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# MEDICARE PAYMENT AND HOSPITAL CAPITAL: FUTURE POLICY OPTIONS

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by Gerard Anderson and Paul B. Ginsburg

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**Prologue:** *At a time when hospitals are largely consumed by the challenging task of implementing Medicare's prospective payment system (PPS), the Reagan administration is putting the finishing touches on a report to Congress which will recommend how capital payments should be incorporated into the new payment scheme. Congress established a deadline of October 1, 1986, for enacting new hospital capital legislation. In this article, two well-respected economists who are often consulted by the public and private sectors for approaches to complicated policy problems, set out options that Congress will consider when it turns to the hospital capital issue. Until one year ago, Gerard Anderson was a central figure within the Department of Health and Human Services (DHHS) in the development of the administration's prospective payment policy. Over the course of his six-year stint at the department, Anderson served four assistant secretaries in a similar technical capacity, thus demonstrating an ability to bridge a broad philosophical gap while maintaining the respect of his political superiors. An economist with a Ph.D. from the University of Pennsylvania, Anderson left DHHS to become associate director of The Johns Hopkins University Center for Hospital Finance and Management. Paul Ginsburg was deputy assistant director for income security and health of the Congressional Budget Office (CBO) before his recent departure for the Rand Corporation. In his six years at CBO, Ginsburg developed a reputation as an analyst who could provide policy guidance on issues independent of that offered by the administration. At Rand, Ginsburg will become involved in consulting with the Health Care Financing Administration on an evaluation of prospective payment. Ginsburg, who holds a Ph.D. in economics from Harvard University, was an associate professor at Duke University before joining CBO.*

**D**uring the past year, considerable debate has focused on how Medicare's system of payment for hospital capital should be revised in order to be consistent with the prospective payment system (PPS). The legislation establishing PPS applies only to inpatient operating costs and requires the Secretary of Health and Human Services (HHS) to report to Congress by October 1984 with a proposal for incorporating capital payment into PPS. It also provides for a backup system of capital payment that will take effect in 1986 if further legislation is not passed. In addition, whatever system is eventually developed for capital may apply retroactively to capital investments initiated after April 20, 1983, thus creating considerable uncertainty for projects under consideration at present.

In such an environment, it is not surprising that numerous groups with an interest in the outcome of this process have held meetings to define the issues from their perspective. These include the hospital industry, investment bankers, equipment manufacturers, hospital financial managers, and health planners. Not only are the long-range implications of various capital financing options of substantial importance to each of these interest groups, but the uncertainty of how Medicare will in the future treat projects undertaken today is a growing concern. To some, the speed of resolution is almost as important as the ultimate outcome.

The importance of this issue makes it a natural topic for policy analysts with interests in hospital capital financing; many have published articles recently.<sup>1</sup> In these articles various payment schemes have been proposed. Indeed, so much has occurred since we wrote on this topic one year ago in *Health Affairs*, another article reviewing the policy options would be appropriate.

In contrast, while some legislation has been introduced in Congress, few hearings have been held and no action taken.<sup>2</sup> Observers suggest that Congress is waiting to see if a consensus will emerge among important interest groups.

In this paper, we begin with a discussion of the importance of capital payment. Then we focus specifically on three issues: (1) the aggregate amount of capital payment, (2) the method of allocating it to individual hospitals, and (3) methods of phasing in a new system.

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### Importance Of Capital Payment

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The degree of attention that Medicare capital payment has generated puzzles many observers. After all, capital costs as defined by Medicare—that is, interest, depreciation, rent, and a return on equity for investor-owned hospitals—amount to only 7 percent of total hospital costs. Nevertheless, the issue of revising Medicare's payment system for capital is indeed an important one. For one thing, hospital capital projects can

have important implications for operating costs. A frequently quoted study estimates that each additional dollar of capital expenditures leads to twenty-two cents in additional annual operating expenditures.<sup>3</sup> However, since additional capital investment will no longer lead to higher per case payments in the new PPS system, the importance of this relationship is now limited to the impact on the volume of admissions. Certain capital expenditures, most notably an increase in the number of beds, can increase the overall admission rate in an area.<sup>4</sup>

Capital payment is of substantial importance to individual hospitals because of the potential for major problems during the transitional period to a new payment system. Hospitals receive widely varying capital payments under the present system. Indeed, our previous paper included data showing that over 5 percent of hospitals have capital costs in excess of 15 percent of operating costs, when the mean percentage is about 7 percent. A clumsy transition would risk financial hardships for hospitals with very large existing obligations.

Capital payment reform is a critical element in the competition between the investor-owned and nonprofit segments of the hospital industry. Under the current cost-based system, capital reimbursement for investor-owned hospitals is much more generous than it is for not-for-profit hospitals. They are paid a return on equity capital and are reimbursed for expense items such as property taxes that not-for-profit hospitals do not pay. For these reasons it is not surprising that the percentage of the hospital's budget spent on capital is significantly higher in investor-owned hospitals. Consideration of a prospective system raises the issue of whether investor-owned hospitals ought to have a capital payment that is higher than that for not-for-profit hospitals.

Finally, discussion of capital payment provides a forum for general concerns about the Medicare prospective payment system. PPS was enacted during an extremely short period, allowing much less time for debate than is customary for major legislation. Many are using the forum of capital payment to raise broad issues related to the use of financial incentives to spur hospital cost containment. Hospitals are asking how they will be able to finance care to indigents and provide for other services that have traditionally been operated at a loss.

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### **Aggregate Amount Of Payment**

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The first decision in developing a capital payment system for Medicare is the total number of dollars to be paid to hospitals. Various participants in the policy discussions have argued for higher or lower payments for capital than under current law. Unfortunately, this debate requires resolution of a more fundamental question: How large a payment would continuation of current policies imply?

**Budget neutrality.** Many analysts appear captivated by a provision in the Social Security Amendments of 1983, which established that Medicare payment for the first two years under PPS shall be "budget neutral." This requires Medicare outlays for inpatient hospital care under PPS to be the same as they would have been under previous law (Tax Equity and Fiscal Responsibility Act of 1982). This provision attempts to separate budgetary policy and the specific techniques of payment to hospitals. Those anxious to follow this example see a potential reduction in controversy if this separation can apply to capital payments as well.

Defining a "budget neutral" amount of capital reimbursement is not straightforward, however. It involves projecting what capital payments would be if the existing cost-based methods for capital were continued in the context of prospective payment for operating costs. Given the extremely limited experience with PPS, the long lead times for major hospital investment projects, and the lags in obtaining Medicare data on capital reimbursements, refined estimates of budget-neutral capital payments are not feasible. For example, investment decisions today may not be reflected until 1986 Medicare cost reports are prepared, and the most recent capital payments data available at this writing are from 1981 cost reports.

Fortunately, historical data indicate that the ratio of capital costs to operating costs is relatively stable. This means that continuing the ratio from 1981 (or the most recent data available) may be a reasonable working definition of budget neutrality. Broadening the market basket to include capital costs would then allow changes in construction costs and interest rates to be reflected in the future.

**Paying more.** Important arguments are made for paying more or less than a "budget neutral" amount. Arguments to pay more stress the fact that current reimbursements are significantly less than replacement costs, that philanthropy has been declining, and that many of the facilities built under the Hill-Burton program are in need of replacement.

The replacement cost argument is the most significant. Current reimbursement follows the norms of public utility regulation. The basis for calculation of depreciation and return on equity is the historical cost of the facility or equipment. In subsequent periods there is no adjustment for inflation. Replacement cost depreciation would adjust for changes in price levels to permit the hospital to replace a comparable piece of equipment at the new higher prices at the end of the period of depreciation. William Cleverly estimates that if capital were reimbursed at replacement cost instead of historical cost, Medicare payment for capital would increase by 20 percent.<sup>5</sup>

The use of historical costs for capital reimbursement probably results in payments to hospitals below the cost of capital, but this result stems primarily from the absence of a return-on-equity payment to not-for-

profit hospitals. Since market interest rates reflect expected future inflation, and Medicare's return-on-equity formula is based on market interest rates, historical cost payments that include return on equity allow for the effects of inflation. The offset is incomplete, however, since no return on equity is paid for capital in not-for-profit hospitals.

A second argument for paying more for capital is that philanthropy is declining as a source of financing for hospital capital expenditures.<sup>6</sup> As a result, hospitals will need additional resources to replace this source of equity capital.

A third argument concerns replacement and modernization needs for facilities built during the early 1950s with Hill-Burton grants. A general rule of thumb is that hospitals should undergo renovation or replacement every twenty-five years. Many hospitals, especially urban public hospitals, have not been renovated during the past thirty years and will soon need significant resources to conform to current standards. However, estimates of the availability of capital under most capital payment scenarios show that there will be sufficient resources in the aggregate to fund these renovation requirements.<sup>7</sup>

**Paying less.** Arguments to pay less than a budget neutral amount emphasize the fiscal pressure on Medicare and projected declines in occupancy rates. The financial difficulties of the Medicare trust fund are well known, but this is not a persuasive argument for lowering capital payments. A key factor is whether the level of payment by Medicare is strictly an issue of fairness, or whether it influences the nature of services available to Medicare beneficiaries. A result of Medicare's significant market share is that establishing diagnosis-related group (DRG) prices is often seen as a tug-of-war between hospitals and taxpayers. Thus, while Medicare is often accused of paying less than the full costs incurred in treating its beneficiaries, it probably pays far more than the incremental costs of treating its patients; and therefore, hospitals still find Medicare patients attractive.<sup>8</sup> Nevertheless, a reduction in payment does affect the revenues collected by hospitals and potentially affects the nature of care provided, for example, diffusion of new technology.<sup>9</sup> In the long run, fiscal pressure considerations may well reflect a tradeoff between government expenditures and the type of hospital care that is delivered.

Projected declines in hospital use argue for lower capital payments. From 1980 to 1983 occupancy rates fell from 76 to 72 percent, with continued decline during the first half of 1984. Declining use means a reduced need for new construction, and reduction rather than renovation of beds. Under an anticipated shift to a smaller hospital system, capital requirements may be reduced substantially.

**Numerical estimates.** In a comprehensive review of hospital needs commissioned by HHS, projections of needs during the 1980s ranged from \$49 billion to \$231 billion.<sup>10</sup> Projections tended to vary according to

assumptions about inflation rates, renovation cycles, and health maintenance organization (HMO) enrollment, with little attention focused on the dramatically different environment for hospitals that is developing. With differences this large, the debate has moved away from developing precise estimates of hospital needs to limited discussion of general principles of paying more or less, with many observers retreating to the concept of budget neutrality. This would probably result in total capital expenditures during the 1980s of less than \$100 billion.

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### Allocation To Individual Hospitals

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Over the past year, numerous organizations and individuals have proposed methods for determining payments to individual hospitals. The various alternatives can generally be categorized as prospective or cost-based options. Much discussion has been linked to the role of health planning, also.

**Prospective options.** The basic prospective proposal is a percentage add-on to the DRG rate. Hospitals would receive a single payment for operating and capital expenses based upon the DRG of the patient. This option is supported by the American Hospital Association and is included in both congressional proposals.<sup>11</sup> Such a proposal would put hospitals entirely at risk for their capital costs, so that they have an incentive to economize in both purchasing and financing decisions. It also bases the level of payment upon the hospital's caseload rather than its ability to raise capital.

Aside from the formidable problems of transition, which are discussed in a later section, the major problem with this approach is the technical one of identifying any of the hospital-specific cost factors that are outside the control of individual institutions; for example, local construction costs. This problem is general to all prospective payment systems. Because of data limitations, those setting prices cannot incorporate into their formulas the many factors that explain variations in hospital costs but are beyond the control of the hospital.

Some of the factors necessary to develop a formula for reimbursing capital expenditures are quantifiable, but others pose conceptual policy issues. For example, regional differences in construction costs can be incorporated as long as investments in data collection are undertaken. Factors which hospitals can control to some extent pose serious conceptual problems. For example, hospitals with strong balance sheets have higher bond ratings and thus face lower costs of capital. Does Medicare want to recognize such cost differences in its payment formula?

The issue of the cost of raising capital is also important for investor-owned hospitals. They point out that their costs of capital are higher due to the need to pay investors a return on their capital, and the hospital's liability for income and property taxes. While their trade association, the

Federation of American Hospitals, appears to support the concept of an add-on to the DRG rate, it argues that investor-owned hospitals should receive an additional payment that reflects these factors. Both the hospital with a bad bond rating and the investor-owned hospital have an argument if the goal is to allow each hospital with a given caseload to purchase the same amount of plant and equipment. But, this argument is inconsistent with the stance of Medicare as a prudent purchaser.

A problem of distortions of relative prices among DRGs is raised by Averill and Kalison and by the Health Industry Manufacturers Association. They argue that the percentage add-on should vary by DRG, based upon the amount of capital required in treatment. By increasing each DRG rate by the same percentage amount, there is an implicit assumption that the ratio of capital to operating costs is the same for each DRG. This option makes sense theoretically but faces technical obstacles. The principal data sources used by HHS to set prospective rates, the Medicare Cost Report and MEDPAR file, do not allocate capital costs by individual cases. Accurate estimates would require major investments in data collection.

In addition, the limited evidence available points to a very small impact for such a refinement. Using data from the Maryland system, Harold Cohen and Jack Keane have shown that cases with the highest percentage of total costs devoted to capital are obstetrical and psychiatric DRGs—DRGs with low Medicare volumes. As shown in our earlier paper, the percentage of the hospital's budget spent on capital is not dependent on its Medicare case-mix index. A more complicated case-mix does not necessarily lead to a higher or lower percentage of the total budget spent on capital. Finally, since capital represents only a small percentage of hospital expenditures, a factor of 4 percent for one DRG and 10 percent for another DRG probably would not affect a hospital's reimbursement substantially. In contrast, recalibration of DRG prices scheduled for the summer of 1985 is likely to have a much greater impact.

**Cost-based options.** Some favor continuation of cost-based reimbursement, but with two exceptions (the National Electrical Manufacturers Association and the National Council for Health Planning and Development), the advocates of this approach all propose revisions to the existing system. The proposed revisions are designed either to make the system stronger or to recognize differences among hospitals. A current problem with all cost-based systems is the opportunity for distortion when one part of the payment system is prospective while the other is cost-based. Hospitals have strong incentives to substitute capital for labor and supplies if payment for the former is cost-based. The magnitude of these potential substitutions could be significant.

One proposal would place upper limits on expenditures on either a per bed or per admission basis. Such an option, which follows the

“Section 223” approach previously used for operating costs, has some similarities to a prospective system. As the limits become tighter, the system comes closer to a prospective payment system. The major problems with this approach are that hospitals with limited ability to acquire capital would always have capital payments below average, as would hospitals at the end of their capital cycle.

A second cost-based option would use replacement cost depreciation instead of historical cost depreciation. Maryland and New Jersey use a version of replacement cost depreciation in their prospective payment programs. By using replacement cost depreciation, the hospital would be able to purchase a new piece of comparable equipment using the revenue generated from depreciation. This would prevent the erosion by inflation of a hospital's equity capital that can occur in historical cost depreciation. It would also reduce incentives for hospitals to replace their capital early in order to maximize reimbursement. However, if replacement cost is used, reimbursement of interest and return on equity would need to be revised in order to maintain consistency. In addition, replacement cost reimbursement would not benefit hospitals that historically have not had access to capital markets.

Some health planners favor a cost-based system with a strengthened planning process. The American Health Planning Association (AHPA), for example, favors statewide limits on cost-based reimbursement for plant and facilities. A planning agency would review project applications competitively, approving no more projects than could be reimbursed under the state limit. While state limits would probably increase the effectiveness of planning in limiting aggregate investment in the hospital industry, many question the ability of such a process to make good decisions, especially concerning major equipment.

**Combination approaches and miscellaneous suggestions.** The Healthcare Financial Management Association and American Health Planning Association have separately proposed a combination approach where capital assets would be divided into facility and movable equipment components. Facilities would continue under the cost-based system, while equipment would be paid prospectively, with a percentage add-on to the DRG rate. The rationale behind the proposal is that transition problems are much more severe for facilities than for equipment, while the advantages of prospective payment are greater for equipment. Their first point is based on facilities having longer lives. The second is based on the assumption that opportunities for substitution between capital and operating costs are greater for equipment than for facilities. HHS estimates that reimbursement for equipment comprises about 40 percent of all reimbursement for capital, so prospective payment incentives would apply to an appreciable segment of investment if this option is chosen.

Other groups, while endorsing neither the prospective nor cost-based



options, have specific suggestions that could be made in combination with either option. The National Association of Public Hospitals wants a special grant program for public hospitals with limited capital resources. One possibility is to expand the FHA-242 program for these hospitals. The Council of Teaching Hospitals wants additional payments for hospitals with a high proportion of indigent care patients.

**Health planning.** In discussions about capital payment there is considerable confusion concerning the role of health planning. Many assume that the current cost-based system implies use of a vigorous planning mechanism, while enactment of a prospective system implies the end of planning. This characterization is not entirely accurate. The continuation of cost-based reimbursement does not guarantee a strong planning program. The case for health planning as we have known it in the 1970s is certainly weakened by the enactment of prospective payment, since hospitals are now at risk for at least Medicare's share of operating costs associated with underused beds and equipment. Thus, it is not difficult to imagine continuing the current system of cost-based capital payment while reducing the scope of health planning. On the other hand, support of cost-based reimbursement for capital may be based on conclusions about the ability of planning to offset the incentives of a cost-based system.

Alternatively, one could employ health planning as part of a completely prospective system of payment for capital. Those with confidence in health planning's potential might see a role for it in influencing the location of additional facilities, and in limiting construction of new beds, since volume of admissions is a concern under the prospective payment system. Thus, debates about the efficacy and desirability of planning can be kept reasonably separate from decisions concerning how to pay hospitals for capital.

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### Transition Problems

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The difficulties of transition from a cost-based to a prospective system are much greater for capital than for operating costs. This stems from the long life of many capital assets and the effects of inflation. Perhaps an example will demonstrate the problems of designing an equitable transition system.

Imagine a hypothetical hospital facility built in year one at a cost of \$20 million, financed entirely with a debt at a 10-percent interest rate, and having a \$10 million annual operating budget. Assuming a twenty-five-year life, cost-based capital reimbursement in the first year would be \$2.8 million (\$2.0 million for interest, \$0.8 million for depreciation), or 28 percent of operating costs. In the twenty-fifth year, reimbursement would be \$0.8 million, and the percentage of the total budget would decline to 1 percent of operating costs, assuming hospital operating costs

increased by 9 percent per year over this period. At the end of the twenty-fifth year, the facility is replaced with another of comparable size, but at much higher prices. If the costs of hospital construction increased at the same 9-percent rate as operating costs, it would cost \$172 million to build the replacement facility. Then, capital reimbursement would increase to \$24 million per year, or 28 percent of operating costs. Now imagine that in the twenty-sixth year, payers abruptly switch to the prospective payment method. They calculate that 7 percent is the budget-neutral add-on to the DRG rate and implement it immediately. In this case, the hospital's payment for that year falls from \$24 million to \$7 million.

The above example illustrates the potential for serious problems of transition. Under the cost-based formula, the hospital received very small capital payments during the years before replacement, but very large payments after replacement. With an abrupt transition, the hospital that recently replaced its plant would go from very low capital payments to only average capital payments at a time when its cash needs become very large. This transition problem is a real one. As indicated above, over 5 percent of hospitals had capital costs exceeding 15 percent of their total costs in 1981.

Transition approaches involve balancing the needs of various hospitals. This means increasing capital payments to hospitals that have just renovated or become operational, while providing sufficient amounts for hospitals that have not recently built, so that they may acquire sufficient resources to pursue projects in the future. A major distinction among various transition approaches is whether assistance should be limited to hospitals with projects that are either completed or "in the pipeline," or whether assistance should be available as well to those with projects not yet initiated. In terms of the hypothetical example, should the hospital get relief if the prospective system had begun in year twenty-four, rather than in year twenty-six?

The most frequently discussed transition option involves paying the hospital the higher of the amount calculated under the prospective formula or under the cost-based formula. The cost-based calculation is usually limited to "old capital," that is, assets in place or committed before the initiation of the prospective payment system. Such an option is probably expensive. It would probably add \$2 billion to Medicare payments for capital in the first year, though additional payments would decline steadily thereafter. A more limited version would restrict the cost-based payments to debt servicing. This would exclude depreciation payments for assets financed other than through debt and return-on-equity payments to investor-owned facilities. Such a transition is included in the Medicare Solvency and Health Care Financing Reform Act introduced by Senator Kennedy and Congressman Gephardt. Another version called "borrow forward," would give assistance in the form of loans.

Loans would be valuable in avoiding imminent defaults and would have to be repaid during a period when the hospital is receiving payments for capital and not making major purchases.

The advantage of the first option is that it avoids paying hospitals less than the hospital anticipated when the debt was incurred. These long-term commitments conformed to the regulatory requirements and incentives at the time they were made. On the other hand, the incentives of the time did encourage some wasteful capital projects and financing methods. The more limited versions would assist hospitals in meeting their immediate financial obligations. In addition, the more limited versions would allow lower payments by Medicare, or in the case of a budget-neutral provision, allow higher payments to hospitals that have not built recently.

Drawing a sharp boundary between completed, committed, and future projects is a real drawback to such a transition, however. While potential default on debt is not a problem for future projects, the inequities inherent in an abrupt switch from prospective to cost-based payment are just as serious. The pattern of cost-based payments could leave institutions in a difficult position to finance desirable replacement projects.

An alternative method for dealing with transitions, a blended formula, would give relief to hospitals with both existing and future projects. Briefly, the blended formula calculates a hospital's capital payments on the basis of the prospective formula and on the basis of the current cost-based formula, with the latter applying to new projects as well. The capital payment is then a weighted average between the amounts calculated under the two formulas. The weight on the cost-based formula would start out high and then decline to zero over time.

In comparison with the first transition option, this one would give somewhat less assistance to those institutions with high cost-based capital payments based on past projects, but would provide significant assistance to new projects begun within a few years after the initiation of the program. Another contrast is that the blend would not necessarily increase Medicare outlays; it is inherently "budget neutral." Such a blended rate over a five-year period is included in Senator Heinz' Medicare Incentives Reform Act.

The American Hospital Association is now advocating a mix of these two options. Hospitals would be given a choice between a cost-based payment based on past projects and those projects required for the hospital to maintain health and safety codes or a blend. Such a combination appears to cost less than their original proposal of a choice between a cost-based amount and a prospective rate, since hospitals with low cost-based payments would receive lower payments than before. However, it is still higher than the blended rate option. In addition, determining what portion of the project is necessary for maintaining health and safety codes is difficult

and is potentially a very large loophole.

Aside from the method used for a transition, a crucial issue to be addressed is the length of the transition period. Krystynak has evaluated different options and concluded that a five- to ten-year period is appropriate.<sup>12</sup> One possibility for implicitly extending the transition period is to allow hospitals to borrow at below-market rates from future capital payment. The more that hospitals are able to borrow from future revenues to pay existing capital obligations, the shorter the explicit transition period required. A borrow-forward provision is included in Senator Heinz' legislation. Cynical observers have looked at all the transition options and then at changes enacted by Congress in recent years and wondered whether hospitals can legitimately plan on lengthy transition periods.

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### **Broader Public Policy Issues**

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The emerging debate on capital payment policy touches on broad policy issues regarding the direction of the health system. The issues stem from recognition of the implications of a more competitive health care system. In many cases, capital payment policy is far less relevant to these issues than DRG payments for operating costs. Nevertheless, discussions of capital tend to evoke thoughts on long-term issues, which swift legislative consideration of the DRG system precluded.

Two implications of a more competitive health system are likely to be debated in the context of capital payment policy: the reduced ability by hospitals to cross-subsidize certain activities, and the importance of competition among hospitals under a fixed-price system of payment. Hospitals have traditionally provided some activities at a loss, subsidizing them with surpluses from other activities. Services to indigents and services with large standby costs such as burn units are examples. Many are concerned that the increased financial pressure on hospitals from prospective payment will reduce funds available to finance these activities.

A particular concern regarding capital payment policy is whether a prospective system will make it more difficult for public hospitals and others delivering large amounts of indigent care to replace obsolete facilities and equipment. While large urban public hospitals as a group would do better under a prospective capital payment system than under the present system, the inability of individual institutions to get large increases in capital payments in response to a new project, as they can under the current cost-based system, could be a significant barrier.

Another issue concerns the nature of competition among hospitals. Under a fixed-price payment system, hospitals are likely to compete more vigorously for Medicare patients. This competition has attractions, especially incentives to prevent declines in quality. But the prospects of the successful hospitals expanding their capacity has some negative

possibilities. Will hospitals that lose market share and get into financial difficulty ask the government for a subsidy on the basis of either value to the community or being the victims of technical shortcomings of the DRG system? If they succeed, then competition among hospitals for Medicare patients could turn out to be costly for taxpayers.

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## Conclusion

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Augmenting Medicare's prospective payment system through developing a method of paying for hospital capital involves decisions concerning the aggregate amount of payment, the method for determining payments to individual hospitals, and a transition from the existing cost-based method to the new method. Given the federal budget deficit, the decline in the number of hospital admissions, and the policy decisions limiting growth in expenditures, the appropriate aggregate amount is probably one of budget neutrality. A prospective method of paying individual hospitals is desirable to encourage cost-effective behavior by hospitals. The need for additional complexity beyond a uniform add-on to the DRG rates does not appear to have been established. Finally, major relief for hospitals whose construction or renovation projects have turned out to be ill-timed with regard to the switch from cost-based payment to prospective payment is essential. Such transitional provisions need to cover at least five years and should include relief for hospitals with projects not already obligated. The blended rate, possibly coupled with provisions for hospitals to borrow forward, is an attractive mechanism to accomplish this.

## NOTES

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11. Statement of the American Hospital Association to the Subcommittee on Health of the Senate Committee on Finance on Capital Financing Under Medicare, 9 March 1984. It has also been incorporated into the two legislative proposals mentioned in note 2 above.
12. Krystynak, "Prospective Payment for Capital."

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