Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE LOSSES ON HOSPITAL SALES

JUNE GIBBS BROWN
Inspector General

JUNE 1997
OEI-03-96-00170

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EXECUTIVE SUMMARY

PURPOSE

To quantify the financial impact of hospital sales on the Medicare program.

BACKGROUND

At the inception of the Medicare program, hospitals were allowed to include the depreciation of assets as an allowable capital-related cost in their annual Medicare cost reports. When a hospital undergoes change of ownership for reimbursement purposes, Medicare guidelines specify that the hospital can receive an adjustment to the facility's final allowable or reimbursable costs based on the gain or loss on depreciated assets at the time of sale. This means that if a hospital's depreciable assets (buildings and equipment) are purchased at higher than the net book value or "value on paper," Medicare shares in the gain. If the hospital's depreciable assets are purchased at less than the net book value, Medicare shares in the loss. Medicare's share of the gain or loss is known as the depreciation adjustment.

Recent increases in hospital sales have raised concerns about Medicare's liability for depreciation adjustments. Our study was aimed at determining just how much Medicare had paid for depreciation adjustments in recent years.

We requested information from two main sources: fiscal intermediaries and the Health Care Financing Administration's regional offices. The scope of our study was acute care hospital changes of ownership that met Medicare requirements for a depreciation adjustment during Fiscal Years 1990 through 1996.

FINDINGS

Medicare lost $223 million and stands to lose another $289 million in depreciation adjustments for hospitals sold between 1990 and 1996.

Fiscal intermediaries reported $453 million in losses and $56 million in gains for a net loss of $397 million on 229 hospitals sold between 1990 and 1996. Of the nearly $400 million net loss reported, $223 million was from hospital sales where the final payment determination has been made. Another $174 million net loss to Medicare has been reported by hospitals but has yet to be settled by the program. We estimate that Medicare could pay out $115 million on an additional 88 hospital sales that have already occurred but for which no financial data was available.

Medicare could lose an estimated $53 million in depreciation adjustments for hospital sales expected in 1997.

Although less than half of the fiscal intermediaries reported being aware of potential hospital sales in their respective areas, these intermediaries identified 41 expected hospital sales for 1997. We estimate that the potential liability to Medicare for these 41 sales could reach $53 million.

Net losses reported to the Medicare program have more than quadrupled between 1990 and 1996.

Net losses reported to the program have increased 322 percent from $29 million in 1990 to $122 million in 1996. For every $1 that Medicare shared in gains, it paid out $8 in losses. While Medicare has shared in the loss for 161 hospital sales, in contrast, it has shared the gain for only 33 hospital sales. Since 1990, Medicare has shared in only one gain for every five losses resulting from depreciation adjustments.

Medicare may be paying more than it should to hospitals sold at a loss during the transition period for capital prospective payments.

The loss to the Federal Government from hospital sales may be greater than the half billion already identified through depreciation adjustments. Medicare may also be paying out more than it should for hospitals sold at a loss and paid under the capital prospective payment system. While Medicare recognizes a loss on assets for depreciation purposes, in most cases it makes no adjustment to a hospital's capital payment methodology to account for the new lower value of the hospital.

Losses from depreciation adjustments also impact the Medicaid program.

Some Medicaid programs are calculating depreciation adjustments when hospitals are sold. Intermediaries could provide data on Medicaid depreciation adjustments for only 10 of the 229 sales transactions with Medicare depreciation adjustments. The Medicaid depreciation adjustments were all losses ranging from $18,000 to $10 million. The 10 sales represented a $16 million loss to the respective Medicaid programs.

RECOMMENDATIONS

Substantial amounts of money are being paid and will continue to be paid in the coming years for an accounting procedure established in the early years of the program. At the beginning of the 1990s, Medicare moved from cost-based reimbursement to a prospective payment system. We believe the policy allowing depreciation adjustments on hospital sales is an unnecessary holdover from the old cost-based reimbursement system that should be discontinued.

We recommend that the Health Care Financing Administration:

- propose legislation to change Section 1861(v)(1)(O) of the Social Security Act to eliminate the requirement that Medicare make adjustments for gains or losses when hospitals undergo changes of ownership;

- propose a similar elimination of depreciation adjustments on hospital sales in the Medicaid program; and

- examine options for recalculating capital transition payments to hospitals undergoing changes of ownership for reimbursement purposes.

AGENCY COMMENTS

The HCFA concurred with our recommendations. The agency stated that proposed legislation entitled "Medicare and Medicaid Fraud, Abuse, and Waste Preventions Amendments of 1997" (Section 205) would use the net book value as the sales price for hospitals undergoing a change of ownership. This proposed change would eliminate the need for a depreciation adjustment. The agency also stated that if depreciation adjustments were eliminated in the Medicare program this change would also be reflected in the Medicaid program. After examining its options, HCFA believes that recalculating the capital transition payments for hospitals undergoing changes of ownership would be inappropriate and inadvisable at this time. While we recognize the complexity of the policy and administrative implications identified by HCFA, we continue to believe that capital payments to hospitals sold at a loss should be redetermined.

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PURPOSE

To quantify the financial impact of hospital sales on the Medicare program.

BACKGROUND

The Hospital Insurance program (Part A) pays for hospital, skilled nursing facility, home health, and hospice care for Medicare beneficiaries. Payments for inpatient hospital care comprised 70 percent of the $116 billion in Part A payments in 1995. Between 1990 and 1994, the number of inpatient short-stay hospital service discharges increased less than 10 percent; in contrast, expenditures for these services increased more than 30 percent.

Medicare payments to most short-stay or acute care hospitals are made through a prospective payment system. For each Part A patient discharge, the hospital is paid based on a reimbursement equation that includes not only direct patient care costs but also capital costs such as the updating and acquiring of buildings and equipment. Prior to the phase-in of a prospective payment system for inpatient capital costs which began in October 1991, Medicare paid for capital costs on a reasonable cost basis as determined by a hospital's annual cost report.

Recent Increases in Hospital Mergers and Sales Activity

In this era of cost-cutting and emphasis on managed care, hospitals are undertaking a number of consolidation measures to enhance their operations. The Public Citizen Health Research Group reported in its June 1996 *Health Letter* that transactions involving 447 community hospitals had been announced or completed in 1995. These hospital transactions included mergers, acquisitions, joint ventures, and leasing agreements.

Medicare's Handling of Hospital Ownership Changes

The Health Care Financing Administration (HCFA) contracts with 54 fiscal intermediaries to process Medicare Part A inpatient hospital payments. The HCFA has provided guidance to these contractors on how to handle changes of hospital ownership, such as mergers or sales, in section 4500 of the Intermediary Manual. Guidelines for handling changes of ownership and disposal of assets are also delineated in sections 130 and 1500 of the Provider Reimbursement Manual.

The fiscal intermediaries are responsible for performing the reimbursement analysis for a hospital change of ownership. Not all hospitals that undergo some type of change of ownership will have their reimbursement affected. The intermediary manual provides examples of what it considers a bona-fide sale or change of

ownership for reimbursement purposes. For the most part, a bona-fide sale would be defined as a sale between two unrelated parties (frequently called "arms-length transactions"). If a change of ownership is recognized for reimbursement, the fiscal intermediary will then calculate whether the transaction results in a gain or loss for the seller, and in what portion of the gain or loss the Medicare program will share.

Gain or Loss on Depreciable Assets at the Time of Hospital Sale

Hospitals through the years were allowed to include the depreciation of assets as an allowable capital-related cost in their annual cost reports. When a hospital undergoes a bona-fide change of ownership for reimbursement purposes, Medicare guidelines specify that the hospital can receive an adjustment to the facility's final allowable or reimbursable costs based on the gain or loss on depreciated assets at the time of sale. This means that if a hospital's depreciable assets (buildings and equipment) are purchased at higher than the net book value or "value on paper," Medicare shares in the gain. If the hospital's depreciable assets are purchased at less than the net book value, Medicare shares in the loss.

Calculating Medicare's Share of the Gain or Loss

As part of the audit or settlement of the final cost report, the fiscal intermediaries are responsible for reviewing the hospital's gain or loss on sale for Medicare purposes. This settlement occurs after receiving the hospital's terminating cost report along with other legal and financial documents having to do with the sale. The hospital must include in this documentation an allocation or distribution of the total sale price among all assets being sold. The guidelines allow for an independent appraisal expert to perform an appraisal to establish the value of the assets being sold. As outlined in section 4505.3 of the intermediary manual, HCFA considers this expert's membership in one of several professional appraiser societies as providing reasonable assurance to the intermediary that the "appraisal results have been prepared in accordance with a code of ethics and professional standards."

Upon establishment of the sale or purchase prices for the depreciable assets, the intermediaries compare the purchase price to the current depreciated value of the assets (original value less depreciation taken in previous years) to determine the amount of gain or loss. Medicare's share of this gain or loss is determined by the ratio of the hospital's Medicare patient costs to all patient costs. A more detailed explanation and examples of depreciation adjustments are provided in Appendix A.

HCFA Workgroup Reviews Medicare Policies for Changes of Ownership

The HCFA's Audit & Reimbursement Steering Committee convened an ad hoc workgroup to review current guidelines for handling changes of ownership. The workgroup consisted of both HCFA and fiscal intermediary staff. Its mission was to recommend to HCFA ways to "modify, update and expand program instructions considered necessary in order to provide current and complete guidance to fiscal

intermediaries and providers, regarding treatment of change of ownership transactions to determine appropriate Medicare reimbursement." The group has transmitted its proposals back to the Steering Committee and they are now under review by HCFA.

Prior to the release of this report, we provided the Office of the Secretary and HCFA with the results of our evaluation.

METHODOLOGY

We requested information from two main sources: fiscal intermediaries and HCFA regional offices. The scope of our evaluation was acute care hospital changes of ownership (except bankruptcies) that met Medicare requirements for a depreciation adjustment during Fiscal Years 1990 through 1996. For the remainder of this report, we will refer to all of these types of ownership changes as hospital sales.

Information Requested from Fiscal Intermediaries

We surveyed all current fiscal intermediaries to determine their experiences with hospital changes of ownership. We requested that each intermediary complete an overview guide regarding hospitals sales that have transpired under their jurisdiction. This guide was developed to provide summary data on the number of hospital sale transactions triggering depreciation adjustments that occurred between 1990 and 1996. We sent requests to 44 organizations that represent all currently contracted fiscal intermediaries in the Medicare program. We received some form of response from all 44 organizations. However, several intermediary organizations service multiple geographic areas and chose to break down their responses by those areas. As a result, our analysis was conducted on 54 separate fiscal intermediary responses received between August and December 1996.

In addition to the overview guide, the intermediaries were asked to complete a fact sheet for each hospital sale where they had received either a terminating cost report or other financial documents from the hospital. We designed these fact sheets to collect detailed financial and descriptive data on each hospital sale. Much of the data requested on the fact sheet could be compiled from the hospital's terminating cost report, sale or purchase agreement, and allocation of sales price documentation.

The number of fact sheets returned by each fiscal intermediary and the thoroughness of data provided on the fact sheets were dependent upon: 1) the volume of hospital sales within the intermediary's jurisdiction, and 2) the comprehensiveness and availability of information provided by hospitals to the intermediaries. Although we had follow-up telephone contacts with many fiscal intermediaries' staff to clarify our information requests, we received some fact sheets that could not be utilized for analysis purposes. These fact sheets contained no financial data, were for hospital transactions that did not trigger a depreciation adjustment calculation, or were for other than acute care hospitals. The thoroughness of the financial data provided on the remaining fact sheets varied. However, every fact sheet used for our analysis had

to provide, at a minimum, financial data on Medicare's share of the gain or loss on depreciable assets. We received 229 fact sheets that met this requirement for analysis.

Information Requested from HCFA Regional Offices

We surveyed the 10 HCFA regional offices to collect data on hospital sales transactions that occurred between Fiscal Year 1990 and the beginning of Fiscal Year 1997. The purpose of this was twofold -- we wanted to 1) verify the summary hospital sales information received from the fiscal intermediaries, and 2) gather regional office staff perspectives on the processing of hospital sales and their coordination with the intermediaries. We received responses from all the regional offices between November 1996 and January 1997.

Calculating the Financial Impact of Hospital Sales on the Medicare Program

We used the data reported from the fiscal intermediaries on the fact sheets to determine the impact of hospital sales with depreciation adjustments. For 171 of the 229 hospital sales with depreciation adjustment data, these adjustments have been settled and are only subject to change if appealed by the hospital. After settlement of the cost report, hospitals have 180 days to appeal intermediary determinations.

We identified 14 settled transactions with pending appeals concerning depreciation adjustments: four of these were for hospitals disputing the amount of gain they must share with Medicare, nine were for hospitals contesting that the loss shared by Medicare should be greater, and one hospital with a zero adjustment was arguing that a loss should have been recognized. We also identified nine transactions where intermediaries indicated that the opportunity to appeal had not yet expired. We included the adjustments for these 23 hospitals in our calculations because the figures do not represent an overstatement of Medicare impact. Indeed, if the appeals are decided in favor of the hospitals, the loss to Medicare would be even greater.

For 58 hospital sales transactions, formal settlement of the terminating cost reports has not been completed; therefore, the depreciation adjustments reported are subject to redetermination by the fiscal intermediaries. These depreciation adjustments have been aggregated to determine the impact on the program. The monetary impact associated with these unsettled depreciation adjustments is identified in the findings.

When we refer to the terms "net losses" or "overall impact" in this report, this refers to the dollar impact that results when aggregated depreciation loss adjustments are compared to aggregated depreciation gain adjustments. Depreciation adjustments for hospitals sold at a loss are presented in negative dollar figures in this report, since these represent Medicare outlays. Depreciation adjustments resulting from gains are presented as positive dollar figures, since these represent payments to the Medicare program. Although the hospital sales transactions that resulted in zero adjustments do not have a financial impact on Medicare, these transactions were included in the calculation of all hospital sale statistics.

Estimating the Financial Impact of Hospital Sales Where Depreciation Adjustments Have Yet To Be Reported

To determine the financial impact of sales that have already occurred but for which no financial data is currently available, we aggregated the total number of sales transactions identified on the intermediary overview guides. In total, the intermediaries identified 317 hospital sales that would meet Medicare requirements for calculating a depreciation adjustment. We subtracted the number of sales with information on depreciation adjustments (229) from the 317 total sales. The difference between these two numbers (88) equals the number of sales without financial data available at this time.

To estimate the depreciation adjustments for the 88 sales that have already occurred but for which no financial information is available, we utilized the depreciation adjustments reported on the fact sheets. We purposefully decided to include in our estimation analysis only the financial data from hospitals where the terminating cost report had been audited and settled by the intermediary. We believed this would provide a more conservative and accurate estimate of average depreciation adjustments. Financial data from 171 settled hospital cost reports was used for this analysis.

We employed a three-step analysis to estimate the net financial impact of hospital sales without data. First, we determined the proportions of gain, loss, and zero adjustments that resulted from the 171 settled transactions. Sixty-nine percent of settled sales were recognized as losses to the Medicare program. Seventeen percent were gains and another 14 percent were zero adjustments. These three proportions were applied to the 88 sales without data to estimate how many transactions would fall into each of the three adjustment categories. Next, we grouped the 171 settled hospital sales by gain, loss, and zero adjustments and determined the average or mean depreciation adjustment for each category. We multiplied the mean statistic for each category by the number of sales without data we had estimated would fall into each of the three categories to quantify overall dollar amounts associated with gains, losses, and zero adjustments. Lastly, we compared the aggregate gain and loss depreciation adjustments to determine a net impact to Medicare.

Estimating the Financial Impact of Potential Hospital Sales

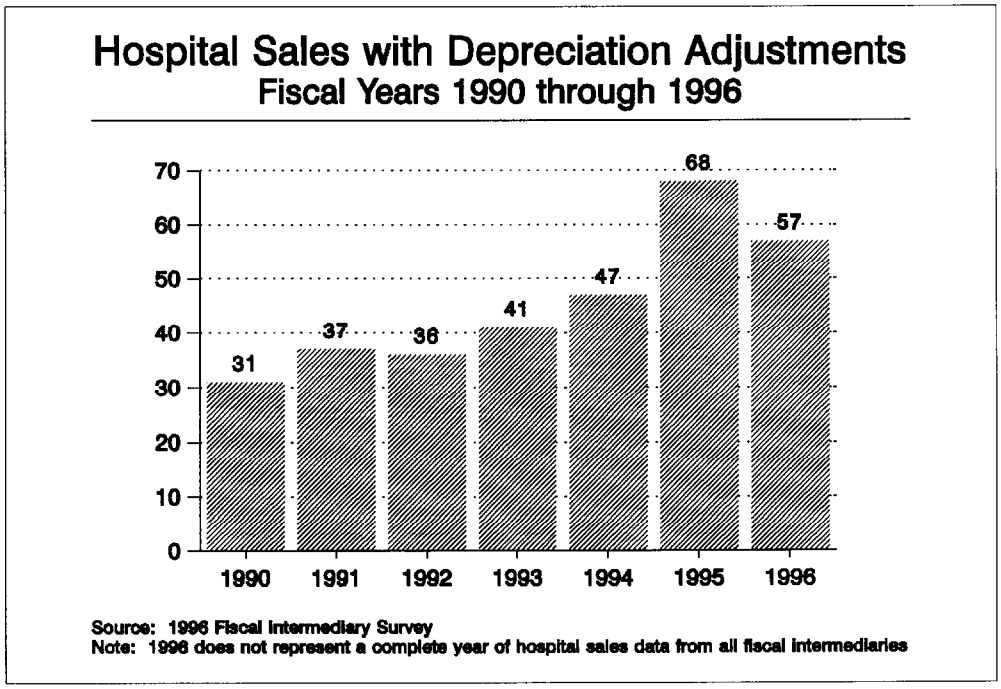
To determine the impact on Medicare from potential sales, we totaled the number of potential sales identified in the intermediary overview guides. We had asked both the intermediaries and HCFA regional offices to provide the number of potential sales they had reason to believe might occur in 1997; however, the potential sales data from the fiscal intermediaries and regional offices did not match. To prevent overinflating the data by combining or comparing the data, we chose to use only the potential sales data from the intermediaries. We selected the intermediary data since they had a higher response rate to the potential sales question than the regional offices. The fiscal intermediaries identified 41 potential sales. We computed the financial impact

of the 41 potential hospital sales identified using the three-step analysis described for hospital sales where depreciation adjustments have yet to be reported.

FINDINGS

MEDICARE LOST $223 MILLION AND STANDS TO LOSE ANOTHER $289 MILLION IN DEPRECIATION ADJUSTMENTS FOR HOSPITALS SOLD BETWEEN 1990 AND 1996.

Over the last 7 years, a total of 317 hospital sales have occurred that met Medicare requirements for calculating a depreciation adjustment. These types of sales have more than doubled between Fiscal Years 1990 and 1995.[1] The chart below provides a breakdown of the hospital sales by year.



Fiscal intermediaries report $453 million in losses and $56 million in gains for a net loss of $397 million on 229 hospitals sold between 1990 and 1996. Medicare has already paid out $223 million of the net loss.

The fiscal intermediaries provided financial data on 229 hospital sales transactions that met Medicare requirements for a depreciation adjustment between Fiscal Years 1990 and 1996. Of the nearly $400 million in net losses reported, $223 million was from 171 hospital sales where the final payment determination has been made. The fiscal intermediaries have audited and settled these hospitals' terminating cost reports.

[1]Fiscal year 1995 was the last complete year of hospital sales data collected from all fiscal intermediaries.

Medicare has already paid out $270 million in losses and received $47 million in gains for these hospitals.

Another $174 million net loss to Medicare has been reported by hospitals but has yet to be settled by the program. This figure is based on 58 hospital sales with reported gain adjustments of $9 million and reported loss adjustments of $183 million. These adjustments have been calculated and reported by hospitals but the intermediaries have yet to settle the terminating cost reports.

Medicare could lose an estimated $115 million on another 88 hospital sales for which no financial data was available.

The fiscal intermediaries reported that there were 317 hospital sales that met Medicare's conditions for calculating a depreciation adjustment. However, for 88 of these transactions, the intermediaries could not provide us with data on the adjustment. Some of the intermediaries had not yet received any financial information on the sale from the hospitals. Others explained that they had received the information but had not yet reviewed it for accuracy.

Using the financial data received from the 171 hospitals with depreciation adjustments finalized by the intermediaries, we calculated both the proportion of sales with gains and losses and the average of the resulting depreciation adjustments. Using the proportions calculated for the settled hospital sales, we estimate that of the 88 sales without data there would be 15 gain adjustments, 61 loss adjustments, and 12 zero adjustments. The average depreciation adjustment for settled hospitals sold at a loss was $2,291,078. For hospitals sold at a gain, the average depreciation adjustment was $1,629,629. By employing the estimated number of adjustments and the average gain and loss statistics, we estimate the 88 sales could result in a net loss to Medicare of $115 million. This figure is an approximation and is furnished to provide only an estimate of the impact on Medicare. The actual financial impact of these sales will not be known until the fiscal intermediaries audit the transactions and settle the final cost reports.

MEDICARE COULD LOSE AN ESTIMATED $53 MILLION IN DEPRECIATION ADJUSTMENTS FOR HOSPITAL SALES EXPECTED IN 1997.

It does not appear that the rate of hospital sales will significantly decrease in 1997. Although less than half of the fiscal intermediaries (24 of 54) reported being aware of potential sales in their respective areas, these intermediaries identified 41 expected hospital sales for 1997.

Using the proportion of gains and losses and the average adjustments of previously settled hospital sales, we estimate that the potential liability to Medicare for these 41 sales could reach $53 million. This estimate provides an indication of the possible impact that upcoming sales could have on Medicare. If all the expected sales do not occur, this could potentially reduce the estimated loss. Conversely, the impact on the

program could be even greater if additional hospitals not identified by the intermediaries undergo sales in 1997.

NET LOSSES REPORTED TO THE MEDICARE PROGRAM HAVE MORE THAN QUADRUPLED BETWEEN 1990 AND 1996.

When comparing Medicare's share of gains and losses on reported hospital sales over the last 7 years, Medicare has never shown an overall gain in any year. Net losses reported to the program have increased 322 percent from $29 million in 1990 to $122 million in 1996. For every $1 that Medicare shared in gains, it paid out $8 in losses. The table below provides the number of hospital sales with gain, loss, and zero adjustments by fiscal year. It also provides the payments associated with gains and losses for each year.

Year	Number of Gains	Total Gains	Number of Losses	Total Losses	Number of Zero Adjustments	Overall Impact on Medicare Program
1990	5	$8,118,271	23	-$36,996,112	3	-$28,877,841
1991	4	$7,401,497	21	-$49,405,907	7	-$42,004,410
1992	8	$18,882,435	22	-$73,461,361	3	-$54,578,926
1993	3	$2,771,716	26	-$43,978,492	7	-$41,206,776
1994	9	$12,778,151	26	-$48,670,697	4	-$35,892,546
1995	4	$6,054,598	24	-$78,456,929	9	-$72,402,331
1996	0	$0	19	-$121,904,534	2	-$121,904,534
Total	33	$56,006,668	161	-$452,874,032	35	-$396,867,364

While Medicare has shared in the loss for 161 hospital sales, in contrast, it has shared the gain for only 33 hospital sales.

Seventy percent of the depreciation adjustments reported for hospital sales (161 of 229) resulted in losses to the Medicare program. Fourteen percent of sales (33 of 229) resulted in gains to the program. The ratio of Medicare losses to gains based on the data from the 229 hospital sales is 5 losses for every 1 gain. There were 35 hospital sales where no gain or loss was recognized. The sales price allocated to depreciable assets for these hospitals was equal to the Medicare net book value of the assets. Therefore, the depreciation adjustment was zero since no gain or loss on depreciable assets was established. We have provided examples of how the three types of adjustments are determined by fiscal intermediaries in Appendix A.

MEDICARE MAY BE PAYING MORE THAN IT SHOULD TO HOSPITALS SOLD AT A LOSS DURING THE TRANSITION PERIOD FOR CAPITAL PROSPECTIVE PAYMENTS.

The loss to the Federal Government from hospital sales may be greater than the half billion already identified through depreciation adjustments. Medicare may also be paying out more than it should for hospitals sold at a loss and paid under the capital prospective payment system. While Medicare recognizes a loss on assets for depreciation purposes, in most cases it makes no adjustment to a hospital's capital prospective payment to account for the new lower value of the hospital. Under Medicare's guidelines, most hospital buyers receive the same capital prospective payments as the previous owner. Section 2807.9 of the Provider Reimbursement Manual states that "if there is a change of ownership subsequent to the base period, the new owner receives capital payments under the same payment methodology and rates as the previous owner if the change in ownership results in a single surviving hospital."

For each Medicare patient discharge, hospitals receive a capital payment based on the methodology selected for the hospital at the beginning of the capital prospective payment transition. Hospitals receiving capital prospective payments during the transition period are paid under two methodologies: "fully prospective" and "hold harmless." At the conclusion of a 10-year transition period, all hospitals will receive payments based solely on the national Federal rate.

Nearly 60 percent of hospital sales reviewed (134 of 229) were reimbursed for capital costs based on a prospective payment methodology. More than 70 percent of the hospitals being paid prospectively (95 of 134) were sold at a loss. Twenty-eight percent of the hospital sales (63 of 229) occurred before Fiscal Year 1992, and thus were sold prior to the implementation of a prospective payment system for capital costs.

Of the hospitals which received capital prospective payments and were sold at a loss, 44 percent were paid under the fully prospective methodology. Fully prospective hospitals receive a combination of Federal and hospital-specific rates during the transition period. Since the hospital-specific rate is not recalculated when a hospital is sold at a loss, these hospitals have received and will continue to receive payments during the transition period based on a rate that was calculated when the hospitals' depreciable assets had much higher values and thus higher associated depreciation costs.

Fifty-five percent of hospitals sold at a loss and receiving capital prospective payments were reimbursed under the hold harmless methodology. Hold harmless hospitals receive either a blend of old and new capital payments or 100 percent of the Federal rate depending on which is higher. After a hold harmless hospital is sold, Medicare does not redetermine the hospital's payment methodology to establish if the hold harmless distinction is still necessary. Therefore, the new owner of a hold harmless

hospital sold at a loss may continue to receive capital reimbursement based on a payment methodology that was determined by the previous owner's above-average capital costs. The Medicare program continues hold harmless payments even though the hospital's current depreciable asset value is now lower.

We recognize that, without recalculating hospital-specific rates for each of the hospitals sold at a loss, there is no precise means to determine the financial impact on the program of continuing to make payments based on the previous owner's methodology and rates. We also realize that not all hold harmless hospitals would lose that distinction, nor would all hospital-specific rates decrease dramatically if the payment methodologies for hospitals sold at a loss were recalculated based on present capital costs. However, the decrease in the value of depreciable assets and, consequently, the associated depreciation costs can be significant. More than half the hospitals sold at a loss (53 percent) had the value of their depreciable assets decrease by more than 50 percent. Thirty-five percent of hospitals sold at a loss had their depreciable asset value drop by more than 70 percent.

LOSSES FROM DEPRECIATION ADJUSTMENTS ALSO IMPACT THE MEDICAID PROGRAM.

The Federal Government does not mandate that State Medicaid programs use specific payment methodologies to determine hospital reimbursement. However, some State programs are calculating depreciation adjustments based on the guidelines established for Medicare when hospitals providing care to Medicaid recipients are sold.

Several of the Medicare fiscal intermediaries performed some type of payment or audit function for State Medicaid programs. We asked these intermediaries if depreciation adjustments for hospital sales were made by these programs. Eleven intermediaries indicated that depreciation adjustments were calculated by State Medicaid programs. These intermediaries also reported that the Medicaid programs used the same rules and procedures as the Medicare program in calculating depreciation adjustments.

Intermediaries could provide data on Medicaid depreciation adjustments for only 10 of the 229 sales transactions. All the depreciation adjustments resulted in losses to the Medicaid program. The individual hospital adjustments ranged from $18,000 to $10 million. These 10 sales represented a $16 million loss to the respective Medicaid programs.

Since the majority of fiscal intermediaries do not serve as contractors to State Medicaid agencies, it is possible that other State Medicaid programs not represented in our review also follow Medicare policy and calculate depreciation adjustments on hospital sales. The impact of depreciation adjustments on the Medicaid program could conceivably be much greater than the $16 million in losses identified from only a small number of hospital sales.

RECOMMENDATIONS

The Medicare program has already paid out hundreds of millions of dollars for depreciation adjustments associated with hospital sales. If the activity surrounding hospital sales continues to increase, the Medicare program could pay out even greater amounts in the coming years.

We have provided evidence in this report that substantial amounts of money are being paid and will continue to be paid in the coming years for an accounting procedure established in the early years of the program. At the beginning of the 1990s, Medicare moved from cost-based reimbursement to a prospective payment system for hospitals. Since that time, Medicare has shared in only one gain for every five losses resulting from depreciation adjustments on hospital sales. We believe the policy allowing depreciation adjustments on hospital sales is an unnecessary holdover from the old cost-based reimbursement system that should be discontinued.

In switching from a cost-based reimbursement methodology to the prospective payment system, the Medicare program recognized the need to constrain rising costs and promote cost effective decision-making in hospitals. Medicare's sharing in gains and losses for hospital sales does not advance the goal the program set out to accomplish when implementing the prospective payment system.

We recommend that the Health Care Financing Administration:

- propose legislation to change Section 1861(v)(1)(O) of the Social Security Act to eliminate the requirement that Medicare make adjustments for gains or losses when hospitals undergo changes of ownership;

- propose a similar elimination of depreciation adjustments on hospital sales in the Medicaid program; and

- examine options for recalculating capital transition payments to hospitals undergoing changes of ownership for reimbursement purposes.

AGENCY COMMENTS

The HCFA concurred with our recommendations. The agency stated that proposed legislation entitled the "Medicare and Medicaid Fraud, Abuse, and Waste Preventions Amendments of 1997" (Section 205) would use the net book value as the sales price for hospitals undergoing a change of ownership. This proposed change would eliminate the need for a depreciation adjustment. The agency also stated that if depreciation adjustments were eliminated in the Medicare program this change would also be reflected in the Medicaid program.

The HCFA responded that after examining options for recalculating capital transition payments for hospitals undergoing changes of ownership, it believes that recalculating payments would be inappropriate and inadvisable at this time. The agency believes it would be contrary to the principle of administrative finality upon which the capital payment system was based. In addition, HCFA stated there would also be the potential for loss to the program since both hospitals sold at a gain and a loss would have their rates recalculated. The HCFA also advised that the recalculation would have a limited application period since the transition for capital prospective payments ends in 2001. The full text of HCFA's comments are provided in Appendix B.

We appreciate HCFA's careful consideration of the issues concerning capital payments to hospitals undergoing changes of ownership. While we recognize the complexity of the policy and administrative implications identified by HCFA, we continue to believe that capital payments to hospitals sold at a loss should be redetermined.

APPENDIX A

EXPLANATION OF DEPRECIATION ADJUSTMENT CALCULATION

Before the fiscal intermediary can verify a depreciation adjustment, the hospital being sold sends a terminating cost report that documents a possible gain, loss, or zero adjustment on depreciable assets for the sale. The hospital should also provide the hospital sale or purchase agreement, an allocation of the sales price, and, if necessary, an independent appraisal that determines the fair market value of the hospital's current assets. The intermediary reviews the terminating cost report and the additional documentation to ensure that they are correct and the calculations are fully supported.

There are several key pieces of information that a fiscal intermediary must have to ensure a correct calculation. The hospital should provide to the intermediary the net sales price which includes cash and any other considerations plus any assumed liabilities. The allocation of the sales price provided should illustrate the types of assets being sold and the portion of the sales price allocated to them. At the present time, this allocation can include both depreciable and non-depreciable assets such as land, buildings, equipment, accounts receivable, medical records, inventory, and many other categories of assets. From this information, the fiscal intermediary should be able to verify the sales price allocated to depreciable assets. This figure is then compared to the net book value of all depreciable assets. The net book value is the original cost or value of an asset less any depreciation taken over the life of the asset. If the sales price allocated to depreciable assets is less than the net book value, there is a loss recognized on the sale of the assets. If the sales price is greater than the net book value of the depreciable assets, a gain is recognized. If the sales price allocated and the net book value of the depreciable assets are equal, then there is no gain or loss and the sale has been an even transaction and zero adjustment occurs.

There are limits to the amount of money that Medicare can gain or lose during a hospital's disposal of depreciable assets. The amount of gain is limited to the amount of depreciation for the asset previously included in allowable costs to the Medicare program through the years. The amount of loss is limited to the undepreciated basis of the asset (original value less any depreciation taken through the years) permitted under the program.

Once the overall gain or loss on depreciable assets is calculated, the intermediary must determine Medicare's share. This share is determined by multiplying the gain or loss by the hospital's Medicare utilization during the years that the assets were in use. Medicare's utilization is determined by comparing Medicare patients' use of the hospital to use by non-Medicare patients. This can be a complicated procedure that can require going back through previous cost reports to determine overall Medicare utilization.

Three examples of depreciation adjustments are presented in this appendix. Example 1 illustrates a depreciation adjustment resulting in a loss. Example 2 provides details on a gain and Example 3 shows a zero adjustment. These are simplified examples meant to illustrate how depreciation adjustments are calculated. The allocation of sales price can include many types of assets that are not included in these examples. We do not present the calculation for determining the Medicare utilization percentage in our examples. Instead, we assigned a Medicare utilization rate of 50 percent to determine Medicare's share of the hospital sale.

Example 1 - Medicare Loss on Sale

Hospital net facility sales prices: **$10,000,000**
(includes cash and any other considerations plus assumed liabilities)

Allocation of the net sales price presented in table below:
(includes both depreciable and non-depreciable assets such as buildings, equipment, accounts receivable, medical records, inventory, and other assets)

DESCRIPTION OF ASSET	DEPRECIABLE ASSET	AMOUNT
Land	No	$3,000,000
Inventory	No	$2,000,000
Buildings	Yes	**$4,000,000**
Major Moveable Equipment	Yes	**$1,000,000**
TOTAL ALLOCATED NET SALES PRICE		$10,000,000

Sales price allocated to Medicare allowable depreciable assets: **$ 5,000,000**
(determined from allocation above = 4,000,000 + 1,000,000)

Net book value of depreciable assets at the date of sale: **$ 7,000,000**
(determined from cost report: original value less depreciation already taken)

Total amount of gain/loss on sale of depreciable assets: **-$2,000,000**
(sales price less net book value for depreciable assets = 5,000,000 - 7,000,000)

Medicare's share of the total gain/loss on sale of allowable depreciable assets **-$1,000,000**
(total gain/loss on depreciable assets multiplied by Medicare utilization percentage including inpatient/outpatient and other components = -2,000,000 x .50)

LOSS TO MEDICARE = $ 1,000,000

Example 2 - Medicare Gain on Sale

Hospital net facility sales prices: **$10,000,000**
(includes cash and any other considerations plus assumed liabilities)

Allocation of the net sales price presented in table below:
(includes both depreciable and non-depreciable assets such as buildings, equipment, accounts receivable, medical records, inventory, and other assets)

DESCRIPTION OF ASSET	DEPRECIABLE ASSET	AMOUNT
Land	No	$1,000,000
Inventory	No	$1,000,000
Buildings	Yes	**$5,000,000**
Major Moveable Equipment	Yes	**$3,000,000**
TOTAL ALLOCATED NET SALES PRICE		$10,000,000

Sales price allocated to Medicare allowable depreciable assets: **$ 8,000,000**
(determined from allocation above = 5,000,000 + 3,000,000)

Net book value of depreciable assets at the date of sale: **$ 7,000,000**
(determined from cost report: original value less depreciation already taken)

Total amount of gain/loss on sale of depreciable assets: **$ 1,000,000**
(sales price less net book value for depreciable assets = 8,000,000 - 7,000,000)

Medicare's share of the total gain/loss on sale of allowable depreciable assets **$ 500,000**
(total gain/loss on depreciable assets multiplied by Medicare utilization percentage including inpatient/outpatient and other components = 1,000,000 x .50)

GAIN TO MEDICARE = $ 500,000

Example 3 - Medicare Zero Adjustment on Sale

Hospital net facility sales prices: **$10,000,000**
(includes cash and any other considerations plus assumed liabilities)

Allocation of the net sales price presented in table below:
(includes both depreciable and non-depreciable assets such as buildings, equipment, accounts receivable, medical records, inventory, and other assets)

DESCRIPTION OF ASSET	DEPRECIABLE ASSET	AMOUNT
Land	No	$2,000,000
Inventory	No	$1,000,000
Buildings	Yes	**$4,000,000**
Major Moveable Equipment	Yes	**$3,000,000**
TOTAL ALLOCATED NET SALES PRICE		$10,000,000

Sales price allocated to Medicare allowable depreciable assets: **$ 7,000,000**
(determined from allocation above = 4,000,000 + 3,000,000)

Net book value of depreciable assets at the date of sale: **$ 7,000,000**
(determined from cost report: original value less depreciation already taken)

Total amount of gain/loss on sale of depreciable assets: **$ 0**
(sales price less net book value for depreciable assets = 7,000,000 - 7,000,000)

Medicare's share of the total gain/loss on sale of allowable depreciable assets **$ 0**
(total gain/loss on depreciable assets multiplied by Medicare utilization percentage including inpatient/outpatient and other components)

NO GAIN OR LOSS TO MEDICARE = $ 0

APPENDIX B

HEALTH CARE FINANCING ADMININSTRATION COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

DATE: JUN - 3 1997

TO: June Gibbs Brown
Inspector General

FROM: Bruce C. Vladeck
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Medicare Losses on Hospital Sales," (OEI-03-96-00170)

We reviewed the above-referenced report that examines Medicare and Medicaid losses on hospital sales. We concur with all three recommendations. Our detailed comments are attached for your consideration.

Thank you for the opportunity to review and comment on this report.

Attachment

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IG	
EAIG	
SAIG	
PDIG	
DIG-AS	
DIG-EC	
DIG-EI	✓
DIG-OI	
DIG-MP	
AIG-LC	
OGC/IG	
ExecSec	✓
Date Sent	6/4

Comments of the Health Care Financing Administration (HCFA) on Office of Inspector General (OIG) Draft Report: "Medicare Losses on Hospital Sales," (OEI-03-96-00170)

OIG Recommendation 1

Propose legislation to change section 1861(v)(1)(O) of the Social Security Act (the Act) to eliminate the requirement that Medicare make adjustments for gains or losses when hospitals undergo changes of ownership.

HCFA Response

We concur. Implementing this recommendation will limit the gaming of Medicare losses in hospital sales. As noted in OIG's report (on page 3), an ad hoc work group, convened by HCFA's Audit and Reimbursement Steering Committee, made several proposals that would revise Medicare payment policies pertaining to changes of ownership. One of these proposals is to amend section 1861(v)(1)(O) of the Act to deem the sales price of an asset that undergoes a change of ownership to be equal to the net book value (historical cost less depreciation taken) of the asset. This would have the effect of eliminating adjustments for gains and losses under Medicare when hospitals or skilled nursing facilities (SNFs) undergo changes of ownership, and is consistent with this recommendation. Moreover, the work group recommended that the proposed statutory amendment be extended to all Medicare providers (currently, section 1861(v)(1)(O) governs hospitals and SNFs only).

HCFA incorporated the work group's recommendations into the proposed legislation entitled "Medicare and Medicaid Fraud, Abuse, and Waste Prevention Amendments of 1997" (section 205). The draft bill was announced by the President on March 25, 1997. This provision would apply to changes of ownership that occur after the third month beginning after the date of enactment of the legislation.

OIG Recommendation 2

Propose a similar elimination of depreciation adjustments on hospital sales in the Medicaid program.

HCFA Response

We concur. In order to receive HCFA approval of a Medicaid state plan change in payment methods and standards, the Medicaid agency must make specific assurances satisfactory to HCFA. One of these assurances, at 42 CFR 447.253(c), addresses changes in ownership of hospitals.

In determining payment when there has been a sale or transfer of the assets of a hospital the state's methods and standards must provide that payment rates can reasonably be expected not to increase, in the aggregate, as a result of changes of ownership more than the payments would increase under Medicare.

Elimination or modification of depreciation adjustment requirements under Medicare would also be reflected in the Medicaid program.

OIG Recommendation 3

Examine options for recalculating capital transition payments to hospitals undergoing changes of ownership for reimbursement purposes.

HCFA Response

We concur. We examined options for recalculating capital transition payments to hospitals undergoing changes of ownership for payment purposes. Following our analysis of the options, we conclude that recalculating capital transition payments would be inappropriate because it would be contrary to some of the principles we sought to encourage in the capital prospective payment system (PPS). One of the main principles embodied in capital PPS is administrative finality. We allow hospitals to move between payment methodologies under very limited circumstances, and we recompute the hospital-specific rate (HSR) only under very specific circumstances.

While there could be savings to the Medicare program, there is also potential for additional costs to the Medicare program. If we recompute the HSR when a provider experiences a loss, we would also be obligated to recompute the HSR when the provider has a gain. Medicare would save money for hospitals sold at a loss, but Medicare may also be obligated to pay out more money to hospitals claiming to have higher capital-related costs, qualifying them for a higher HSR. The OIG report suggests making major policy changes in the area of recomputing the HSR which could lead to a continuous reevaluation of the HSR.

At the end of the transition in 2001, the capital PPS will be fully prospective. All hospitals will be paid 100 percent of the Federal rate, and their payments will bear no relationship to their actual capital expenditures. The earliest this option could be implemented is fiscal year 1999, which will be the eighth year of the 10-year transition period for capital PPS. Given the limited application of the OIG recommendation, we believe it would be inadvisable to make such a change at this time.