BY THE COMPTROLLER GENERAL

Report To The Congress

OF THE UNITED STATES

Use Of Unaudited Hospital Cost Data Resulted In Overstatement Of Medicare's Prospective Payment System Rates

When the Department of Health and Human Services (HHS) computed Medicare's prospective payment rates for inpatient hospital services, it used unaudited cost reports. Because unaudited cost reports frequently include items that Medicare does not allow and the law calls for setting the prospective rates based on allowable costs, GAO performed a recalculation using audited cost reports for a sample of hospitals. A comparison of the HHS and GAO computations showed that the rates would be an estimated 2.98 percent lower using audited data.

Also, HHS did not remove all hospital capital costs from the data used to compute the prospective rates. These costs should have been removed because capital costs are paid separately from the prospective rates. GAO estimates that removing the remaining capital costs from the prospective payment computation would lower the rates by an estimated 1.29 percent and prevent double payment for these costs.

GAO recommends that HHS correct its data base for computing the prospective payment rates to remove the overstatement resulting from using unaudited cost data and the inclusion of some capital costs. Doing so would reduce Medicare payments by an estimated $940 million in fiscal year 1986 and by over $8 billion during fiscal years 1986-90.

GAO/HRD-85-74
July 18, 1985

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON D.C. 20548

B-219307

To the President of the Senate and the
Speaker of the House of Representatives

The Congress, through the Social Security Amendments of 1983 (Public Law 98-21), revised the method used to pay hospitals under Medicare as a means of controlling the growth in Medicare costs. The Congress substituted, for the former cost reimbursement system, a prospective payment system (PPS), which establishes in advance a payment rate for each Medicare patient discharged from the hospital based on the patient's diagnosis. When the Health Care Financing Administration (HCFA), within the Department of Health and Human Services (HHS), set the rates to be used under PPS, it

--used unaudited hospital cost data to compute the average cost per Medicare discharge, which in turn is the basis for determining the amount of payment for each Medicare discharge, and

--did not remove all capital costs from the hospital cost data even though these costs are paid separately from the PPS rates.

We estimate that, because of these two factors, Medicare payments are about 4.3 percent higher than they would be if HCFA used audited cost data to compute them and removed all capital costs from the data. This percentage translates into projected excessive Medicare payments of about $940 million in fiscal year 1986 and of over $8 billion during fiscal years 1986-90.[1] If the four states operating under PPS waivers--Maryland, Massachusetts, New Jersey, and New York--are included in our estimates, excessive Medicare payments increase to about $1.2 billion in fiscal year 1986 and $10.4 billion during fiscal years 1986-90.[2] The law requires that waiver states pay no more than would be paid under PPS; thus, a reduction in PPS rates should result in a reduction in waiver states' payment rates.

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[1]These estimates are detailed in appendix I.

[2]These estimates are detailed in appendix II.

BACKGROUND

PPS covers hospital operating costs for routine, ancillary, and intensive care inpatient services.[3] Whereas the former cost reimbursement system retrospectively paid, within certain limitations, the actual reasonable costs incurred by a hospital to provide patient services, PPS sets in advance the rate Medicare will pay for each discharge. This gives hospitals an incentive to control their costs because they profit or lose depending on whether their costs are below or above the prospective payment rates.

PPS payment rates are based on two key numbers. The first is the HCFA-established weight for the diagnosis related group (DRG) that the patient's case falls into. Each of the 468 DRGs is a set of diagnoses that are expected to require the same level of hospital resources to treat the patient. Each DRG's weight represents the ratio of average costs to treat a patient falling in that DRG to the average cost of treating all Medicare patients. The second number is the average cost of treating Medicare patients (referred to as the standardized amount). The prospective payment rate for a DRG is computed by multiplying that DRG's weight by the standardized amount.[4] This report deals with the accuracy of HCFA's computation of the standardized amount.

HCFA computed the standardized amount using data in a computerized file of hospital cost reports for cost reporting periods ended during fiscal year 1981. This file included data on 5,501 hospitals. For about 99 percent of these cost reports,

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[3]Capital costs, direct medical education costs, and outpatient services costs continue to be paid on a reasonable cost basis. Also, psychiatric, children's, rehabilitation, and long-term care hospitals or hospital units are exempted from PPS and continue to receive reasonable cost reimbursement.

[4]During the PPS phase-in period (fiscal years 1984-86), the actual payment to a hospital is a blend of the hospital-specific and federal rates. The hospital-specific portion is based on the hospital's actual reasonable costs per Medicare discharge generally during its fiscal year 1982 cost reporting period. The federal portion is based on the amount calculated using the PPS methodology. In fiscal year 1986 the federal portion will be 75 percent, and in fiscal year 1987 and later it will be 100 percent. This report deals only with the federal portion.

the intermediaries--insurance companies such as Blue Cross plans and Mutual of Omaha that are under contract with HCFA to process and pay hospital claims for Medicare--had neither desk reviewed these cost reports for completeness and computational accuracy nor field audited them to determine the accuracy of reported costs.

OBJECTIVES, SCOPE, AND METHODOLOGY

We undertook this review primarily to determine the effect of HCFA's use of unaudited cost reports on the determination of the standardized amount used in computing PPS payment rates. We also wanted to determine the effect of HCFA's not removing all capital costs from the data used to determine the standardized amount. To do this, we randomly sampled 418 of the 5,501 hospitals whose cost reports were used to prepare the computerized file used by HCFA to compute the standardized amount. We compared the unaudited cost data included in HCFA's computer file with the data on the cost reports after they had been field audited by the intermediaries.

We developed a computer program, using HCFA's PPS methodology for computing the standardized amount, which compared the hospitals' average cost per discharge using unaudited and audited data. Our program also removed capital costs that had not, but should have been, excluded from the data used by HCFA. We calculated the percentage difference between the average cost per Medicare discharge as HCFA computed it and the average cost per Medicare discharge that would have been derived using audited cost data after removing additional capital costs. We projected the results of our sample to the universe of hospitals and total Medicare payments to them and computed the sampling error for the population. The review was conducted from October 1984 through April 1985 in accordance with generally accepted government auditing standards.

More details on our methodology and the sampling error are presented in appendix III.

USE OF UNAUDITED COST DATA OVERSTATED PPS PAYMENT RATES

Section 1886(d)(2)(A) of the Social Security Act required HHS to determine allowable hospital operating costs per discharge for a base period and to use this amount as the basis for computing prospective payment rates. The base period was to be the most recent cost reporting period for which data were available. HCFA decided to use its computerized file of fiscal year

1981 hospital cost report data for this purpose. However, a substantial portion of the costs in this computerized file represented unallowable costs because the cost reports from which it was extracted had not undergone the review and audit process, which historically reduces reported costs significantly.

Under the cost reimbursement system that preceded PPS, hospitals submitted cost reports after the end of their accounting years.[5] These submitted cost reports were virtually all later desk reviewed by the intermediaries to assure completeness and computational accuracy. In addition, most of the cost reports were field audited by the intermediaries to verify that only allowable costs were included.[6] However, of the 5,501 hospitals reflected in HCFA's computerized file, only 62 had been desk reviewed or field audited. Thus, about 99 percent of the hospital cost report data in the file represented unreviewed and unaudited data.

Intermediary desk reviews and field audits on the average substantially reduce submitted costs by removing unallowable costs from them. For example, our analysis of data maintained by HCFA on cost reports that were only desk reviewed shows that these reviews on the average reduced hospital reported costs by 5.3 percent in fiscal year 1981 and 6.9 percent in fiscal year 1982.

To determine the effect of using unaudited cost data to compute the standardized amount for PPS, we reviewed a randomly selected sample of 418 hospitals and compared the costs HCFA used to compute the standardized amount to the field audited costs. This comparison showed that unallowable costs included in the submitted cost reports averaged 2.98 percent of total operating costs per discharge.

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[5]Medicare law requires hospitals to continue submitting cost reports under PPS through fiscal year 1987.

[6]The allowability of costs is defined by the Medicare law and regulations. Generally speaking, costs are allowable if they are necessary to the provision of patient care and are reasonable. During field audits, the intermediaries check reported costs against the legal requirements for allowability and exclude from the cost reports any costs that they determine are not allowable.

The allowable average cost per discharge computed by HCFA for the sample hospitals was overstated by about $73 per discharge. Projections of our sample results to the universe of hospitals are included on page 6.

SOME CAPITAL COSTS ARE INAPPROPRIATELY INCLUDED IN PPS RATES

Under section 1886(a)(4) of the Social Security Act, hospitals continue to be paid for their capital costs on the basis of reasonable cost reimbursement. Therefore, all capital costs should have been removed from the data used to compute the standardized amount for PPS. However, in reviewing HCFA's computation for the standardized amount, we noted that some capital costs were not removed.

Capital costs are those associated with providing the facilities and equipment necessary to furnish patient care. They include such things as depreciation on owned buildings and equipment, interest on debt incurred to obtain such items, and lease payments for necessary buildings and equipment.

In computing the standardized amount, HCFA did not exclude capital costs allocated to ancillary departments and special care units from the general services departments, such as the administrative cost center. HCFA officials agree that these capital costs were not excluded in calculating the standardized amount. One official told us it would have taken a lot of time to identify and exclude these capital costs and that HCFA had only a limited time in which to compute the PPS rates.

Our analysis of the data on the audited cost reports for our 418 sample hospitals showed that including a portion of capital costs overstated the average cost per discharge for these hospitals by an average of 1.29 percent. This would result in an overstatement of the average cost per discharge computed by HCFA for the sample hospitals by about $32 per discharge. Projections to the universe of hospitals are presented on page 6.

The HHS Inspector General's Office has a draft report dealing with this same issue of nonexclusion of some capital costs from the computation of PPS rates. In commenting on that draft report, HCFA said that its budget neutrality adjustments would have largely eliminated any potential for overpayments from including capital costs. Section 1886(e)(1) of the Social Security Act requires that PPS must be budget neutral for fiscal years 1984 and 1985; that is, PPS payments must be no more or no

less than would have been paid under the former cost reimbursement system. HCFA maintains that the adjustments it made for budget neutrality purposes would have largely removed, for fiscal years 1984-85 payments, the capital costs that were included in computing the standardized amounts.

HCFA's budget neutrality position is immaterial for fiscal year 1986 payment rates because the budget neutrality provision does not apply to that year. Moreover, directly removing the remaining capital costs from the computation of the standardized amount is a more accurate and sure way of ensuring that PPS rates are not overstated in fiscal year 1986 because of including capital costs.

Concerning the effect of the budget neutrality provision on unallowable costs, HHS stated in the preamble to the final PPS regulations included in the January 3, 1984, Federal Register (p. 255) that it had not made any budget neutrality adjustments or adjustments to the standardized amounts for unallowable costs that might be excluded through desk reviews or field audits.

PROJECTION OF SAMPLE FINDINGS TO THE UNIVERSE OF HOSPITALS

As discussed earlier, our comparison of the HCFA-computed average cost per discharge using unaudited costs to the figure using audited costs showed that HCFA computations included on the average 2.98 percent of unallowable costs. Also, HCFA's inclusion of some capital costs in its computations resulted in a 1.29-percent overstatement in the average cost per discharge for the sample hospitals. Thus, the average cost per discharge for the sample hospitals were overstated by a total of 4.27 percent. We projected this result to the universe of hospitals paid under PPS. This resulted in an estimated available reduction in Medicare payments of $940 million for fiscal year 1986 and of $8.33 billion over fiscal years 1986-90. At the 95-percent confidence level, our estimate of the overstatement in the standardized amount is 4.27 percent plus or minus 0.76 percent.

The above dollar estimates do not include Medicare payments in the four states with waivers to PPS--Maryland, Massachusetts, New Jersey, and New York. Because the Medicare law requires payments in states with waivers not to exceed what payments would be under PPS, it is reasonable to include these states in estimating the maximum available reductions in Medicare expenditures. Doing so increases the estimated available reductions to $1.18 billion for fiscal year 1986 and $10.4 billion for fiscal years 1986-90.

Details on these projections are included in appendixes I and II.

CONCLUSIONS

Because unaudited costs include unallowable costs, HCFA's use of unaudited data to compute the average cost per Medicare discharge overstated the standardized amount used to determine PPS payments. The standardized cost is further overstated because HCFA did not remove all capital costs from the data used to compute the average cost per Medicare discharge. We believe that HCFA needs to adjust the standardized amount to remove the influence on it of these two errors. We estimate that this would reduce Medicare payments to hospitals by about $1 billion in fiscal year 1986.

As long as HCFA continues to use its 1981 cost data as the base period for PPS, adjustments need to be made to assure that PPS rates do not reflect unallowable costs or capital costs. In the future, HCFA may rebase PPS--that is, recompute the standardized amount using a more recent base year. If HCFA rebases, we believe it should use audited cost data for this purpose and handle capital costs appropriately.

RECOMMENDATIONS TO THE SECRETARY OF HHS

We recommend that the Secretary direct the Administrator of HCFA to adjust the standardized amounts for fiscal year 1986 to remove the overstatement resulting from using unaudited cost data and the inclusion of some capital costs in calculating the base year costs. We also recommend that the Secretary direct the Administrator to use audited cost data and assure capital costs are appropriately handled if the standardized amount is rebased.

AGENCY COMMENTS AND OUR EVALUATION

In commenting on this report (see app. IV), HHS said that our findings support its proposal to freeze prospective payment rates for fiscal year 1986. HHS believes that it has justified freezing the prospective payment rates for fiscal year 1986, at the same level as fiscal year 1985, using reasons other than those we identified--the effect of using unaudited data and including capital costs in the rates' computation. HHS did not believe a reduction below current rates was appropriate at this time. According to HHS, this would be the result if it implemented our recommendation to adjust the standardized amount to

remove the overstatement resulting from using unaudited data and including some capital costs.

HHS believes that its computation of the prospective payment rates was done in accordance with the law because the law did not specify the use of audited data. However, as pointed out on page 3, the law specifies the use of allowable costs to compute the rates, and we estimate that the unaudited data included 2.98 percent in unallowable costs. In our opinion, the use of audited cost data would provide HHS with the statutorily required allowable cost data it needs to compute prospective payment rates. However, considering the relatively short time (about 4 months) HHS had to compute the prospective rates for fiscal year 1984, using unaudited data for that year may have been reasonable. We do not believe the same is true for later fiscal years when more time was available.

HHS also said that although the prospective rates are likely overstated by the amount of costs disallowed through the audit process, it does not know the precise proportion that applies to capital and other costs that continue to be paid on a reasonable cost basis. Our estimate of 2.98 percent in unallowable costs does not include any audit adjustments for capital costs or other items paid on a cost basis; it includes only costs covered by the prospective rates. We also estimate that 1.29 percent of the prospective rates as calculated by HHS represent costs that should have been excluded from the calculations because they continue to be paid on a cost basis.

HHS also believed that our savings estimates are too high because we used Congressional Budget Office (CBO) Medicare cost projections, which HHS says overstate inpatient benefit outlays. We used CBO data because the Congress normally uses these data for budgetary purposes. If we had used HHS' projections, our estimate of available savings would have been 6 percent lower for fiscal year 1986 and about 9 percent lower for the fiscal years 1986-90 period.

HHS agreed with our other recommendation to use audited data and assure that capital costs are appropriately handled if the standardized amount is rebased. HHS said it would be some time before audited cost reports would be available for rebasing purposes for periods when the prospective payment system was in effect.

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We are sending copies of this report to the Senate Committee on Governmental Affairs, the House Committee on Government Operations, the Senate and House Committees on Appropriations, and the Senate and House Committees on the Budget; the Director, Office of Management and Budget; the Secretary of HHS; and other interested parties.

Charles A. Bowsher

Comptroller General
of the United States

APPENDIX I

COMPUTATION OF ESTIMATED REDUCTIONS IN MEDICARE EXPENDITURES (EXCLUDING WAIVER STATES) ACHIEVABLE BY USING CORRECTED COST DATA

	Fiscal year					5-year
	1986	1987	1988	1989	1990	total
	(billions)					
Estimated Medicare hospital payments under PPS[a]	$48.142	$53.357	$59.107	$65.609	$72.826	$299.041
Less estimated payments to						
Waiver states - 17.5%[b]						
Capital costs - 7%[c]						
Direct med. ed. - 3%[c]						
Exempt hospitals - 2%[c]						
Total - 29.5%	14.202	15.740	17.437	19.355	21.484	88.217
Total related to PPS hospitals	33.940	37.617	41.670	46.254	51.342	210.824
Hospital-specific portion[d]						
Less 35% - 1986	11.879					11.879
Less 10% - 1987		3.762				3.762
Total	$22.061	$33.855	$41.670	$46.254	$51.342	$195.183
Reduction in Medicare expenditures based on 4.27% overstatement of PPS rates	$ 0.94	$ 1.45	$ 1.78	$ 1.98	$ 2.19	$ 8.33

[a]Estimated Medicare hospital payments are based on CBO staff estimates, which include annual increases based on the projected increase in the hospital market basket plus 0.25 percent, and estimated increases in admissions and in the Medicare population.

[b]Estimated Medicare hospital payments were reduced to eliminate estimated payments to the hospitals in the four waiver states. A 17.5-percent reduction was computed by the HHS Office of Inspector General based on the ratio of total costs of hospitals in waiver states to total costs for all 5,631 hospitals in the fiscal year 1981 cost data.

[c]CBO estimates of the costs of those items that are not included in PPS rates.

[d]During fiscal year 1986 and part of fiscal year 1987, PPS payments will include a hospital-specific portion. The amounts shown represent CBO's estimate of that portion of total PPS payments in fiscal years 1986 and 1987, which are hospital specific.

NOTE: Numbers do not add across due to rounding.

APPENDIX II

COMPUTATION OF ESTIMATED REDUCTIONS IN MEDICARE EXPENDITURES (INCLUDING WAIVER STATES) ACHIEVABLE BY USING CORRECTED COST DATA

	Fiscal year					5-year
	1986	1987	1988	1989	1990	total
	(billions)					
Estimated Medicare hospital payments under PPS[a]	$48.142	$53.357	$59.107	$65.609	$72.826	$299.041
Less estimated payments to						
Capital costs - 7%[b]						
Direct med. ed. - 3%[b]						
Exempt hospitals - 2%[b]						
Total - 12%	5.777	6.403	7.093	7.873	8.739	35.885
Total related to PPS hospitals	42.365	46.954	52.014	57.736	64.087	263.156
Hospital-specific portion[c]						
Less 35% - 1986	14.828					14.828
Less 10% - 1987		4.695				4.695
Total	$27.537	$42.259	$52.014	$57.736	$64.087	$243.633
Reduction in Medicare expenditures based on 4.27% overstatement of PPS rates	$ 1.18	$ 1.80	$ 2.22	$ 2.47	$ 2.74	$ 10.40

[a]Estimated Medicare hospital payments are based on CBO staff estimates, which include annual increases based on the projected increase in the hospital market basket plus 0.25 percent, and estimated increases in admissions and in the Medicare population.

[b]CBO estimates of the costs of those items that are not included in PPS rates.

[c]During fiscal year 1986 and part of fiscal year 1987, PPS payments will include a hospital-specific portion. The amounts shown represent CBO's estimate of that portion of total PPS payments in fiscal years 1986 and 1987, which are hospital specific.

NOTE: Numbers do not add across due to rounding.

APPENDIX III

METHODOLOGY

To obtain our sample of 418 hospitals, we randomized the 5,630 hospitals for which data were included on HCFA's computerized file. There were 129 hospitals on the list that were exempted from PPS, leaving a total universe of 5,501 hospitals that HCFA used to develop PPS rates. We first randomly selected and reviewed 31 hospitals with field audited cost reports. We selected field audited cost reports for our review because field auditing represents an on-site examination of the completeness and accuracy of costs reported to the Medicare program. From this initial sample we determined through standard statistical techniques that a sample of 400 was needed to project the results to the universe of hospitals. We chose 450 hospitals in anticipation that some would be eliminated for various reasons.

Thirty-two hospitals were eventually dropped from the sample for the following reasons:

--Ten cost reports had not been field audited, although intermediary officials told us all cost reports in our sample had been.

--Fifteen hospitals were excluded because of such problems as hospitals using a cost report format different from the standard format or not being required to complete all the forms.

--Cost reports at two hospitals combined their hospital and skilled nursing facility costs.

--Cost reports for five hospitals could not be located or the data were illegible or missing.

To extract the necessary data to compute the cost per discharge, we visited 42 intermediaries in 34 states and had 17 other intermediaries send copies of the field audited cost reports to us or to one of the intermediaries that we visited.

We extracted the same data from the field audited cost reports that HCFA had extracted from the submitted cost reports to determine how much of the cost per discharge used by HCFA reflected unallowable costs. We also extracted the data necessary to identify any capital costs not excluded by HCFA.

We designed a data-extraction form similar to the form HCFA used to extract data from cost reports it used to develop the cost per discharge. We added a section to obtain the additional

data needed to identify capital costs relating to ancillary and special care units, which should have been excluded in HCFA's development of prospective payment rates. The data we extracted from field audited cost reports were independently verified for accuracy. The data for each hospital included in our sample were then entered into a computer. The entered data were then verified twice by different staff to our original data-extraction forms.

Using HCFA specifications we developed a program to compute the cost per discharge. To test the accuracy of our program, we duplicated HCFA's cost per discharge for each hospital using the data HCFA extracted from the cost reports and our program. In three cases, we could not duplicate HCFA's cost per discharge because of errors in the hospital-submitted cost reports.

We compared the average cost per discharge used by HCFA to our cost per discharge computed using audited costs. Audited costs yielded an average reduction of $73 from the HCFA-computed cost. We also compared our cost per discharge using audited costs and excluding capital costs, which resulted in an additional average reduction of $32. Dividing these cost reductions by the HCFA average cost per discharge yielded reductions of 2.98 and 1.29 percent, respectively, for a combined reduction of 4.27 percent.

We estimated the reduction in Medicare expenditures achievable through using corrected data by multiplying the applicable estimated Medicare payments by the 4.27-percent reduction in average cost per discharge. At the 95-percent confidence level, our estimates of the overstatement of the standardized amount is 4.27 percent plus or minus 0.76 percent. This means that, if we had selected additional samples, 95 percent of the time the overstatement would fall between 3.51 and 5.03 percent.

APPENDIX IV

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

JUN 14 1985

Mr. Richard L. Fogel
Director, Human Resources
Division
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Fogel:

Thank you for the opportunity to comment on your draft report, "Use of Unaudited Hospital Cost Data and Inclusion of Capital Costs Results in Excessive Medicare Payments." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

Richard P. Kusserow
Inspector General

Enclosure

Comments of the Department of Health and Human Services on the General Accounting Office Draft Report, "Use of Unaudited Hospital Cost Data and Inclusion of Capital Costs Results in Excessive Medicare Payments"

Overview

GAO reports that the Health Care Financing Administration (HCFA) in setting payment rates under the prospective payment system (PPS) used unaudited hospital cost data to compute the average cost per Medicare discharge which, in turn, is the basis for determining the amount of payment for each Medicare discharge; and, did not remove all capital costs from the hospital cost data even though these costs are paid separately from the PPS rates. As a result, GAO estimates that Medicare payments are about 4.3 percent higher than they would be if HCFA used audited cost data to compute them and removed all capital costs from the data. When this estimate is projected (GAO randomly sampled 418 of the 5,501 hospitals whose cost reports were used to develop the prospective payment rate), GAO reports excessive Medicare payments of about $940 million in fiscal year 1986 and over $8 billion during fiscal years 1986-1990.

GAO Recommendation

That the Secretary direct the Administrator of HCFA to adjust the standardized amounts for fiscal year 1986 to remove the overstatement resulting from using unaudited cost data and the inclusion of some capital costs in calculating the base year costs. We also recommend that you direct the Administrator of HCFA to use audited cost data and assure capital costs are appropriately handled if the standardized amount is rebased.

Department Comment

While GAO's findings quite clearly support our proposal to use a zero update factor for the FY 1986 prospective payment rates, we do not believe any further downward adjustment is appropriate at the present time because the correct approach to implementing the statute was taken.

Section 1886(d)(2) of the Act requires the Secretary of HHS to use the most recent cost reporting period for which data is available (not the most recent cost reporting period for which audited data is available) to determine the PPS rates. Because of the short time frame between enactment of P.L. 98-21 and the statutory implementation date of PPS, the most recently available data were the 1981 cost reports, which were unaudited. Had we chosen to use audited data, the most recent data we could have used at the time would have been from 1979. Using the 1981 data, we were able to exclude capital costs allocated from the depreciation cost center to ancillary departments and special care units. However, the 1981 cost reports did not have a mechanism for identifying capital costs indirectly allocated to special care and ancillary services from other general service cost centers. Moreover, as you know, auditing cost reports is extremely time consuming. For example, in order to develop the hospital specific portion of the PPS rates we audited all 1982 cost reports. This activity required substantial effort over the course of an entire year.

HCFA has studied the impact of audit on the prospective payment rates based on the audit results of the 1982 cost reports. The Secretary, in determining the PPS rates for FY 1986, considered the results of that study. The Department agrees

APPENDIX IV

that the Federal rates are likely to be overstated by the amount recovered as a result of audits. However, we also indicated in the regulation that we do not know the precise proportion that applies to capital and other pass through costs. Since we have decided to propose FY 1986 standardized amounts set at the same level as those for FY 1985, making corrections now to reflect the audit data would have no practical effect.

In addition to disagreeing on GAO's overall recommendation, we believe the savings figures GAO has provided are too high. They are based on CBO's baseline, which overstates inpatient benefit outlays.

We agree with that part of GAO's recommendation that any future rebasing of the standardized amounts should use audited cost data, which provides for the exclusion of all capital costs. The revised PPS cost report is specifically designed to identify all capital costs. However, it will be some time before these audited cost reports become available.

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