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STATEMENT OF MICHAEL ZIMMERMAN

ASSOCIATE DIRECTOR, HUMAN RESOURCES DIVISION

BEFORE THE

SUBCOMMITTEE ON HEALTH

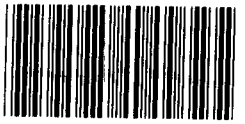
AND

SUBCOMMITTEE ON OVERSIGHT

HOUSE COMMITTEE ON WAYS AND MEANS

ON THE EFFECTS OF CHANGES IN PROVIDER OWNERSHIP ON CAPITAL COSTS

Mr. Chairman and members of the Subcommittees, we are pleased to be here today to discuss how hospital mergers can increase Medicare and Medicaid payments for capital costs. Our review of one large merger showed substantial increases in capital costs resulting from a change in ownership. The Medicare and Medicaid programs will reimburse the new owner for some of the increase in costs. Future acquisitions will also increase Medicare and Medicaid payments for capital costs unless the present cost reimbursement system is changed. The Social Security Amendments of 1983 (P.L. 98-21) provide for incorporating capital costs into the prospective payment system by October 1, 1986, if a plan acceptable to Congress is developed.



The first part of my statement will focus on the information presented in our report to Representative Gradison entitled Hospital Merger Increased Medicare and Medicaid Payments for Capital Costs (GAO/HRD-84-10, December 22, 1983). Next, as you requested, I will briefly discuss the incentives for acquisitions provided by the federal income tax code. Finally, I will describe some of the ways states under Medicaid reimburse capital costs for nursing homes after acquisitions.

THE GAO REPORT

As requested by Representative Gradison, we examined the Hospital Corporation of America (HCA) acquisition of Hospital Affiliates International (HAI) from INA Corporation to show what can happen to costs when hospitals change ownership. On August 26, 1981, HCA purchased HAI's assets, which consisted of 54 hospitals, 18 nursing homes, at least 10 medical office buildings, and 42 other corporate entities such as hospital management companies. HCA paid INA $425 million in cash (which HCA borrowed) and 5.39 million shares of stock valued at $190 million. In addition, HCA assumed HAI's debt of about $270 million.

Costs Increased Substantially

Our analysis of HCA's corporate records focused on changes in interest expense, depreciation, and corporate-level management expense (home office expense) because these costs are most likely to change significantly as the result of an acquisition.

Our analysis showed that, during the first year after the acquisition, the 54 acquired hospitals' costs increased by about $55 million. These increased costs will have to be recouped through increased revenues from hospital payors or absorbed by HCA, which would result in decreased corporate earnings.

We estimated that overall annual interest costs increased by about $62.5 million, nearly tripling, because of borrowing to finance the acquisition. In addition, depreciation on the hospitals and medical office buildings increased by about $8.4 million per year, almost 90 percent, as a result of HCA's revaluing these acquired assets. Based on information from HCA officials and unaudited home office cost reports, the estimated home office cost savings for the first year were about $15.7 million. Officials said that the savings resulted from home office staffs being reduced and home office costs being spread over more hospitals.

Effect of HCA's Increased Capital Costs on Medicare and Medicaid Costs

To measure the effect on Medicare and Medicaid costs, we allocated HCA's claimed costs for depreciation, interest, and home office expenses to these programs for two hospitals suggested by HCA. We estimated that for the year following the acquisition:

--The overall increase in costs due to changes in these three items was about $1 million at one hospital and $300,000 at the other.

--The portion of these increased capital costs allocated by HCA to Medicare and Medicaid was $465,000 at one hospital and $117,000 at the other.

--At the two hospitals, the increase in capital costs per patient day allocated to Medicare in HCA's cost reports was about $26 and $21, respectively.

--At the two hospitals, the increase in capital costs per patient day allocated to Medicaid in HCA's cost reports was about $31 and $27, respectively.

HCA Misinterpreted Medicare Reimbursement Policy

Medicare policies permit assets to be revalued and additional interest and depreciation expenses to be reimbursed following changes in provider ownership if certain conditions are met. However, Medicare reimbursement policies include some controls that limit the increases. For example, Medicare will not pay for purchased goodwill--that is, the amount paid to the seller that exceeds the market value of the acquired assets--and Medicare has controls over the methods used to assign a fair market value to acquired assets.

We questioned the procedures HCA used for Medicare cost reporting purposes (which are also generally used by Medicaid) to allocate interest to the acquired hospitals and to value the acquired assets and compute depreciation on them. HCA based its position on its interpretation of Medicare policies and on Generally Accepted Accounting Principles (GAAP), which are designed to provide rules for reporting the financial position, results of operations, and changes in the financial position of an entity for present and potential investors and creditors. Although GAAP normally represents the appropriate principles for financial reporting purposes, it is not always appropriate for a cost reimbursement system such as Medicare uses. Under Medicare, GAAP can be used only when Medicare's principles of reimbursement do not cover a situation.

The HCA methods that we questioned would tend to increase Medicare payments to the hospitals. Medicare's paying agents have not yet determined the amount of increased costs the program will allow, and they may disallow the items we questioned when a final determination of the hospitals' allowable costs is made. Specifically, HCA used the following methods that we questioned:

--HCA allocated debt and related interest to Medicare using a method different from the one prescribed by the program. This resulted in higher capital costs being allocated to Medicare.

--HCA discounted the debt assumed from HAI that bore interest rates below the market rate at the time of acquisition. The effect of discounting was to increase the interest claimed from Medicare.

--HCA assigned inaccurate values to the real assets because of inconsistent practices in the appraisal and depreciation processes. Specifically, (1) useful lives used in appraising the acquired assets were different from the Medicare-approved lives used in depreciating them, (2) acquired assets were assumed to have no salvage value when depreciation was calculated, and (3) values were assigned to leased assets that resulted in higher interest and depreciation expenses being claimed. In addition, the appraisals' independence and accuracy are questionable because the appraised values were changed at HCA's request. This change would have the effect of increasing the assets' value by $28.2 million above the value that would have been computed using Medicare-approved useful life estimates and thus increase the allowable debt and depreciable base by the same amount.

HCA generally disagreed with our findings and believes it has correctly claimed reimbursement from Medicare in accordance with the program's policies. We believe, however, that HCA has misinterpreted Medicare reimbursement policy and that the questions we raised concerning the costs it claimed are appropriate.

We recommended that HHS (1) consider our findings when finalizing payments to HCA related to the HAI acquisition and (2) clarify the Medicare policies discussed in the report to prevent misinterpretations by providers in future acquisitions.

Another reason to clarify the Medicare policies on accounting for acquisitions is that, if an acceptable method for including capital costs in prospective payments is developed, it will be important to know what allowable costs were in the past and will be in the future because prospective payment rates are normally based on costs.

THE FEDERAL INCOME TAX SYSTEM CAN PROVIDE INCENTIVES FOR CHANGES IN OWNERSHIP

We believe that current Medicare reimbursement policies for capital costs are relatively neutral toward influencing a decision to buy or sell a hospital. That is, because Medicare payments are based on the new owner's costs (with some limitations), they do not provide a large incentive one way or the other to anyone considering selling or buying a hospital. However, Medicare's policies do remove much of the risk from purchasing a hospital because the buying entity is guaranteed payment of its capital costs to the extent that Medicare beneficiaries use the hospital. Also, the entity can retain under the prospective payment system any savings it can generate through operating efficiencies. But Medicare policy is only one of the federal policies involved. Another set of policies, namely

federal tax policies designed to stimulate investment in new facilities and equipment, can provide incentives toward buying and selling existing hospitals. A few examples follow.

Federal income tax law permits owners of real property such as hospital buildings to use accelerated depreciation over a 15-year period. Thus, a hospital building, which according to the American Hospital Association normally has an estimated useful life of 40 years, can be fully written off in 15 years. From an income tax standpoint, it may pay to change ownership every 6 or 7 years because, by that time, more than half of the facility's depreciation can be taken. Also, from the seller's viewpoint, some of the gain made on the sale may be taxed as a long term capital gain, of which only 40 percent is taxable as income. From the buyer's viewpoint, interest on any loans obtained to finance the acquisition as well as accelerated depreciation on the hospital's newly established value are deductible from income. Also, the buyer may be able to qualify for an investment tax credit on at least some of the equipment acquired.

ALTERNATIVE PAYMENT METHODS FOR CAPITAL COSTS AFTER ACQUISITIONS

Capital costs consist primarily of interest and depreciation costs. As shown by our report on one merger, both of these costs can increase substantially after an acquisition. Another

capital cost which Medicare pays that can be significantly affected by an acquisition is return on equity. Depending mainly on the difference in investment between the old and new owners, return on equity could either increase or decrease.

In response to the Subcommittees' request, we identified alternatives to current Medicare policies for recognizing capital costs after an acquisition. We reviewed the various mechanisms states use under Medicaid for this purpose as well as other possible methods. We identified a range of options that vary from allowing no change in capital costs after an acquisition to imposing less stringent controls on only the depreciation side of capital costs.

First, I would like to discuss a rationale that could be used for controlling capital costs after a sale. Under a cost-based reimbursement system for capital costs, when a hospital enters the program, the hospital and the government in effect enter an agreement under which the hospital agrees to serve government beneficiaries at the payment rate resulting from the government's reimbursement rules and the government agrees to pay the hospital its actual capital costs. Over the facility's life, the government will fully pay for that part used by its beneficiaries. If the hospital is sold and because of factors not related to the program (increased land values, inflation in the cost of building hospitals, etc.) the new

owner's capital costs are higher than those of the old owner, the government should not be obligated to pay these increased costs. The rationale for this is that the government is only going to pay for the facility once based on its original costs.

On the other hand, the rationale from the hospital seller's and buyer's prospective for allowing payments for capital costs to increase is that the hospital's circumstances have changed and the government should recognize this change. The seller would argue that not recognizing increased capital costs would diminish the property's value because a buyer would not pay as much for it knowing that the government will not allow passing through all increased costs.

A range of alternatives follows.

--Limit the buyer's allowable depreciation to the level allowed to the seller. Wisconsin has this kind of a policy for Medicaid nursing home payments. This would keep depreciation constant after the sale. However, Medicare savings would be relatively small, as would the impact on the buyer, because increases in interest costs are often much higher than increases in depreciation.

--Limit capital costs to maximum amounts per day based on the facility's age. The maximum amounts would be set based on construction costs per bed when the facility was

built or began participating in the program. Ohio uses this limitation under Medicaid for all nursing homes regardless of whether a sale is involved, but Medicare could use the policy for sales only. For example, in Ohio, for a facility constructed and/or licensed between December 31, 1957, and January 1, 1968, the payment shall not exceed

(a) $3.50 per inpatient day if the cost of construction was $3,500 or more per bed, or

(b) $2.50 per inpatient day if the cost of construction was less than $3,500 per bed.

The buyer could receive actual interest and depreciation expenses unless they exceed the limit. This policy would establish a ceiling on the increases in capital costs. It would require establishing cost limits based on construction costs at the time a facility was built or entered the program. This could be difficult for older facilities because the records identifying costs may not be readily available.

--Limit capital costs after sales to the capital costs incurred by a selected percentage of hospitals. For example, Kansas limits payments for nursing homes under Medicaid to the costs incurred by 85 percent of the

nursing homes participating in Medicaid. Kansas applies this limit to all facilities, but Medicare could apply it only to acquired facilities. The buyer could receive actual capital costs unless they exceeded the limit. The percentile at which the limit is established can be selected to achieve the level of savings desired or accomplish another policy objective.

--Limit capital payments to amortization based on the seller's mortgage payment. New York uses this policy, based on the original provider's mortgage payments, for proprietary nursing homes participating in Medicaid. This policy in effect pays the original owner's cash flow needs for capital-related costs. If a buyer's capital cash flow needs are higher than the seller's, New York does not recognize them. This policy does not pay depreciation in the traditional sense, but rather pays the principal based on the original owner's mortgage.

There are many possible variations of the policies outlined above. Each policy and each variation would produce different savings for Medicare and would have different impacts on buyers and sellers. Also, each could provide different incentives to buyers and sellers. For example, controlling only depreciation increases should have little impact on buyers and sellers and should produce limited Medicare savings. On the other hand, if

no increase in interest or depreciation were allowed, a buyer would probably think twice before paying much more for a hospital than its depreciated book value and Medicare savings should be much larger.

None of the policies discussed above specifically address controlling changes in Medicare's return of equity payments, but the same types of limitations could be placed on them. Also under Medicare's hospital prospective payment system, hospitals can now realize a profit by holding their operating costs below the prospective payment level. Some have questioned whether, given this, it is also necessary to pay a return on equity as well. Under their Medicaid programs, a number of states do not directly include a return on equity payment in computing their prospective payment rates for nursing homes.

This concludes my statement. We will be glad to answer any questions you may have.