

In recent years, AHA has initiated meetings and discussions with staff of the Office of Research and Statistics (ORS) of the Social Security Administration (SSA) to discuss the Administration's efforts to devise and implement a uniform reporting system for health care facilities. In February 1976 AHA met with ORS to discuss not only the government's efforts to develop a uniform reporting system, but also to discuss how that system would relate to various accounting techniques. Thus, from the outset, HEW has received the hospital industry's position on the reporting-accounting issues.

In April 1976, AHA received a first request from HEW/SSA for an official response to its draft proposed system. AHA responded in May 1976 that an accounting system which lacks flexibility when applied to a variety of institutions cannot be implemented without impairing management and accounting innovation.[9] AHA emphasized

---

[8] See also Section III below.

[9] See Appendix 1.

the importance of flexible accounting systems and noted that such flexibility is a requisite for the wide diversity, scope and complexities of health care institutions.

AHA met with HEW staff again early in 1977 and the result of this meeting was an agreement that a uniform accounting system is not only costly, but also unnecessary as a prerequisite for the reporting of various uniformly determined cost data. Therefore, AHA understood that HCFA would devise a uniform reporting system without requiring uniform accounting as well.

AHA supported this principle in a letter dated July 14, 1977 to Mr. Grant Spaeth, Deputy Assistant Secretary of HEW,[10] and reaffirmed its agreement with HCFA in a subsequent letter on October 3, 1977.[11] Thereafter the basis of this understanding was carried forth in the enactment of Section 19 of P.L. 95-142,[12] which authorizes the Secretary to establish "a uniform system for the reporting by a facility of. . . [certain] information. . ."[13]

Therefore, the concept of uniform reporting as understood between HCFA and AHA was consistent with that embodied in the statutory

---

10 Appendix 2.

11 Appendix 3.

12 42 U.S.C. §1320a et seq.

13 42 U.S.C. §1320a(a).

framework of the Medicare/Medicaid Anti-Fraud and Abuse Amendments of 1977.[14] [15]

One of AHA's activities over the several months following the issuance of a March, 1978 draft manual was to urge HEW to undertake a demonstration project to assist in the determination of what SHUR would cost to implement. AHA stressed that such a project should be undertaken because of the disparity between estimates of the HCFA and those of AHA.[16]

Convinced of the value of such a project and making plans to undertake it, HEW, nevertheless, persisted in its efforts to

---

[14] 42 U.S.C. §1320a.

[15] Since that time, AHA has continued to provide information to HEW's Office of Policy, Planning and Research (OPPR) in its efforts to develop the system envisioned by Section 19. Section 19 of P.L. 95-142 requires the development of an appropriate uniform reconciliation system--a system to be used by the provider to report from the hospital's individual accounting method the uniformly required information. However, preliminary drafts of the manual developed by OPPR demonstrated that HEW efforts were directed toward devising a uniform accounting manual.

AHA objected to those drafts, primarily because the manual was predicated on the development of a mandatory uniform accounting system as a prerequisite to any reporting system. (See Appendix 3.) In addition, the accounting manual was designed to support a reporting system that had as yet been undeveloped.

In March 1978, a new draft of the manual was released. This draft, entitled System for Hospital Uniform Reporting (SHUR), included a uniform accounting system and, for the first time, a uniform reporting system. However, this system contained excessive reporting requirements and the data being required by this system had unidentified uses and users. During this period, AHA staff met with representatives of HEW, OPPR, HCFA and Congressional staff to once again convey the concerns of the hospital industry with the SHUR manual.

[16] See Section III below.

publish the manual in July 1978. It was not until January 23, 1979 that SHUR was published as an NPRM, but the SHUR manual itself was distributed to interested parties in October 1978.

AHA has convened two task forces, comprised of hospital industry representatives, to discuss and analyze the SHUR proposal. On January 24, 1979, the AHA convened its first task force to discuss general membership concerns with the SHUR proposal. Subsequently, on February 12, 1979, the second task force met to assess technical aspects of the proposal. AHA will continue to take active participation on the SHUR issue and, on behalf of the hospital industry, will continue its involvement in this rulemaking process.

III. MAJOR OBJECTIONS OF THE HOSPITAL INDUSTRY TO THE SHUR PROPOSAL

A. The SHUR Proposal Has Been Improperly Developed and Its Release Is Premature.

Despite the many years that HEW has been working on the SHUR system, the release of this proposal is premature. HEW has failed to analyze the proposed regulation's economic impact and has not considered alternative systems. HEW has also failed to identify the uses for, and the users of, the information that the proposal would require hospitals to report. Finally, HEW has proposed for implementation a system whose burdensome costs and practical implementation problems have not been properly considered.

HEW Has Failed To Conduct An Economic Impact Analysis.

Despite the clear cost burdens of the SHUR proposal, HEW has made no attempt to prepare a regulatory analysis as to its economic impact. Such a study is required of major regulatory proposals by President Carter's Executive Order 12044, and by HEW's revised "Operation Common Sense."[17]

---

[17] See 43 FR 12663, Section 3, and 43 FR 23121, Section I.C.

When the SHUR proposal was published, HEW stated that it was undertaking a study to establish more precisely the cost of implementing and operating the SHUR. HEW said that:

> the study will also assess any additional reporting burden placed on the hospital by implementing the proposed system. The study will examine hospitals' effort to meet existing requirements and the resultant change in burden effort to meet the SHUR requirements.[18]

While the objectives of this study are appropriate, and indeed necessary, it should have been completed prior to the issuance of an NPRM. However, HEW states that the results of this study[19] will allow HEW to determine if a regulatory analysis is needed. This procedure conflicts with the entire purpose of a regulatory analysis--to determine before issuance of a regulatory proposal whether the contemplated proposal would be consistent with other regulatory systems and with economic necessities. In view of the great disparity in the estimates regarding the cost of implementation of this proposed system,[20] it was particularly important that HEW conduct such an analysis before publishing the SHUR as a proposed rule. Unfortunately, HEW has published this proposal before performing the required regulatory analysis, contributing to the many areas in which this proposal has been improperly developed.

---

18 44 FR 4743.

19 To be discussed below in Section III B.

20 See Section III B.

HEW Has Failed To Identify How The Enormous Amount Of Hospital Data Required Under SHUR Will Be Used.

The great amount of data to be reported under SHUR is a major concern of the hospital industry. Collecting and reporting departmental data in minute and immaterial detail serves no purpose until the uses of such data and, more importantly, the users of such data have been identified.

AHA urges HEW to determine, and to specify, the uses and users of the data to be reported upon which a national uniform reporting system could be based using the highest level of aggregate data--data that will result in the ability of the users to make meaningful decisions. Aggregate level reporting would substantially reduce, instead of increase, the concomitant costs of a new reporting system. AHA contends that proper decision-making by the users of the uniform reporting system can be made--and should be made--without the excessive detail proposed in the SHUR manual.

As stated above, the reporting system set forth in the proposal is designed to capture an enormous amount of data for purposes which have not yet been defined. The proposal states only that the purpose in collecting such data is "to obtain comparable cost and related data on all participating hospitals for reimbursement, effective cost and policy analysis, assessment of alternative reimbursement mechanisms and health planning."[21] However, the

---

21 44 FR 4741.

proposal fails to explain what use will be made of the intended "comparable" data. It is clear that HEW seeks to require hospitals to report all data related to cost issues so that such data could be used to meet whatever needs HEW eventually finds for this data. AHA objects to this HEW attempt to collect data without defining the uses to which it will be put. In fact, it is not clear that there is, or ever will be, any use for some of the data to be provided.[22]

These are concerns not only of the hospital industry. All of these and other concerns were raised by Jay B. Constantine, Chief Health Professional Staff Member, United States Senate Committee on Finance, to the U.S. General Accounting Office (GAO), requesting the GAO to review the SHUR as proposed and determine whether

---

[22] AHA also objects to the proposal because of its failure to avoid even more duplicative and burdensome reporting by the hospital industry. The SHUR as proposed must be regarded as failing to address the needs of other agencies within DHEW. The NPRM states, for instance, that the purpose of §19 "is to obtain comparable cost and related data. . . for reimbursement, effective cost and policy analysis, assessment of alternative reimbursement mechanisms, and health planning." 44 FR 4741.

It is significant that the February 2, 1979 Federal Register contains another NPRM (44 FR 4842)--one that pertains to State Medical Facilities Plans--which sets forth requirements for an extraordinary amount of statistical and other data, some of which is cost-related. (In fact, much of the data is already available on existing Medicare cost reports or could be obtained through minor changes to those cost reports.) This demonstrates yet another deficiency that results from developing a system without first determining the uses and users of that system, for, if the uses are in fact similar to those intended for SHUR, this section of the NPRM would, of course, be duplicative and unnecessary.

the system is "in line with the objectives of Section 19 of Public Law 95-142 and whether there is unnecessary or overly burdensome detailed information required which could be reduced or eliminated."[23] In support of Mr. Constantine's request to GAO, AHA urges HEW to proceed no further with its plans for implementation until after thorough reconsideration of all problems and issues raised in the comments it receives on the SHUR proposal.

AHA also objects to implementing the SHUR proposal because of the failure of the Medicare Bureau and HCFA to develop adequate information systems with respect to existing information it has on Medicare cost reports. The 1972 Social Security Amendments (P.L. 92-603) authorized the Secretary of HEW to develop and impose prospective limitations on various hospital cost components.[24] In July 1974, HEW developed and implemented limitations on inpatient routine service costs.[25] The resulting methodology utilizes bed size, geographic locations, and per capita income for grouping hospitals; limitations for each group are determined upon cost information obtained from Medicare intermediaries. This information is collected in the aggregate--that is, as total routine cost.

---

[23] See Appendix 5.

[24] Section 223, codified as 42 U.S.C. 1395x and 1395cc.

[25] 42 C.F.R. §405.460.

The Medicare Bureau was asked in 1977 to provide AHA with the component costs[26] of each of the hospital groupings. The Medicare Bureau advised AHA that it was unable to do so. This resulted from the fact that, while the Medicare Bureau had the information in the form of hard copy (i.e., complete cost reports), none of the information had been entered into a management information system.

Before any attempt is made to implement the SHUR, HCFA should develop not only the necessary systems to capture and utilize the SHUR data, but also systems to handle the existing Medicare cost report information. We believe that a substantial amount of valuable information is presently contained in the Medicare cost report. If HCFA would utilize this source of information, much of the need for the SHUR requirements would be avoided.

B. The SHUR Proposal Will Impose Tremendous Costs With No Compensatory Benefits

The proposal for SHUR would result in new regulations for the hospital industry whose implementation will impose tremendous costs--both to health care providers and to the government. Such a proposal is particularly inappropriate at a time when the

---

[26] Specifically, depreciation, maintenance and operation of plant, laundry, and housekeeping, etc.

federal government and health care providers alike have been called upon to scrutinize more carefully their activities and to reduce unnecessary costs.

While estimates on the cost of implementation of this proposed system vary, there is no doubt that those costs would be well into the hundreds of millions of dollars.[27] Because of the great disparity in these cost estimates, AHA has contended that a demonstration project to determine the cost of compliance with SHUR must be undertaken before the system is proposed for implementation.

Therefore, over a period of several months, AHA convinced DHEW to undertake a demonstration project for this purpose. A request for proposal (RFP) was signed between HCFA and an accounting firm to conduct the demonstration project. This study is designed to document the cost that hospitals would incur in converting to the SHUR as well as the cost of reconciling their current accounting systems to the SHUR reporting requirements.

During discussions with AHA, HCFA determined that in order for the study to be valid, it must be conducted in a minimum of 50 randomly selected hospitals. After HCFA identified the test

---

[27] While the Health Care Financing Administration (HCFA) contends that the average cost of initial implementation and the annual maintenance of SHUR will approximate $3,000 to $10,000 per hospital, the American Hospital Association estimates that the implementation cost alone could reach $100,000 or more per hospital. If, on the conservative side, the average cost per hospital is $50,000, this will result in a national implementation cost of $300 million.

hospitals for the on-site test evaluations, AHA and state hospital associations agreed to assist the HCFA effort by obtaining permission to conduct the study from the hospitals that had been selected.

A preliminary study methodology was presented to AHA for its review and comment. AHA made several recommendations to improve the methodology and objected to the refusal to adopt a method by which the implementation cost estimates were to be validated, i.e., actual implementation of the system at a sample of the test sites.

The methodology first identifies those aspects of SHUR which have different reporting requirements than the requirements that are presently imposed on hospitals. The cost of compliance is then estimated through a process whereby the consultants for the study, together with representatives of each test hospital, attempt to quantify the effort and therefore the cost necessary to be expended in determining and satisfying the information requested under the available alternatives.[28] The serious flaw in this approach is that there is no actual implementation of the SHUR manual at these various sites which would verify the estimated implementation costs.

---

[28] SHUR permits hospitals the option of (1) reconciling their present accounting system to meet the SHUR requirements at year-end by means of reclassification entries or (2) converting their present accounting system to meet the SHUR requirements on a day-to-day basis so that year-end reporting can readily be obtained. The methodology requires cost estimates under both options.

Despite flaws in the study's methodology, preliminary results indicate that the costs of implementing the SHUR manual greatly exceed the estimates originally advanced by the HCFA. As a part of its role in monitoring the project, AHA has contacted many of the hospitals involved in the cost review experiment. As these comments are being prepared, several preliminary observations can be made:

- The estimated cost of implementation varies significantly from hospital to hospital. In some hospitals the estimated cost has been low, while in others the cost has been estimated to range from $100,000 to $150,000. If the final results of the study indicate an average cost of $50,000 in the test hospitals, this would result in a national implementation cost of approximately $300 million ($50,000 x 6,000 hospitals = $300,000,000). Thus, the preliminary results of HCFA's own study demonstrate that HEW should have performed a regulatory analysis as required by Executive Order 12044 before publishing the SHUR as a Proposed Rule.[29]

- The study does not include costs associated with data processing and programming changes of the test site hospitals which purchase or time-share their data processing services. Data processing changes are a costly undertaking.[30] Failure to recognize such costs drastically distorts and further underestimates the cost of adhering to the SHUR.

- Many of the hospitals involved in the experiment revealed that they did not have the opportunity to fully understand and assess the SHUR requirements prior to the evaluation. Participating hospitals were not always offered the choice of estimating costs under both alternatives.

---

[29] 43 FR 12663. One of the criteria [required by the Executive Order] to be employed by a governmental agency in determining whether a regulatory analysis should be performed is that the regulations "would result in a major increase in costs or prices for individual industries, [or] levels of government..." 43 FR 12663. Another is that the regulations would result in "an annual effect on the economy of $100 million or more." 43 FR 12663. Certainly the SHUR proposal falls in one if not both of these categories and yet HEW has failed, as stated above, to conduct a regulatory analysis prior to publishing the SHUR proposal.

[30] Unless the test site hospital owns its data processing equipment.

> Rather, only one method--either year-end reconciliation or day-to-day conversion--was utilized. This situation also distorts true cost determinations.

Notwithstanding the above, AHA asserts that, when completed, the study will support the Association's contention that there are excessive costs associated with implementing the SHUR as proposed, and that the cost of compliance would be out of proportion to any potential benefits the SHUR system could provide. In fact, HEW has not indicated that it has ever performed an analysis of the claimed potential benefits of SHUR.

AHA further asserts that because there has been no evidence justifying the need for the present SHUR proposal, HEW has proceeded contrary to the intent of Congress. The legislative history of P.L. 95-142 reveals that Congress did not intend to impose enormous cost and administrative burdens on the providers of health care. The following position of the Interstate and Foreign Commerce Committee is significant in this respect:

> The Committee views the disclosure requirements imposed by the bill to be of critical importance in the process of detecting and determining fraudulent and abusive practices within the Medicare, Medicaid...programs. The Committee does not intend, however, for these requirements to be unduly burdensome on providers,... It is, therefore, expected that implementation and administration will be accomplished in such a way as to preclude unnecessary additional administrative burdens on those complying with them.[31] [Emphasis added.]

---

[31] H.R. Rep. No. 393, 95th Cong., 1st Sess. (1977), reprinted in [1977] U.S. Code Cong. & Ad. News. 3055.

The costs and benefits, of course, cannot be compared until each has been established. Despite AHA's concerns and recommendations to HEW/HCFA that the methodology being employed lacks a basis of verification, HCFA has refused to include experimental implementation of the SHUR as part of the current study. This refusal is based on HEW's assertion that it has insufficient time to conduct such studies. HCFA has stated that hospitals will need at least 18 to 24 months to implement its reporting system and that HEW does not want to delay adoption of SHUR by the hospital industry. AHA objects to this refusal to properly assess the costs and the consequences of this comprehensive proposal and contends that HEW's proposal results in a violation of the Congressional intent.

It should be noted that a similar situation existed with the national implementation of the Professional Standards Review Organization (PSRO) program: HEW quickly developed and implemented the PSRO program without proper testing or evaluation. Experience has demonstrated many problems with the PSRO system that need corrective action,[32] and remedying these deficiencies in an ongoing program has proved difficult.

Certainly, it is much easier to correct problems associated with test programs than to modify programs that have been fully implemented. Therefore, AHA requests HEW to conduct a study in which

---

[32] Many of these problems have been cited by the General Accounting Office (GAO) in its September 12, 1978 Report to the Congress. See Appendix 4.

the SHUR is actually implemented in a sample of hospitals. Only after the results of this study have been obtained and appropriate modifications made to SHUR should HEW implement a new reporting system.

C. Medicare Reimbursement Should Not be Premised on SHUR

AHA opposes HEW's attempt to combine a uniform reporting system with Medicare reimbursement such that a provider's reimbursement is premised upon a system for hospital uniform reporting. The objection to combining these two systems is that they are based on entirely different and, in fact, incompatible principles.

A fundamental principle of the Medicare program is that Medicare pays all the costs of program beneficiaries and pays none of the costs of non-beneficiaries. To determine each of these costs, HEW developed a system of cost reporting under Medicare which recognizes differences between institutions and their approaches to the delivery of health care. The system provides for flexibility to reflect the economic reality of individual hospital operations and organization structures and to insure adequate reimbursement for the cost of services actually provided. In contrast, SHUR does not provide for this flexibility because the purpose of this uniform reporting system is to compare data elements that relate to defined functional activities regardless of the particular characteristics of the institution.

Comparability of data does not necessarily reflect accurate determinations of the true cost of services provided to program beneficiaries.[33] Therefore a system for the uniform reporting of selected hospital information should only be combined with a Medicare cost reporting system that recognizes and accommodates differences from institution to institution so that the costs of treating patients under Medicare are fairly borne by the Medicare program.

Further, in attempting to use SHUR to alter the reimbursement system, HEW has exceeded statutory authority. There is no basis in P.L. 95-142 for premising reimbursement on the SHUR; the purposes of the statute do not include reimbursing health care providers on the basis of a uniform reporting system. In fact, nowhere in the legislation governing uniform reporting is reimbursement mentioned. Therefore, HEW has proceeded without authority to premise reimbursement on SHUR.

---

[33] For example, the proposed SHUR requires that data processing costs be allocated to various functional cost centers on the basis of "central processing unit" (CPU) time. (CPU measures actual machine usage.) However, this allocation does not reflect the true cost of the entire data processing function because a particular data processing effort may have been extended to several other hospital departments. Specifically, if a large effort is provided by the hospital's data processing department in developing medical record information, allocations based upon the CPU time statistic would not reflect this effort. Therefore, there is no assurance that such an allocation results in payment by Medicare for services provided to its beneficiaries. Likewise, if considerable effort was directed at the provision of services to a non-allowable Medicare cost center, e.g., non-patient care research, then Medicare would be paying non-allowable costs. Both results would contravene rational financing and the Medicare law itself. (42 U.S.C. 1395x(v)).

HEW's attempt to combine the systems in this way is contrary to the legislative history of P.L. 95-142. During the introduction of the amendment to P.L. 95-142 that resulted in Section 19, there was no discussion with respect to combining uniform reporting with Medicare and Medicaid reimbursement. However, there was a most significant discussion of reimbursement in the context of Section 19 during the joint hearing before the Subcommittee on Health of the U.S. House of Representatives' Committee on Ways and Means and the Subcommittee on Health of the U.S. House of Representatives' Committee on Interstate and Foreign Commerce. In presenting testimony at the hearing on H.R. 3 and proposed amendments thereto, AHA stated that

> the proposed amendments. . . suggest that the Secretary of Health, Education and Welfare could change [such] reimbursement in any way he chooses, and then require all hospitals to enter into arrangements with Blue Cross and private insurors, as well as with Medicare and Medicaid, that adhere to the reimbursement approaches designed by the Secretary.[34]

At this point in the AHA testimony, Representative Paul Rogers interrupted to say: "May I point out here that you misread the bill. I don't think there is <u>any authority to have the Secretary back that up, either to change reimbursement</u>."[35] [Emphasis added.]

---

[34] Testimony of the American Hospital Association before the Subcommittee on Health of the U.S. House of Representatives' Committee on Ways and Means and the Subcommittee on Health of the U.S. House of Representatives' Interstate and Foreign Commerce Committee on H.R. 3 and H.R. 4211, March 7, 1977.

[35] <u>Joint Hearings before the Subcommittee on Health of the U.S. House Committee on Ways and Means and the Subcommittee on Health of the U.S. House Interstate and Foreign Commerce Committee</u>, 95th Cong., 1st Sess. 226 (1977).

The above supports the AHA position that Congress did not intend to base Medicare reimbursement on a system for hospital uniform reporting. In attempting to do so, HEW has violated the intent of Congress.

In view of the above, AHA urges HEW to maintain any system for hospital uniform reporting separate from Medicare reimbursement.

D. The SHUR Proposal Results in a Requirement of Uniform Accounting

As discussed in Section II, while the SHUR NPRM purports only to require uniform hospital reporting of cost-related information, the draft SHUR manual states clearly that it contains a uniform accounting system. While AHA opposes the imposition of any system of uniform hospital accounting, whether implemented directly or indirectly, it should be emphasized that AHA does not object to responsible implementation of a system for uniform hospital reporting. In fact, AHA has long supported the concept of a uniform reporting system and will continue to do so.

The accounting requirements in HCFA's current proposal are contained in the SHUR manual, which

> provides a uniform accounting system incorporating the chart of accounts, definitions, principles and statistics required. . . to be used by hospitals to reach the uniform reconciliation of financial and statistical data necessary for uniform reporting under [Section 19 of] this act [P.L. 95-142].[36]

---

[36] Draft SHUR Manual, page 0.2 [Emphasis added.]

The introduction to the manual also states that, "in developing a uniform accounting system, it was recognized that the system must provide the data necessary to support management and the different regulatory systems, cost allocation systems, disclosure requirements and state reporting requirements which exist." It further states that the purpose of the uniform accounting system is to "provide a common standard of measurement and communication through the use of uniform [accounting] principles."[37] The implication of all of this is, of course, that a uniform accounting system is necessary in order for uniform reporting to be achieved. AHA believes, to the contrary, that a uniform accounting system should not be required as a basis of uniform reporting.

As stated earlier, the proposed rule would require all Medicare and Medicaid hospitals to report on the costs of their operation and the volume of their services, both in the aggregate and by functional accounts. If, in order to comply with the detailed reporting requirements under the SHUR proposal, hospitals are forced to convert their internal accounting systems, effective and efficient management of those hospitals will be severely reduced. Such a result would obtain because functional accounting does not provide the information necessary to the successful management of a hospital; costs are assigned to cost centers based on prescribed definitions of functional activities and not

---

[37] Draft SHUR Manual, page 0.2.

on the basis of a particular department's responsibility for incurring and controlling its costs. Therefore, any system that would, directly or indirectly, impose a uniform accounting system on hospitals is unacceptable to the hospital industry.

Moreover, the Medicare/Medicaid Anti-Fraud and Abuse Amendments of 1977 provide no legal basis for HEW to require the imposition of a uniform hospital accounting system. A key provision of Section 19 provides:

> the uniform reporting system for a type of health services facility. . . shall provide for appropriate variation in the application of the system to different classes of facilities. . . within that type. . . In reporting under such a system, hospitals shall employ such chart of accounts, definitions, principles, and statistics as the Secretary may prescribe in order to reach a uniform reconciliation of financial and statistical data for specified uniform reports to be provided to the Secretary.[38]

Thus, the statute itself recognizes that there are variations in the financial and statistical data routinely utilized by hospitals. While the "reconciliation" of accounts was intended by this language, a system of uniform accounting as it is incorporated in the present proposal was not contemplated. Nowhere in Section 19 is there any requirement for implementation of a uniform hospital accounting system, nor is there any authority for HEW to impose such a requirement by regulation.

---

[38] Social Security Act §1121(a), 42 U.S.C. §1320(a). [Emphasis added.]

The legislative history of P.L. 95-142 further demonstrates that Section 19 was not intended to provide for a uniform accounting system for hospitals. The Congressional Budget Office reported to the House Committee on Ways and Means that the legislation does not mandate a uniform accounting system, as follows:

> Although proposals have been made to require uniform accounting as well as uniform reporting, the bill does not mandate a uniform accounting system. Your committee was not prepared to conclude that a uniform accounting system is necessary in order to generate the required comparable data. Your committee is inclined to believe at this time that the uniform reporting system, with specific documentation for the reported costs as part of the organization's accounting system is sufficient. . . [Emphasis added.][39]

Congress indicated that a uniform accounting system might be considered at some future time if--and only if--an evaluation of uniform reporting proves insufficient to assure reliable and comparable data:

> Although this bill[40] does not require uniform accounting as well as uniform reporting, the Committee is convinced that the Secretary of HEW should develop a model uniform accounting system and that he should have the authority to require the use of such parts as he finds necessary in the future if his evaluation of uniform reporting indicates that it has not been sufficient to assure reliable and comparable data. . .[41] [Emphasis added.]

---

[39] H.R. Rep. No. 393, Pt. 1, 95th Cong., 1st Sess. 75 (1977).

[40] H.R. 3 as amended, which was enacted as P.L. 95-142.

[41] H.R. Rep. No. 343, 95th Cong., 1st Sess. 83 (1977), Reprinted in [1977] U.S. Code Cong. & Ad. News 3086.

Therefore, Congress intended that a system for uniform reporting be developed, implemented and tested before HEW requires hospitals to employ a uniform system of accounting. By proceeding to require uniform accounting before even attempting to develop a responsible reporting system, HEW has exceeded statutory authority and has ignored the intent of the authorizing Congress.

AHA urges HEW to reconsider its attempt to impose uniform accounting on the hospital industry and, instead, to devise a more responsible, less burdensome system to obtain the necessary hospital data.

IV. SPECIFIC CONCERNS AND TECHNICAL PROBLEMS

The preceding section discussed the AHA's major concerns regarding the conceptual development of the SHUR system. This section is intended to provide additional comments concerning the more technical problems associated with the SHUR itself. Problems exist in several key areas including: (A) the inability of the SHUR to reflect comparable and meaningful data, (B) the use of functional reporting as a concept, (C) various definitional aspects, (D) the SHUR's direct reporting of certain specific costs, (E) the development and use of standard units of measure, and (F) the required use and purposes of the SHUR forms.

A. Comparability Problems

The NPRM states that "the purpose [of the SHUR] is to obtain comparable cost and related data on all participating hospitals for reimbursement, effective cost and policy analysis, assessment of alternative reimbursement mechanisms and health planning."[42] We believe the information required by SHUR in its present format will not achieve an accurate or realistic comparison of hospital cost data. The SHUR presently requires hospitals to report only cost and statistical data; no provision is made for the collection

---

[42] 44 FR 4741

of various nonfinancial data which is absolutely essential to explain the financial data being reported.

For example, the SHUR requires the allocation of depreciation expense on major movable equipment to each of the prescribed functional cost centers where such equipment is located. In the absence of any specified purpose for this requirement, we must assume this information will be utilized by the HCFA in determining, among other things, the appropriateness of depreciation expense of major movable equipment for interhospital comparisons. Unfortunately, this information alone will not provide any user of the system with vital information concerning the age of such equipment, the numbers of such equipment, or the technological sophistication of such equipment. Thus, attempts at comparability of this item are totally lost.

Furthermore, SHUR requires that employee benefits be assigned directly to the functional cost centers based on the number of full-time equivalent employees. Allocating these costs, which is not only a time consuming exercise, but also an expensive project because of the extraordinary amount of needed recordkeeping and data processing, will not reveal the extent of employee benefits offered by an institution. This is true whether an institution offers a higher level of benefits when compared to another, or whether the institution is unionized, or whether there are differences in wages and benefits within a defined geographic area. Therefore, SHUR will not, as the NPRM intends, collect data that can be compared in a meaningful manner.

The NPRM also states the uniform reporting system must provide information on the "(1) cost and volume of services; (2) rates; (3) capital assets; (4) discharge data; and (5) billing data."[43] In view of the recent emphasis placed on the importance of preambles to Notices of Proposed Rulemaking by government and others, information contained in the NPRM should state the exact purpose of implementing the SHUR. SHUR's enabling legislation provides that the uniform reporting system would require the following information: "(1) the aggregate cost of operation and the aggregate volume of services, and (2) the cost and volume of services for various functional accounts and subaccounts."[44] It is recommended that a second NPRM include a correction of this discrepancy.

B. Functional Reporting

The SHUR is premised on a functional reporting system. The majority of, if not all, hospitals currently employ a responsibility reporting system. Responsibility reporting accumulates data in accordance with a hospital's organizational structure and therefore provides management with an effective tool for evaluating each department's performance. In fact, the Joint Commission on Accreditation of Hospitals (JCAH) recommends that a hospital employ a responsibility type reporting mechanism.[45]

---

43 44 FR 4742.

44 42 U.S.C. §1320a.

45 Accreditation Manual for Hospitals, 1979 ed., Joint Commission on Accreditation of Hospitals, p. 52.

The difference between a responsibility reporting system and a functional reporting system becomes apparent if, for example, we look at the accounting treatment required for the salary of a nurse assigned to the operating room. In a responsibility reporting system, the entire direct (salary) cost of the nurse would probably be assigned only to the operating room cost center. Under the functional reporting mechanism, however, the only cost permitted to be accumulated in the operating room center would be those associated with the nurse for time spent in providing assistance during surgery.

It is common for such individuals to spend part of their time performing other tasks, such as, reordering or replenishing supplies of the operating room, or performing administrative duties. In these situations, the costs associated with the reordering of supplies and the provision of administrative services would have to be charged to those functional centers. However, reporting this level of detail may not provide significant overall cost differences from one hospital's operating room to another hospital's operating room.

Prudent business practices dictate that primary responsibility for management reporting systems lie within the internal requirements of the organization. Only secondary considerations follow from external needs. While SHUR permits hospitals the option of reconciling a responsibility reporting system at year-end or converting on a day-to-day basis to the functional requirements

of SHUR, hospitals may be forced to convert to the proposed SHUR requirements on a day-to-day basis, because of the extremely complicated and costly year-end reclassification entries that would have to be made in order to meet the SHUR requirements. At best, hospitals will be forced at great expense to maintain two separate reporting systems, one responsibility-oriented and the other functionally-oriented so that, respectively, management's needs are fulfilled and JCAH's standards are met, and the hospital is able to comply with SHUR. Hospitals object to the tremendous problems and extensive costs this situation creates.

C Definitional Problems

The SHUR contains several items which run contrary to generally accepted accounting principles (GAAP). Both the legislation creating SHUR and the NPRM announcing the availability of the SHUR are silent regarding balance sheet items. AHA therefore questions the magnitude and emphasis being placed on these accounts. Also, SHUR aptly addresses the issue of materiality in two areas, but, in a third, goes on to require an overly conservative application of the process. Further, the SHUR's handling of its capitalization requirement is overly restrictive. The materiality and capitalization issues point to the costly pervasiveness of the information required by the SHUR, yet there is no clear evidence that such information will result in comparable data and meaningful information.

Problems with GAAP

Several of the early SHUR manual drafts required many reporting practices which varied significantly from GAAP. The September 29, 1978, version has greatly reduced the number of inconsistencies between GAAP and SHUR requirements. However, several still exist. For example, SHUR requires that "long-term security-investments are to be valued at hospital cost if purchased or, if acquired by donation, at the fair market value at the date of the gift."[46] In contrast, GAAP requires marketable securities to be carried at the lower of cost or market value, determined at the time the balance sheet is prepared.

Similarly, SHUR appears to violate GAAP with respect to the treatment of malpractice insurance costs. SHUR states that

> self insurance by a hospital for potential losses due to unemployment, workman's compensation and malpractice claims, asserted or otherwise, places all or part of the risk of such losses on the hospital rather than insuring against all or part of such losses with an independent insurer, and payments into the fund or pool are to be considered as insurance expense for purposes of this [SHUR] report. Loss payments, even in excess of amounts in the fund or pool are not considered insurance expense.[47] [Emphasis added.]

However, the amount considered insurance expense under GAAP is the total amount actuarially determined to cover probable losses

---

[46] Draft SHUR Manual, page 1.15.

[47] Draft SHUR Manual, page 1.25.

plus any amounts beyond such insurance reserves that a hospital might incur for actual losses in any given year.

Furthermore, SHUR appears to allow the use of any generally accepted inventory valuation method (e.g., fifo, lifo, average, etc.). However, the manual states that any method "may be used as long as it is consistent with that of the preceding accounting period."[48] Because the manual provides no instructions for changing inventory valuation methods, it must be assumed that such changes are not permitted. Therefore, while SHUR appears to permit any of several generally accepted accounting methods of valuating inventories, it restricts changes to other methods in contradiction to GAAP.

Balance Sheet Requirements

As stated earlier, the principle purpose of the SHUR is to obtain information regarding: "1) the aggregate cost of operation and the aggregate volume of services, and 2) the cost and volume of services for various functional accounts and subaccounts..."[49] Chapter 1 of the SHUR manual devotes considerable effort in stating its reporting principles and accounting concepts regarding balance sheet information. If the primary thrust of the SHUR is

---

48 Draft SHUR Manual, page 1.20.

49 42 U.S.C. §1320a.

to obtain information concerning expenses and statistics, it seems impractical to require extensive and costly changes to obtain balance sheet information. In fact, AHA questions the requirement for balance sheet data; it appears that the requirement is not needed to fulfill SHUR's legislative directive. However, if the SHUR can justify the reporting of specific balance sheet items and requires the items to be reported in a manner that restricts the use of generally accepted accounting principles, a basic reconciliation of the hospital's reported line item to that required by SHUR could simplify this entire process.[50]

Materiality

The SHUR manual discusses the concept of materiality in three separate areas. First, section 1180 states that "materiality is an illusive concept with the dividing line between material and immaterial amounts subject to various interpretations. It is clear, however, that an amount is material if its exclusion from

---

[50] For example, if the HCFA desires to restrict the reporting of the net value of fixed and major moveable assets to reflect depreciation expense on the straight-line method conversion from an accelerated method under GAAP to the straight-line method under SHUR could be accomplished through the use of a simple reconciliation schedule. This would result in a reduction of SHUR requirements, its instructions and, most importantly, the cost of preparation.

the financial statements would cause misleading or incorrect conclusions to be drawn by users of the statements."[51] [Emphasis added.]

Next, section 3200 states that

> it should be noted that reclassification must be made for material amounts of misplaced cost. Material is defined, for the purposes of this manual, as an amount equivalent to an aggregate amount of misplaced costs in excess of the lesser of:
>
> 1) 3% of the direct costs of the functional cost center transfered to or from, or
>
> 2) one-quarter of 1% of the total annual operating expenses.
>
> However, in no case is a reclassification necessary if the aggregate amount of misplaced cost per cost center is less than $1,000.[52] [Emphasis added.]

A definition of materiality is also contained in Appendix A-glossary. This definition states

> the relative importance, when measured against a standard of comparison, of all items (cumulative by cost center or account) included in or admitted from books of accounts or financial statements, or any procedure or change in procedure that conceivably might affect such statements. An amount is material if its exclusion from or inclusion in on an accounting statement would make it misleading.[53] [Emphasis added.]

---

51 Draft SHUR Manual, page 1.6.

52 Draft SHUR Manual, page 3.25.

53 Draft SHUR Manual, page A-24.

The definition of materiality contained within the glossary tends to complement the definition contained in section 1180. These two definitions support GAAP. However, the formulistic definitions delineated in section 3200 contradict the basic thrust of GAAP. Because materiality is a concept based on judgments, a restrictive and/or formulistic definition of this concept is not only unnecessary, but unwise. The result will be to cause institutions to incur substantial costs for recordkeeping to determine the need for any possible reclassifications.

Since hospitals will have to determine, under the SHUR's definition, whether they have incurred costs considered material, it will be a costly undertaking for a hospital to accumulate many small costs, and then find that they total only $999.00. In that case, the cost would not be subject to reclassification because the amount does not exceed the SHUR's materiality threshold.

Furthermore, by SHUR's own formulistic approach, comparability is lost. $1,000 in a 50-bed hospital, for example, is probably more material than $1,000 in a 500-bed facility. Therefore, AHA recommends that SHUR simply accept the concept of materiality for reporting purposes as expressed under GAAP and dispense with adherence to a formulistic approach.

Capitalization

Current Medicare policy requires capitalization of assets with a historical cost of at least $150 and a minimum estimated useful

life of two years. In contrast, SHUR requires that "if a depreciable asset has at the time of its acquisition an estimated useful life of three or more years, and a historical cost of at least $300, its cost must be capitalized, and written off ratably over the estimated useful life of the asset."[54] Thus we have a clear conflict between two government agencies over the issue of determining a threshold for capitalizing or expensing an asset.

Moreover, in this rapid inflationary environment, restricting limits for capitalization may, within a very short period, require extensive recordkeeping for small purchases as the value of the dollar continues to shrink. No benefit to comparability is realized by mandating a specific dollar amount as a capitalization policy. Rather, we believe adherence to GAAP and verification of hospital financial positions by independent year-end audit will provide sufficient safeguards to insure that hospitals are accurately expensing or capitalizing their assets. Adherence to GAAP will also relieve hospitals of additional, time-consuming, and costly recordkeeping.

D. Direct Reporting of Specific Costs

The concept of functional reporting as mandated by the SHUR requires the allocation of direct expenses to the functional

---

[54] Draft SHUR Manual, page 1.21.

center receiving or providing services. SHUR requires direct costing for such items as:

- Depreciation expense on major moveable equipment
- Salary and payroll related employee benefits
- Employee fringe benefits
- Medical supplies
- Drugs
- Maintenance of plant
- Data processing expenses
- Central patient transportation

Most, if not all, of these costs traditionally have been maintained by hospitals in individual accounts. As already noted, SHUR is intended to develop a comparable data base regarding hospital operations so that government can make meaningful decisions. It is AHA's position that allocation of these costs as prescribed by the SHUR will not enhance that objective.

Moveable Equipment: Depreciation Expense

Section 1612 requires the

> cost of depreciation and rent/lease on moveable equipment which is utilized solely by a functional cost center must be directly assigned to that functional cost center based upon specific identification through plant ledger records. Where the cost of depreciation or rent/lease of the moveable equipment is utilized by two or more functional cost centers, the depreciation or rent/lease applicable to such moveable equipment must be

> directly assigned to such functional cost centers based upon cost center usage.[55]

Accumulation of this data in the functional cost center without specific nonfinancial information will not yield comparable data regarding the age of such equipment, the numbers of such equipment or, for that matter, the terms of rent/leasing arrangements. Therefore, AHA recommends that depreciation and rental expenses on moveable equipment be recorded as a separate unassigned functional cost center.

Salary and Payroll Related Employee Benefits

Section 1613 requires that salary cost

> must be assigned directly to the functional cost center to which the employee is assigned. This assignment must be based on each employee's actual...hours performed within...cost center multiplied by that employee's hourly salary rate while performing the...service.[56]

Not only will compliance with this requirement be a costly operation, we also question the effect of the requirement on determining comparability. Further, the provision requiring that float personnel be directly assigned to the functional cost center where they are providing services rather than to an administrative cost center further exacerbates a very difficult recordkeeping process. This is especially true in hospitals that do not use

---

55 Draft SHUR Manual, page 1.28.

56 Draft SHUR Manual, page 1.29.

some form of electronic data processing. Again, if the purpose of the SHUR is to obtain comparable data requiring the functional cost allocation of salary expense without other specific nonfinancial information, such as the number of float personnel maintained by a hospital, meaningful conclusions cannot be reached.

Employee Fringe Benefits

Section 1614 requires that the cost of nonpayroll related employee benefits be assigned directly to the functional cost centers based upon the number of full-time equivalent employees.[57] Again, AHA recommends these costs be maintained in a separate unassigned functional cost center. Without the inclusion of specific information regarding the level of fringe benefits offered employees and other information pertaining to union contracts, geographic factors, etc., considering this cost data comparable is inappropriate.

Plant Maintenance

Section 1617 requires that the

> cost of noncapitalizable nonroutine maintenance and repairs directly assignable to a single cost center must be transferred to the cost center receiving the service. These costs

---

[57] Draft SHUR Manual, page 1.30.

> include all direct expenses incurred by the plant operations and maintenance cost center in performing such services.[58]

AHA recommends that this requirement be eliminated and that all noncapitalizable, nonroutine maintenance and repairs be recorded in the plant operations and maintenance cost center. In the absence of nonfinancial information, requiring alloction of these direct costs to the functional cost center receiving the services does not provide evidence of the nature of the services being rendered. It also does not provide comparability among institutions since the information fails to recognize the age of a facility and/or its equipment. Therefore, recording these costs in the functional cost center in which the services are rendered creates serious distortions and prevents meaningful decision-making.

Data Processing

Section 1618 requires that "all the direct cost incurred in operating an electronic data processing center shall be transferred to the using cost center on the basis of CPU (central processing unit time)."[59] Previously it was noted that allocating data processing cost on CPU time does not equate services rendered by

---

58 Draft SHUR Manual, page 1.31.

59 Draft SHUR Manual, page 1.31.

the data processing department with the actual user departments. It is recognized that data processing is an important and costly variable used in the provision of hospital operations. Therefore, it is imperative that the true cost associated with the use of data processing by using centers be carefully identified. AHA recommends that either data processing costs be maintained in an unassigned functional cost center or realistic allocation bases be developed to distribute the data processing costs to the users of the system in a manner that equitably and accurately relates to usage.

Central Patient Transportation

Section 1619 requires that

> central patient transportation cost of transporting patients to and from ancillary services are considered a part of the ancillary services function of the hospital. Therefore, all such costs, wherever they are incurred, must be transferred to the appropriate ancillary service cost centers for reporting purposes.[60]

We do not believe transportation costs are significant enough to require functional treatment. Rather, we believe such costs could be appropriately and adequately handled by either permitting the hospital to include the cost associated with central patient transportation to be accumulated in an unassigned functional cost center or to be allocated to ancillary departments based upon

---

[60] Draft SHUR Manual, page 1.32.

simple sampling techniques. This would reduce extensive record-keeping requirements while not affecting comparability of information.

E. Standard Units of Measure

The standard unit of measure (SUM), according to the SHUR, is required to provide a uniform statistic for measuring costs. SHUR provides that the standard units of measure for revenue producing cost centers are an attempt to measure the volume of services rendered to patients while those for nonrevenue producing cost centers are an attempt to measure the volume of support services rendered. The standard units of measure are further cited as the mechanism by which SHUR data is translated "to facilitate cost and revenue comparisons among peer group health facilities."[61] The AHA believes most of the required standard units of measure will not accomplish this objective.

In several situations a meaningful standard unit of measure does not exist. For example, in its list of standard units of measure, SHUR requires each $1,000 of gross patient revenue as a measure of hospital and professional malpractice insurance, each $1,000 of patient revenue to evaluate short-term interest expense, each $1,000 of total hospital operating expenses to evaluate general accounting functions, each $1,000 of funds pledged to evaluate

---

61 Draft SHUR Manual, page 3.40.

fundraising, etc. The units derived from such computations do not reveal anything about the facility other than there is "so much" expense per $1,000.

In other instances, SUMs are defined too rigidly. For example, the SHUR relies on the number of gross square feet to include the total floor area of the plant including common areas (hallways, stairways, elevators, lobbies, closets, etc.) as a unit of measure for plant operations and security. Many hospitals have in the past kept square footage on a net basis. The net basis excludes the nonproductive common areas of elevator shafts, lobbies, and nonproductive space from the statisical basis. Mandating the use of gross square footage will require many hospitals to recalculate square footage statistics for their entire plant. This could be a very costly undertaking.

The intent of mandating a singular method for developing a uniform definition of square footage is to remove apparent differences for comparison purposes. However, we are not convinced that in this instance prescribing a uniform definition of square footage measurements will result in uniformity and comparability. To minimize conversion costs and burden in adopting either the net or gross square footage method, the HCFA should require the one most commonly utilized by all hospitals.

Nonetheless, comparability distortions will still arise using either square footage system because no information concerning

the physical design of each hospital is being considered. Some may have larger common areas than others, some may be high rise facilities, while others may be sprawling complexes.

To a large extent, the design of a facility depends upon location (urban or rural) and its age. Therefore, careful consideration must be given to square footage statistics when used for allocation purposes in order for the data to be useful and meaningful.

The standard units of measure for many similar type cost centers are different. For example, the therapies--physical, occupational, respiratory, speech, and recreational--provide therapeutic treatments to patients in similar ways. However, the SUMs for these departments vary significantly. In some areas, relative value units are used, while in others, treatments or encounters of service are used. While we are concerned with the reliability of some of the relative value units, we are even more concerned with the use of visits as the SUM for defining treatments. We believe the latter does not adequately account for variances in mix or degree of difficulty in providing care.

Many of the clinic services SUMs count a visit as each registration of a patient in that particular unit of the hospital. Multiple services performed in any of these units during a single registration are only recorded as one visit. Use of this SUM in this manner seriously distorts comparability of services provided. Not only do we believe the SUM deficient for its failure to

recognize mix and intensity factors, but also that similar cost centers should have similar defined standard units of measure.

F. SHUR Reporting Forms

In reviewing the proposed SHUR reporting forms, the issue concerning the required use of the requested data is recurring. Because the SHUR manual was developed without first determining the use and users of the system, we must not only question the purpose of obtaining much of the information, but also the purpose to which it will be used. Without knowing the latter, it is not possible to accurately address the efficiency of the forms and the validity of the requested information. As a result, our comments are limited, for the most part, to a discussion that either reveals noncompatability of the collected information or questions the purposes for seeking the data. In addition, we have a serious concern with the thrust of the certification statement.

Our comments are also limited to a discussion of worksheets A through E; these forms represent the major additions and/or changes to the existing Medicare cost reports. Since these forms provide part of the input to the remaining forms, any modifications or eliminations may cause the remaining forms to revert to the existing Medicare cost reporting system (which we are not reviewing in the context of the SHUR NPRM).

Certification Statement

The cover page to the uniform report contains a certification statement setting forth the language of sections 1877 (a)(i) and 1909 (a)(i) of the Social Security Act. The statement details possible penalities to be imposed for knowingly making false statements or representations of fact in completing the uniform report. We believe the presence and current location of the certification statement fosters a perception of federal government intimidation.

Below the certification statement is a paragraph requiring certification by the chief administrative officer, chief financial officer, and the preparer of the uniform report. The language of this certification differs significantly from the certification page of existing Medicare cost reports which certifies that the cost report is prepared in accordance with applicable instructions "except as noted." Deletion of the phrase "except as noted" signifies that no exception will be recognized by the Health Care Financing Administration in filing a uniform report inconsistent with its appropriate instructions. Together with the certification statement alluding to possible penalties for failure to comply with prescribed instructions for completing the uniform report, this could negate the entire appeal process dealing with Medicare cost reports.

At present, the only mechanism for hospitals to air grievances concerning disputed Medicare cost report issues is for them to take exception along with such items in the filing of the cost report. In order to preclude possible criminal prosecutions for failure to comply with SHUR instructions, hospitals may simply complete their Medicare cost reports in total compliance with instructions contained therein, having realized a loss of Medicare reimbursement, and having waived their rights for future appeal.

Worksheet A-1: General Hospital Information

This particular worksheet requires general hospital information. Most, if not all, of this information should be readily available from a hospital's records. Nonetheless problems may exist with obtaining accurate information because of a lack of clarity in the instructions and the purpose for which such information is to be used.

Item no. 4 regarding type of hospital requires teaching hospitals to indicate whether they are university teaching or university affiliated. A review of the instruction regarding completion of this activity could result in hospitals answering both questions. We do not believe a response to both questions is intended. Perhaps an important element, i.e., type of ownership, is missing and needs to be included.

Similarly, item no. 6 concerning medical education programs seek to identify which medical education programs are provided by the hospital. However, no information regarding the level of activity of such programs is requested. Simply indicating that a hospital has approved programs does not reveal their level or magnitude.

Again, item no. 7 concerning health planning requires the identification of a number of certain specified medical procedures. Such information in its present format will not reveal meaningful data. As an example, one of the items requires hospitals to submit the number of cancer patients who received megavoltage radiation therapy during the fiscal year. The hospital is required to count each patient only once, regardless of the number of treatments. Obviously, reporting in this manner significantly distorts the true level of service provided by a given institution.

Worksheet A2-1: Services Inventory
Worksheet A2-2: Services Inventory

According to section 4430 of the SHUR manual these worksheets are intended to "provide an inventory of services offered by the hospital. The listing of services is not intended to be all inclusive. Each service must be coded in accordance with the codes provided."[62] As noted with worksheet A-1, the purpose of

---

62 Draft SHUR Manual, page 4.14.

requiring this form is not identified nor is the use of the required information. Distortions will definitely result if the purpose of this form is for grouping hospitals according to their service mix, because not only is the data to be supplied ambiguous, but also the instructional definitions do not provide a level of clarity to insure that all hospitals understand what they are reporting. For example, a hospital can respond that a listed service is not maintained in the hospital, but is available from outside contractors. Listing the availability of the service does not reveal how often, if ever, such a service is utilized, or the scope of providing such services, if it is required. The question is raised, therefore, as to whether the supplying agency can always provide the service when called upon. In order to make such data meaningful, the instructions must state the purpose for requesting the information, as well as who is going to use it and in what manner.

Worksheet B-1: Daily Hospital Services Stastics

This worksheet requires hospitals to identify daily hospital service statistics, including licensed beds, beds available, and total inpatient days, by age, pediatric, maternity and other categories for specified cost centers. In states which have no licensing functions problems could exist with hospitals trying to report their bed complement, especially by the types the form requires. The instructions must clarify how to report beds in

non-licensing states. Also, the instructions do not address the handling of statistics if a hospital should have an overflow condition; for instance the instructions do not specify the handling of a maternity patient who is placed in a medical/ surgical area because the maternity area is temporarily fully occupied.

Finally the concept of swing beds, i.e., placing skilled nursing care or long-term care patients in acute areas, is not addressed. While the swing bed concept is presently experimental, legislation may soon be passed expanding its use. Failure to recognize these and other similar problems can cause further distortions of the information requested by overstating one statistic and understating others.

Worksheet B-4: Real and Tangible Property Financed and Real Property Rented

Part I of this form is aimed at obtaining information "regarding financing on real and tangible property as of the last day of the hospital's reporting period."[63] While hospitals should be able to provide this information, we believe the form as proposed is seriously deficient and will hamper effective data collection efforts. The form only contains one line for hospitals to report their method of financing, for example, building and equipment.

---

63 Draft SHUR Manual, page 4.22.

If a hospital secures financing under multiple means, i.e., conventional mortgages, tax exempt bonds, etc., or finances its plant and equipment at different times and thereby incurs different interest rates for any of the listed financial mechanisms, a hospital will not be able to insert all of the necessary information. Therefore, the form needs careful revision. Before the form is revised, however, the purpose of securing this information needs to be addressed in order to insure that the collection of such information has a purpose and that the data reported will achieve its desired purpose.

Worksheet B-5: Interns, Residents, and Fellow Profile

This form requires hospitals to report "the numbers of interns, residents, and fellows on the hospital's medical staff by clinical specialty on the last day of the hospital's fiscal year."[64] First, a definitional problem exists. The "intern" designation has been eliminated. Second, requiring hospitals to report this statistic as of the last day of their fiscal year fails to recognize possible rotational staff assignment. These individuals would be excluded from the computations. The form also fails to provide information relative to the experience of these individuals. The result could be serious distortions if the raw data is used for

---

64 Draft SHUR Manual, page 4.24.

comparison purposes. Without a stated purpose for the collection of this information, it is impossible to comment further.

Worksheet C-1: Balance Sheet
Worksheet C-3: Statement of Changes in Fund Balances
Worksheet C-4: Statement of Changes in Financial Position - Unrestricted Fund

Since SHUR requires information regarding the: "(1) the aggregate cost of operation and the aggregate volume of services, and (2) the cost and volume of services for various functional accounts and subaccounts,"[65] there is no purpose served by requiring hospitals to submit detailed information on their financial position. These forms do not reveal anything about the cost of hospital operations or volumes of services. Furthermore, requiring hospitals to report restricted funds, as the form mandates, in the general (unrestricted) fund is not only arbitary, but contrary to many laws and long-term debt covenants (which may, for example, require specific sinking fund accumulations).

No comparable conclusions can be drawn from the information reported; it is seriously distorted by the inclusion of restricted fund balances. Because the NPRM does not address Balance Sheet information, we recommend that the HCFA completely delete requirements for this information.

---

[65] U.S.C. §1320a.

Worksheet D-1: Statement of Patient Care Services Revenue
Worksheet D-2: Statement of Operating and Non-Operating Revenue

These worksheets (1) summarize gross patient revenue by revenue centers and (2) are used to report other non-operating revenue. The NPRM does not address the reporting of revenue--only costs, volume and services. Additionally, these worksheets contain fundamental violations of the concept of matching expenses and revenues. For example, the cost of data processing services sold to others must be accumulated within the hospital's administrative and general cost center while the instructions in these forms require the revenue to be reported in other operating revenue. Therefore, these forms should be deleted.

Worksheet E-1: Statement of Patient Care Expenses
Worksheet E-2: Statement of Other Operating and Non-Operating Expenses

These worksheets report expenses by the SHUR's definitional breakdown of natural classification of expense categories and the standard units of measure for each functional cost center. We believe these worksheets can be modified to achieve a level of uniform reporting embracing the intent of Section 19 without excessive detail and cost. We will expand upon this contention in Section V.

Worksheet E-3: Health Facility Manpower Statistics

Worksheet E-3 requires the reporting of all salaries, wages and full time equivalent employees by 11 designated classifications. The information required will be burdensome to gather, especially for those hospials not employing a data processing payroll accounting system.

The reason for collecting the data is not specified. If it is for comparison purposes, however, we believe the reported data will be deficient. First, small hospitals, because of the apparent burden of completing this form, are excused from its preparation. Secondly, the form requires full time equivalent to be determined by dividing total worked hours by 2080. This figure represents a normal 40 hour work week. Yet, not all hospitals have a standard 40 hour week; many are on 37 1/2 hours while others are on 35 hours. Furthermore, no information concerning vacation policies or other similiar leave programs is incorporated. As a result, the information may not prove reliable for comparison purposes. This worksheet should therefore be deleted.

Worksheet E-4-1)
Worksheet E-4-2)
Worksheet E-4-3): Cost Allocation Statistical Matrix
Worksheet E-4-4)

These worksheets, according to the SHUR, "report the required statistics for cost allocation."[66] SHUR further states that "the purpose of cost allocation is to determine the total or full costs of operating the revenue producing centers of the hospital."[67] The SHUR contains the definitions and sources of statistics for cost allocations in section 4582.

Several serious problems exist with the reporting of the required information. In a number of instances the cost allocation bases for these worksheets differ from the required standard units of measure calculation. Some also differ from the cost allocation statistics for Medicare cost finding. For example, the Medicare statistic for allocating laundry expense is dry and clean pounds processed while the allocation statistic for this worksheet is dry and clean pounds distributed.

The instructions to these worksheets also are incomplete. The instructions refer the reader to other sections of the SHUR for a further explanation of definitions and other material to be

---

66 Draft SHUR Manual, page 4.32.

67 Draft SHUR Manual, page 4.34.

relied upon in completing the worksheets. However, the instructions have left those section numbers blank. The end result of all the reported data is not incorporated into any other forms. Therefore, the data appears to be an open-ended mechanism for government manipulations without unknown reasons or purposes.

Because the purpose or purposes of these worksheets are basically unknown, the data required in several instances is contrary to other SHUR requirements; the instructions are incomplete and the forms appear to be an open-ended mechanism for governmental manipulation, the worksheets should be deleted.

V. AHA PROPOSED ALTERNATIVE TO SHUR

The following is a recommendation to help develop a less detailed and less costly System for Hospital Uniform Reporting. An AHA task force was formed for the primary purpose of reviewing the proposal, developing comments, and recommending an alternative to the proposed SHUR. The task force believes that the major component of any uniform reporting system is the proper identification and reporting of direct costs. These costs represent the majority of cost items that can, if properly identified, distinguish one hospital from another. The format of worksheet E-1 begins to offer the basis of such a system. Worksheet E-1 is a statement of patient care services expense. It lists the hospital's cost centers and requires specific information concerning direct costs attributed to each of the cost centers. AHA is in the process of developing a cost accounting manual that will further develop the basis of such a system.

Direct Cost Approach

Many of our comments indicate a belief by the hospital industry that the SHUR will not achieve one of its basic objectives -- comparability of different institutional operations. The SHUR proposal is too concerned with accounting for every cost situation. Further, it does not seek non-financial data that is necessary to identify hospital differences.

The most important and readily controllable components of any hospital department are its direct costs. Present Medicare cost reporting forms only provide information of direct departmental costs in the aggregate, i.e., by total salaries and non-salaries. Expanding the level of information to several components by department -- that include vital nonfinancial data -- could result in an extremely effective uniform reporting system at minimal cost and inconvenience to the provider.[68]

Also, pertinent standard units of measure recognizing valid differences and intensity could be included. The result would be knowledge of the direct components of hospital departments. Analysis could then be made without risk of erroneous conclusions stemming from improper allocation bases or short-term uncontrollable fixed costs.

Throughout this brief discussion on this approach, no indirect or overhead costs are addressed. These costs should remain within

---

[68] For example, HCFA could require the following information for the radiology department:
1. Total salaries for assigned personnel;
2. Total fringe benefits for assigned personnel, based upon hospital sampling techniques;
3. Professional fees designated by specified natural classifications;
4. Medical supplies designated by major types;
5. Non-medical supplies designated by major types;
6. Purchased services designated by major types;
7. Other direct expenses;
8. Depreciation expense designated for major moveable equipment with information concerning types, numbers, and ages, etc.;
9. Rental/lease agreements designating the terms and types of leases and equipment, etc.

their appropriate cost centers. We would not burden hospitals with extensive reclassification of these costs because they are (1) non-controllable for the most part and (2) difficult for inter-hospital comparison purposes unless substantiated by excessive non-financial data. Rather, GAAP and year-end audit review should govern and validate these items. We are also not suggesting that every hospital department undergo reporting, only those in which a majority of costs are incurred and which the HCFA requires data for decision-making. Again, this is to reduce the costs of compliance and monitoring.

AHA Development

One of the fundamental differences that exist in accounting for a hospital's expenses in providing services and that of a typical business is the multitude and diversity of the hospital product when compared to that of a business. Hospitals produce virtually thousands, if not tens of thousands, of products, i.e., the types of care and treatments rendered. Because of this factor, hospitals, in cooperation with third-party payers, developed cost finding -- not cost accounting -- as a means of determining the average cost of providing units of care. Unfortunately, cost finding, while extremely useful for certain things, is very inaccurate for measuring and comparing costs among different institutions.

The AHA is currently developing a new cost accounting manual for hospitals. While it does not prescribe an exact accounting

system, it begins to address a more rational and accurate method for the recording of the direct resources used in the provision of health care. This manual is currently approaching a final draft version. It is our intention to share it with you because we believe it would be useful in developing a reporting system acceptable to both HEW/HCFA and the hospital industry.

On behalf of the hospital industry, AHA is most willing to meet with HEW/HCFA to further discuss development of an appropriate uniform reporting system.

Appendix 1

AMERICAN HOSPITAL ASSOCIATION
840 NORTH LAKE SHORE DRIVE CHICAGO, ILLINOIS 60611 TELEPHONE 312-280-6000
TO CALL WRITER, PHONE 312-645-9449

May 25, 1976

James M. Kaple, Ph.D.
Chief, Program Experimentation Branch
Division of Health Insurance Studies
Department of Health, Education, and Welfare
Social Security Administration
Office of Research and Statistics
Baltimore, Maryland 21235

Dear Dr. Kaple

The American Hospital Association appreciates the opportunity to provide comments on the draft Accounting Manual developed in accordance with Section 1533(d) of P.L. 93-641. We realize that this document is the result of extensive efforts by you and your staff, and we hope you will accept our comments on a constructive basis.

In reviewing your document, it became quite apparent that the AHA Chart of Accounts for Hospitals served as a principle source document in your work. Unfortunately in adapting our Chart of Accounts you have so altered both its principles and purpose as to give rise to serious concerns on our part regarding the direction taken and the propriety of such adaption.

Unlike the AHA Chart, your manual fails to consider the significant difference between accounting for revenue and payment for service. Specifically, whereas the AHA Chart is "addressed to the recording and reporting of financial information for management accounting and public reporting purposes," your manual clearly was developed for reimbursement purposes. Any mandated chart of accounts which incorporates third-party reimbursement principles may not result in accurate, meaningful financial statements under generally accepted accounting principles. For example, the capitalization policy for depreciable assets specifying dollar limits over which expenditures for assets must be capitalized, (Chapter II, page 27), and the requirement that the depreciation method must be straightline, (Chapter II, page 28), are current Medicare reimbursement requirements and are not the only methodologies authorized under general accounting principles.

The introduction to your accounting manual, (Chapter I), states that uniform accounting offers management control over the affairs of the hospital

CABLE ADDRESS AHAOFF

through internal and inter-hospital comparisons. However, the adoption of your proposed chart of accounts:

- May reduce efficient cost control by inhibiting "responsibility" accounting;
- Would result in misinterpretations vis-a-vis efficiency and managerial effectiveness, since quality and levels of service cannot be measured by accounting data.

Section 1533(d) 3(C), provides for "an appropriate application of such system(s) in the different types of institutions. . .and different sizes. . ." However, your proposal lacks the flexibility for realistic adoption by many small institutions which have limited resources to implement such a detailed system. For larger institutions, this may be less sophisticated than that already in place--thus, your proposal would represent a step backwards in general management effectiveness.

We wish to emphasize that although uniform accounting appears useful in theory, realistically, a mandated system which lacks flexibility when applied to a variety of institutions, large and small, may not be implemented without impairing management and accounting innovation. Your proposal, as well as any such mandated system, could restrict health care management and accounting systems to a general level of mediocrity and increase administrative and accounting costs substantially. Further, any cost containment measures already in effect may be severely hampered by the restrictions on management prerogative and the associated increased costs.

The proposed chart of accounts also is contrary to Section 1533(d) 3(B) which states: "A uniform system for calculating rates to be charged to health insurers and other health institution payors by health service institutions. . .shall provide that such rates reflect the true cost of providing services to each such category of patients." The proposed accounting manual is not suitable for rate determination purposes as it does not include the necessary financial and reporting requirements that must be considered when payments are determined. Rates determined from such a system must recognize the total cost of providing services as outlined in the American Hospital Association's Statement on the Financial Requirements of Health Care Institutions and Services.

The importance of a flexible accounting numbering system - a requisite for the wide diversity, scope and complexities of health care institutions--and adherence to generally accepted accounting principles as recognized by the leading Accounting Bodies cannot be overemphasized.

The AHA Chart of Accounts for Hospitals currently embodies these requirements, and should be accepted as the guiding accounting manual for the health care industry. Further, uniform reporting, which appears to be your goal, can be

accomplished using the AHA Chart by defining the reporting document(s) and specifying the detail required.

In addition to the above general comments, listed below are specific comments on the Accounting Manual, which we suggest you consider.

Reference	Extracts from Proposed Manual	Comments
Chapter II, Page 15	Cost to Related Organizations	Third-Party Reimbursement principles and techniques which have been included in the proposed accounting manual. We do not believe that a mandated accounting system should incorporate third-party reimbursement principles.
" " Page 16-23	Direct Assignment of Costs	
" " Page 25	Basis of Valuation (of Assets)	
" " Page 26&27	Capitalization of Depreciable Assets	
" " Page 28	Depreciation Method	
" " Page 33	Contribution by Vendors	
Chapter III		
Section C, Page 31	Medical Supplies Charged to Patients	
Section C, Page 34	Drugs Charged to Patients	
Chapter II, Page 17 - First Paragraph	"The use of statistics based upon actual data...or... estimated tests will not be acceptable...for the direct assignment of costs."	This statement contradicts statements made in Page 15 (salary cost of nursing service), and in Chapter III, Section C, Page 51, (kitchen costs).
Chapter II, Page 22 - Last Paragraph	"Overhead will be charged to each job order monthly."	This would be an administrative nightmare.
Chapter III		
Section C, Page 36&37	Refers to "Triage", "Observation Room" and "Primary Care."	Triage, Observation Room and Primary Care are integral components of emergency room, and would be almost impossible to individually identify.

Dr. Kaple/4

5/25/76

Section C, Page 46	Refers to "Research Administrative Offices" and "Educational Administrative Offices."	The terminology is too restrictive. This would require setting up an additional office (cost center) not presently in existence, thus adding additional costs and confusion.
Chapter III		
Section C, Page 49	Maintenance and Repairs	This is subdivided between carpentry, plumbing, etc.; each category having a specific account number. If this system is mandated, subdivision of costs of one individual who performs all categories would again be an administrative headache and would lead to obvious inaccuracies.
Section C, Page 55	Fiscal Services	The structure of the institutions should dictate the classification of the components of Fiscal Services Subaccounts should not be mandated, but should be optional.
Chapter IV, Page 7	Number of Deliveries	This should include <u>all</u> deliveries within the facility, not only those born in the delivery room.

In addition to the above, we look forward to presenting additional comments on your proposed manual at our meeting on May 26 and 27, 1976.

We again want to thank you for the opportunity to provide these comments, and look forward to providing continued assistance in the further development of your proposal.

Sincerely

Lawrence A. Hill
Executive Vice President

Appendix 2

American Hospital Association

J. ALEXANDER McMAHON
President

C
O
P
Y

July 14, 1977

Dear Mr. Spaeth

This is to confirm the agreement between staff of HEW and the American Hospital Association as to appropriate language to be recommended for inclusion in several legislative proposals now under consideration in Congress. Specifically, the recommended language will apply to accounting and reporting requirements expected of the hospital industry. It is understood this agreed upon language will be conveyed by you to the appropriate parties within Congress as a joint recommendation of AHA and DHEW.

While the American Hospital Association has continually supported the concept of uniform reporting, it has opposed the development and implementation of a uniform accounting system for hospitals. We, however, acknowledge that it would be appropriate to have a uniform set of standards by which hospitals would reconcile their internal financial and statistical information to uniform reports at such times as they are required.

Per the agreement established between Mr. Allen Manzano, Vice President of the American Hospital Association and you and your staff, it is agreed that appropriate language to be included in various pieces of legislation regarding accounting and reporting requirements will hereafter refer only to uniform reporting and uniform reconciliation. Specifically, the following language has been agreed upon as to be proposed for inclusion in these pieces of legislation:

840 North Lake Shore Drive • Chicago, Illinois 60611 • 312 645-9400

> Hospitals will employ the chart of accounts, definitions, principles, and statistics, as prescribed by the secretary, necessary to reach a uniform reconciliation of financial and statistical data for specified uniform reports to be provided to the Department of Health, Education, and Welfare.

It was further agreed at that meeting that any legislative committee report include comment on the intent of this wording to mean that reconciliation of financial and statistical data to a uniform reporting system would be in accordance with functional areas of accounting. Further, such reconciliations would not be required on a day-to-day basis, but, rather only at such times as uniform reports are required.

It was also agreed that in the development of a chart of accounts, definitions, principles, and statistics, the secretary will, in addition to others, consult with various health industry representatives as to the appropriateness of such requirements to be promulgated.

In addition to the above agreements, we wish to stress the importance that recognition be given to the fact that additional costs will be incurred by hospitals as a result of these legislative requirements and the associated promulgations. We, therefore, stress the importance that such costs must be recognized by all payers as appropriate and, therefore, rightfully included as an element for payment.

We earnestly are interested in working with you and your staff as soon as possible in reaching agreements as to the appropriate chart of accounts, definitions, principles, and statistics to be developed and promulgated in order to establish the appropriate uniform reconciliation and reporting systems.

Sincerely yours,

/S/
J. Alexander McMahon

Mr. Grant Spaeth
Deputy Assistant Secretary
200 Independence Avenue, S.W.
South Portal Building
Room 406G
Washington, DC 20201

cc: Clifton Gaus
Robert Derzon
Allen Manzano
Lee Epstein

Appendix 3

American Hospital Association

JOHN ALEXANDER McMAHON
President

October 3, 1977

Dear Mr. Derzon

The agreement reached between your office and the American Hospital Association, as outlined in my letter to Grant Spaeth on July 18, has generated considerable discussion and concern by the hospital industry. The two concerns generally expressed by the field are:

1. Our support for a Secretary determined "chart of accounts" in the proposed legislative language, if taken out of context, could imply our endorsement of uniform accounting to which the field is strongly opposed rather than uniform reporting, which the field can support, and

2. The intent of the agreement which is explained in the letter, may be lost in the interpretation of the legislative language.

The American Hospital Association fully supports the intent of the agreement, but I feel that a revision to the proposed language is necessary to remove the grounds for the opposition of hospitals that results from the present language. The revised language for inclusion in legislation is:

"A functional reporting system necessary for cost reporting shall be developed by the Secretary for use by hospitals. This system shall be supported by such definitions, principles, and statistics necessary to reconcile data from the hospital accounting system with the requirements of the DHEW reporting system. A reconciliation may be required only for purposes of required reports and only as of such dates as are required for the uniform reports to be filed with DHEW. The Secretary will develop the reporting system with the consultation of representatives of the health industry to assure the appropriateness of the system to be promulgated."

840 North Lake Shore Drive • Chicago, Illinois 60611 • 312 645-9400

I must continue to stress the importance that there be a clear understanding that the reconciliation will not be done on a day-to-day basis but only at such time as the uniform reports are required. Further, the additional costs to the hospital associated with such a system must be recognized and included as an element of payment for federal programs.

The change in the proposed legislative language does not change the intent of our original agreement. It is intended to reaffirm our mutual position while eliminating a possible misunderstanding of our agreement.

We hope to continue working with your staff in the development of the uniform reporting system and its supporting elements. Allen J. Manzano of my staff will be glad to meet with you to discuss this matter at your convenience.

Sincerely

J. Alexander McMahon

Mr. Robert Derzon
Administrator
Health Care Financing
Administration
Department of Health,
Education, and Welfare
Room 5006, South Building
330 C Street, S.W.
Washington, D.C.

Appendix 4

BY THE COMPTROLLER GENERAL

Report To The Congress

OF THE UNITED STATES

HEW Progress And Problems In Establishing Professional Standards Review Organizations

The Department of Health, Education, and Welfare's effort to establish professional standards review organizations has been hindered by

- organizational limitations,
- resource constraints,
- delays in issuing program regulations and guidance, and
- the lack of aggressive contract administration.

It has also been hindered by physician opposition.

Although many of the problems appear to be solved, action is required to promulgate needed regulations and improve contract administration. In addition, the Congress should consider using a demonstration phase before authorizing full-scale implementation of similar programs.

HRD 78 92
SEPTEMBER 12, 1978

Appendix 5

COPY

February 2, 1979

The Honorable
Elmer B. Staats
Comptroller General of
the United States
General Accounting Office
441 G Street, N. W.
Washington, D. C. 20548

Dear Mr. Staats:

In January 1979, the Department of Health, Education, and Welfare made available for comment as a proposed regulation its proposed System for Hospital Uniform Reporting (SHUR). This proposed reporting system is in response to section 19 of Public Law 95-142--the Medicare/Medicaid Anti-Fraud and Abuse Amendments which requires the Secretary to establish, by regulation, for each type of health services facility or organization, a uniform system for the reporting of:

1. the aggregate cost of operation and the aggregate volume of services;

2. the costs and volumes of services for various functional accounts and subaccounts;

3. rates by category of patient and class of purchaser;

4. capital assets as defined by the secretary, including capital funds, debt service, lease agreements used in lieu of capital funds, and the value of land, facilities, and equipment; and

5. discharge and bill data.

The Act further provides that in reporting under such a system, hospitals shall employ such chart of accounts,

COPY

definitions, principles, and statistics as the Secretary may prescribe in order to reach a uniform reconciliation of financial and statistical data for specified uniform reports to be provided to the Secretary. With respect to the latter requirement, it was the intent of the conferees (as expressed in the Report) in accepting the Senate version of section 19 that the reconciliation of data not be required on a day-to-day basis but only at such times as the uniform reports are required, and only for the purposes of such reports.

Section 19 was enacted to deal with the problem of the variations in the information contained in Medicare and Medicaid cost reports and the need for comparable cost and related data for effective cost and policy analysis, the assessment of alternative reimbursement mechanisms, and, in certain situations, the identification and control of fraud and abuse. On the other hand, it was also the intent that in the development and implementation of the uniform reporting requirements, the Secretary should take into account the administrative costs for the institutions and the Department as well as the relationship of those costs to improved program administration.

The Committee has received reports that SHUR, as proposed by the Department, contains requirements for detailed data that go considerably beyond the Congressional intent. More specifically, it has been alleged that in substantial part the system has been designed as a research tool as opposed to a uniform cost reporting system.

Accordingly, it would be appreciated if GAO could undertake a review of the proposed SHUR designed to cover the following areas:

1. How much additional data is being required by SHUR than is now required by Medicare's existing cost reporting system?

2. What use does HEW intend to make of that additional data with regard to meeting the objectives of section 19 of Public Law 95-142 or other specific provisions of law?

3. How do the reporting requirements and chart of accounts of SHUR compare with the hospital Chart of Accounts recommended by the American Hospital Association (AHA) and the reporting system under AHA's Hospital Administrative Service program?

4. What steps has the Department taken to assess the additional costs to hospitals of establishing and meeting SHUR requirements? Would it be appropriate for Medicare and Medicaid to assume a larger-than-normal share of additional costs of installation of the SHUR system in hospitals?

5. Does the General Accounting Office have any suggestions for simplifying the proposed reporting system which would be consistent with meeting the objectives of section 19?

Overall, it would be helpful and useful to the work of the Finance Committee if an independent and objective judgment could be obtained from you as to whether the reporting system as proposed by HEW is in line with the objectives of section 19 of Public Law 95-142 and whether there is any unnecessary or overly burdensome detailed information required which could be reduced or eliminated.

Of course, we expect that the results of your review will be shared with the Committees on Ways and Means and Interstate and Foreign Commerce of the House of Representatives.

Sincerely,

Jay B. Constantine
Chief
Health Professional Staff

JCiguf

American Hospital Association—Analysis and Evaluation of the HCFA Study on the Cost of Implementing SHUR

INTRODUCTION

In October 1978, the Health Care Financing Administration (HCFA) contracted with Morris, Davis and Company to study and evaluate the cost of implementing HCFA's proposed System for Hospital Uniform Reporting (SHUR). The study has now been completed in 50 hospitals selected by the HCFA. On April 16, 1979, Morris, Davis and Company reported their preliminary results to the HCFA.

The American Hospital Association has reviewed and analyzed the Morris, Davis report and firmly believes the results of the study cannot and do not accurately determine the total cost hospitals will incur in adopting and implementing SHUR.

From the outset of the study, AHA has expressed a fundamental concern with the methodology to be used by HCFA in arriving at its conclusion for determining the cost of adopting and implementing SHUR. We have argued with the HCFA for the need to validate the results of the study by monitoring actual implementation of SHUR in a subsample of the 50 hospitals in order to test the results of the estimation process. The Morris, Davis estimates range from a low of $0 to a high of $195,400 in the 44 reported hospitals. This extreme range supports our cause for concern that the estimated may not be reliable unless the validation step takes place. Morris, Davis has stated in its report that they have made "no inferences beyond the 50 study hospitals." However, the AHA has learned that the HCFA has already established a national cost of adopting SHUR based on the Morris, Davis study. We understand the HCFA estimates the national cost of adopting the SHUR at approximately $65.6 million. AHA totally disagrees with this assumption for four basic reasons.

First, because the HCFA has refused to validate the estimation phase of the study through an actual implementation process and because of the wide discrepancy of results reported within the test site hospitals, and for additional reasons set forth below, the AHA believes that no valid conclusions can be drawn from the results of the reported hospitals.

Secondly, AHA believes that the 50 hospitals do not represent a valid statistical sample. AHA does not believe that a test using only 50 hospitals is sufficient for reliable statistical inference; that is, the sample is not statistically valid for extrapolating estimates for the universe. For example, thirty-two (32) percent of hospitals in the study are located in states that presently require uniform reporting. Nationally, only about 20 percent of hospitals are located in states requiring uniform reporting. Becuase several of these state programs are similar in nature to SHUR, the effect of having a disproportionte number of sample hospitals in these states tends to reduce the reported impact of SHUR costs. Also, the system employed by the HCFA in selecting the 50 hospitals, as explained below, places further concern on the validity of the sample.

Thirdly, the American Hospital Association has had discussions with many of the test hospitals. During these discussions, we learned of severe and serious problems with the methodology used to capture SHUR costs. Morris, Davis has assumed that the collection of many statistics, standard units of measure (SUMs) and allocation of expenses, payroll in particular, can be accomplished through a sampling technique. The entire purpose of the SHUR is to uniformly allocate and collect costs, statistics, and sums. The September 29, 1978 SHUR manual does not contain instructions, etc., to permit sampling techniques. We take serious exception to this aspect of the methodology because it significantly underestimates the final result. In fact, Morris, Davis acknowledges this controversy and acknowledges that the magnitude of this difference is to understate the SHUR cost by nearly 50 percent or by HCFA's calculation, $35 million.

Fourthly, the HCFA estimate does not include, because the Morris, Davis contract did not require it, any costs associated with non-hospital SHUR activity. HCFA's estimate fails to acknowledge SHUR costs that will be incurred by both federal and local governments, fiscal intermediaries, and others. The processing, storage, retrieval, and analysis of SHUR data will be extensive. To overlook such costs seriously distorts any final conclusions.

SPECIFIC AREAS OF CONCERN WITH THE METHODOLOGY

(A) Selection of hospitals/methodology

As previously noted, the 50 hospitals selected for the study were chosen by the Health Care Financing Administration. HCFA randomly selected, after stratifying for bed size categories, geographic factors, etc., a list of 50 hospitals as potential

candidates. The HCFA also ran a backup list of 50 hospitals in the event one of the initial 50 hospitals chose not to participate in the study. Over 20 percent of the original hospitals (11 hospitals) declined to participate in the study. This necessitated the selection of 11 alternative hospitals from the backup sample. The selection of the 11 alternative hospitals was performed by the HCFA. The final selection process of the 50 test hospitals has resulted in a disproportionate number of hospitals located in states that currently require a uniform reporting system. Moreover, we question whether 50 hospitals chosen in this manner is a statistically valid sample, particularly since one of the original intentions in the selection process was to insure inclusion of bed size, geographic and ownership representation but not necessarily on a statistically represenetative basis.

Thirty-two (32) percent of the hospitals are located in states which presently require uniform reporting whereas the national percentage of hospitals located in states requiring uniform reporting more closely approximates 20 percent. Morris, Davis acknowledges the cost of adopting SHUR in states not requiring uniform reporting is five times the average cost of adopting SHUR in states with uniform reporting requirements. ($15,283 for nonuniform reporting states vs. $3,338 for hospitals located in uniform reporting states.)

(B) Approach/alternative costing bases

The methodology accepted by the HCFA and undertaken by Morris, Davis in arriving at a cost of adopting SHUR is centered on two alternatives. The first alternative is for the hospital to reclassify at year-end its current accounting and statistical information, while the second alternative is for the hospital to convert its accounting information system to collect SHUR "compatible" data on a routine basis.

Morris, Davis stated in performing this study, that it tried to eliminate any cost associated with a hospital's desire to simply upgrade its current management and accounting information system even though such changes could impact SHUR requirements. Morris, Davis stated, that it tried to only ascertain those costs attributable to the SHUR. Obviously, such a technique is subjective in nature, and best estimates of including or excluding costs based on hospital management decisions play an important part in determining the resulting cost. The AHA does not wish to comment upon the subjectiveness of this process, but only to include within this analysis mention thereof.

Morris, Davis noted that where it disagreed with the approach selected by a hospital (reclassification vs. conversion), Morris, Davis made the final determination as to what it thought was an appropriate course of action the hospital would select, and therefore, estimated the cost of implementing SHUR under either alternative. The study methodology called for the determination of costs to be agreed upon with hospital management.

While Morris, Davis indicated that it tried to reconcile differences, if any, with hospital personnel, the AHA has learned in discussions with hospitals involved in the study, that for the most part, these hospitals did not know the final projected costs that are included within the Morris, Davis report. Therefore, we question the validity of the numbers portrayed by Morris, Davis. Such unilateral action on the part of the contractor places the validity of the methodology in serious question.

Morris, Davis acknowledges "a hospital will rarely elect to comply with SHUR using strictly one of the two options and will probably comply with SHUR using some combination of the two options." It is AHA's understanding that the HCFA believes the only cost of implementing SHUR that should be acknowledged by DHEW, are the costs attributable to the minimum reclassification amounts determined by the Morris, Davis study.

A direct conflict exists between a theoretical and a practical resolution of implementing and adopting the SHUR. What the HCFA cannot overlook is the fact that SHUR is a reporting document and not a day-to-day management information system. Hospitals must preserve accounting flexibility in order to exercise managerial control of an institution. Therefore, and as Morris, Davis aptly notes, there will be additional costs which must be attributable to the SHUR beyond those reported as simple reclassification methodologies. The SHUR clearly permits hospitals options for adopting SHUR. Whatever method or methods a hospital employs to adhere to the SHUR will be reflected in a hospital's cost of operation and, therefore, borne by the federal government.

Another important element not taken into consideration by Morris, Davis in its study are possible consulting service expenditures for the evaluation of alternatives and design of programs for complying with SHUR. Morris, Davis mentions the importance of this factor. AHA agrees that these costs cannot be overlooked in computing a national cost of implementing the SHUR. Nonetheless, these costs are excluded from the final results.

Morris, Davis also indicates that in developing cost estimations only portions of additional personnel required to maintain the SHUR were developed. In other words, full time equivalents (FTE) were developed as fractions. In reality, hospitals cannot hire fractions of individuals to perform SHUR data requirements. Failure to clearly identify these issues resulting in a further dilution of the reported cost estimations.

We believe a most serious error in the methodology used by the contractor in evaluating the reclassification cost figures is the use of sampling techniques to gather statistics and standard units of measure as well as the allocation of expenses, in particular payroll costs. The AHA strongly believes that the September 29, 1978, SHUR manual clearly prohibits hospitals from sampling statistics and standard units of measures for purposes of reporting SHUR information. To do as Morris, Davis has done, in our opinion, greatly underestimates the true cost and nature of complying with SHUR.

Morris, Davis acknowledges that many hospitals believe they canot sample statistics and SUMs. As a result, Morris, Davis has determined the additional reclassification costs based upon this requirement. It increases the average reclassification methodology by more than 50 percent. The effect of this issue alone based on HCFA's extrapolation of $65.6 million as a national cost of implementing the SHUR, would cause such costs to total nearly $100 million ($65.6 million x 1.50) and this amount is still understated for other cited deficiencies.

(C) Uniformity of approaches to cost estimation

Morris, Davis acknowledges that a major objective of the study was "to insure that for all of the hospitals the cost estimations were performed in a uniform manner." Morris, Davis cites several factors that "made this difficult." While Morris, Davis has reported that the field work was accomplished by analysts "who were experienced with hospitals and hospital information systems," the AHA believes otherwise. In several instances, hospitals reported to AHA that many of the analysts were new to the health care field or were not totally familiar with SHUR requirements. Additionally because of the time frame in which Morris, Davis performed its work, it has to deploy a large number of auditing teams and in at least one documented case the auditors were on location only 45 minutes.

We believe the large number of different individuals doing the field work has resulted in a lack of uniformity of data collection. For example, Morris, Davis report major estimated costs were reviewed with top level administrators "at the conclusion of the field work or after project management review." To the contrary, many hospitals have informed the AHA that they did not understand the work being performed, that they did not understand cost estimates which may or may not have been discussed by the analysts with them, and in many situations were not advised of the final results. Even as this analysis is being prepared many institutions do not know how the final amounts were determined. One of the stipulations hospitals understood in entering into this study was that they would receive copies of work papers, etc., attesting to the data collection and its result. Most hospitals have not received these documents. Many others who have received some data do not know what it means.

SUMMARY OF FINDINGS

Morris, Davis reported its findings for 44 hospitals on April 16, 1979. The six remaining hospital studies were not completed prior to the report date, but those results, as well as any changes because of errors, differences of opinion, etc., to the original 44 hospitals will be presented to the HCFA in a forthcoming addendum.

The following tables are extracted from the April 16 report:

TABLE 1.—SUMMARY OF OPTION 1 AND OPTION 2 COST ESTIMATES

	Average	Low value	High value	Standard deviation
Option 1:				
Simple reclassification	$620	0	$9,898	.....
Reclassification with study	10,878	0	53,519	.....
Optional 1 total	11,498	0	53,545	$14,941
Option 2:				
One time	12,741	0	94,924	.....
Ongoing	22,255	0	146,844	.....

TABLE 1.—SUMMARY OF OPTION 1 AND OPTION 2 COST ESTIMATES—Continued

	Average	Low value	High value	Standard deviation
Option 2 total	34,996	0	195,388	48,967

[NOTE.—HCFA has weighted the $11,498 average cost by bed size to arrive at its national cost of $65.6 million. Furthermore, the HCFA has utilized 6,848 Medicare and Medicaid providers in arriving at its weighted average cost. This produced a weighted average cost of $9,600 per hospital ($65.6 million ÷ 6,848 hospitals).]

The Morris, Davis report identifies only a limited number of its findings by bed size groupings. For the most part, conclusions reached in the study are only reported as unweighted averages.

In an attempt to make our conclusions comparable to the HCFA's AHA will utilize only the total number of community hospitals, 5,881 in analyzing the Morris, Davis report. We believe use of this number is not only appropriate but perhaps conservative because community hospitals have been proven to scientifically represent the universe of hospitals.

If the Morris, Davis reported average ($11,498) for reclassification is multiplied by 6,848 Medicare and Medicaid providers, the total cost of SHUR would equal, by HCFA standards, $78.7 million. If the $11,498 is multiplied by only 5,881 community hospitals, the amount is $67.6 million; approximately the $65.6 million the HCFA has determined.

TABLE 2.—*Estimated impact on total cost estimates of ongoing collection of SHUR statistics and SUM's*

Option 1 total	$11,498
Less: Option 1 costs of producing statistics and sums	−2,078
Option 1 less option 1 costs for statistics and SUM's	9,420
Add: Systems costs of producing statistics and SUM's	+8,033
Revised option 1 costs with systems approach to statistics and SUM's.	17,453

As previously mentioned, Morris, Davis is very cognizant that many of the study hospitals believe, as does the AHA, that sampling techniques are not permitted in accumulating statistics and standard units of measure.

Morris, Davis projected a reclassification cost for hospitals maintaining an ongoing collection of SHUR data shown above in table 2. This calculation would result in a total national cost of approximately $103 million for hospitals to comply with SHUR. ($17,453 × 5,881 hospitals).

TABLE 3.—FREQUENCY AND AVERAGE OF RECLASSIFICATION COST ESTIMATES BY NUMBER OF ADMISSIONS AND UNIFORM REPORTING

[Number of study hospitals in parentheses]

	State uniform reporting					
	With		Without		Total	
Number of admission	Amount	Number	Amount	Number	Amount	Number
Under 4,000	$786	4	$8,185	14	$6,304	18
Over 4,000	4,425	10	21,494	16	14,929	26
Total	3,388	14	15,283	30	11,498	44

TABLE 4.—FREQUENCY AND AVERAGE OF CONVERSION COST ESTIMATES BY NUMBER OF ADMISSIONS AND UNIFORM REPORTING REQUIREMENTS

	State uniform reporting					
	With		Without		Total	
Number of admissions	Amount	Number	Amount	Number	Amount	Number
Under 4,000	$2,123	4	$18,742	14	$15,273	18
Over 4,000	[1] 9,909	[1]10	71,581	16	[1] 48,953	[1]26
Total	6,941	14	46,913	30	34,201	44

[1] This figure excludes hospital number 40 because of the significant negative cost estimate of $21,603.

Tables 3 and 4 reveal the large differences for hospitals located in uniform vs. nonuniform reporting states. For the reclassification method, hospitals presently in nonuniform reporting states will incur costs 5 times those in uniform reporting states.

Based upon a proper mix of uniform and nonuniform reporting states, the following costs can be developed:

1. 5,881 hospitals:	
80 percent in nonuniform reporting states	$4,705
20 percent in uniform reporting states	1,176
Total	5,881
2. 4,705 × 15,283 (see table 3 totals)	71,907,000
1,176 × 3,388 (see table 3 totals)	3,984,000
Total	75,891,000

The HCFA's cost of SHUR is stated as $65.6 million. Because the sample is skewed towards hospitals in uniform reporting states, it is understated by more than 15 percent ($75.9 million − $65.6 million = $10.3 million; $10.3 million ÷ $65.6 million = 15.7 percent).

SAMPLE PERCENTAGES—COST BASED UPON TOTAL HOSPITAL EXPENDITURES

The individual hospital results calculated by Morris, Davis are attached. Morris, Davis, in calculating the average cost of implementing SHUR, also calculated SHUR costs as a percentage of 1977 total hospital operating expenses reported in the AHA Guide to the Health Care Field, 1978 edition.

This amounted to .29 percent for the reclassification methodology (option 1) and .99 percent (option 2) for the conversion methodology. The AHA *Guide* reports total 1977 nonfederal short term general and other special hospital expenditures as $51.6 billion.

AHA economists and statisticians believe careful consideration should be given to this calculation. A weighting of this factor results in a national SHUR implementation cost, using the reclassificaiton methodology, of nearly $150 million, more than twice the cost recorded by the HCFA ($51.6 billion× .29 percent=$149,640,000).

Similarly, the conversion methodology would result in a national SHUR implementation cost of more than $500 million ($51.6 billion× .99 percent+$510,840,000).

It is important to remember that Morris, Davis acknowledge that "a hospital will rarely elect to comply with SHUR using strictly one of the two options and will probably comply with SHUR using some combination of the two options." With this assumption, and with the above reported results, it is clearly evident that national implementation of SHUR will well exceed $100 million perhaps $200 million, if not more.

Based upon the sample size, the standard deviation of $14,941, reported by Morris, Davis for the reclassifcation option, and inferences about total hospital expenditures, AHA statisticians predict with 95 percent confidence that the actual cost of implementing SHUR ranges from 1.02 percent of total hospital expenditures to a negative .45 percent. Thus the cost estimates of implementing SHUR vary from a high of $522.2 million to $0. Such an extreme variance occurs because the standard deviation is larger than the reported average cost of implementing SHUR, i.e., $11,498 vs. $14,941, and, thus, results in a negative margin of error.

From a statistical perspective the wide variance in the cost estimate distribution and the resultant negative margin of error cast significant doubt about the reliability of the study's results. Consequently, no reasonable reliance can be placed on any cost estimate derived from this study. The validity of the HCFA's claim, which is based on this study, that the national cost of implementing the SHUR is $65.5 million is certainly questionable. Unfortunately, although the AHA firmly believes that the HCFA cost estimates are low, we are hampered by the nature of the results from deriving a more reliable estimate.

OTHER DEFICIENCIES

AHA is very concerned with the lack of hospital knowledge concerning the results reported by Morris, Davis. Many hospitals were only aware that costs were being gathered for either the reclassification or the conversion method but not for both. Additionally, several hospitals have complained that the results significantly understate the estimates derived with the audit teams during the on-site visits by either Morris, Davis and/or its subcontractor. For example, two large hospitals have documented that a significant portion of cost associated with the reclassification option were deleted from the final results. The amounts represent nearly $35,000 in one hospital and $57,000 in another hospital. Elimination of nearly $100,000 from the sample average result of $11,498 understates the average by over $2,000 and by nearly $12 million on a national basis. AHA has learned that a serious dispute exists between the audit team and Morris, Davis concerning the appropriateness of these costs. The audit team has, we understand, informed Morris, Davis that it believes these costs must be included if the results of determining the reclassification costs in these two hospitals are to be validated.

In another instance one of the six hospitals currently not reported in the April 16 report, understands that the cost for adopting SHUR on a reclassification basis would amount ot $313,464. AHA understands in this instance, there again appears to be a difference of opinion between the audit team and Morris, Davis. If Morris, Davis, as it has chosen in other instances, modifies this cost, it does so without the concurrence of either the hospital or the audit team. This particular hospital has a very significant cost for adopting the SHUR; the amount approximates $313,000. When added to the total of the reclassification methodology, it will have the effect of increasing the average cost by nearly $7,000 per hospital. The magnitude of this increase when extrapolated on a national basis will increase the cost by more than $40 million. ($313,000+45=6,955×5,881 hospitals)

The AHA also understands that another hospital whose costs are not included in the initial Morris, Davis report believes its costs of complying with SHUR to exceed $150,000. With the inclusion of this hospital, with its understanding at present of the cost of adopting SHUR on a reclassification basis will further increase the average by over $3,000 or another $15 million.

Therefore, AHA believes the preliminary results of the Morris, Davis study severely underestimates the cost of adopting SHUR as shown below, for the reclassification option methodology.

Ongoing status and sums methodology difference ($5,955×44 hospital)—($17,453−$11,498) per Morris, Davis report	$262,000
Two hospitals with costs omitted ($35,000+$57,000)	92,000
Two excluded hospitals from Morris, Davis report ($313,000+$150,000)	463,000
Total average of missing costs of 46 hospitals	817,000
Missing hospital cost ($817,000÷46) average	17,760
Total average ($17,760)×total hospitals (5,881)	104,500,000
Adjustment for weighting of nonuniform reporting states (refer to page 7)	10,300,000
HCFA initial projection	65,600,000
Total cost of adopting SHUR utilizing the reclassification method	180,400,000

CONCLUSIONS

Because of serious shortfalls regarding the Morris, Davis study, such as:

Major differences concerning the allowability of sampling statistics and standard units of measure (SUMs);

Possible validation problems with the selection of the 50 hospitals, because of a disproportionate number of sample hospitals located in uniform reporting states, etc;

Exclusion of non-hospital costs in processing and handling SHUR data;

The exclusion of consultant service costs;

Unilateral cost decisions made by the contractor;

Lack of hospital knowledge of final results;

The magnitude and range of findings;

A standard deviation larger than the average cost;

A margin of error calculation resulting in a possible range of compliance exceeding $500 million; and

The vast discrepancies and missing data reported to the AHA, Morris, Davis, and others,

Places the entire result of the study, and in particular, the HCFA total cost projection in total uncertainty.

The AHA wishes to maintain the confidentiality of the hospitals involved in the Morris, Davis study. For that reason, this analysis does not make specific reference to any hospital. However, the AHA has on file the supporting documentation to verify our arguments made herein.

AHA more than ever, believes the cost of implementing and maintaining the September 29, 1978, SHUR version will greatly exceed $100 million. HCFA has promised to modify the SHUR. However, the cost estimation study is premised upon the September 29, 1978, SHUR version. In order for all concerned, government, public, and hospitals, to truely understand the ramification and interactions of the SHUR, AHA urges again that the HCFA perform immediately as required by Executive order 12044, a regulatory analysis. A regulatory analysis will help clarify cost implications and the use and users of SHUR data.

SUMMARY OF COST ESTIMATES BY HOSPITAL

	OPTION ONE				OPTION TWO			
	Simple Reclass	Reclass With Study	Total	%	One-Time	Ongoing	Total	%
	$ 954	$ 150	$ 1,104	.01	$ 1,127	$ 239	$ 1,366	.01
	240	0	240	.01	0	240	240	.01
	9,898	2,551	12,449	.01	2,042	41,336	43,378	.35
	204	8,489	8,693	.01	14,280	13,908	28,188	.25
	425	16,471	16,896	.22	45,740	146,844	192,584	2.53
	0	800	800	.02	0	800	800	.02
	0	0	0	-	0	0	0	-
	577	32,758	33,335	.16	94,924	100,464	195,388	.68
	0	0	0	-	0	0	0	-
	216	10,166	10,382	N.R.	8,611	16,874	25,485	N.R.
	61	6,102	6,163	.51	2,483	7,266	9,749	.81
	495	6,377	6,872	.37	4,241	12,390	16,631	.89
	129	28,657	28,786	.49	19,207	17,173	36,380	.62
	1,576	12,451	14,027	.05	12,350	32,295	45,145	.15
	85	25,690	25,775	.22	6,901	42,167	49,068	.41
	0	17,500	17,500	.08	0	17,500	17,500	.08
	26	53,519	53,545	.26	50,629	57,647	108,276	.52
	500	3,739	4,239	.40	2,533	6,057	8,590	.80
	0	0	0	-	0	0	0	-
	434	12,553	12,987	.03	9,154	22,933	32,087	.07
	10	1,600	1,610	.17	0	1,600	1,600	.01
	5,502	24,030	29,532	.05	63,921	95,086	159,007	.27
	68	46,400	46,468	.19	8,211	48,333	56,754	.23
	617	7,897	8,514	.64	13,599	12,248	25,847	1.96
	559	6,308	6,867	.31	7,555	7,554	15,109	.69
	111	19,499	19,610	4.31	7,944	52,006	59,950	13.18
	228	50,446	50,674	.24	35,236	73,464	108,720	5.22
	96	19,213	19,309	N.R.	25,463	45,497	71,960	N.R.
	356	12,003	12,359	.06	21,198	14,608	35,806	.01
	211	2,197	2,408	.01	10,036	5,598	15,634	.08
	562	5,552	6,114	.28	19,298	6,984	25,282	.12
	522	749	1,271	.02	4,393	3,103	7,496	.13
	247	1,141	1,388	.02	3,846	1,904	5,750	.09
	123	3,585	3,708	.35	1,612	5,635	7,247	.68
	899	8,599	9,498	.67	13,820	22,278	36,098	2.53
	228	3,854	4,082	.20	11,453	5,782	17,237	.84
	333	5,265	5,578	.16	6,957	265	7,222	.21
	22	1,279	1,301	N.R.	7,466	1,977	9,443	N.R.
	360	6,255	6,615	.02	0	0	0	-
	305	752	1,057	.08	2,484	2,217	4,701	.35
	0	2,000	2,000	N.R.	0	2,000	2,000	N.R.
	50	2,988	3,038	.01	1,510	3,896	5,406	.01
	12	1,504	1,516	.50	908	1,593	2,501	.82
	37	6,546	6,583	.01	5,220	6,998	12,218	.01
tal	$27,278	$478,615	$505,893	N/A	$547,864	$956,979	$1,504,843	N/A
g. Cost	$ 820	$ 10,678	$ 11,498	.29	$ 12,741	$ 22,255	$ 34,996	.99

the "%" figures are our cost estimates expressed as a percent of 1977 total operating expenses reported to AHA.)

APPENDIX

GAO Response to AHA Letter

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

HUMAN RESOURCES
DIVISION

SEP 14 1979

HR9-70

The Honorable Herman F. Talmadge
Chairman, Subcommittee on Health
Committee on Finance
United States Senate

Dear Mr. Chairman:

The Subcommittee staff has asked that we review the comments of the American Hospital Association (AHA) dated August 9, 1979, pertaining to our July 26, 1979, testimony before your Subcommittee on the proposed System for Hospital Uniform Reporting (SHUR).

Because it appears futile to debate what others may infer from our testimony, we are limiting our observations to those three matters where AHA has characterized our testimony as inaccurate or incorrect.

Nature of SHUR and MONITREND

AHA stated that we made inaccurate assumptions about the nature of SHUR and MONITREND (the AHA uniform reporting system). AHA believes that the assumptions may lead to erroneous conclusions about the compatibility of the two systems.

We compared the two SHUR forms and instructions for reporting operating and nonoperating expenses with the two-page MONITREND reporting form and instructions. The two SHUR forms contain about 730 of the 10,100 data elements currently planned for the entire SHUR system; the MONITREND forms contain about 320 data elements. As we pointed out in our testimony, SHUR requires hospitals to provide a more detailed breakout of costs by cost center (such as salaries and wages, employee benefits, and utilities) than MONITREND.

We believe that MONITREND and that portion of the SHUR system where the primary purpose is uniform reporting on a functional basis are similar in the cost and statistical data to be reported.

Carrying forward the numbers on the SHUR uniform cost reporting forms to other forms in the proposed system to be used for reimbursement is the principle concern of the industry. Nevertheless, it is our view that, while the motives for obtaining data may be different, motives would not preclude a comparison of the similarities in the reporting forms and the instructions for obtaining and reporting the data.

Number of data elements required to be reported by hospitals

AHA points out that we were incorrect in stating that the burden on hospitals would be reduced because hospitals would not have to report all data elements if they did not have all the functions or services included in SHUR.

In the first place, we did not state that the burden would be reduced, but merely qualified our presentation of the charts on page seven of our statement to the effect that, of the 10,100 data elements in the current version of SHUR, hospitals would not have to report on those that pertained to functions or services that the hospital did not have. We have rechecked this statement with the Department of Health, Education, and Welfare, and it is correct. We also stated on page eight of our testimony that the uniform reporting requirements regarding cost and cost-related data--not the new data elements--probably represented the biggest burden caused by SHUR. We estimated that only about 18 percent of the costs of correcting the incompatibilities between SHUR requirements and the hospitals' information systems represented the new SHUR data requirements. Thus, we believe AHA criticisms of our testimony in this regard were not only inaccurate but unfair.

Comparison of AHA charts of accounts and SHUR chart of accounts

AHA characterized our testimony on the similarities of AHA's suggested chart of accounts to SHUR's chart of accounts as "incorrect and misleading." The basis for this characterization by AHA is that SHUR would serve a different purpose and would be mandatory. Irrespective of the purpose or mandatory nature of a chart of accounts, it is essentially a document listing account numbers, titles, and account descriptions in narrative form. As requested by the Subcommittee, we compared

AHA's 1976 document with the January 1979 and current versions of the SHUR manual and, as summarized in our statement, we found a high degree of similarity in the major revenue and expense accounts. Although the account numbers were different, the account titles were often the same and the narrative account descriptions in many cases were identical--word for word. This was a relatively straightforward factual determination involving the comparison of two public documents, and we fail to see how the motive or purpose behind the documents could make the documents themselves, or the identical words in both documents, different.

Finally, AHA stated that "* * * the SHUR chart of accounts would be mandated and, therefore, restrictive of management discretion * * *." We believe this statement is misleading. Hospitals would be required to use the SHUR chart of accounts on a once-a-year basis to reclassify and report cost and statistical data. Hospitals would not have to replace their existing chart of accounts with the SHUR chart--this is the same approach which could be used by hospitals which participate in MONITREND. A chart of accounts that defines reporting centers is to supply uniform data for comparing hospitals.

We appreciate this opportunity to comment on AHA's observations on our testimony.

Sincerely yours,

Gregory J. Ahart

Gregory J. Ahart
Director

○