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HUMAN RESOURCES
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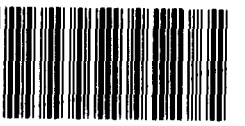

The Honorable Rudy Boschwitz
United States Senate

Dear Senator Boschwitz:

Subject: Information on Medicare's Hospital Inpatient Routine Operating Cost Reimbursement Limits for Duluth-Superior (HRD-82-24)

This is in response to your referral of a letter from Mr. Thomas G. Bell III, a member of the Board of Trustees of Miller-Dawn Hospital in Duluth, Minnesota. Mr. Bell questioned the methodology that the Department of Health and Human Services' Health Care Financing Administration (HCFA) used in establishing Medicare's reimbursement limits for hospital inpatient routine operating costs. He asked that we investigate HCFA's methods in establishing the wage index used in the July 1, 1979 and 1980, reimbursement limits.

The hospital inpatient routine operating cost reimbursement limit is the ceiling placed on Medicare payments to hospitals for such routine costs as room, board, and general nursing services. These limits are established under section 223 of Public Law 92-603 and are currently set, as required by section 2143 of Public Law 97-35, at 108 percent of the mean of routine costs of hospitals. Generally, hospital costs in excess of the limits are not reimbursed by Medicare.

To establish hospital reimbursement limits HCFA divides the hospital's routine costs into two parts--a wage portion representing employee salaries and a nonwage portion representing all other routine costs incurred by the hospital. HCFA develops wage indexes for each Standard Metropolitan Statistical Area (SMSA) and for non-SMSA areas in each State. To do this HCFA obtains data from the Department of Labor's Bureau of Labor Statistics (BLS) on the average wage level of the hospital industry nationwide, by SMSA

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and non-SMSA areas of each State. These data are derived by BLS from information on quarterly employment reports filed with the States for their unemployment compensation programs. The wage index for each SMSA and non-SMSA is computed by dividing the BLS data for the area in question by the nationwide data. This ratio is then multiplied by the national wage portion of the reimbursement limit, and the result is the wage portion of the overall limit for the area in question.

HCFA and BLS officials agree that there are inherent problems in using BLS data in the way HCFA does. HCFA officials, however, point out that these data are the best currently available. Some problems which would affect the wage index for particular areas are:

--The wage indexes developed by HCFA are based on data which is 2 years old. For example, 1978 data were used to develop the 1980 indexes.

--Because wages are not reported on a full-time equivalent basis two types of employment practices might distort the wage indexes. Part-time personnel, regardless of hours worked, are counted the same as full-time workers. Therefore, the wage index will be distorted downward to the extent that an area employs a larger proportion of part-time workers. 1/ Another distortion of the index can result from regional differences in the use of overtime. Since the BLS data do not differentiate between straight time and overtime wages, which are generally paid at a higher hourly rate, areas whose hospitals use a higher proportion of overtime will have a higher wage index than an area with less overtime, even if the base wage rates of their staffs are comparable.

--The data do not distinguish among hospital occupational categories. Accordingly, physicians included on a hospital payroll would tend to substantially increase the average overall wages paid by the hospital due to the physicians' significantly higher salary. Therefore, an area where hospitals have a higher proportion of salaried physicians would have a higher wage index.

1/For example, if a hospital employs 10 full-time workers at $10 an hour, its average wage would appear in the data as $10 per hour. However, if another hospital employs 20 half-time workers at $10 per hour, its average wage would appear in the data as $5 per hour.

--Confidentiality requirements preclude BLS from disclosing wage and employment data for areas with fewer than three hospitals. For these 26 areas, HCFA uses estimated rather than the actual indexes. This problem would not affect the Duluth area.

We identified several problems which may have had an impact on the Duluth-Superior SMSA wage index. However, BLS and the Minnesota State employment agency officials were unable to say whether these were the only problems with the Duluth-Superior wage index. First, these officials told us that the hospitals in the Duluth-Superior SMSA employ a high percentage of part-time workers which, as explained earlier, could lower the wage index. Second, the BLS data are not normally audited for accuracy. BLS officials explained that, because there are about 300 different areas with their own wage index, BLS does not have the capability of auditing the data. Audits are done only if BLS has been requested to or it has reason to believe that there is a problem with the data. Officials of the Minnesota and Wisconsin State employment agencies, which supply the data for the Duluth-Superior SMSA to BLS, said that they do not audit the data provided to them by the hospitals. The State agencies merely review the information for reasonableness. HCFA officials explained that they have no access to the data and, therefore, depend on BLS to provide accurate data.

One source of error in the development of the index has been incorrect reporting. For example, in the Duluth-Superior SMSA gross payroll data used to develop the 1980 wage index were understated by about $1 million in 1 year because the Miller-Dawn Hospital forgot to include its executive payroll. This error, when subsequently reported to BLS, resulted in an upward revision of the wage index.

Our review of the wage index for the Duluth-Superior SMSA showed that the index was computed properly based on BLS data for the years beginning July 1, of 1979, 1980, and 1981. We also noted that HCFA has excluded data from governmental hospitals from its calculation of the wage index for Duluth-Superior because inclusion would have lowered the index. For example, the index for Duluth-Superior for 1979 was 0.7809, but would have been 0.7302 if government hospital wage and employment figures were included.

Due to the inherent limitations of the BLS data, HCFA is exploring alternative methods of developing a wage index for use in establishing reimbursment limits. Until a better method is developed for establishing the wage index, hospitals which believe the wage index for their area incorrectly reflects their wage structure can request from HCFA an exception to the reimbursement

limit. Medicare regulations (42 C.F.R. 405.460 (f)(8)) permit an exception if the hospital can demonstrate that its labor costs vary by more than 10 percent from those included in the promulgation of the limits.

We trust that this information will be of assistance to you and Mr. Bell.

Sincerely yours,

Gregory J. Ahart
Director