Statement of

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The recently enacted Social Security Amendments include a major change in the way Medicare reimburses hospitals for most of their costs, a switch to prospective payment. But the amendments do not change Medicare's method of reimbursement for capital costs--that is, interest, rent, and depreciation expenses associated with the acquisition of facilities and equipment.1/ Under the new system, reimbursement rates for operating costs will be set in advance, but hospitals will continue to be paid retrospectively for Medicare's share of capital costs. The Congress made clear, however, that it intends to consider changes in capital reimbursement policy within the next three years, to make it conform to the new prospective system used for operating costs.

My testimony will present background on capital spending by hospitals and discuss some options for Medicare's capital reimbursement policy. Decisions on the role of health planning, which this Subcommittee is preparing to make, are closely related to those concerning Medicare's reimbursement of capital costs.

BACKGROUND

Medicare is responsible for 37 percent of all community hospital revenues, and reimbursement for capital expenses constitutes only about 7 percent of these receipts--$3.2 billion in fiscal year 1984. Nevertheless, the

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1. The Social Security Amendments of 1983 (P.L. 98-21). Capital costs also include payment for return on equity to investor-owned hospitals, which P.L. 98-21 reduced from a rate of 1.5 times the interest rate earned on balances in the Hospital Insurance Trust Fund to 1.0 times that rate.

influence of capital reimbursement on total Medicare outlays is much greater than this small percentage would indicate. Investment in new plant and equipment, often embodying new technology, is closely related to the increase over time in the average number of diagnostic and therapeutic services provided during a hospital stay. This factor, frequently labeled "intensity," has played a dominant role in hospital cost increases, particularly in the last several years. It is estimated that every dollar spent on new facilities and equipment generates an additional 22 cents each year in costs for personnel and supplies.2/

Additions to facilities may also raise costs by inducing increased hospital admissions. One estimate is that a 10 percent increase in the number of hospital beds per capita increases admission of Medicare patients by 4 percent.3/

Although there is no consensus on how much capital is needed--partly because of its contribution to the quality of care--it is generally believed that, in the aggregate, too much has been spent on hospital facilities and equipment. For example, it is argued that there are more hospital beds than necessary, since the current ratio of 4.4 beds per thousand population is higher than the 4.0 guideline commonly accepted by health planning

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2. Arthur D. Little, Inc. "Development of an Evaluation Methodology for Use in Assessing Data Available to the Certificate of Need (CON) and Health Planning Programs," Final Report, April 1982, p. 189.

3. Paul B. Ginsburg and Daniel M. Koretz, "Bed Availability and Hospital Utilization: Estimates of the 'Roemer Effect,'" Health Care Financing Review, September 1983, in press.

agencies. In addition, some argue that hospitals purchase too much equipment because each wants to be able to offer the latest technology, even though it may be used infrequently, and because physicians order many procedures that contribute little to quality care.

Despite this excess capacity in the aggregate, some hospitals are unable to finance needed modernization. Anecdotal evidence indicates that this is particularly true of urban public hospitals and others with a large share of indigent patients.

THE CURRENT REIMBURSEMENT SYSTEM

Under the new prospective payment system for operating costs, rates will be set in advance for each of the Diagnostic Related Groups (DRGs). In the next three years, these rates will vary by region and by whether or not the hospital is located in an urban area. Extra payments will be made to teaching hospitals and for unusually costly cases. Medicare's share of capital costs, however, will continue to be paid retrospectively, based on the proportion of costs attributable to Medicare patients in each hospital.

This combination of prospective payment for operating costs with retrospective reimbursement of capital costs will encourage projects that substitute capital for labor. Because capital costs are fully reimbursed, but labor costs directly reduce hospitals' net incomes, hospitals will have an incentive to pursue labor-saving investments even when they increase total costs. To the extent that other payers also pay operating costs

prospectively but fully reimburse capital costs, this incentive will be stronger.

On the other hand, even though capital costs are fully reimbursed, the prospective payment system is likely to discourage investment in equipment and facilities that would increase operating costs. Since hospitals can keep the difference whenever their costs are below the DRG payment rate, but must absorb the loss if their costs are higher, they have an incentive to avoid capital investments that would lead to higher operating costs. To the extent that costs not reimbursed by Medicare can be shifted to other payers, however, hospitals are less likely to cut their capital spending. In addition, hospitals may accept increased operating costs if adding beds or new equipment allows the hospital to serve additional patients, since payment is made on a per-case basis.

Another incentive to limit capital spending may come from the required review of hospital capital projects. Under the Social Security Amendments of 1983, states must by 1986 begin reviewing projects that exceed $600,000 before hospitals may be reimbursed for Medicare's share of the capital costs.[4/] By stipulating prior approval, in contrast to the explicit disapproval required under the previous statute, the amendments may

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4. Section 1122 of the Social Security Amendments of 1972 authorizes the Secretary of Health and Human Services to enter into voluntary agreements with states to establish boards to review proposed hospital capital projects in excess of $100,000; the Social Security Amendments of 1983 require states to establish boards by 1986, and raise the review ceiling to $600,000.

prevent more projects. On the other hand, there is some reason to believe that capital review programs may not cut capital spending, particularly in states without a commitment to this type of regulation. Although not conclusive, studies of stricter review programs--those that require approval for licensure, not just Medicare payment--have not found these programs to be successful in limiting the growth of hospital capital costs.5/

Recent changes in Medicare's reimbursement policies do not settle the issue of whether health planning is needed for capital costs other than those allocated to Medicare. For one, Medicare's policies alone may not provide enough incentives to limit overall costs. Moreover, even if they do limit overall capital spending, it might still be desirable to have a planning process to improve the distribution of capital among hospitals. The prospective payment system may reallocate capital to the most efficient hospitals--those that earn a surplus--but those may not be the hospitals that most need to modernize or expand.

OPTIONS

Several options exist for changing the way Medicare reimburses hospitals for capital costs--such as including all reimbursement for capital in the DRG-based prospective rates; including equipment costs in the

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5. Congressional Budget Office, Health Planning: Issues for Reauthorization, March 1982.

prospective rates, but continuing to pass through costs of facilities; and establishing statewide capital spending limits.

Include All Reimbursement for Capital in the DRG Rates

One alternative to continuing full reimbursement of capital costs--one that will occur in fiscal year 1987 unless the Congress acts--would be to include them in the DRG rates, by increasing each DRG rate by a uniform percentage. Although some DRGs rely more on equipment than others, these differentials are already built into the DRG rate for operating costs. This occurs because the relative rates for each DRG are based on the charges for services used by those patients, which hospitals set to cover both capital and operating costs.

Reimbursing capital costs through the DRG rates would have several advantages. First, capital payments by Medicare would be predictable and controllable. Future outlays for Medicare would not be affected by the possible hospital building boom that some are predicting, except for the impact such a boom might have on admission rates. Instead, total payments would be determined by Medicare's operating costs, marked up by a capital adjustment factor.

Second, hospitals would have an incentive to reduce capital costs as well as operating costs. For example, hospitals would seek to delay projects when interest rates are high, whereas now they do not because all interest

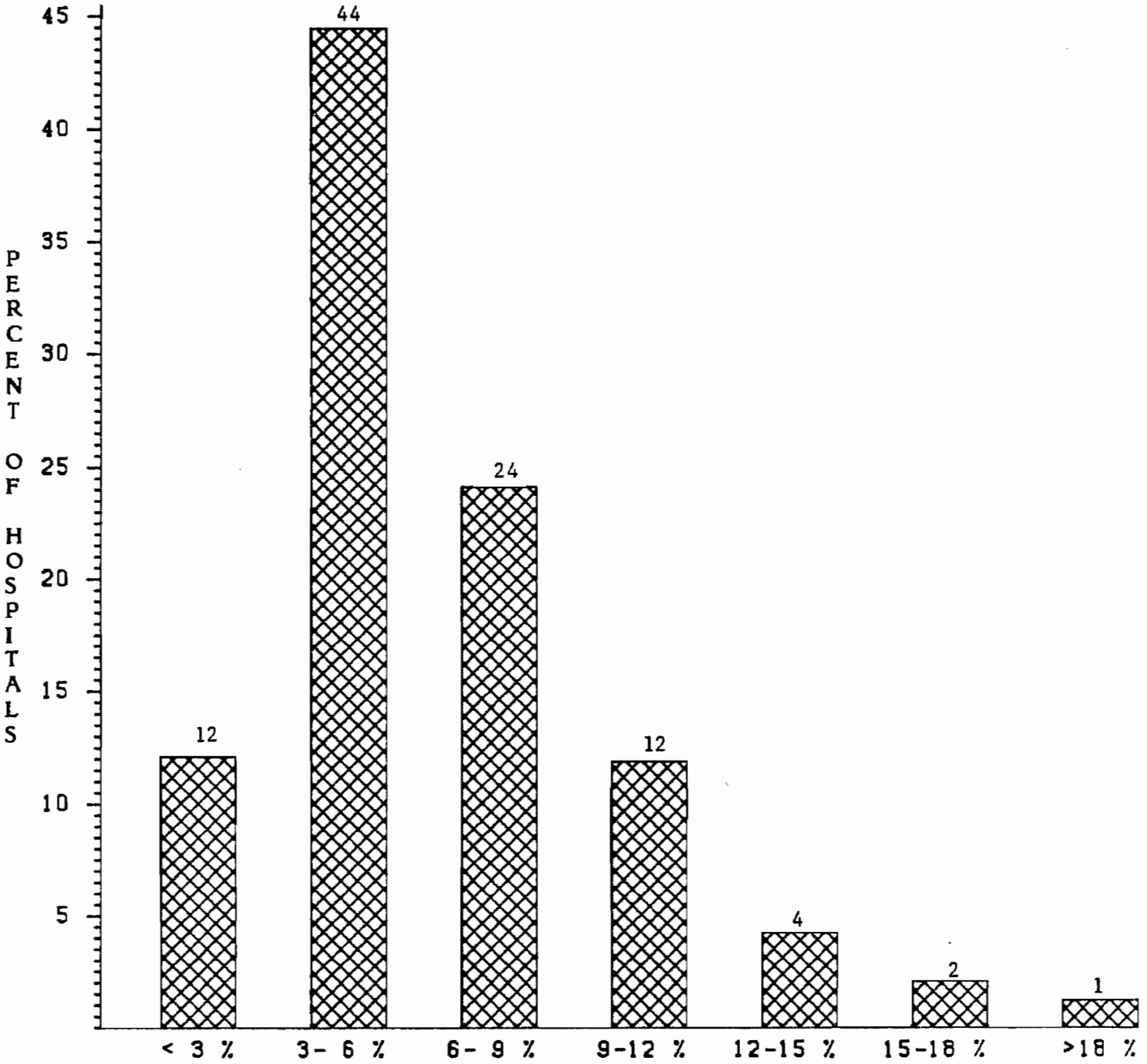
costs are reimbursed. In addition, this approach would avoid the incentive that unintentionally exists under current law to substitute capital for labor.

The major drawback of this option is that the transition from the current system would place hospitals needing to modernize or expand at a disadvantage. The source of this transition problem is that hospital capital expenses are "lumpy." Large projects occur infrequently, so hospitals tend to have much higher than average capital expenses in some years and much lower expenses in others. The proportion of hospital expenses attributed to capital averages 6 percent, but can range up to 25 percent for an individual hospital (see Figure). As a result, hospitals that are beginning or that have recently completed large projects would have actual expenses greater than their reimbursement through the DRG rates. A partial solution would be to "grandfather" some of the costs of projects planned or begun before the new policy took effect.

In the long run--perhaps 20 years--"lumpiness" would not be a problem. Hospitals would be able to meet large capital costs by accumulating reimbursements until they were needed. In addition, hospitals with operating costs below the DRG payment rates would have extra funds available for capital projects.

A second possible drawback is that including capital costs in the prospective rates might discourage improvements in the quality of care.

DISTRIBUTION OF HOSPITALS ON THE BASIS OF
THEIR CAPITAL COSTS AS A PROPORTION OF THEIR TOTAL COSTS, 1980[a]



a. This distribution is based on hospitals filing Medicare cost reports for the 1980 accounting year. Capital costs include depreciation, rent, and interest, but exclude return on equity.

Because the DRG rates would be the same regardless of quality, hospitals would not be rewarded for purchasing new equipment or modernizing to improve quality--the same problem that exists under prospective payment for operating costs. In contrast, under the current system, all capital costs are reimbursed--regardless of their efficiency or their effects on quality.

Finally, this option would not address the issue of targeting. Hospitals with a large share of indigent patients--which also often serve large numbers of Medicare and Medicaid patients--would still have difficulties financing large investments.

Include Reimbursement for Equipment in the DRG Rates

A variant of the previous option would include equipment costs in the DRG rates, but pass through capital costs for constructing or renovating buildings. This would offer the advantages of prospective payment for investments in equipment--namely, making payments predictable and controllable, encouraging efficiency, and avoiding most of the incentives to overinvest in capital as a substitute for labor. At the same time, the transitional problem resulting from including costs for all capital in the prospective rates would be avoided, because costs of larger investments would still be passed through.

Since there are currently no data on the share of capital expenses attributable to equipment as distinguished from other investment, errors in

setting the adjustment factor could increase costs or create unintended barriers to the addition of new technology or more modern equipment. But the necessary data could be obtained. In the meantime, since capital reimbursements account for only 7 percent of total Medicare payments, any errors would be relatively small.

A long-run disadvantage of including only equipment costs in the DRG rates is that incentives to limit capital spending for large projects would be lost. Further, some incentives to invest in relatively expensive capital to lower operating costs would continue.

Establish Statewide Capital Spending Limits

Another approach would be to establish statewide limits on capital spending, perhaps a percentage of DRG reimbursements in the state. Hospitals would apply to the planning authority for project approval in order to have Medicare pay for its share of the project's capital costs. The designated authorities could be the review panels required under current law, or they could be part of a more extensive health planning process, such as the system implemented under the Health Planning and Resources Development Act of 1974 (P.L. 93-641).

Along with predictability and control of Medicare's payments for capital, a possible advantage of this option would be improved targeting. The state planning authority would review applications and might direct the

funds where it determined the need to be greatest. On the other hand, improved targeting is not a guaranteed outcome of the planning process, and some oppose an expanded role for government in the allocation of capital.

A variation on this option would offer states the choice between developing such a system and including reimbursement for capital costs in the DRG rates. States opposed to planning could choose the second alternative. States that already have planning programs would benefit from the limit on total hospital investment that they could approve, since it would force them to make trade-offs between competing proposals, whereas the current system does not.

CONCLUSION

Modifying Medicare's policy for reimbursing the capital costs of hospitals to conform with the new system of prospective payments for operating costs is an important issue. The choice of how to do this is difficult, however, and involves balancing some complex technical issues. It also involves several different goals: limiting total Medicare payments for capital, encouraging hospitals to be efficient, and allocating payments to hospitals most in need of modernization. Finally, decisions on how to reimburse capital costs under Medicare are closely related to the appropriate role of health planning.