

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**OFFICE OF INSPECTOR GENERAL
TESTIMONY
BEFORE THE
SUBCOMMITTEE ON OVERSIGHT
AND
INVESTIGATIONS
COMMITTEE ON ENERGY
AND COMMERCE
ON
HOSPITAL CAPITAL COSTS
MARCH 31, 1993**



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Good morning, I am George M. Reeb, the Assistant Inspector General for Health Care Financing Audits for the Department of Health and Human Services (HHS). With me today is John M. Hapchuk, Director of Programs and Operations Audits for Health Care Financing Audits within the Office of Inspector General (OIG). Pursuant to your request, we are here today to discuss the review we completed last year of hospital capital costs. Our analysis, which covered the first 5 years under the Medicare Prospective Payment System (PPS), showed that hospital capital costs grew substantially during this period, much faster than leading economic indexes. Average yearly increases in capital costs over this period were about 11.5 percent, rising from \$9.9 billion in PPS year one to \$15.6 billion in year five. In addition, the hospitals' allocation of these costs to the Medicare program rose from \$3 billion to almost \$5 billion--an overall increase of about 60 percent. This

growth occurred during a period in which there were a number of unused hospital beds. The Congress and the Administration recognized these large cost increases given unused beds were unsustainable under Medicare and began in Fiscal Year (FY) 1987 to reduce the Medicare payment for capital costs.

Our concern, however, is that the newly enacted law to create a Medicare capital reimbursement system using prospective rates is based upon inflated historical costs as part of the formula calculation. These inflated historical costs include payments for unused hospital capacity and fail to account for certain hospital interest income as an offset in paying capital costs. We recommended that the Health Care Financing Administration (HCFA) propose legislation to continue mandated reductions in capital payments beyond FY 1995, as an interim measure, to recognize that historical costs used in

setting PPS rates are inflated. We further recommended that HCFA should determine the extent of the capital payment reductions that are needed to fully account for the unused capacity and the exclusion of certain interest income used in calculating the base period historical costs. This revised capital payment reduction percentage should then be reported to the Congress. With your permission, Mr. Chairman, I will enter our final audit report, Analysis of Hospital Capital Costs (A-09-91-00070), into the record. My testimony will summarize the findings of this report.

BACKGROUND

The HHS is the Federal Government's principal agency for promoting the health and welfare of Americans and providing essential human services to persons of every age group. The Department's two largest health programs are the Medicare and

Medicaid programs, which are administered by HCFA.

Medicare provides health insurance coverage to approximately 36 million beneficiaries aged 65 and older and to certain disabled individuals. The Medicaid program provides grants to States for the medical care of more than 30 million low-income people. Expenditures for the Medicare program totalled \$140 billion in FY 1992.

Created in 1976, the OIG is statutorily charged to protect the integrity of department programs, as well as promote their economy, efficiency, and effectiveness. We meet our challenge through a comprehensive program of audits, inspections, program evaluations, and investigations.

Over the years, the OIG has proved to be a sound investment. In FY 1992, the OIG generated savings, restitutions, penalties,

and interest of over \$61 for each Federal dollar invested in its operations. We also imposed 1,739 administrative sanctions on individuals and entities who defrauded or abused the Medicare and Medicaid programs or their beneficiaries. Successful health care prosecutions in the criminal courts have also dramatically increased, from 20 in 1982 to 168 in FY 1992.

One of the most important pieces of legislation for elderly and disabled Americans in recent decades is Title XVIII of the Social Security Act, better known as the Medicare program. Enacted in 1965, Medicare is the largest Federal health program, covering a wide array of medical services, including inpatient hospital care, physician services, home health care, and skilled nursing facility care for the elderly and disabled population.

Medicare is administered through two trust funds. The Hospital Insurance Trust Fund, commonly referred to as Medicare Part A, is funded through payroll taxes. The Medical Insurance Trust Fund, commonly referred to as Medicare Part B, is financed through premiums from beneficiaries, as well as through amounts appropriated from general revenues.

Since 1983, Medicare has reimbursed most hospitals for their operating costs, but not capital costs, through a payment system based on prospectively set rates. This payment system was designed to control escalating costs by creating an incentive for hospitals to operate efficiently as they were paid a flat amount, depending on the patient's treatment diagnosis. Although the Congress intended that all costs would be eventually covered by

prospective payments, capital costs were specifically excluded from the PPS legislation, pending further study.

Capital-related costs include expenses such as 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 these depreciable assets, and taxes on land or depreciable assets used for patient care.

Efforts to incorporate payments for capital costs into PPS were delayed over the years because of disagreements over the methodology to be used to determine the predetermined fixed payments. In an attempt to control escalating payments during the transition to predetermined capital payments, the Congress mandated across-the-board reductions in Medicare payments for capital costs in the Omnibus Budget Reconciliation Acts of

1986, 1987, 1989, and 1990. 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:

- ◆ 3.5 percent from October 1, 1986 through November 20, 1987;
- ◆ 7.0 percent from November 21, 1987 through December 31, 1987;
- ◆ 12.0 percent from January 1, 1988 through September 30, 1988;
- ◆ 15.0 percent from October 1, 1988 through September 30, 1989; and
- ◆ 15.0 percent from January 1, 1990 through September 30, 1991.

The Medicare reimbursement for capital costs will be transformed into a complete predetermined rate, as opposed to cost reimbursement, over a 10-year period beginning with FY 1992. Reimbursement for capital predetermined rates will be based on historical costs, less the congressionally mandated 10 percent reduction, through FY 1995. The 10 percent reduction is scheduled to lapse after FY 1995.

PROBLEMS WITH THE HISTORICAL CAPITAL COSTS

In our audit, we reviewed changes in capital costs for 5,248 Medicare PPS hospitals for FYs 1984 through 1988, which were the first 5 years of PPS.

Unlike Medicare's PPS payments related to hospital operating costs which grew at reasonable levels under PPS, hospital capital costs have increased substantially.

Total capital costs for the 5,248 hospitals we analyzed, increased 57.3 percent during the first 5 years of PPS, from about \$10 billion in FY 1984 to almost \$16 billion in FY 1988. 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. Capital costs per patient discharge increased from \$313 in FY 1984 to \$523 in FY 1988, an average increase of 13.7 percent per year. We noted that 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 31.8 million in PPS-1 to 29.9 million in PPS-5, a reduction of 6 percent.

Percentage increases in capital costs were significantly higher than increases in three leading economic indexes. Capital costs increased two to three times faster than changes in the

Consumer Price Index (which increased an average of 3.5 percent per year), the Hospital Market Basket Index (an average increase of 3.9 percent), and the annual PPS update factor (an average increase of 1.9 percent). The capital increases were also, on the average, almost twice the rate of growth in new plant and equipment expenditures in business which grew an average of 6.2 percent per year.

A substantial portion of the increases in capital costs was caused by a relatively small group of hospitals. Less than 19 percent of the 5,248 hospitals accounted for 80 percent of the annual cost increases. The high-cost hospitals were primarily large, urban, nonprofit, teaching facilities. In fact, teaching facilities comprised only 19 percent of the hospitals analyzed, but they accounted for 43 to 47 percent of the high capital cost hospitals for PPS-2 through PPS-5.

Medicare's cost reimbursement system for capital failed to curb the escalating costs, and, indeed, may have contributed to the problem. Third party payers that allow reimbursement of capital costs, regardless of unused capacity and 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 has prevented Medicare from absorbing the full impact of the cost increases.

INFLATED HISTORICAL COSTS

Although we agree that congressional and administrative action of folding capital costs into PPS represents a major and much needed reform to control capital cost expenditures, we believe that the basis upon which the PPS capital rates are being set--historical costs--is inflated.

Based on our analysis, we concluded that the historical costs used in setting PPS rates are inflated, because: (1) unused capacity in hospitals has caused more capital costs to be incurred than economically necessary, and (2) an inappropriate element--that of not considering certain hospital interest income in calculating capital costs--is still included in the historical costs.

UNUSED CAPACITY

The hospital industry has experienced unused capacity for years. The Grace Commission reported in 1983 that there was an excessive surplus of hospital beds as far back as the mid-1970s when between 68,000 and 264,000 beds went unused annually. 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.

As part of our analysis, we computed average bed occupancy rates during the first 5 years of PPS. The bed occupancy rate is a percentage of beds used to total beds available for use.

For example, if a hospital had 100 beds available, but only 60 were used daily by patients, it is said to have an occupancy rate of 60 percent. We found that while hospital capital costs increased substantially, the hospitals operated at low bed occupancy rates. The average occupancy rate for all hospitals during FY 1984 was 53.9 percent and the average occupancy rate for each year between FY 1985 and FY 1988 was about 61

percent. As such, it does not appear that the large increases in capital costs are related to demands on hospital capacities.

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 only measure for evaluating all capital expenditures, the rates do give an overall picture of utilization and the unused capacity in the industry.

EXCLUSION OF CERTAIN INTEREST INCOME

In addition to capital costs being inflated by unused capacity, previous OIG audits disclosed that historical capital costs included several other inappropriate elements. In 1985, the OIG issued a report that identified six issues that would

significantly impact capital PPS rates. In our most recent analysis, we followed up on these six issues. For five of the six issues, legislative, regulatory, and programmatic changes, and the passage of time, addressed the problems. However, there is one significant issue that has yet to be corrected which still results in inflated capital costs. This issue involves waivers of interest income offsets.

Waivers of interest income offsets involve Medicare accounting rules on the treatment of interest income earned by hospitals. Under Medicare cost reimbursement principles, providers are generally required to offset interest income from investments against interest expenses incurred through capital expenditures. The purpose of the offset rule is to ensure that Medicare does not pay for unnecessary interest expense. The exception, however, allows hospitals to earn interest on funds set aside for

future capital improvements, termed "funded" depreciation, while being reimbursed by Medicare for current capital projects.

We believe that using Medicare trust funds to subsidize future capital needs of the hospital industry is not appropriate because there is not a current or anticipated shortage of hospital beds and Medicare is already paying interest and depreciation for buildings currently being used in the program.

Another exception of the offset rule allows hospitals to shelter interest income earned on funds donated to them. This exception for interest income should also be removed because 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. We do not advocate that the donated funds themselves be used to offset capital costs; merely that interest earned on the investment of these donated funds be used to offset incurred interest expense.

The cost of interest offset loopholes to Medicare is substantial, running into billions of dollars. For example, when our 1984 report on "funded" depreciation was issued, we estimated that closing this loophole would have saved the Medicare program about \$3.7 billion over the then 5-year budget cycle.

We believe that the PPS rules for capital payments do not adequately address the issues of unused capacity and the exclusion of certain interest income in calculating capital costs. Under the capital PPS rules, payments will be made using a

predetermined amount per discharge divided for a 10 year phase-in period between a hospital-specific and a Federal rate. For FY 1993, the Federal rate for each discharge will be \$417.29. Although the overall capital payments will be reduced by a congressionally mandated 10 percent through FY 1995, using a base of inflated historical costs will result in a perpetuation of the payment for unused capacity for the future.

RECOMMENDATIONS

Before closing, I would like to reiterate for the Subcommittee our recommendations. Basically, we recommended to HCFA that legislation be sought to extend the mandated reductions in capital payments beyond FY 1995 to recognize that historical costs used in setting PPS rates are inflated. We also recommended that they determine, and report to the Congress,

the actual capital payment reductions needed to fully account for the inflated historical costs.

Reducing capital payments will help assure that Medicare will be able to pay for care provided in the future. As you know, the Board of Trustees of the Medicare trust funds stated in its 1992 annual reports that it continues to be concerned about the solvency of the funds. The Board concluded that the Hospital Insurance Trust Fund may be exhausted by the year 2002 and that the Supplementary Medical Insurance Trust Fund is experiencing an alarmingly rapid growth in program outlays. The Board of Trustees urged the Congress to take actions to control costs. The recommendations contained in our report would contribute to the cost containment effort.

Mr. Chairman, this concludes my prepared testimony. I will be happy to answer any questions that you may have.