



Memorandum

APR 21 1992

Date

From

R. P. Kusserow
Richard P. Kusserow
Inspector General

Subject Analysis of Hospital Capital Costs (A-09-91-00070)

To

William Toby
Acting Administrator
Health Care Financing Administration

The attached final audit report analyzes hospital capital costs during the first 5 years of Medicare's prospective payment system (PPS). We found that capital costs increased much faster than other leading economic indexes, even though the hospital industry had significant excess capacity. The ability of hospitals to pass capital costs through to third party payers, such as Medicare, on a cost reimbursement basis was an important factor for capital expenditures increasing, despite relatively low hospital utilization.

The Health Care Financing Administration (HCFA) has recently implemented regulations to pay capital costs prospectively, which should help curb the rise in capital costs. However, we noted that the basis for the PPS rates--historical costs--is inflated because: (1) excess capacity in the hospital industry has caused more capital costs to be incurred than economically necessary and (2) inappropriate elements (waivers of interest income offsets and depreciation on federally funded assets) are included in the costs.

We recommend that HCFA propose legislation to continue mandated reductions in capital payments beyond Fiscal Year 1995 to recognize that historical costs used in setting PPS rates are inflated because of excess hospital capacity and the inclusion of inappropriate elements. The HCFA should determine the extent of the capital payment reductions that are needed to fully account for the excess capacity and inappropriate elements. This revised capital payment reduction percentage should then be reported to the Congress.

The HCFA generally concurred with our position on excess capacity but did not agree on the issues of interest income waivers and depreciation on federally funded assets.

Page 2 - William Toby

Overall, HCFA believed that anticipated congressional reductions and the implementation of PPS for capital costs would fully address the intent of our recommendation. We believe that our recommendation is still valid. The HCFA has not presented any evidence that future reductions will eliminate inflated PPS rates caused by excess capacity and other inappropriate cost elements.

Please advise us, within 60 days, on actions taken or planned on our recommendations. If you have any questions, please call me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits at FTS 646-7104. Copies of this report are being sent to other interested top departmental officials.

Attachment

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**ANALYSIS OF HOSPITAL CAPITAL
COSTS**



**Richard P. Kusserow
INSPECTOR GENERAL**

A-09-91-00070

SUMMARY

This Office of Inspector General (OIG) study shows that hospital capital costs have soared in recent years, despite excess hospital capacity. To rein in these spiraling costs, the Health Care Financing Administration (HCFA) issued rules to pay capital costs using a prospective payment system (PPS) based on historical costs.

Although the HCFA rules to pay capital costs prospectively represent a much needed reform, the OIG believes that the historical costs to be used in setting PPS rates are inflated, because: (1) excess capacity in the hospital industry has caused more capital costs to be incurred than economically necessary and (2) inappropriate elements are included in the costs.

Since 1983, hospitals have obtained Medicare reimbursement for operating, but not capital, costs under PPS. The PPS is designed to give hospitals an incentive to operate efficiently as they are paid a flat amount, depending on the patient's diagnosis. Although the Congress intended that all costs would be eventually covered by prospective payments, capital costs were excluded for further study. Until recently, capital costs were paid separately based on Medicare's share of actual reasonable costs.

Unlike Medicare's payments related to hospital operating costs which grew at reasonable levels under PPS, hospital capital costs soared. The OIG analysis of changes in capital costs for 5,248 hospitals over the first 5 PPS years showed that:

- o The average yearly increase in capital costs for the 5,248 hospitals ranged from 9.7 percent to 14.3 percent per year, or an average yearly growth of 11.5 percent. These rates of increase were two to three times more than the Consumer Price Index (CPI), the Hospital Market Basket Index, and the PPS update factor. In addition, they were almost twice the rate of growth in new plant and equipment expenditures by business.
- o In terms of patient discharges (which would be the payment basis under the proposed PPS), capital cost increases per discharge averaged 13.7 percent per PPS year, which was even greater than the overall capital expenditure increases.

- o Only action by the President and the Congress prevented Medicare from absorbing the full impact of the capital cost increases. Legislation was enacted which effectively reduced Medicare's sharing in the increased costs.
- o The large increases in capital costs occurred even though the hospitals operated at low bed occupancy: 54 percent of available beds in the first year and about 61 percent in each of the last 4 years.
- o The large increases in capital costs were caused by a relatively small group of high-cost hospitals. Less than 19 percent of the 5,248 hospitals accounted for 80 percent of the cost increases in each year of our review. The high-cost hospitals were primarily large, urban, nonprofit, and teaching facilities. They tended to have slightly higher occupancy rates (about 67 percent on the average) than the industry average.

Medicare's cost reimbursement system for capital failed to curb the escalating costs and, indeed, may have contributed to the problem. Few industries could operate at relatively low utilization while significantly increasing capital expenditures as has the hospital industry. Third party payers that allow reimbursement of capital costs, regardless of excess capacity and the low economies of scale associated with it, permit such anomalies to occur. Only action by the President and the Congress in recent years to limit Medicare participation in capital costs by mandating reductions (15 percent in Fiscal Year (FY) 1991) has prevented Medicare from absorbing the full impact of the cost increases.

Ultimately, the most effective solution to reining in capital costs is to pay these costs using a PPS. Just as it did for operating costs, prospective payment for capital costs provides both economic incentives and limits to assure prudent spending.

The HCFA issued final rules on August 30, 1991 to fold capital costs into PPS over a 10-year period beginning on October 1, 1991. The PPS rates will be based on historical costs, less a congressionally mandated reduction of 10 percent. The 10 percent reduction, however, will last only through FY 1995.

A problem in basing the PPS rates on historical capital costs is that they are inflated due to uneconomical costs caused by excess capacity. In addition, the historical costs include inappropriate elements. A prior OIG report identified six cost elements which were not appropriate and should not have been included in a base for future capital PPS rates. While four of the issues in our prior report have been corrected, there are still two significant inappropriate elements that would adversely

affect capital PPS rates. They are: waivers of interest income offsets and depreciation allowances on federally financed assets.

We recommend that HCFA propose legislation to continue mandated reductions in capital payments beyond FY 1995 to recognize that historical costs used in setting PPS rates are inflated because of excess hospital capacity and the inclusion of inappropriate elements. The HCFA should determine the extent of the capital payment reductions that are needed to fully account for the excess capacity, unnecessary interest waivers, and depreciation allowances on federally financed assets that have yet to be corrected from our previous report. This revised capital payment reduction percentage should then be reported to the Congress.

The HCFA generally concurred with our position on the issue of excess capacity but did not agree with our recommendation as it applied to interest income waivers and depreciation on federally funded assets. Overall, HCFA believed that anticipated congressional reductions and the implementation of PPS for capital costs would fully address the intent of our recommendation.

We believe that our recommendation is still valid. There is no evidence that future reductions will eliminate inflated PPS rates caused by excess capacity and other inappropriate cost elements.

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INTRODUCTION

Background

Prospective Payment System

When the Hospital Insurance (HI) Trust Fund was established in 1965, the Congress stipulated that hospitals were to be reimbursed their actual costs for services provided to program enrollees. However, in 1983 the Congress made a dramatic change in payment policy. The reform provided that hospitals would be reimbursed for most inpatient costs under the prospective payment system (PPS). The new system was designed to control escalating costs by creating an incentive for hospitals to operate in a cost-effective manner. Hospitals would be paid a fixed amount per discharge depending on how a patient was classified within a diagnosis related group (DRG). A hospital's profitability would depend on how its actual costs to treat a patient compared to the pre-established fixed payment.

When the Congress established PPS in 1983, it specifically excluded capital-related costs. While the Congress intended that all hospital costs would eventually be covered by prospective fixed payments, it recognized that further study was necessary on the precise methods to incorporate capital costs. Under the HI program, capital-related costs include depreciation, leases and rentals for the use of facilities and/or equipment, interest incurred in acquiring land or depreciable assets used for patient care, insurance on depreciable assets used for patient care, and taxes on land or depreciable assets used for patient care.

Excess Hospital Capacity

The hospital industry has had excess capacity for years. The President's Private Sector Survey on Cost Control (PPSSCC), also referred to as the Grace Commission, reported in 1983 that estimates of surplus hospital beds between 1976 and 1980 ranged from a low of 68,887 to a high of 264,000.

For most industries, plant utilization is a major factor in decisions to add or modernize facilities. Low utilization is a deterrent to such additions or modernizations because capital costs may not be recovered. The hospital industry differs in that hospitals could often pass on costs to payers even if utilization was low because third party payers, like Medicare,

paid on a cost reimbursement basis. Such cost reimbursement policies created inherent **disincentives** for efficiencies and economies. As the PPSSCC reported¹ in 1983:

"Excess capacity in general acute care hospitals has arisen from a number of causes which act in unison. The dominant cost-based third-party reimbursement system covers the costs of both filled and empty beds and used and unused services. The same system insulates patients and communities from the costs of beds and services which might not be used. Emphasis on high technology, begun in medical school, prompts physicians to request high technology services from hospitals. Since physicians are necessary to provide patients and revenues, hospitals generally comply with these requests. The reimbursement system insulates hospitals from market tests of effective demand for requested services. (Emphasis supplied)"

The PPSSCC added:

"Guaranteed reimbursement by Medicare and Medicaid of interest, depreciation, and the amortized costs associated with construction is possibly the single most potent factor in hospitals' ability to raise debt capital, regardless of need for services... Although Medicare influence on individual hospitals varies widely, the symbolic impact of Medicare immunity to excess capacity concerns can hardly be overestimated."

Both the PPSSCC and the General Accounting Office (GAO), which reviewed the PPSSCC's findings and recommendations, concluded that excess hospital capacity produces unnecessary costs. The PPSSCC stated that:

"A major issue facing the Health Care System is unnecessary and costly duplicative patient care capacity. A surplus of hospital beds and services contributes to rising health care costs because:

- o Maintenance and staffing are required to keep the unneeded capacity open.

¹ "Report on Department of Health and Human Services Public Health Services/Health Care Financing Administration," dated August 31, 1983.

- o The very availability of that redundant capacity may encourage unnecessary hospital utilization.
- o Additional capital investment is required for updating or replacing obsolete facilities (maintain total level of capacity)."

In its review of the PPSSCC findings, the GAO concluded:*

"Excess hospital capacity increases the overall cost and Medicare's cost of providing hospital services. Some form of incentives/disincentives to control excess capacity is needed..."

...GAO agrees that controls are needed to ensure that unreasonable capital costs are not paid..."

Although there is a general consensus that excess capacity is economically undesirable, there are no exact standards on what are acceptable levels of plant and equipment utilization. The PPSSCC acknowledged in its report that it is difficult to measure excess capital precisely. In the same review, the PPSSCC stated that no exact estimate of the net savings achievable by reducing excess hospital capacity can be made. With that qualification, the PPSSCC made a rough estimate of Medicare savings (about \$939 million in 3 years) if excess capacity were eliminated. The GAO, however, concluded that the estimate was too high but did not report an independent estimate.

Other Inappropriate Elements in Capital Costs

In addition to capital costs being inflated by excess capacity, previous Office of Inspector General (OIG) audits disclosed that historical capital costs included several other inappropriate elements. The OIG issued a summary report³ in 1985 which identified seven issues dealing with Medicare cost reimbursement for capital. Six of the seven issues had significant implications for capital PPS payments.⁴ The six were: (1) gains on sales of assets, (2) revaluations of assets on sales, (3) return on equity payments, (4) waivers of interest income

² "Compendium of GAO's Views on the Cost Saving Proposals of the Grace Commission," GAO/OCG-85-1, dated February 19, 1985.

³ "Capital Cost Issues that Need to be Addressed in Developing Medicare Reimbursement Policy," ACN 14-52083, dated May 13, 1985.

⁴ The seventh issue (duplicate payment for capital costs) affected PPS rates for operating but not capital costs.

offsets, (5) depreciation allowances on federally financed assets, and (6) minimum salvage values on depreciable assets.

Based on our findings, we believed that past Medicare payments of capital costs to hospitals had been excessive (several billion dollars over a 5-year period). We recommended that the cost features questioned by our audits not be continued in a capital PPS.

Attempts to Fold Capital Costs into PPS

Efforts to incorporate payments for capital costs into PPS have been stalled over the years. The delays have occurred because of disagreement over the methodology to be used to determine the fixed payments. Recently, the Health Care Financing Administration (HCFA) finalized regulations requiring the inclusion of payments for capital costs within PPS. A chronology of some of the more significant efforts to incorporate capital costs into PPS follows:

- o The Social Security Amendments of 1983 required that capital costs be reimbursed under PPS beginning with Fiscal Year (FY) 1987.
- o On June 3, 1986, HCFA published a notice of proposed rulemaking in the Federal Register to amend the regulations to incorporate capital costs into PPS beginning with FY 1987.
- o On July 2, 1986, The Urgent Supplemental Appropriations Act for FY 1986 postponed the inclusion of capital costs until FY 1988.
- o On October 21, 1986, the Omnibus Budget Reconciliation Act (OBRA) of 1986 further revised the exclusion of capital costs until FY 1988 or later at the Secretary's discretion.
- o On May 19, 1987, HCFA published another notice of proposed rulemaking in the Federal Register to amend the regulations to incorporate capital costs into PPS beginning with FY 1988.
- o On September 1, 1987, HCFA published a final rule in the Federal Register to amend the regulations to incorporate capital costs into PPS beginning with FY 1988.
- o On December 22, 1987, the OBRA of 1987 voided HCFA's final rule and required the Secretary to establish a prospective payment for capital costs beginning with FY 1992.

- o On February 28, 1991, HCFA published another notice of proposed rulemaking in the Federal Register to amend the regulations to incorporate capital costs into PPS beginning with FY 1992.
- o On August 30, 1991, HCFA published its final rules in the Federal Register to incorporate capital costs into PPS beginning with FY 1992.

Mandated Reductions

In an attempt to control escalating costs during the transition to PPS, the Congress mandated across-the-board reductions in Medicare payments for capital costs. Hospital reimbursements were determined by reducing actual capital costs allocable to the program by a specified percentage. The specific percentage reductions and applicable periods were as follows:

- o 3.5 percent for portions of cost reporting periods occurring October 1, 1986 through November 20, 1987;
- o 7.0 percent for portions of cost reporting periods occurring November 21, 1987 through December 31, 1987;
- o 12.0 percent for portions of cost reporting periods occurring January 1, 1988 through September 30, 1988; and
- o 15.0 percent for portions of cost reporting periods occurring October 1, 1988 through September 30, 1991.

Fiscal Year 1991 Legislation

On November 5, 1990, the OBRA of 1990 was enacted. The 15 percent payment reduction previously in effect was continued for all hospitals through FY 1991. The Administration's proposal to increase the reductions to 25 percent for urban hospitals was not enacted. The estimated FY 1991 savings for the 15 percent payment reduction are expected to be \$810 million.

The new law also specified capital cost reductions for periods subsequent to FY 1991. The aggregate payments made during FY 1992 through FY 1995 under PPS are to be set in a manner that will result in savings equivalent to a 10 percent reduction in payments that would otherwise have been made using the old reasonable cost basis. The change to a 10 percent reduction is contrary to the recent practice of increasing payment reductions to restrain capital costs. The 10 percent reduction is scheduled to lapse after FY 1995.

On August 30, 1991, the HCFA published final rules in the Federal Register to begin the implementation of the new capital payment

reforms contained in OBRA of 1990. The new system became effective on October 1, 1991.

Scope

The objectives of our review were to:

- o Analyze changes in hospital capital costs during the first 5 PPS years.
- o Relate cost changes to hospital occupancy rates.
- o Determine which hospitals accounted for most of the cost changes.
- o Ascertain if corrective action had been taken on the six inappropriate cost elements identified in our prior summary report⁵ that would significantly impact capital PPS rates.
- o Determine if the rules to pay capital costs on a PPS basis adequately address the issues of excess hospital industry capacity and inappropriate cost elements.

The hospitals included in our review were selected from HCFA's Hospital Cost Report Information System (HCRIS). The HCRIS is a national database of financial and statistical information extracted from hospital cost reports. The reports are submitted annually to fiscal intermediaries (FIs) which process and review the data. The FIs submit cost report data to HCFA for inclusion in HCRIS.

The information contained in HCRIS is variable, being updated quarterly to reflect information from the most current version of each hospital's cost report. Since the reports may be in different stages of review at any point in time, cost report versions may vary among hospitals or even for the same hospital in different years. The different versions are: (1) as submitted, (2) settled without audit, (3) settled with audit, (4) reopened, and (5) audited but not settled. Our review was based on the most current data through the quarter ended March 31, 1990.

⁵ See Footnote 3, Page 3.

We obtained HCRIS data for the first 5 PPS years. Our review included hospitals with FYs beginning on or after:

- o October 1, 1983 and before October 1, 1984 (PPS-1).
- o October 1, 1984 and before October 1, 1985 (PPS-2).
- o October 1, 1985 and before October 1, 1986 (PPS-3).
- o October 1, 1986 and before October 1, 1987 (PPS-4).
- o October 1, 1987 and before October 1, 1988 (PPS-5).

To ensure comparability between the periods reviewed, we excluded data for hospitals (ranging from 262 to 460 per period) which did not submit cost reports in each of the 5 periods. We also excluded a small number (ranging from 5 to 16 per period) of hospitals which had obvious data errors. Following these adjustments, data for 5,248 hospitals remained for our analytical review.

Our review did not include any verification of costs reported by hospitals. The accuracy of HCRIS cost data was the subject of a prior OIG audit entitled "Validation Review of the Hospital Cost Report Information System," A-07-88-00120, dated April 30, 1990. The audit found an accuracy rate in excess of 99 percent for data elements tested and concluded that the small error rate was considered irrelevant by system users. In addition, our review did not include a breakdown and analysis of the various types of capital costs. Due to the limitations of the data available in HCRIS, we were unable to identify specific costs, such as those associated with new construction, renovations, and equipment, to name a few.

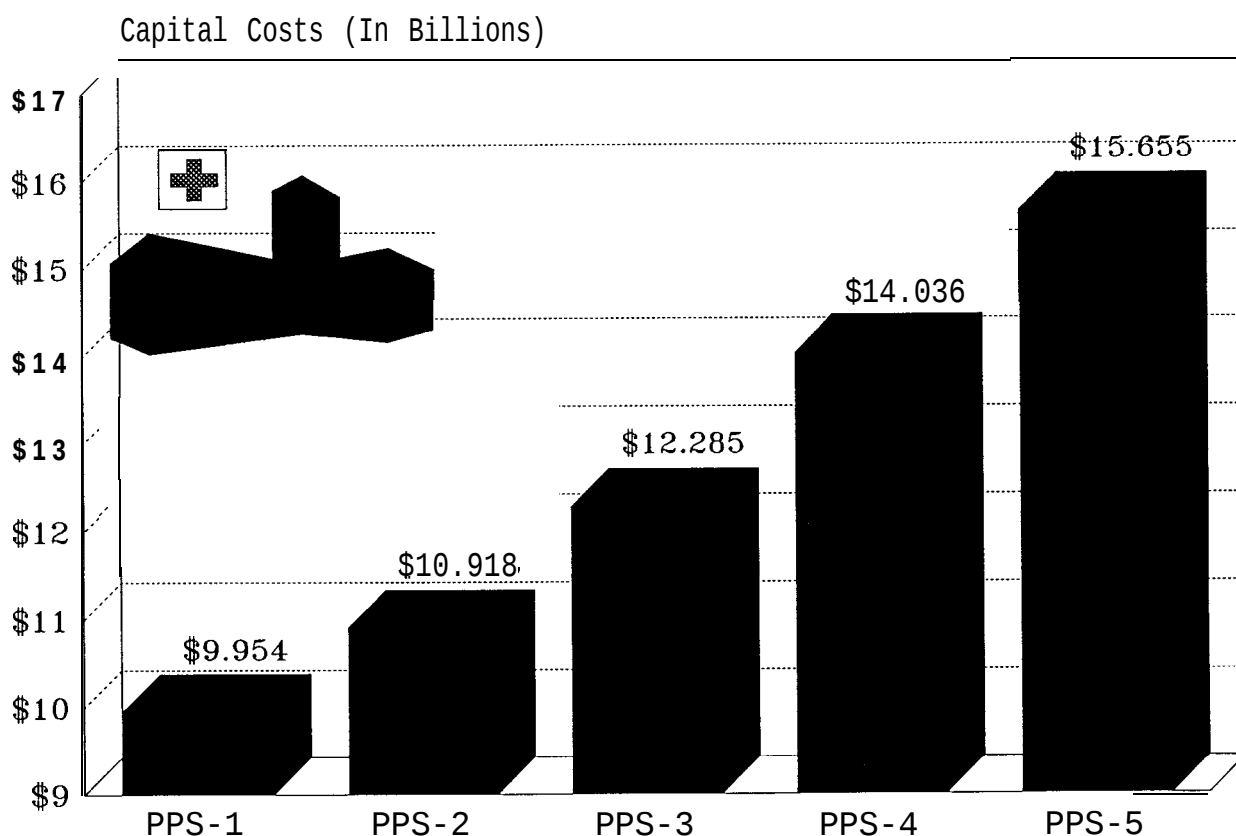
We did not evaluate the rationale or basis for the percentage reductions in Medicare payments for capital costs as they were mandated by the Congress.

Our review was made in accordance with Government Auditing Standards. The review was performed by the Office of Audit Services in Sacramento, California and was completed in October 1991.

FINDINGS AND RECOMMENDATIONS

Total capital costs for the 5,248 hospitals analyzed increased significantly over the 5-year period covered by our review. During PPS-1, total hospital capital costs amounted to \$9.954 billion while PPS-5 costs were \$15.655 billion, an increase of 57.3 percent. The yearly rates of increase ranged from a low of 9.7 percent to a high of 14.3 percent, or an average of 11.5 percent per year. (See Exhibit A for further details on capital cost increases by hospital classification.)

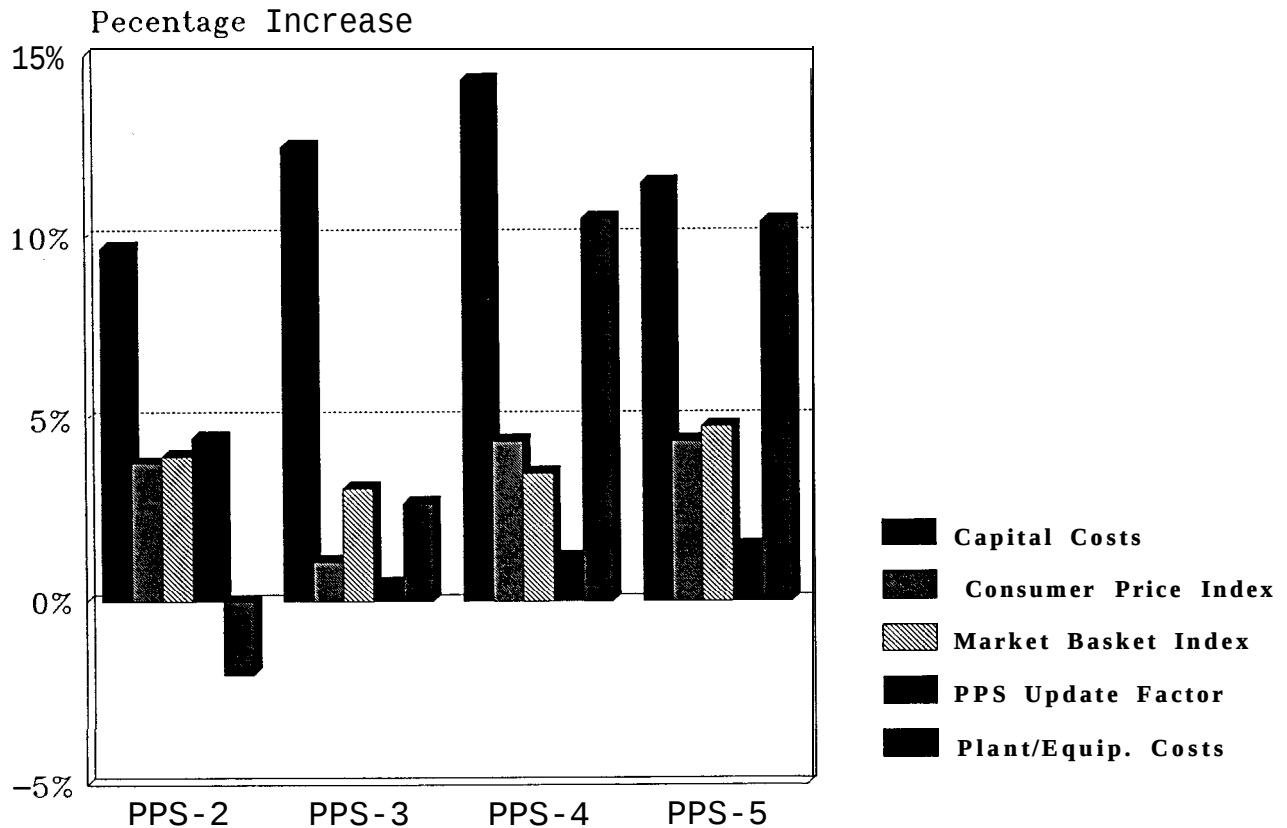
Capital Costs for 5,248 Hospitals PPS-1 through PPS-5



Capital Costs Increased More Than Other Costs

The increases in capital costs were significantly higher than increases in other costs. Capital costs increased two to three times faster than changes in the Consumer Price Index (CPI), Hospital Market Basket Index, or the annual PPS update factors. They were also, on the average, almost twice the rate of growth in new plant and equipment expenditures by business.

Relative Cost Increases PPS-2 through PPS-5



The CPI⁵ is a measure of the average change in all consumer prices over time. During the period covered by our review, the increases in the CPI ranged from 1.1 percent to 4.4 percent, or an average of 3.5 percent per year, significantly less than the average of 11.5 percent for capital costs.

The Hospital Market Basket Index reflects price changes of goods and services purchased by hospitals. From PPS-2 through PPS-5, the index increases ranged from 3.1 percent to 4.8 percent, or an average of 3.9 percent per year, which was also much less than the average increase in capital costs.

The PPS update factor is another measure of price increases. The factor is used to adjust Medicare DRG payment rates. The update factor takes into account changes in the Hospital Market Basket Index, as well as changes in hospital productivity, technological advances, quality of care, and long term cost-effectiveness of services. During our review period, the factor ranged from 0.5 percent to 4.5 percent, or an average of 1.9 percent per year. As such, the update factor increases were also significantly less than the increases in capital costs.

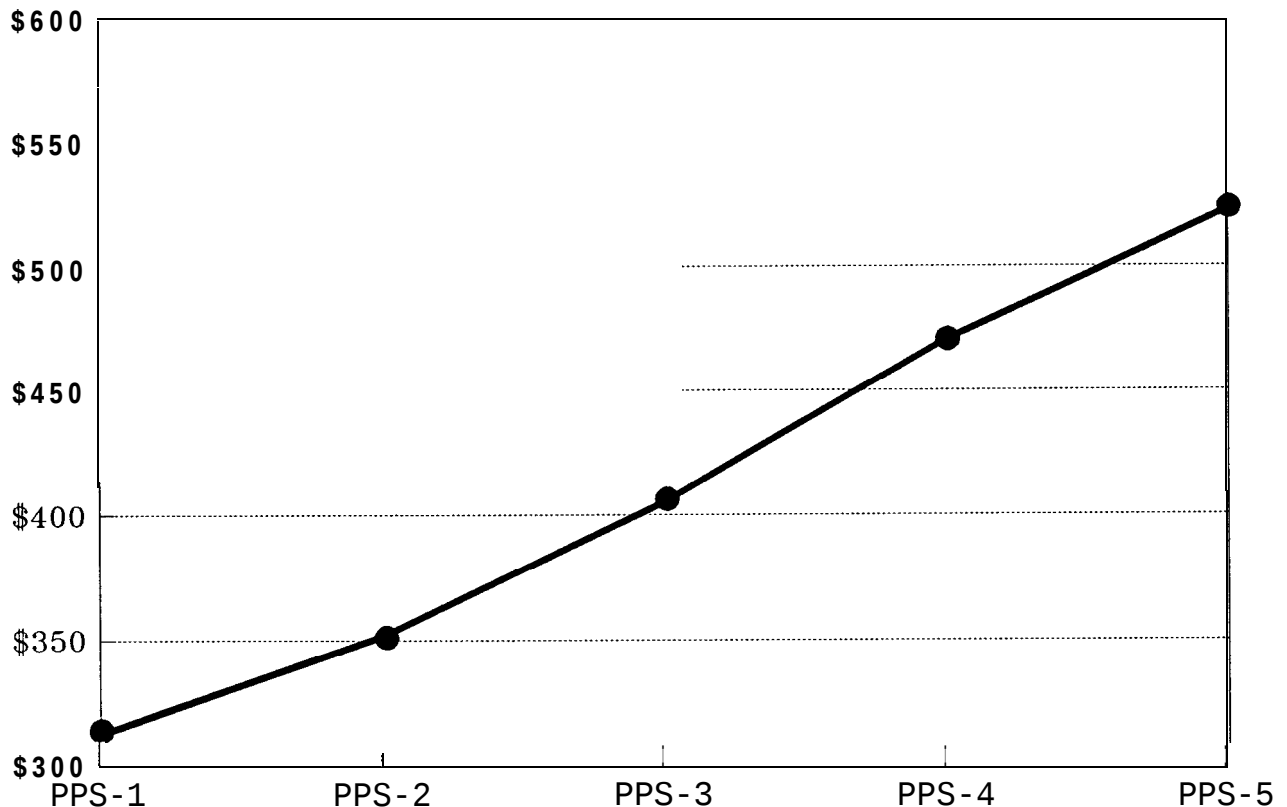
Data on new plant and equipment expenditures by business (see footnote 5) are published by the Department of Commerce. The data are part of surveys of business cycle indicators that are made by the Statistical Indicators Branch of the Department of Commerce. For our review period, the percentage increase ranged from a minus 2.0 percent to 10.5 percent, or an average of 6.2 percent per year.

⁵The CPI and data on new plant and equipment expenditures by business are reported on a calendar year (CY) basis. However, the Hospital Market Basket Index and PPS update factors cover Federal FYs beginning October 1 and ending September 30. For purposes of comparisons in PPS-1, which covered the period October 1, 1983 through September 30, 1984, we used the CPI and data on new plant and equipment expenditures for CY 1984. For PPS-2 comparisons, we used the CPI and data on new plant and equipment expenditures for CY 1985, and so on for PPS-3, PPS-4, and PPS-5.

Capital Costs Per Discharge Soar

Not only did capital costs outstrip leading economic indexes, they skyrocketed in relation to patient discharges. Capital costs per discharge increased from \$313 in PPS-1 to \$523 in PPS-5, an average increase of 13.7 percent per year.

Capital Costs Per Discharge PPS-1 through PPS-5



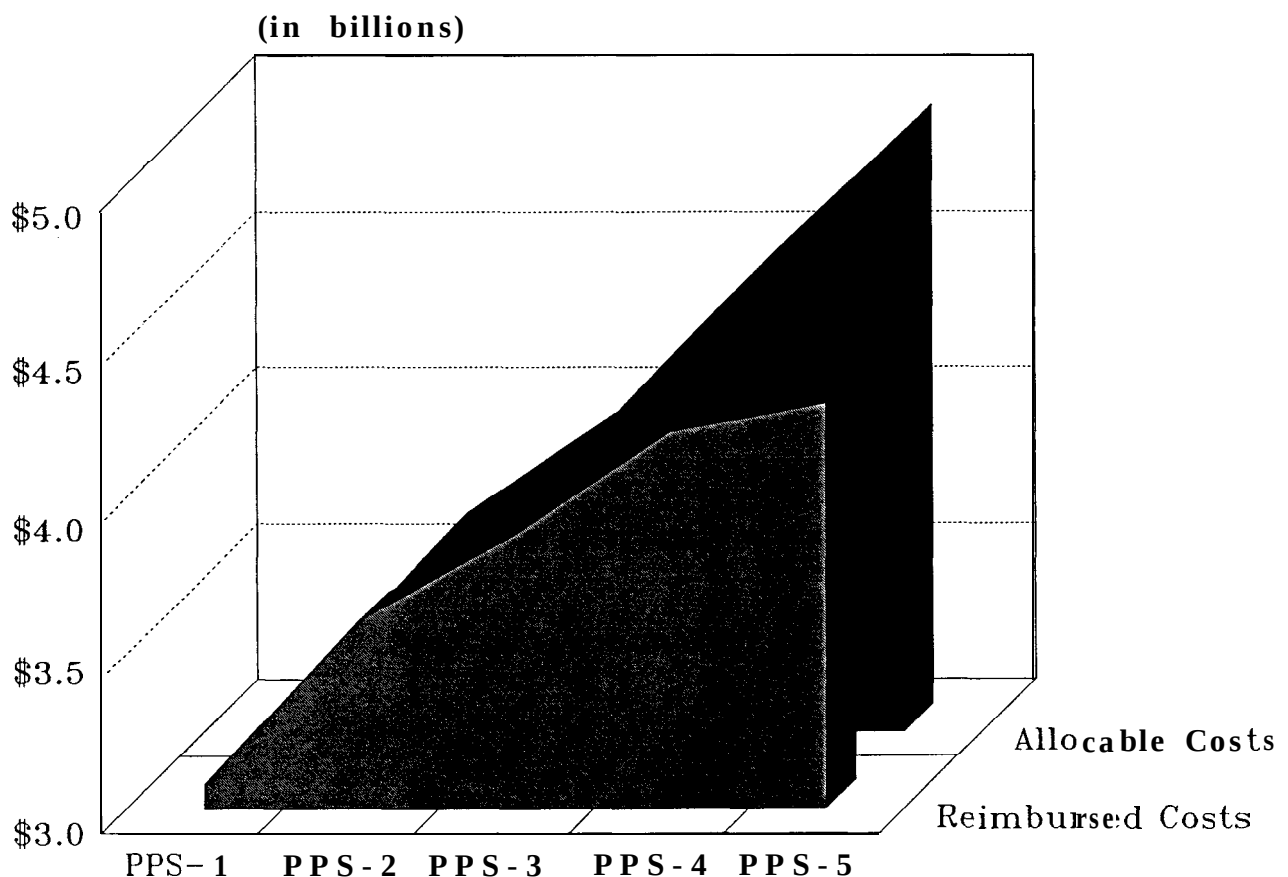
The increases in capital costs per patient discharge were greater than the yearly rates of increase in capital costs because patient discharges declined during the period. Patient discharges went from 31,803,886 in PPS-1 to 29,944,851 in PPS-5, a reduction of 6 percent.

Medicare Reimbursements Increased at a Slower Rate

The increase in the Medicare program's allocable share of capital costs roughly paralleled the changes in total capital costs. Capital costs allocable to Medicare amounted to \$3.079 billion for PPS-1 while PPS-5 costs were \$4.922 billion, an increase of 59.9 percent. The yearly increases ranged from a low of 9.2 percent in PPS-3 to a high of 17.3 percent in PPS-2.

Although Medicare's share of capital costs increased significantly, actual reimbursements to hospitals grew more slowly. Reimbursements amounted to \$3.079 billion during PPS-1 and \$4.299 billion in PPS-5, an increase of 39.6 percent. The yearly increases ranged from a low of 2.1 percent in PPS-5 to a high of 17.3 percent in PPS-2. Medicare reimbursements were less than its share of allocable costs because of the payment reductions mandated by the Congress beginning October 1, 1986. The payment reductions have continued in an effort to control escalating capital costs.

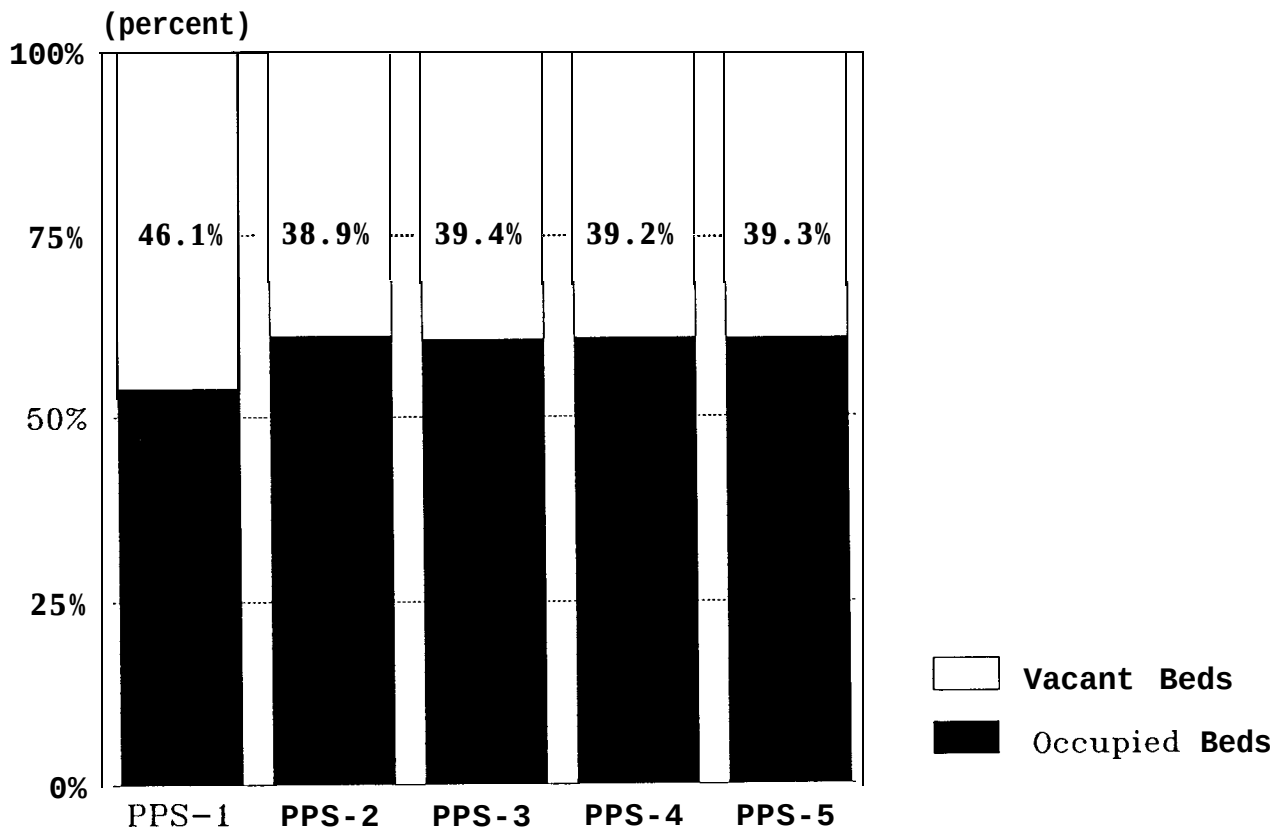
Medicare Capital Costs PPS-1 through PPS-5



Capital Costs Increased Despite LOW Occupancy Rates

As part of our analysis, we computed average bed occupancy rates for each PPS period. The average occupancy rate for all hospitals during PPS-1 was 53.9 percent. During PPS-2, the occupancy rate jumped to 61.1 percent and leveled off with rates of 60.6 percent, 60.8 percent, and 60.7 percent for PPS-3, PPS-4, and PPS-5, respectively. As such, it does not appear that the large increases in capital costs are related to demands on hospital capacities.

Hospital Bed Utilization PPS-1 through PPS-5



An argument could be made that occupancy rates are not relevant to all capital costs. That is, capital costs may change because of factors, such as the addition of high technology equipment, which may not be directly linked to bed capacity. While occupancy rates may not be the best measure for evaluating all

capital expenditures, the rates do give an overall picture of hospital utilization and the excess capacity in the industry.

Most Cost Increases Caused by a Few Hospitals

A substantial portion of the increases in capital costs was caused by a relatively small group of high-cost hospitals. We found that 80 percent of the increases were attributable to less than 19 percent of the 5,248 hospitals in each year reviewed. In PPS-2, PPS-3, PPS-4, and PPS-5, 80 percent of the capital cost increases were reported by only 853 (16.3 percent), 865 (16.5 percent), 907 (17.3 percent), and 967 (18.4 percent) of the 5,248 hospitals, respectively. (See Exhibit B for further details on capital cost increases for high-cost hospitals by classification.)

The high-cost hospitals were primarily large, urban and nonprofit. A disproportionate number were also teaching facilities. That is, teaching facilities comprised only 18 percent to 19 percent of the hospitals analyzed, but they accounted for 43 percent to 47 percent of the high-cost hospitals for PPS-2 through PPS-5.

The average annual percentage increases in capital costs for all high-cost hospitals ranged from a low of 26.8 percent in PPS-5 to a high of 35.2 percent in PPS-2. The average annual capital cost increases ranged from a low of \$1.453 million in PPS-2 to a high of \$1.823 million in PPS-4, over five to seven times the average increases we found for all the hospitals in our review.

Our analysis also disclosed that the high-cost hospitals had slightly higher occupancy rates. While the overall occupancy rates for all hospitals averaged about 61 percent for PPS-2 through PPS-5, high-cost hospitals had average occupancy rates of about 67 percent during this period. As such, higher capital costs seem to correlate with higher rates of occupancy. However, we did find several hospitals with extremely high increases in capital costs, but with relatively low occupancy. For example, one Illinois hospital reported capital costs of about \$2,600 for PPS-2 and about \$1.1 million the following year, an increase of over 40,000 percent. Its occupancy rate dropped from about 59 percent to 58 percent for the same periods and then declined even further to about 42 percent in PPS-5.

Historical Costs Inflated for Inappropriate Elements

We followed up on the six issues in our prior summary report (see footnote 3) that would have significantly impacted capital PPS rates. For four of the six issues, legislative, regulatory, and programmatic changes were made to address the problems identified in our report. The issues satisfactorily resolved for capital PPS considerations were: (1) gains on sales of assets,

(2) revaluations of assets on sales, (3) return on equity payments, and (4) minimum salvage values on depreciable assets.

The two significant issues that have yet to be corrected and still result in capital costs being inflated are: waivers of interest income offsets and depreciation allowances on federally financed assets. The inclusion of these inappropriate elements in historical capital costs will result in capital PPS rates being overstated and could cause Medicare to spend billions of dollars unnecessarily in coming years.

Interest Income. The waivers of interest income offsets involve Medicare loopholes on the accounting treatment of interest income earned by hospitals. Under Medicare cost reimbursement principles, providers are generally required to offset interest income against interest expenses. This policy helps assure that Medicare does not pay for unnecessary borrowing costs. Interest expenses usually will not be reimbursed to the extent that a hospital has funds on hand and earning interest.

An exception to the offset rule, however, is permitted for interest earned on "funded" depreciation. The exception was created to encourage hospitals to set aside funds for future capital needs. However, we believe that using Medicare Trust Funds to subsidize future capital needs of the hospital industry is not appropriate, given that:

- 0 There is a national surplus of hospital beds.
- 0 No shortage of hospital beds is predicted in the near future.
- 0 Medicare is already paying interest and depreciation for buildings currently being used in the program.

Another income loophole allows providers to shelter interest income earned on donated funds. Like the loophole for interest earned on "funded" depreciation, the exception for interest on donated funds should be removed. Medicare should only pay for necessary interest costs. If a hospital has funds on hand earning interest income and still elects to borrow funds and pay interest, Medicare should share in the interest expense only to the extent that it exceeds interest income.

The cost of the interest offset loopholes to Medicare is substantial, running into billions of dollars. For example, when our report on "funded" depreciation was first issued in December 1984, we estimated then that closing this loophole would have saved Medicare and Medicaid over \$4.7 billion in a 5-year budget cycle. About \$3.7 billion, or 78 percent, of the \$4.7 billion savings would have been related to Medicare.

Federally Funded Depreciation. Another Medicare policy that unnecessarily inflates capital costs is the payment for depreciation on assets financed with Hill-Burton grants or other Federal funds. The policy essentially results in duplicate Federal payments for the same assets: once through a construction grant and again as a capital reimbursement by Medicare.

The Medicare policy of allowing depreciation on Hill-Burton assets conflicts with cost principles applicable to other Federal programs. For example, the following criterion for determining costs applies to grants and contracts with nonprofit institutions:

**Computation of the use allowance and/or depreciation will exclude both the cost or any portion of the cost of grounds, buildings and equipment borne or donated by the Federal government (45 CFR Part 74, Appendix F)."

The primary reason for Medicare's reimbursing Hill-Burton depreciation was to provide hospitals with funds to maintain productive capacity for the future. That rationale was developed in 1966. Given the current excess hospital capacity, the rationale would no longer seem to justify the Government effectively paying twice for the same asset.

The savings that would result from the removal of Hill-Burton depreciation from the historical costs to be used in setting PPS rates would be substantial. We estimated that for just 1 year (1984) Medicare capital costs had been overstated by \$34 million for the Hill-Burton element.

Capital PPS Rules

The OIG believes that the PPS rules for capital payments do not adequately address the issues of excess capacity and inappropriate cost elements.

Under the capital PPS rules, payments will be a predetermined amount per discharge. The payments will be based on historical costs, less a congressionally mandated reduction of 10 percent through FY 1995. During the 10-year transition period, rates will generally be based on a blend of a national average Federal rate and a hospital specific rate.

The FY 1992 Federal rate will be determined by updating the FY 1989 Medicare inpatient capital cost per discharge by the estimated increase in Medicare capital costs per discharge. The rate will be adjusted for each hospital to account for case mix, outlier cases, geographic location, indirect medical education costs, additional large urban hospital costs and disproportionate share costs.

The FY 1992 hospital specific rates will be based on each hospital's Medicare allowable inpatient capital costs per discharge for its latest 12-month cost reporting period ending on or before December 31, 1990. The 1990 costs will be updated to FY 1992 based on the increase in national average capital costs per discharge. Hospital specific rates will be adjusted for transfers in each hospital's base period discharge count and case mix index.

For the period FY 1993 through FY 1995, both the Federal rate and hospital specific rates will be updated based on a moving 2-year average of actual increases in capital related costs per discharge for the period 3 and 4 years before the year in question. After FY 1995, payment rate updates will take into consideration changes in the capital market basket and other changes resulting from new technology and other factors.

Although the 10 percent congressional reduction helps in limiting Medicare participation in the uneconomical costs caused by the excess industry capacity and by the inappropriate elements identified in our previous audits, it is set to expire after FY 1995.

Conclusions and Recommendations

Despite experiencing relatively low bed utilization in recent years, hospitals have continued to increase capital expenditures. The rates of capital increases have significantly exceeded other leading economic indexes. Medicare and other third party payers which reimburse capital on a cost reimbursement basis were partly responsible for this economic paradox. Cost reimbursement systems do not provide incentives or disincentives for providers to restrain capital spending.

The problem of seemingly uncontrolled hospital capital spending had also existed with hospital operational spending. However, the advent of PPS in 1983 quickly slowed the rate of increases in operational expenditures.

Just as PPS has controlled the operational side of hospital expenditures, it can also slow down the capital side. The HCFA recently published final rules that pay capital costs on a PPS basis, effective October 1, 1991.

Although the HCFA rules to fold capital costs into PPS represents a major and much needed reform, the basis upon which the PPS rates will be set--historical costs--is inflated. The historical costs are higher than economically warranted because they are: (1) based on excess hospital capacity and (2) include inappropriate elements (waivers of interest income offsets and

federally funded depreciation). The precise amount of inflated historical costs cannot be readily determined.

We recommend that HCFA propose legislation to continue mandated reductions in capital payments beyond FY 1995 to recognize that historical costs used in setting PPS rates are inflated because of excess hospital capacity and the inclusion of inappropriate elements. The HCFA should determine the extent of the capital payment reductions that are needed to fully account for the excess capacity, unnecessary interest waivers, and depreciation allowances on federally financed assets that have yet to be corrected from our previous report. This revised capital payment reduction percentage should then be reported to the Congress.

HCFA's Comments

The HCFA generally agreed with our position on the issue of excess capacity. However, HCFA believed that the issue would be addressed through the congressionally mandated reductions in capital expenditures along with reductions anticipated from the implementation of the capital PPS. As such, HCFA believed that any need to react to excessive capital spending should be largely eliminated by FY 1996.

With regard to the offset of interest income earned on funded depreciation, HCFA believed that such a policy would result in increased Federal expenditures. That is, it was HCFA's view that the current policy results in eventual savings when hospitals use interest income earned on funds set aside to replace capital assets instead of incurring interest expense on funds that would need to be borrowed otherwise.

In its comments on the issue of interest earned on donated funds, HCFA stated that the Social Security Act precluded the deduction of such income from operating costs. While the provision is applicable to nonprofit hospitals, it has always been applied to all hospitals. The HCFA also stated that any change to its policy would serve as a disincentive to potential donors and thus penalize providers.

With respect to the federally funded depreciation, HCFA did not believe that Hill-Burton depreciation should be removed from the capital PPS base-year rates. The HCFA has made a commitment to Hill-Burton hospitals to allow the depreciation in exchange for the hospitals' agreements to provide free care to indigent beneficiaries.

The HCFA also included two general comments in its response. The first comment questioned the continuation of a payment reduction factor for all hospitals since most of the cost increases were caused by a few hospitals. The second comment concerned the charts contained in Exhibit A. The HCFA did not believe that the

charts supported our premise that excess capacity caused large increases in capital costs. Instead, it thought the charts showed that hospitals with high occupancy rates have had the highest average capital costs percentage increases.

In summary, HCFA believed that future congressional capital reduction efforts and the implementation of PPS for capital costs would fully address the intent of our recommendation. (The HCFA's reply is included in its entirety as an Appendix to this report.)

OIG's Comments

The HCFA believes that the excess capacity issue will be resolved by the end of FY 1995. However, it presented no evidence to support this opinion. Indeed, the available evidence indicates that it will be many years, much beyond FY 1995, before Medicare PPS rates will significantly benefit from changes in hospital capital spending behavior.

The Medicare capital PPS rates, which are effectively based on actual costs through FY 1992, have built-in inflated costs. For example, the most significant components of the rates are depreciation and interest on hospital buildings. As previously noted, building utilization has been low, with occupancy rates averaging only 61 percent in the last 4 years of our study. Since buildings may be depreciated for as many as 40 years and since most existing hospital buildings have been constructed or renovated in recent years, depreciation on excess capacity will continue to be passed through to Medicare for some time. The same is true for interest on long term mortgages on those buildings. Only when hospitals dispose of unnecessary buildings and refrain from constructing/renovating new, unneeded facilities will depreciation (and interest) costs subside. It is then that Medicare will benefit, and it is highly unlikely that such benefits will accrue by the end of FY 1995.

The HCFA's view that Medicare will benefit in the future by hospitals having set aside funds to replace capital assets does not justify paying for interest costs today that are not warranted, especially in light of the poor financial condition of the Medicare Trust Fund. The waiver of the interest offset for funded depreciation was created in 1966 to help hospitals fund future capital needs. Given the national surplus of hospital beds and the fact that Medicare already pays for interest and depreciation on existing buildings, the policy of waiving the interest offset is not warranted. The policy is an anachronism that will cost Medicare dearly unless an adjustment is made to the PPS rates.

The HCFA claim that offsetting interest income on donated funds would be a disincentive to potential donors does not appear to be

valid. The donations themselves are not offset against the hospitals* operating costs. The HCFA did not provide any evidence that donors would not have made their donations if the interest on the contributions were offset against interest expense claimed by hospitals on their Medicare cost reports. Indeed, HCFA provided no evidence that donors were even aware of Medicare cost reporting rules.

The Medicare policy of allowing hospitals to claim depreciation on federally financed Hill-Burton assets effectively resulted in the Government paying twice for the same assets. Medicare justified the duplicate payment on the basis that it helped hospitals maintain productive capacity. In our opinion, that was not sufficient justification then and certainly not now with the excess capacity. The HCFA indicated that the Medicare policy was also created so that hospitals would provide free care to indigent beneficiaries. Yet, this reasoning does not seem valid since hospitals were already required to provide free care to the indigent by the terms of their Hill-Burton grants.

With respect to HCFA's concern about questioning the continuation of the mandated reductions for all hospitals when only a few hospitals appear responsible for the large increases, across-the-board reductions have existed since FY 1987 when they were first mandated by the Congress. The reductions will also apply to all hospitals during the first 4 years of the transition period for capital PPS. The high-cost hospitals may well be affected the most by the reductions because their capital costs exceed the national average. Accordingly, they may well bear the largest portion of the reduction while those hospitals with costs below the average could gain.

Also, with regard to HCFA's comment that our report stated that excess capacity caused large increases in capital costs, no such statement was made. Instead, our report said that historical costs were higher than economically necessary in part because of excess capacity.

And finally, HCFA's comment that the report's charts (Exhibits) showed that hospitals with high occupancy rates had the largest cost increases needs clarification. While it is true that these hospitals did have slightly higher occupancy rates than other hospitals, their occupancy rates were nonetheless low, averaging only 67 percent.

EXHIBITS

CAPITAL COST INCREASES FOR ALL HOSPITALS
PPS-2

	Number of Providers	Total Capital Costs	Total Capital Cost increase	Average Capital Cost Increase	Average Capital Cost % Increase
Teaching Hospitals	965	\$5,097,956,916	\$323,829,267	\$335,574	6.8%
Nonteaching Hospitals	<u>4,283</u>	<u>5,820,071,041</u>	<u>640,470,915</u>	149,538	12.4
TOTALS	<u>5,248</u>	<u>\$10,918,027,957</u>	<u>\$964,300,182</u>	183,746	9.7
Urban Hospitals	2,704	\$9,209,213,265	\$832,755,271	307,972	9.9
Rural Hospitals	<u>2,544</u>	<u>1,708,814,692</u>	<u>131,544,911</u>	51,708	8.3
TOTALS	<u>5,248</u>	<u>\$10,918,027,957</u>	<u>\$964,300,182</u>	183,746	9.7
Nonprofit Hospitals	2,978	\$7,910,303,794	\$759,089,072	254,899	10.6
Proprietary Hospitals	804	1,540,277,191	219,562,485	273,088	16.6
Other Control	<u>1,466</u>	<u>1,467,446,972</u>	<u>-14351,375</u>	-9,789	-1.0
TOTALS	<u>5,248</u>	<u>\$10,918,027,957</u>	<u>\$964,300,182</u>	183,746	9.7
Hospital Capacity:					
Under 50 Beds	892	\$156,512,733	\$13,891,771	15,574	9.7
50 to 99 Beds	1,235	589,803,235	60,584,746	49,056	11.4
100 to 249 Beds	1,767	2,989,413,973	372,982,125	211,682	14.3
250 to 399 Beds	726	2,747,457,869	291,532,975	401,561	11.9
400+ Beds	<u>628</u>	<u>4,434,840,147</u>	<u>225,308,565</u>	358,772	5.4
TOTALS	<u>5,248</u>	<u>\$10,918,027,957</u>	<u>\$964,300,182</u>	183,746	9.7
Hospitals With Occupancy Rates of:					
Under 20%	265	\$67,194,992	\$-614,329	-2,318	-0.9
20 to 39.9%	1,250	773,273,852	113,418,093	90,734	17.2
40 to 59.9%	1,833	3,278,486,969	329,310,585	179,657	11.2
60 to 79.9%	1,617	5,373,302,405	428,312,495	264,881	8.7
80% and over	<u>283</u>	<u>1,425,769,739</u>	<u>93,873,338</u>	331,708	7.0
TOTALS	<u>5,248</u>	<u>\$10,918,027,957</u>	<u>\$964,300,182</u>	183,746	9.7

NOTES

- o The source for the data shown above and in accompanying exhibits was HCFA's Hospital Cost Report Information System.
- o The total capital cost increases represent the differences between capital costs for the PPS period specified and the capital costs reported by the same hospitals in the prior PPS period.

CAPITAL COST INCREASES FOR ALL HOSPITALS
PPS-3

	Number of <u>Providers</u>	Total Capital <u>Costs</u>	Total Capital Cost <u>Increase</u>	Average Capital Cost <u>Increase</u>	Average Capital Cost <u>% Increase</u>
Teaching Hospitals	975	\$5,799,234,105	\$718,741,208	\$737,170	14.1%
Nonteaching Hospitals	<u>4,273</u>	<u>6,485,650,321</u>	<u>648,115,261</u>	151,677	11.1
TOTALS	<u>5,248</u>	<u>\$12,284,884,426</u>	<u>\$1,366,856,469</u>	260,453	12.5
Urban Hospitals	2,708	\$10,419,632,054	\$1,201,055,140	443,521	13.0
Rural Hospitals	2,540	<u>1,865,252,372</u>	<u>165,801,329</u>	65,276	9.8
TOTALS	<u>5,248</u>	<u>\$12,284,884,426</u>	<u>\$1,366,856,469</u>	260,453	12.5
Nonprofit Hospitals	2,966	\$8,835,176,057	\$952,368,756	321,095	12.1
Proprietary Hospitals	905	1,817,980,288	245,969,749	271,790	15.6
Other Control	1,377	<u>1,631,728,081</u>	<u>168,517,964</u>	122,381	11.5
TOTALS	<u>5,248</u>	<u>\$12,284,884,426</u>	<u>\$1,366,856,469</u>	260,453	12.5
Hospital Capacity:					
Under 50 Beds	900	\$172,747,600	\$14,558,536	16,176	9.2
50 to 99 Beds	1,243	671,746,367	68,121,673	54,804	11.3
100 to 249 Beds	1,765	3,301,987,986	292,513,528	165,730	9.7
250 to 399 Beds	737	3,157,706,373	312,765,231	424,376	11.0
400+ Beds	<u>603</u>	<u>4,980,696,100</u>	<u>678,897,501</u>	1,125,867	15.8
TOTALS	<u>5,248</u>	<u>\$12,284,884,426</u>	<u>\$1,366,856,469</u>	260,453	12.5
Hospitals With Occupancy Rates of:					
Under 20%	288	\$63,496,085	\$3,813,682	13,242	6.4
20 to 39.9%	1,362	1,017,573,468	57,223,726	42,014	6.0
40 to 59.9%	1,777	3,639,480,096	366,615,931	206,312	11.2
60 to 79.9%	1,560	6,004,914,284	718,692,369	460,700	13.6
80% and over	<u>261</u>	<u>1,559,420,493</u>	<u>220,510,761</u>	844,869	16.5
TOTALS	<u>5,248</u>	<u>\$12,284,884,426</u>	<u>\$1,366,856,469</u>	260,453	12.5

CAPITAL COST INCREASES FOR ALL HOSPITALS
PPS-4

	Number of <u>Providers</u>	Total Capital <u>Costs</u>	Total Capital Cost <u>Increase</u>	Average Capital Cost <u>Increase</u>	Average Capital Cost <u>% Increase</u>
Teaching Hospitals	975	\$6,745,769,876	\$898,426,603	\$921,463	15.4%
Nonteaching Hospitals	<u>4,273</u>	<u>7,290,137,717</u>	<u>852,596,564</u>	199,531	13.2
TOTALS	<u>5,248</u>	<u>\$14,035,907,593</u>	<u>\$1,751,023,167</u>	333,655	14.3
Urban Hospitals	2,708	\$11,956,277,374	\$1,536,645,320	567,447	14.7
Rural Hospitals	<u>2,540</u>	<u>2,079,630,219</u>	<u>214,377,847</u>	84,401	11.5
TOTALS	<u>5,248</u>	<u>\$14,035,907,593</u>	<u>\$1,751,023,167</u>	333,655	14.3
Nonprofit Hospitals	2,990	\$10,133,924,290	\$1,263,273,815	422,500	14.2
Proprietary Hospitals	1,019	2,097,641,326	213,123,380	209,150	11.3
Other Control	1,239	<u>1,804,341,977</u>	<u>274,625,972</u>	221,651	18.0
TOTALS	<u>5,248</u>	<u>\$14,035,907,593</u>	<u>\$1,751,023,167</u>	333,655	14.3
Hospital Capacity:					
Under 50 Beds	910	\$195,221,004	\$17,924,010	19,697	10.1
50 to 99 Beds	1,253	760,571,835	67,332,480	53,737	9.7
100 to 249 Beds	1,756	3,736,050,150	412,069,729	234,664	12.4
250 to 399 Beds	748	3,722,067,859	487,998,891	652,405	15.1
400+ Beds	<u>581</u>	<u>5,621,996,745</u>	<u>765,698,057</u>	<u>1,317,897</u>	15.8
TOTALS	<u>5,248</u>	<u>\$14,035,907,593</u>	<u>\$1,751,023,167</u>	333,655	14.3
Hospitals With Occupancy Rates of:					
Under 20%	313	\$72,999,250	\$531,127	1,697	0.7
20 to 39.9%	1,361	1,139,707,927	95,693,609	70,311	9.2
40 to 59.9%	1,741	4,107,234,429	460,847,185	264,703	12.6
60 to 79.9%	1,493	6,424,434,356	881,906,941	590,695	15.9
80% and over	<u>340</u>	<u>2,291,531,631</u>	<u>312,044,305</u>	917,777	15.8
TOTALS	<u>5,248</u>	<u>\$14,035,907,593</u>	<u>\$1,751,023,167</u>	333,655	14.3

CAPITAL COST INCREASES FOR ALL HOSPITALS
PPS-5

	Number of <u>Providers</u>	Total Capital <u>Costs</u>	Total Capital Cost <u>Increase</u>	Average Capital Cost <u>Increase</u>	Average Capital Cost <u>% increase</u>
Teaching Hospitals	999	\$7,643,836,447	\$815,146,102	\$815,962	11.9%
Nonteaching Hospitals	4,249	<u>8,011,213,344</u>	<u>803,996,096</u>	189,220	11.2
TOTALS	5,248	\$15,655,049,791	\$1,619,142,198	308,526	11.5
Urban Hospitals	2,708	\$13,369,272,916	\$1,412,995,542	521,786	11.8
Rural Hospitals	<u>2,540</u>	<u>2,285,776,875</u>	<u>206,146,656</u>	81,160	9.9
TOTALS	5,248	\$15,655,049,791	\$1,619,142,198	308,526	11.5
Nonprofit Hospitals	2,983	\$11,204,480,051	\$1,160,622,325	369,079	11.6
Proprietary Hospitals	1,031	2,437,758,682	256,926,244	249,201	11.8
Other Control	1,234	<u>2,012,811,058</u>	<u>201,593,629</u>	163,366	11.1
TOTALS	5,248	\$15,655,049,791	\$1,619,142,198	308,526	11.5
Hospital Capacity:					
Under 50 Beds	933	\$215,441,196	\$15,408,816	16,515	7.7
50 to 99 Beds	1,237	818,826,136	69,323,133	56,041	9.2
100 to 249 Beds	1,745	4,147,408,810	435,716,462	249,694	11.7
250 to 399 Beds	747	4,155,672,333	388,363,382	519,897	10.3
400+ Beds	<u>586</u>	<u>6,317,701,316</u>	<u>710,330,405</u>	1,212,168	12.7
TOTALS	5,248	\$15,655,049,791	\$1,619,142,198	308,526	11.5
Hospitals With Occupancy Rates of:					
Under 20%	376	\$115,279,762	\$1,382,727	3,677	1.2
20 to 39.9%	1,309	1,313,634,569	114,292,738	87,313	9.5
40 to 59.9%	1,719	4,650,182,031	481,934,223	280,357	11.6
60 to 79.9%	1,496	7,054,203,448	736,455,202	492,283	11.7
80% and over	<u>348</u>	<u>2,521,749,981</u>	<u>285,077,308</u>	819,188	12.7
TOTALS	5,248	\$15,655,049,791	\$1,619,142,198	308,526	11.5

CAPITAL COST INCREASES FOR HIGH-COST HOSPITALS
PPS-2

	Number of <u>Providers</u>	Total Capital <u>Costs</u>	Total Capital Cost <u>Increase</u>	Average Capital Cost <u>Increase</u>	Average Capital Cost <u>% increase</u>
Teaching Hospitals	363	\$2,853,896,226	\$622,554,448	\$1,715,026	27.9%
Nonteaching Hospitals	<u>490</u>	<u>1,902,362,097</u>	<u>616,673,434</u>	<u>1,258,517</u>	48.0
TOTALS	853	<u>\$4,756,258,323</u>	<u>\$1,239,227,882</u>	<u>1,452,788</u>	35.2
Urban Hospitals	734	\$4,449,092,780	\$1,118,514,978	1,523,862	33.6
Rural Hospitals	<u>119</u>	<u>307,165,543</u>	<u>120,712,904</u>	<u>1,014,394</u>	64.7
TOTALS	853	<u>\$4,756,258,323</u>	<u>\$1,239,227,882</u>	<u>1,452,788</u>	35.2
Nonprofit Hospitals	601	\$3,697,523,432	\$921,685,531	1533,587	33.2
Proprietary Hospitals	148	562,983,104	211,640,414	1,430,003	60.2
Other Control	<u>104</u>	<u>495,751,787</u>	<u>105,901,937</u>	<u>1,018,288</u>	27.2
TOTALS	853	<u>\$4,756,258,323</u>	<u>\$1,239,227,882</u>	<u>1,452,788</u>	35.2
Hospital Capacity:					
Under 50 Beds	3	\$4,952,510	\$3,081,866	1,027,289	164.7
50 to 99 Beds	44	65,603,259	33,870,581	769,786	106.7
100 to 249 Beds	280	841,917,762	314,982,816	1,124,939	59.8
250 to 399 Beds	211	1,077,316,707	285,964,807	1,355,283	36.1
400+ Beds	<u>315</u>	<u>2,766,468,085</u>	<u>601,327,812</u>	<u>1,908,977</u>	27.8
TOTALS	853	<u>\$4,756,258,323</u>	<u>\$1,239,227,882</u>	<u>1,452,788</u>	35.2
Hospitals With Occupancy Rates of:					
Under 20%	1	\$2,235,315	\$2,148,018	2,148,018	2460.6
20 to 39.9%	62	188,532,427	95,830,783	1,545,658	103.4
40 to 59.9%	269	1,090,881,364	324,797,240	1,207,425	42.4
60 to 79.9%	424	2,611,853,791	594,828,589	1,402,898	29.5
80% and over	<u>97</u>	<u>862,755,426</u>	<u>221,623,252</u>	<u>2,284,776</u>	34.6
TOTALS	853	<u>\$4,756,258,323</u>	<u>\$1,239,227,882</u>	<u>1,452,788</u>	35.2

NOTES

- o The source for the data shown **above** and in accompanying exhibits was **HCFA's** Hospital Cost Report information System.
- o The total capital cost increases represent the differences between capital costs for the PPS period specified and the capital costs reported by the same hospitals in the prior PPS period.

CAPITAL COST INCREASES FOR HIGH-COST HOSPITALS
PPS-3

	Number of <u>Providers</u>	Total Capital <u>Costs</u>	Total Capital Cost <u>Increase</u>	Average Capital Cost <u>Increase</u>	Average Capital Cost <u>% Increase</u>
Teaching Hospitals	374	\$3,377,266,498	\$729,270,491	\$1949,921	27.5%
Nonteaching Hospitals	<u>491</u>	<u>2,164,029,427</u>	<u>564,965,563</u>	<u>1,150,643</u>	35.3
TOTALS	<u>865</u>	<u>\$5,541,295,925</u>	<u>\$1,294,236,054</u>	<u>1,496,227</u>	30.5
Urban Hospitals	763	\$5,238,003,355	\$1,172,772,988	1,537,055	28.8
Rural Hospitals	<u>102</u>	<u>303,292,570</u>	<u>121,463,066</u>	<u>1,190,814</u>	66.8
TOTALS	<u>865</u>	<u>\$5,541,295,925</u>	<u>\$1,294,236,054</u>	<u>1,496,227</u>	30.5
Nonprofit Hospitals	595	\$4,187,544,712	\$897,127,522	1,507,777	27.3
Proprietary Hospitals	170	755,825,096	249,777,453	1,469,279	49.4
Other Control	<u>100</u>	<u>597,926,117</u>	<u>147,331,079</u>	<u>1,473,311</u>	32.7
TOTALS	<u>865</u>	<u>\$5,541,295,925</u>	<u>\$1,294,236,054</u>	<u>1,496,227</u>	30.5
Hospital Capacity:					
Under 50 Beds	4	\$3,128,907	\$2,455,025	613,756	364.3
50 to 99 Beds	52	85,123,337	38,222,883	735,055	81.5
100 to 249 Beds	241	808,666,189	257,658,547	1,069,123	46.8
250 to 399 Beds	233	1,274,113,377	293,132,723	1,258,080	29.9
400+ Beds	<u>335</u>	<u>3,370,264,115</u>	<u>702,766,876</u>	<u>2,097,812</u>	26.3
TOTALS	<u>865</u>	<u>\$5,541,295,925</u>	<u>\$1,294,236,054</u>	<u>1,496,227</u>	30.5
Hospitals With Occupancy Rates of:					
Under 20%	6	\$6,287,261	\$5,066,417	844,403	415.0
20 to 39.9%	58	152,455,423	53,762,491	926,940	54.5
40 to 59.9%	262	1,206,587,374	309,658,789	1,181,904	34.5
60 to 79.9%	445	3,145,969,105	701,312,017	1,575,982	28.7
80% and over	<u>94</u>	<u>1,029,996,762</u>	<u>224,436,340</u>	<u>2,387,621</u>	27.9
TOTALS	<u>865</u>	<u>\$5,541,295,925</u>	<u>\$1,294,236,054</u>	<u>1,496,227</u>	30.5

CAPITAL COST INCREASES FOR HIGH-COST HOSPITALS
PPS-4

	Number of <u>Providers</u>	Total Capital <u>Costs</u>	Total Capital Cost <u>Increase</u>	Average Capital Cost <u>Increase</u>	Average Capital Cost <u>% Increase</u>
Teaching Hospitals	413	\$4,256,869,727	\$898,977,935	\$2,176,702	26.8%
Nonteaching Hospitals	<u>494</u>	<u>2,564,809,446</u>	<u>754,132,765</u>	<u>1,526,585</u>	41.6
TOTALS	<u>907</u>	<u>\$6,821,679,173</u>	<u>\$1,653,110,700</u>	<u>1,822,614</u>	32.0
Urban Hospitals	808	\$6,461,279,618	\$1,510,709,633	1.869690	30.5
Rural Hospitals	<u>99</u>	<u>360,399,555</u>	<u>142,401,067</u>	<u>1,438,395</u>	65.3
TOTALS	<u>907</u>	<u>\$6,821,679,173</u>	<u>\$1,653,110,700</u>	<u>1,822,614</u>	32.0
Nonprofit Hospitals	629	\$5,148,887,317	\$1,181,854,370	1,878,942	29.8
Proprietary Hospitals	162	801,208,292	248,581,964	1,534,457	45.0
Other Control	<u>116</u>	<u>871,583,564</u>	<u>222,674,366</u>	<u>1,919,607</u>	34.3
TOTALS	<u>907</u>	<u>\$6,821,679,173</u>	<u>\$1,653,110,700</u>	<u>1,822,614</u>	32.0
Hospital Capacity:					
Under 50 Beds	4	\$6,394,954	\$4,655,859	1,163,965	267.7
50 to 99 Beds	38	65,584,100	33,817,806	889,842	106.5
100 to 249 Beds	252	1,010,951,858	350,723,542	1,391,760	53.1
250 to 399 Beds	269	1,777,744,256	459,773,946	1,709,197	34.9
400+ Beds	<u>344</u>	<u>3,961,004,005</u>	<u>804,139,547</u>	<u>2,337,615</u>	25.5
TOTALS	<u>907</u>	<u>\$6,821,679,173</u>	<u>\$1,653,110,700</u>	<u>1,822,614</u>	32.0
Hospitals With Occupancy Rates of:					
Under 20%	2	\$2,762,789	\$1,866,704	933,352	208.3
20 to 39.9%	72	211,654,935	94,586,790	1,313,705	80.8
40 to 59.9%	<u>264</u>	<u>1,445,125,721</u>	<u>408,829,424</u>	<u>1,548,596</u>	39.5
60 to 79.9%	451	3,695,039,554	835,985,479	1,853,626	29.2
80% and over	<u>118</u>	<u>1,467,096,174</u>	<u>311,842,303</u>	<u>2,642,731</u>	27.0
TOTALS	<u>907</u>	<u>\$6,821,679,173</u>	<u>\$1,653,110,700</u>	<u>1,822,614</u>	32.0

CAPITAL COST INCREASES FOR HIGH-COST HOSPITALS
PPS-5

	Number of <u>Providers</u>	Total Capital <u>Costs</u>	Total Capital Cost <u>increase</u>	Average Capital Cost <u>Increase</u>	Average Capital Cost <u>% Increase</u>
Teaching Hospitals	452	\$4,871,426,548	\$886,753,623	\$1,961,844	22.3%
Nonteaching Hospitals	<u>515</u>	<u>2,836,790,255</u>	<u>742,947,518</u>	<u>1,442,617</u>	35.5
TOTALS	<u>967</u>	<u>\$7,708,216,803</u>	<u>\$1,629,701,141</u>	<u>1,685,317</u>	26.8
Urban Hospitals	859	\$7,278,226,995	\$1,488,880,508	1,733,272	25.7
Rural Hospitals	<u>108</u>	<u>429,989,808</u>	<u>140,820,633</u>	<u>1,303,895</u>	48.7
TOTALS	<u>967</u>	<u>\$7,708,216,803</u>	<u>\$1,629,701,141</u>	<u>1,685,317</u>	26.8
Nonprofit Hospitals	690	\$5,854,724,510	\$1,179,719,819	1,709,739	25.2
Proprietary Hospitals	166	888,135,238	264,131,305	1,591,152	42.3
Other Control	<u>111</u>	<u>965,357,055</u>	<u>185,850,017</u>	<u>1,674,324</u>	23.8
TOTALS	<u>967</u>	<u>\$7,708,216,803</u>	<u>\$1,629,701,141</u>	<u>1,685,317</u>	26.8
Hospital Capacity:					
Under 50 Beds	9	\$14,002,495	\$6,798,219	755,358	94.4
50 to 99 Beds	40	79,235,965	37,158,694	928,967	88.3
100 to 249 Beds	276	1,149,778,634	369,344,670	1,338,205	47.3
250 to 399 Beds	288	2,030,989,087	453,094,689	1,573,245	28.7
400+ Beds	<u>354</u>	<u>4,434,210,622</u>	<u>763,304,869</u>	<u>2,156,228</u>	20.8
TOTALS	<u>967</u>	<u>\$7,708,216,803</u>	<u>\$1,629,701,141</u>	<u>1,685,317</u>	26.8
Hospitals With Occupancy Rates of:					
Under 20%	9	\$13,137,586	\$8,202,700	911,411	166.2
20 to 39.9%	73	275,719,600	110,175,175	1,509,249	66.6
40 to 59.9%	301	1,811,684,371	448,513,580	1,490,078	32.9
60 to 79.9%	443	3,871,506,268	751,803,598	1,697,074	24.1
80% and over	<u>141</u>	<u>1,736,168,978</u>	<u>311,006,088</u>	<u>2,205,717</u>	21.8
TOTALS	<u>967</u>	<u>\$7,708,216,803</u>	<u>\$1,629,701,141</u>	<u>1,685,317</u>	26.8

APPENDIX



DEPARTMENT OF HEALTH & HUMAN SERVICES RECEIVED
OFFICE OF INSPECTOR

Health Care
Financing Administration

Memorandum

Date NOV 25 1991
From Gail R. Wilensky, Ph.D. gw
Administrator
Subject OIG Draft Report: "Analysis of Hospital Capital Costs" (A-09-91-00070)
To Inspector General
Office of the Secretary

We have reviewed the subject draft report which describes **OIG's** analysis of hospital costs during the first 5 years of Medicare's prospective payment system (PPS). **OIG** found that capital costs increase much faster than other leading economic indexes, even though the hospital industry had significant excess capacity. The ability of hospitals to pass capital costs through to third party payers, such as Medicare, on a cost reimbursement basis was an important factor for capital expenditure increases, despite relatively low hospital utilization.

In the report, **OIG** acknowledges the effects that **HCFA's** proposed regulation to pay capital costs prospectively will have in controlling capital cost. However, **OIG** still believes that the historical costs upon which the proposed **PPS** rates will be based are inflated. To address this concern, **OIG** recommends that **HCFA** propose legislation to continue mandated reductions in capital **payments** beyond fiscal year 1995 to recognize that historical costs used in setting **PPS** rates are inflated because of excess hospital capacity and the inclusion of inappropriate elements. Attached for your consideration are our detailed comments on this recommendation.

Thank you for the opportunity to review and comment on this report. Please advise us whether you agree with our position on the report's recommendation at your earliest convenience.

Attachment

Comments of the Health Care Financing Administration
on the OIG Draft Report:
"Analysis of Hospital Capital Costs"
(A-09-91-00070)

OIG Recommendation

HCFA should propose legislation to continue mandated reductions in capital payments beyond fiscal year (FY) 1995 to recognize that the historical costs used in setting Prospective Payment System (PPS) rates are inflated because of excess hospital capacity and the inclusion of inappropriate elements. HCFA should determine the extent of the capital payment reductions that are needed to fully account for the excess capacity, unnecessary interest waivers, and depreciation allowances on federally financed assets that have yet to be **corrected** from our previous report. This revised capital payment reduction percentage should then be reported to the Congress.

HCFA Response

We agree there is some validity to **OIG's** position with regard to the issue of excess capacity. However, we believe this issue will be properly addressed with the congressionally-mandated reductions in capital expenditures along with reductions anticipated by the implementation of the capital PPS. Consequently, any need to react to hospital excesses in capital spending by hospitals should be largely eliminated by **FY** 1996. Effective with cost reporting periods starting on and after October 1, 1991, hospitals will begin receiving payment for capital costs on a prospective per discharge basis rather than on actual allowable costs. Also, hospitals will have faced two more cost reporting periods subject to a reduction in aggregate payments along with 2 years of capital prospective payments. During this period, excess capacity and capital spending can be expected to be significantly reduced.

In general, the waiver of interest income offset would result in an increase of federal funds expended. However, under the concept of "funded depreciation," **OIG** has failed to recognize that these offsets will result in savings when hospitals use monies (including the interest earned) from the established funds to replace capital assets. To the extent that funded depreciation is utilized in place of borrowing to replace provider assets, the program does not share in provider interest expenses which would **otherwise** be incurred.

In response to **OIG's** findings on page 20 concerning an income loophole to shelter interest income earned on donated funds, Section 1134 of the Social Security Act precludes Medicare from deducting unrestricted grants, gifts or endowments, or income earned on such donations, from hospital operating costs. While this provision addresses nonprofit hospitals, it has always been applied to all hospitals.

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We believe it would be inappropriate now to treat proprietary hospitals differently in establishing the capital PPS rates. If HCFA changed its policy of not offsetting income earned on restricted funds, it could serve as a disincentive to potential donors and thus penalize providers.

With respect to the federally-funded depreciation issue, OIG believes that duplicate payments were made for assets financed with Hill-Burton grants (once for the construction grant and again for capital reimbursement). While this appears to be true, HCFA is responsible for honoring its commitment to Hill-Burton hospitals in exchange for their agreement to provide free care to indigent beneficiaries in an amount equal to the grant amount. We believe it would be inappropriate to remove this element from computation of the capital PPS base-year rates.

Therefore, we believe the result of Congressional efforts and the implementation of PPS will fully address the intent of OIG's recommendation.

General Comments

Page 18 - The report points out that most cost increases are caused by a few hospitals. In fact, it states that 80 percent of the increase is caused by 19 percent of the hospitals. To continue a payment reduction factor for all hospitals when the increase is caused by only a small percentage seems an overly severe measure.

Pages 25-28 - Regarding the charts entitled "Capital Cost Increases for All Hospitals," we did not find support for OIG's premise that excess capacity caused large increases in capital costs. Instead, the charts show that hospitals with the high occupancy rates have had the highest average capital costs percentage increases.