

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE PAID NEW HOSPITALS
THREE TIMES MORE FOR THEIR CAPITAL
COSTS THAN THEY WOULD HAVE BEEN
PAID UNDER THE INPATIENT
PROSPECTIVE PAYMENT SYSTEM**

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Principal Deputy Inspector General

August 2021
A-07-19-02818

Office of Inspector General

<https://oig.hhs.gov/>

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

Report in Brief

Date: August 2021

Report No. A-07-19-02818

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL



Why OIG Did This Audit

Medicare regulations require that established hospitals be paid for capital costs through the Inpatient Prospective Payment System (IPPS). These regulations also allow new hospitals to be exempt from the IPPS payment methodology for capital costs and, instead, to be paid for these costs on a cost reimbursement basis for their first 2 years of operation. The stated rationale for this IPPS exemption is that new hospitals may not have adequate Medicare utilization in those initial 2 years and may have incurred significant startup costs.

Our objective was to determine the potential cost savings to Medicare if the IPPS exemption were removed such that capital payments to new hospitals would be paid under the IPPS.

How OIG Did This Audit

Our audit covered Medicare program payments totaling \$423.2 million for capital costs that were paid to 112 new hospitals under the current (reasonable cost) methodology for Federal fiscal years 2012 through 2018. We calculated what the IPPS payments to new hospitals would have been by using the Provider Statistical and Reimbursement Reports, cost report data from the Centers for Medicare & Medicaid Services' (CMS's) Healthcare Cost Report Information System, and inpatient claim data. We also compared actual capital costs and utilization reported by 35 of the 112 new hospitals.

Medicare Paid New Hospitals Three Times More for Their Capital Costs Than They Would Have Been Paid Under the Inpatient Prospective Payment System

What OIG Found

We identified significant potential cost savings to Medicare if the IPPS exemption were removed and capital payments to new hospitals were made through the IPPS. For the 112 new hospitals that we reviewed, Medicare paid a total of \$283 million more for capital costs than it would have paid if these hospitals had been paid through the IPPS. The IPPS exemption resulted in new hospitals being paid three times more—or an average of almost \$1.3 million more per cost report—under the reasonable cost methodology than if they had been paid for their capital costs under the IPPS.

With respect to the reasons for the IPPS exemption, we compared the first 2 years of operation with the subsequent 2 years of operation of the 35 new hospitals for which such data were available and determined that in the first 2 years of operation, average Medicare-related capital costs were only 3 percent higher and average Medicare utilization was 15 percent lower.

Most of these new hospitals (approximately 59 percent) were also part of chain organizations that might have been able to provide reserve capital to their new hospitals if needed.

What OIG Recommends and CMS Comments

We recommend that CMS review the findings in this report and, if it determines that a separate payment methodology for capital costs at new hospitals is no longer warranted, change its regulations to require new hospitals to have their Medicare capital costs paid through the IPPS with an option for payment adjustments or supplemental payments if necessary.

CMS concurred with our recommendation and stated that it would further review our findings and determine whether any modifications to the capital payment methodology for new hospitals should be proposed in future Federal rulemaking.

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INTRODUCTION

WHY WE DID THIS AUDIT

Medicare regulations require that payments to established hospitals for capital costs be made through the Inpatient Prospective Payment System (IPPS). These regulations permit new hospitals to be exempted from the IPPS payment methodology for capital costs and, instead, permit them to be paid for these costs on a cost reimbursement basis for their first 2 years of operation. The stated rationale for this IPPS exemption is that new hospitals may not have a population of Medicare patients adequate to cover capital costs in those initial 2 years and may have incurred significant capital startup costs that would not be covered through the IPPS. Because IPPS payments are made on a per-discharge basis, a hospital is only paid for its capital costs each time it discharges a Medicare patient; accordingly, with all other things being equal, a hospital that experiences fewer Medicare patient discharges will receive lower payments for capital costs than a hospital with a higher number of Medicare patient discharges. We designed this audit to evaluate the validity of the assumptions stated in the rationale for the IPPS exemption, to determine the potential savings to Medicare if the IPPS exemption for new hospitals were removed.

OBJECTIVE

Our objective was to determine the potential cost savings to Medicare if the IPPS exemption were removed such that capital payments to new hospitals would be paid under the IPPS.

BACKGROUND

Medicare Program

Under the provisions of Title XVIII of the Social Security Act, the Medicare program provides health insurance for people aged 65 years and older, people with disabilities, and people with permanent kidney disease. The Centers for Medicare & Medicaid Services (CMS) administers the program. Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for patients after hospital discharge. CMS contracts with Medicare administrative contractors (MACs) to, among other things, process and pay claims submitted by hospitals.

New Hospitals

Federal regulations define a “new hospital” as a hospital that has operated (under previous or current ownership) for less than 2 years (42 CFR § 412.300(b)). These regulations also clarify situations for which the IPPS exemption does not apply. One such situation involves a hospital that closes and subsequently reopens. Another such situation involves a hospital that has been in operation for more than 2 years but has been participating in the Medicare program for less than 2 years.

Capital Costs

Capital costs include depreciation, interest expense, leases, insurance, and taxes, and are reported on the hospital's annual cost report to Medicare. For these costs to be allowable, they must conform to the requirements in 42 CFR part 413, subpart G. One such requirement is that assets must be depreciated using straight-line depreciation (or 150-percent straight-line depreciation in limited circumstances that do not bear upon this audit). New hospitals subject to the IPPS exemption are paid 85 percent of their Medicare-related capital costs; we refer to this as "reasonable cost methodology" for this report. (Language in Medicare cost reports also refers to this payment as "payment under reasonable cost.") (Form CMS-2552-10, Worksheet L, Part II).

Inpatient Prospective Payment System

Under the IPPS, Medicare pays hospitals predetermined rates for patient discharges. The rates vary according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned and the severity level of the patient's diagnosis. The DRG payment is, with certain exceptions, intended to be payment in full to the hospital for all inpatient costs associated with the beneficiary's stay.

Inpatient Prospective Payment System Base Payments

CMS sets two IPPS base payment rates annually, one for operating costs and one for capital costs. These two components make up the per-discharge payment that CMS makes to an IPPS hospital. The operating base payment is intended to cover labor and supply costs, while the capital base payment is intended to cover capital costs (i.e., depreciation, interest expense, leases, insurance, taxes, and other capital-related costs). These base payments are multiplied by a diagnosis-related factor to adjust for costs that vary by the patient's illness. The IPPS payment to a hospital also includes add-on payments such as the disproportionate share hospital adjustment and indirect medical education payment.¹

Implementation of the IPPS

Before implementation of the IPPS in October 1983, hospitals were paid under a retrospective cost-based payment system for both operating and capital costs, meaning that essentially, hospitals were paid what they spent. This cost-based payment system provided little incentive for hospitals to control costs and as a result, hospital costs increased at a rate that was much higher than the overall rate of inflation. Accordingly, a primary motive for implementation of the IPPS was to create incentives for hospitals to operate efficiently, while ensuring that

¹ The Medicare program includes provisions under which Medicare-participating hospitals that serve a disproportionate share of low-income patients may receive disproportionate share hospital adjustments, which are a percentage add-on payment applied to the DRG payment rate. Indirect medical education refers generally to an additional payment for a Medicare discharge to reflect the higher patient care costs of teaching hospitals relative to non-teaching hospitals.

payments are adequate to compensate hospitals for their reasonable costs in furnishing necessary high-quality care to Medicare beneficiaries.

The implementation of the IPPS in 1983 affected payment only for the operating costs that a hospital incurred. Capital costs incurred by a hospital continued to be paid on a retrospective basis until the capital IPPS (which addresses payment for the capital costs that a hospital incurred) was implemented in August 1991 (with an effective date of October 1991). As part of the implementation, CMS allowed for a 10-year transition period:

- For established hospitals, the transition period used a phased-in approach that blended a hospital-specific rate and a Federal-specific rate and that slowly phased out the hospital-specific rate by 10 percent each year for 9 years, at which point the hospital would be paid 100 percent of the Federal-specific rate (i.e., the capital payment under the IPPS) going forward.
- The transitional period also allowed new hospitals to be exempted from the capital IPPS and instead to be paid 85 percent of their reasonable capital costs for their first 2 full years of operation. After the second year, the hospital would no longer be exempt and would be paid the capital payment under the IPPS. In 2002, when the 10-year transitional period was set to expire, CMS extended this IPPS exemption for new hospitals indefinitely (42 CFR § 412.304(c)(2)).

CMS's Rationale for Creating and Extending the Inpatient Prospective Payment System Exemption

In a February 1991 proposed rule, CMS proposed to pay new hospitals through the IPPS.² However, in comments summarized in the August 1991 final rule, commenters opposed this proposal by expressing concerns that “payment levels may not be adequate for hospitals that are built late in the transition period” and that a “hospital’s first year costs per case may not be sufficiently representative to establish an appropriate hospital-specific rate.”³ CMS agreed with the commenters and instituted the IPPS exemption for new hospitals during the 10-year transition period.

When the 10-year transition period was set to expire at the end of Federal fiscal year (FY) 2002, CMS extended the IPPS exemption for new hospitals in the August 1, 2002, final rule.⁴ CMS’s rationale as expressed in the August 1, 2002, final rule echoed the concerns of the commenters on the February 1991 proposed rule 10 years earlier: that these new hospitals need special protection as the DRG-based IPPS may not be adequate initially to cover their capital costs.

² 56 Fed. Reg. 8476, 8494 (Feb. 28, 1991).

³ 56 Fed. Reg. 43358, 43418 (Aug. 30, 1991).

⁴ 67 Fed. Reg. 49982, 50113 (Aug. 1, 2002).

Specifically, CMS stated three reasons for its extension of the IPPS exemption.⁵ The first reason was that new hospitals may incur significant startup costs. The second reason was that new hospitals may initially have lower Medicare utilization (i.e., a lower population of Medicare patients). Because capital prospective payment system payments are made on a per-discharge basis, lower utilization would mean lower overall payments. The third reason was that new hospitals may not yet have had an opportunity to build up capital reserves to finance capital projects.

Medicare Cost Reports

Hospitals submit cost reports to their MACs annually. The cost reports are based on the hospitals' financial and statistical records, and hospitals attest to the accuracy of the data when submitting their cost reports. After acceptance of each cost report, the MAC performs a tentative settlement, then reviews the cost report and conducts an audit, if necessary, before final settlement. The MAC then issues a Notice of Program Reimbursement. As the final settlement document, this notice shows whether payment is owed to the hospital or to the Medicare program.

HOW WE CONDUCTED THIS AUDIT

Our audit covered Medicare program payments totaling \$423,236,287 for capital costs that were paid to 112 new hospitals under the reasonable cost methodology for FYs 2012 through 2018.⁶

We calculated what the IPPS payments to new hospitals would have been by using the Provider Statistical and Reimbursement Reports (PS&Rs) to determine DRG payments, cost report data from CMS's Healthcare Cost Report Information System (HCRIS) to determine both indirect medical education payments and capital disproportionate share adjustments, and inpatient claim data to determine capital outlier payments.⁷ We also used HCRIS data to compare actual capital costs and utilization reported by 35 of the 112 new hospitals under their first 2 years of operation and their subsequent 2 years of operation, as only these had the 2 years of operation under the reasonable cost methodology and 2 years of operation under the IPPS that were necessary for our comparison.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain

⁵ 67 Fed Reg. at 50101.

⁶ Of the 112 new hospitals, 101 were located in urban areas and 11 were located in rural areas as determined by the U.S. Census Bureau. We selected this FYs 2012 through 2018 audit scope to ensure that we were able to review at least two full cost reports submitted by a sufficient number of new hospitals.

⁷ The PS&R system is maintained by CMS; it accumulates statistical and reimbursement data applicable to the processed and finalized Medicare Part A and Part B claims.

sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains details of our audit scope and methodology.

FINDINGS

We identified significant potential cost savings to Medicare if the IPPS exemption were removed and capital payments to new hospitals were made through the IPPS. For the 112 new hospitals that we reviewed, Medicare paid a total of \$283,021,741 more for capital costs than it would have paid if these hospitals had been paid through the IPPS. The IPPS exemption resulted in new hospitals being paid approximately 3.01 times more—or an average of \$1,269,156 more per cost report—under the reasonable cost methodology than if they had been paid for their capital costs under the IPPS.

With respect to the reasons that CMS provided (in the August 1, 2002, final rule) for the IPPS exemption, we compared the first 2 years of operation with the subsequent 2 years of operation of the 35 new hospitals discussed in “How We Conducted This Audit” and determined that in the first 2 years of operation:

- average Medicare-related capital costs were only 3 percent higher and
- average Medicare utilization was 15 percent lower.

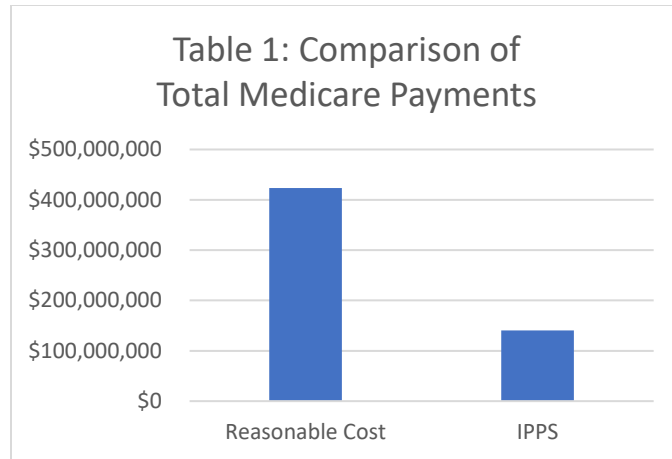
Most of these new hospitals (approximately 59 percent) were also part of chain organizations that might have been able to provide reserve capital to their new hospitals if needed. The results of our comparison thus suggest that CMS’s rationale for continuing the IPPS exemption is not sufficient to justify the difference in payments.

MEDICARE WOULD HAVE REALIZED SIGNIFICANT SAVINGS IF NEW HOSPITALS HAD BEEN PAID THROUGH THE INPATIENT PROSPECTIVE PAYMENT SYSTEM FOR CAPITAL COSTS

Medicare Payments for Capital Costs

Total Payments

Medicare paid the 112 new hospitals a total of \$423,236,287 under the reasonable cost methodology for FYs 2012 through 2018. If these 112 hospitals had been paid under the IPPS for capital costs (i.e., if the IPPS exemption had been removed for those hospitals), Medicare would have paid a total of \$140,214,546. Table 1 on the following page graphically depicts this difference.



The difference, \$283,021,741, represents funds that Medicare could have saved by requiring new hospitals to be paid for their capital costs under the IPPS.

Payments per Cost Report

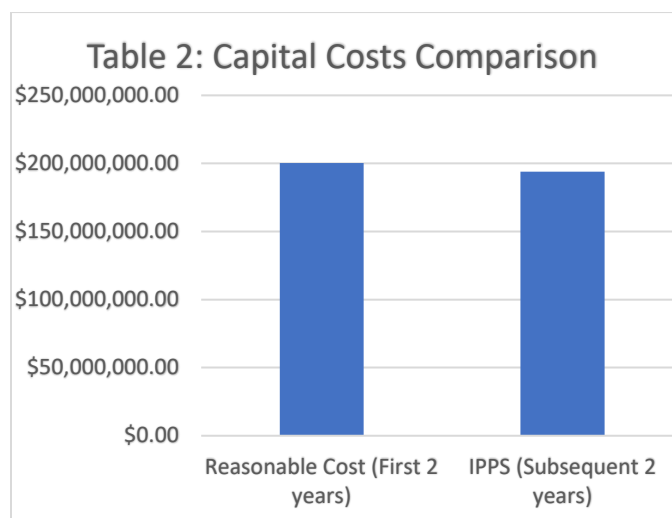
The \$423,236,287 that Medicare paid under the reasonable cost methodology equated to each of the 112 new hospitals being paid approximately \$1,897,920 per cost report for its capital costs. The \$140,214,546 that the new hospitals would have been paid under the IPPS equated to an average of \$628,765 per cost report that each of the new hospitals would have been paid for its capital costs under that system. There was thus a difference of approximately \$1.2 million per cost report between: (1) what the new hospitals were paid for their capital costs under the reasonable cost methodology and (2) what they would have been paid for these costs under the IPPS. Stated differently, the new hospitals were paid approximately 3.01 times more under the reasonable cost methodology than they would have been paid under the IPPS.

Moreover, we identified significant variability in the payments from one new hospital to the next. The differences in payment per cost report ranged from one new hospital that was paid \$98,546 *less* under the reasonable cost methodology than it would have been paid under the IPPS to another new hospital that was paid \$8,159,605 *more* under the reasonable cost methodology than it would have been paid under the IPPS. For the cost reports we reviewed, the median amount (i.e., the midpoint) of the difference between what new hospitals were paid for their capital costs under the reasonable cost methodology and what they would have been paid for these costs under the IPPS was \$752,572.

CMS's Rationale for Continuing the Inpatient Prospective Payment System Exemption Is Not Sufficient To Justify the Difference in Payments

Capital Costs

One reason CMS cited for continuing the IPPS exemption was that capital costs are higher in the first 2 years for new hospitals because of significant startup costs. However, new hospitals had only a small increase in capital costs, on average, in their first 2 years of operation compared to their subsequent 2 years of operation. The 35 hospitals for which we compared actual capital costs and utilization reported Medicare-related capital costs in their first 2 years of operation that were only 3 percent higher than their capital costs in the subsequent 2 years.⁸ We compared the capital costs that new hospitals incurred in the first 2 years of operation with those incurred in the subsequent 2 years of operation. For these new hospitals, the first 2 years of capital costs (paid under the reasonable cost methodology) totaled \$200,370,990 and the subsequent 2 years of capital costs (paid under the IPPS) totaled \$193,940,344, as shown in Table 2.



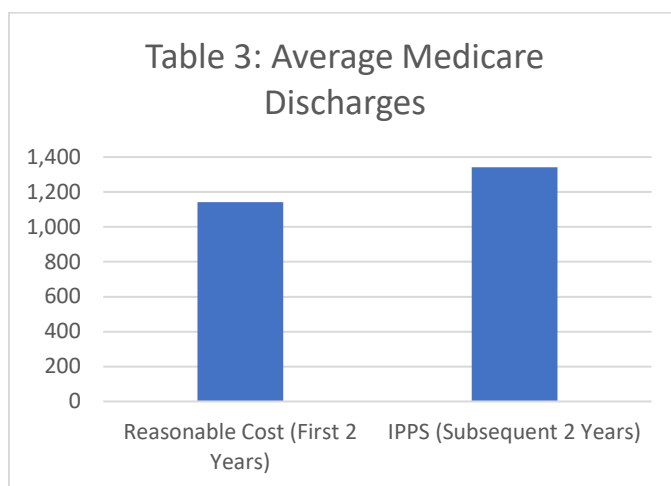
Of these 35 new hospitals, 21 had lower capital costs in their first 2 years of operation than they did in the subsequent 2 years. The variations ranged from one new hospital reporting 274-percent higher capital costs in its first 2 years of operation than in its subsequent 2 years, to two new hospitals that each reported 63-percent lower capital costs in its first 2 years of operation than in its subsequent 2 years.

Medicare Utilization

Another reason CMS cited for the IPPS exemption was that Medicare utilization is lower for a new hospital in its first years of operation, which, because DRG payments are predetermined

⁸ As reported on Form CMS-2552-10, Worksheet D, Parts I and II.

and are based on Medicare patient discharges, would result in lower DRG payments. We found that, on average, new hospitals do have a lower Medicare utilization in their first 2 years of operation. For the 35 hospitals for which we compared actual capital costs and utilization, the average number of Medicare discharges was about 15 percent lower for the first 2 years of operation than it was for the subsequent 2 years of operation, as shown in Table 3. Because the DRG payments are predetermined and are based on Medicare patient discharges, we used Medicare utilization as another point of comparison for our analysis. Specifically, we compared Medicare discharges in the first 2 years of operation with discharges in the subsequent 2 years of operation of the new hospitals.



Of these 35 new hospitals, 32 had lower Medicare utilization in their first 2 years of operation than they did in the subsequent 2 years of operation. The variations ranged from one new hospital that reported 71-percent lower Medicare utilization in its first 2 years of operation than in its subsequent 2 years, to another new hospital that reported 232-percent higher Medicare utilization in its first 2 years of operation than in its subsequent 2 years.

Capital Reserves

The third reason that CMS cited for the IPPS exemption is that new hospitals may not yet have had an opportunity to build up previous years' capital reserves to finance capital projects. However, approximately 59 percent of the 112 new hospitals were part of chain organizations that might have been able to provide reserve capital to their new hospitals if needed.

CONCLUSION

For the 112 new hospitals that we reviewed, Medicare would have realized \$283,021,741 in cost savings if these hospitals had been paid through the IPPS for their capital costs. Although new hospitals incur slightly higher capital costs and have somewhat lower Medicare utilization during their first 2 years of operation than they do in the subsequent 2 years, these differences are not so significant as to justify capital payments that are triple what they would have been

paid through the IPPS. If CMS determines that new hospitals require increased payment for capital costs, it could make payment adjustments or supplemental payments within the framework of the IPPS. Such payments would not be based solely on cost and would still allow CMS to realize significant cost savings. By using the IPPS for new hospitals in lieu of cost reimbursement, CMS could create incentives for hospitals to operate more efficiently.

RECOMMENDATION

We recommend that the Centers for Medicare & Medicaid Services review the findings in this report and, if it determines that a separate payment methodology for capital costs at new hospitals is no longer warranted, change its regulations to require new hospitals to have their Medicare capital costs paid through the IPPS with an option for payment adjustments or supplemental payments if necessary.

CMS COMMENTS

In written comments on our draft report, CMS concurred with our recommendation. CMS also stated that it would further review our findings and determine whether any modifications to the capital payment methodology for new hospitals should be proposed in future notice-and-comment rulemaking. CMS's comments appear in their entirety as Appendix B.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered Medicare payments totaling \$423,236,287 for capital costs that were paid to 112 new hospitals under the reasonable cost methodology for FYs 2012 through 2018 (footnote 6), as identified within CMS's HCRIS.

We determined that internal control was not significant to the audit objective.

We performed audit work from June 2019 to May 2021.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- met with MAC officials to gain an understanding of the extent to which capital costs are audited on hospitals' cost reports;
- held discussions with CMS officials regarding any research CMS has conducted on capital costs at new hospitals;
- obtained HCRIS data for FYs 2012 through 2018 for all hospitals;
- assessed the reliability of the HCRIS by comparing HCRIS data to data in cost reports actually submitted by hospitals;
- identified all new hospitals whose capital costs had been paid under the reasonable cost methodology;⁹
- compared what each new hospital was paid under the reasonable cost methodology to what the new hospital would have been paid under the IPPS and
 - obtained PS&R reports for the periods that the new hospitals were paid under the reasonable cost methodology,
 - calculated the indirect medical education payments and disproportionate share hospital adjustments that the new hospitals would have been paid under the IPPS, and

⁹ Form CMS-2552-10, Worksheet L, Part II.

- calculated the capital outlier payments that the new hospitals would have been paid under the IPPS;
- compared the capital costs and Medicare discharges at 35 of the 112 new hospitals under their first 2 years of operation and their subsequent 2 years of operation (“How We Conducted This Audit” and footnote 8);
- used HCRIS data to identify which of the new hospitals in our analysis were part of chain organizations;¹⁰ and
- discussed the results of our audit with CMS officials on February 26, 2021.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

¹⁰ Hospitals identify whether they are part of a chain organization on Form CMS-2552-10, Worksheet S-2, Part I.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator

Washington, DC 20201

DATE: July 13, 2021

TO: Christi A. Grimm
Principal Deputy Inspector General
Office of Inspector General

FROM: Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services *Chiquita Brooks-LaSure*

SUBJECT: Office of Inspector General (OIG) Draft Report: Medicare Paid New Hospitals Three Times More for Their Capital Costs Than They Would Have Been Paid Under the Inpatient Prospective Payment System (A-07-19-02818)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. CMS is committed to providing Medicare beneficiaries with high quality health care while ensuring accurate payments to providers and facilities.

CMS uses a prospective payment system for capital-related costs. While capital costs for established hospitals are made under the Inpatient Prospective Payment System (IPPS), new hospitals are exempt from the IPPS payment methodology for capital costs and, instead, are paid 85 percent of reasonable costs for their first two years of operation. CMS implemented this payment provision to provide special protection for new hospitals in response to concerns raised during notice-and-comment rulemaking that prospective payments under a diagnosis-related group system may not be adequate initially to cover the capital costs of newly built hospitals, as these hospitals may not have sufficient occupancy in those initial two years to pay for potentially significant capital startup costs. Because capital IPPS payments are made on a per discharge basis, a hospital only receives payments for its capital-related costs upon discharge of its Medicare patients. In addition, unlike established hospitals, new hospitals do not have an opportunity to reserve previous years' capital prospective payment system payments to finance capital projects.

CMS established the payment methodology for new hospitals in order to provide more appropriate payments to new hospitals for their capital-related costs since initial capital expenditures may reasonably exceed the per discharge capital IPPS payment based on the federal rate. CMS sets the capital IPPS federal rate annually, but the rate is based on industry-wide average capital costs rather than the experience of a new hospital. CMS designed the policy to allow new hospitals to provide efficiency in the delivery of services and still make reasonable payments for their capital expenditures during their first two years of operation.

CMS recognizes the importance of making accurate payments to hospitals and as such, CMS will consider the OIG's report and findings in determining appropriate next steps.

OIG's recommendation and CMS' response are below.

OIG Recommendation

We recommend that the Centers for Medicare & Medicaid Services review the findings in this report and, if it determines that a separate payment methodology for capital costs at new hospitals is no longer warranted, change its regulations to require new hospitals to have their Medicare capital costs paid through the IPPS with an option for payment adjustments or supplemental payments if necessary.

CMS Response

CMS concurs with this recommendation. CMS will further review the OIG's findings and determine whether any modifications to the capital payment methodology for new hospitals should be proposed in future notice-and-comment rulemaking.