United States General Accounting Office 130333

GAO

Report to the Honorable Sam Nunn
United States Senate

June 1986

PUBLIC HOSPITALS

Sales Lead to Better Facilities but Increased Patient Costs

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535801 / 130333

United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-223097

June 20, 1986

The Honorable Sam Nunn
United States Senate

Dear Senator Nunn:

This is our report, which you requested, on the sale and lease of public and nonprofit hospitals in the Southeastern United States. The report discusses the reasons for such sales and leases, the resulting improvements to facilities and additions of services, the increase in costs and charges after the transactions, and the lack of comparable data on the effects on the provision of care to indigents.

As requested by your office, we are not making additional distribution of the report for 3 days. At that time we will send copies to interested congressional committees and other parties.

Sincerely yours,

Richard L. Fogel
Director

Executive Summary

Purpose

Because a number of public hospitals had been sold or leased to for-profit firms and because information about such transactions was lacking, Senator Sam Nunn asked GAO to develop information. Specifically, he wanted information on (1) the circumstances leading to the decisions to sell or lease the hospitals, (2) the effects of the changes in control on local communities and taxpayers, and (3) the effects on Medicare and Medicaid payments after the transactions.

Senator Nunn also asked GAO to review several acquisitions of not-for-profit hospitals and several acquisitions of hospitals by not-for-profit entities. GAO's review covered 40 sales or leases of hospitals that took place during 1980-82 in the Southeastern United States. The Southeast was selected because it reportedly had been particularly active in changes of ownership for public and not-for-profit hospitals.

Background

The vast majority of the nation's counties and cities operate hospitals In rural counties, the county-operated hospital is often the only hospital. By law or custom, public hospitals generally serve all people in their area, regardless of ability to pay, and they reportedly provide about twice as much uncompensated care to the medically indigent as other hospitals when measured as a percentage of total hospital expenses.

For-profit hospital firms increased their presence in the industry from 8.3 percent of hospital beds in 1978 to 9.8 percent in 1984. One reason for this increase has been the acquisition through lease or purchase of public and not-for-profit hospitals by for-profit firms. To a lesser extent, not-for-profit hospital firms have also acquired public and not-for-profit hospitals.

GAO identified 40 public and voluntary not-for-profit hospitals that had been leased or sold during 1980-82 in the Department of Health and Human Services' (HHS') Atlanta region, which covers the Southeast. Of these, 30 were acquisitions by for-profit firms and 10 were by not-for-profit entities. GAO analyzed cost and charge information on Medicare cost reports for these 40 hospitals and visited 11 of them.

Results in Brief

The 11 hospitals GAO visited had been suffering financial difficulties and needed substantial renovation or modernization. The former operators were generally unable or unwilling to fund the hospitals' deficits or raise the capital necessary to improve them. The acquiring firms aggressively pursued acquisition and promised to fix the hospitals' deficiencies.

Data for the 40 hospitals showed that, after the change in control, charges for ancillary services generally increased dramatically, utilization of services sometimes also increased, and Medicare costs went up. In all but 1 of the 11 hospitals GAO reviewed in detail, the new operators made investments to renovate or replace the hospitals that should have increased their ability to provide quality care.

Because of a lack of comparable data, GAO could not quantify the effect the changes in hospital control had on the amount of indigent care provided. The sale, lease, or associated agreements for the public hospitals contained provisions governing indigent care by the new operators, but the local governments were not assuring compliance with these provisions.

Principal Findings

Reasons for Sale

The 11 hospitals GAO visited were sold or leased primarily because they were losing money. Nine of the 11 had lost money during the year before sale or lease. All 11 needed substantial renovation, modernization, or replacement and were not generating sufficient revenue to fund these needs. The operators were unable or unwilling to fund the deficits or raise the capital needed for hospital improvements. Also, for social or political reasons, the operators did not believe they could increase hospital charges sufficiently to overcome these financial problems. (See ch. 2.)

Former Operators Satisfied With Performance of New Operators

The former operators of 10 of the 11 hospitals GAO visited were satisfied with the new operators' performance. Also, the new operators had generally kept their promises to renovate, modernize, or replace the acquired hospitals. As a result, the hospitals offered expanded services and/or better equipment and were in a position to offer better quality care.

GAO compared, where available, the results of hospital inspections before and after acquisition. Of the 11 hospitals, 7 were cited for deficiencies before acquisition, but only 4 were cited after. (See pp. 26-28.)

Hospital Charges Increase After Acquisition

The new operators generally increased hospital charges for ancillary services—such as drugs, laboratory services, and X-rays—as measured by ancillary service charges per discharge. Ancillary service costs also increased but not as much as charges, which resulted in increased gross profit margins—charges minus costs—for ancillary services. Because Medicare and Medicaid payments are based on costs, not charges, increasing charges alone should not affect these programs' payments to the hospitals. However, private insurers and self-paying patients generally pay based on charges, so their costs increased.

For the 40 acquisitions GAO identified, on the average, ancillary service charges per discharge increased 46 percent, ancillary costs per discharge increased 37 percent, and gross profit margins on ancillary services increased by $222 per discharge. On the average, acquiring for-profit firms increased ancillary charges per discharge 32 percent more than not-for-profits. (See pp. 31-35.)

Lack of Data on Changes in Indigent Care

GAO could not compare the amount of free care provided by hospitals before and after acquisition because of a lack of comparable data. Data were usually available for the pre-acquisition period, but not for the post-acquisition period.

The sale or lease agreements for the nine public hospitals GAO visited included either specific or general provisions regarding the new operators' responsibilities for indigent care. Despite the contractual provisions, the hospitals generally did not have records to document the extent of indigent care provided. Moreover, the local governments did not monitor the hospitals' compliance. (See ch. 4.)

Hospital Costs Increased More Than Hospital Inflation

Hospital acquisitions resulted in significant increases in hospitals' capital costs, return-on-equity payments from Medicare, and administrative expenses. These three items accounted for about 67 percent of the total cost increases per discharge for the 30 hospitals acquired by the for-profit firms and about 40 percent of the total for the 10 hospitals acquired by the not-for-profit firms. (See ch. 5.)

Capital costs (interest, depreciation, and lease payments) increased an average of 109 percent on a cost-per-discharge basis. One reason was that the new operators paid more for the hospitals than the net book value (historical cost less accumulated depreciation) of the former operators. This resulted in higher depreciation. Also, the new operators often

borrowed money to fund a large part of the purchase price; thus, interest costs increased. Finally, lease payments substantially exceeded the former operators' capital costs for the leased hospitals. The Deficit Reduction Act of 1984 set limits on Medicare's allowances for interest, depreciation, and, if applicable, return on equity for hospitals changing ownership after July 18, 1984.

Medicare does not pay a return on equity to public or not-for-profit hospitals, so for the 30 hospitals converted to for-profit status after acquisition, return on equity represented a new Medicare cost. Medicare return-on-equity payments averaged about $101 per discharge and totaled about $2.9 million annually for the affected hospitals.

Finally, although 38 of the 40 hospitals were acquired by multihospital chains, which often claim to be able to reduce administrative costs, average administrative costs per discharge increased by about $123 per discharge, or 76 percent, after acquisition. This was substantially higher for the periods involved than the increase in the hospital market basket index, which measures the price changes of the goods and services bought by hospitals.

Recommendations

Because the matters in this report relating to the Medicare and Medicaid programs have generally been addressed through recent changes in law, GAO is not making recommendations.

Comments by Interested Parties

HHS said it had reviewed the report with interest and had no comments. The National Association of Public Hospitals said GAO's analysis of the effects of ownership transfer showed similar causes of and results from transfers that it has observed. The Federation of American Health Systems said that it had no quarrel with the information GAO presents but that it believed some points needed to be presented in a different context to be as fair and meaningful as possible. The American Hospital Association said the report presents an interesting perspective on a complex issue. The Association expressed concern that some of the data could be misinterpreted. See the end of chapters 3, 4, and 5 for a discussion of these organizations' comments.

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Abbreviations

A&G	administrative and general
AFDC	Aid to Families with Dependent Children
GAO	General Accounting Office
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
JCAH	Joint Commission on Accreditation of Hospitals
SSI	Supplemental Security Income

Introduction

Senator Sam Nunn wrote to us expressing concern about the lack of information on the effects of the acquisition of not-for-profit facilities by for-profit (investor-owned) firms. He asked us to provide information on

- the circumstances leading to the decision by the former operators to sell the hospitals,
- the effects of such changes in control on local communities and taxpayers, and
- the effects on Medicare and Medicaid payments after the acquisitions.

We met with Senator Nunn and agreed to focus on the lease or sale of public hospitals to for-profit firms. Leases were included because operating control of a hospital usually changes under a lease as it does under a sale.[1] Senator Nunn asked that we include several acquisitions by not-for-profit firms. To measure the effect of the acquisitions on local communities, we agreed to consider (1) any improvements to the facilities or expansion of services, (2) changes in the charges for hospital services, and (3) if possible, changes in the amounts of uncompensated care provided to indigents in the community. We agreed to use data from hospitals' Medicare cost reports before and after the acquisitions to determine the changes in the hospitals' charge levels and in the amounts claimed for Medicare reimbursement. Medicare is a national program with uniform payment methods, whereas Medicaid is a state-operated program with many variations in payment methodologies.

Background

Most counties and cities have publicly owned hospitals to serve their residents. These hospitals represent about 30 percent of the nation's acute care general hospitals and are primarily financed by the revenues they receive through charges for the services provided. When these revenues are insufficient to cover public hospitals' costs, the local governments have financed the differences. Generally, by law or custom, public hospitals treat all persons, regardless of their ability to pay. Many public hospitals were constructed or renovated, in whole or in part, with money provided through the federal Hill-Burton program.[2] In these cases the hospitals were required to provide a reasonable amount of

[1]In this report, we refer to both sales and leases as acquisitions

[2]The 1946 legislation authorizing the federal health facilities construction program was cosponsored by Senators Lister Hill and Harold Burton and became popularly known as the Hill-Burton program Between 1946 and 1974, the program provided federal grants for constructing public and not-for-profit hospitals. From 1970 to 1976, the program provided direct loans to public health facilities and guaranteed loans made by commercial lenders to not-for-profit facilities.

uncompensated services to the indigent population as a condition for receiving Hill-Burton financial assistance.[3]

Hospitals organized as voluntary, not-for-profit entities, such as church-operated hospitals, represent the largest group of hospitals in the country (about 55 percent). These institutions also are primarily supported by the revenue they receive through charges for services provided, supplemented with charitable contributions and income from endowments. State licensure requirements generally provide that these hospitals must treat any person, regardless of ability to pay, for emergencies. Many voluntary, not-for-profit hospitals also received financial assistance under the Hill-Burton program; as a result, they are required to provide reasonable amounts of uncompensated care to indigents.

Proprietary or for-profit hospitals are the third group (about 15 percent of the total). They depend on revenues received for services provided to cover their costs, and if the costs are higher than revenues, they incur a loss. Conversely, if revenues exceed costs, the owners make a profit. State licensure requirements concerning the provision of emergency services without regard to a person's ability to pay also generally apply to the for-profit hospitals. However, the Hill-Burton uncompensated care requirements do not apply because proprietary hospitals were not eligible for financial assistance under that program.

Since the late 1970's, for-profit hospital firms have increased their presence in the hospital industry from 8.3 percent of hospital beds in 1978 to 9.8 percent in 1984. One of the reasons for this increase has been the acquisition through lease or purchase of public and not-for-profit hospitals by for-profit firms. To a lesser extent, not-for-profit hospital firms have also acquired public and not-for-profit hospitals.

Medicare and How It Pays Hospitals

The Medicare program, authorized by title XVIII of the Social Security Act (42 U.S.C. 1395), became effective on July 1, 1966. Medicare pays much of the health care costs of eligible persons aged 65 or older and certain disabled persons. The program is administered by the Health Care Financing Administration (HCFA), a component of the Department of Health and Human Services (HHS).

[3]The reasonable volume of uncompensated services to be provided annually is the lower of 3 percent of the facilities' annual operating costs less reimbursement from Medicare and Medicaid or 10 percent of the federal assistance received, adjusted for inflation.

Medicare consists of two parts. Part A—hospital insurance for the aged and disabled—covers inpatient hospital care, home health care, inpatient care in a skilled nursing facility after a hospital stay, and several other institution-based services. Part A is principally financed by payroll taxes, which are paid by employers, employees, and self-employed persons. During fiscal year 1984, over 29 million people were eligible for part A benefits, and benefit payments amounted to about $41.5 billion, of which about $40 billion was for inpatient hospital care.

Part B—supplementary medical insurance for the aged and disabled—covers (1) physicians' services, (2) outpatient hospital care, (3) home health care, and (4) other medical and health services. Part B is financed by beneficiaries' monthly premiums (25 percent of program costs) and appropriations from general revenues (75 percent). During 1984, about 29 million people were enrolled in part B, and benefit payments amounted to about $19.5 billion, of which about $2 billion was for outpatient hospital care.

Until fiscal year 1984, Medicare reimbursed each hospital for its actual allowable costs of providing services to Medicare beneficiaries. Beginning in 1974, under the authority of section 223 of the Social Security Amendments of 1972 (Public Law 92-603), HHS established limits on reimbursements for routine inpatient costs (room, board, and general nursing costs).

Section 101 of the Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97-248) expanded the application of the limits to include both routine and ancillary service costs (such as operating room, radiology, and laboratory services) for hospitals' cost reporting periods beginning on or after October 1, 1982. These limits were applied to (1) the rate of increase in the average cost per discharge from one year to another for each hospital and (2) the average cost per discharge based on the average costs of similar hospitals adjusted for the relative complexity of the hospital's case mix.

For cost reporting periods beginning on or after October 1, 1983, inpatient hospital services are paid based on Medicare's prospective payment system established under the Social Security Amendments of 1983 (Public Law 98-21). This system, which is being phased in over a 4-year period, generally pays hospitals fixed amounts based on the Medicare patients' diagnoses or treatment using 468 groups of related diagnoses.

Medicare's various cost reimbursement limits and its prospective payment system do not apply to outpatient hospital services or to capital costs, which are "passed through" on a reasonable cost basis.

Reimbursement for Capital Costs

Capital costs are facility costs associated with furnishing the buildings and equipment necessary to provide patient care. Allowable capital costs under Medicare include lease payments for or depreciation of these assets as well as interest paid on funds borrowed to acquire them. Under both the cost reimbursement limits and prospective payment system, capital costs are passed through—that is, they are not considered in computing the maximum payable amounts under cost reimbursement or in establishing the prospective rate and are paid to the facility on an actual reasonable cost basis. Thus, Medicare will generally pay the percentage of capital costs that reflects the ratio of Medicare utilization to total utilization. For example, if Medicare patients used 40 percent of the services provided by a hospital, Medicare would pay 40 percent of the hospital's capital costs.

The prospective payment law requires HHS to report to the Congress on the methods, along with proposals for legislation, by which capital-related costs associated with inpatient hospital services can be included in the prospective payment system. The prospective payment law authorizes capital costs to be included in the payment rates beginning October 1, 1986. The Congress has established reimbursement limits for revaluing assets after a change in ownership. These limits, which were included in section 2314 of the Deficit Reduction Act of 1984 (Public Law 98-369), basically prohibit any increase in Medicare or Medicaid payments for capital costs after a change in ownership.

Administration of Payments

Medicare contracts with insurance companies, such as Blue Cross and Mutual of Omaha, to determine the amount of Medicare payments individual hospitals will receive. These paying agents are called intermediaries. Each year hospitals submit cost reports to the intermediaries detailing hospital costs and allocating a portion of them to Medicare and Medicaid based on utilization of services by each program's beneficiaries. The intermediaries have not yet finally determined how much of the costs associated with several of the hospital acquisitions included in our review will be recognized as allowable for the Medicare program.

Hospital Payments Under Medicaid

The Medicaid program, authorized under title XIX of the Social Security Act effective January 1, 1966, is a federal/state program that pays for health care for eligible low-income persons. States design and operate their Medicaid programs within the framework provided by federal law and regulations. HCFA is responsible for the federal administration of Medicaid.

States are required to cover under Medicaid a broad range of health care services, including inpatient and outpatient hospital services, and may elect to cover virtually any other health service. Regarding hospital services, until fiscal year 1982 states were required to use Medicare's reasonable cost methodology to pay hospitals. Section 2173 of the Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35) repealed this requirement to allow the states greater flexibility in paying hospitals. Since this change in federal requirements for paying hospitals under Medicaid, most of the states have established prospective payment systems, but the features of these plans vary from state to state. Because of the variations among the state payment methods, we did not attempt to trace the increases in cost due to the acquisition of individual hospitals through the various states' Medicaid rate-setting methodologies.

Objectives, Scope, and Methodology

In accordance with our agreements with Senator Nunn, our review had three objectives. First, we wanted to determine the circumstances or reasons leading to the decisions to sell or lease public or voluntary, not-for-profit hospitals. (This issue is discussed in ch. 2.) Second, we wanted to determine how these acquisitions affected local communities through changes in services and hospital charges (ch. 3), and any changes in providing indigent care (ch. 4). Third, we wanted to determine how the changes in ownership or control affected payments under the Medicare program specifically and under the Medicaid program in general terms (ch. 5).

To identify the universe of public and not-for-profit hospitals that had been acquired during calendar years 1980, 1981, and 1982 in HHS' Atlanta region,[4] we contacted officials from the HHS region, the states in that region, and Medicare intermediaries. We did not include acquisitions after 1982 because cost data for hospitals acquired in 1983 or later generally were not available. We selected the Atlanta region because, according to HHS, the Southeastern United States had been particularly

[4]Covers Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee We did not include Tennessee because of problems in obtaining necessary data

active in changes of ownership for public and not-for-profit hospitals and because Senator Nunn expressed a special interest in this area.

No single federal or state office could provide a complete list of hospital acquisitions for each state. Based on our contacts with HHS, the states, and the intermediaries, we identified 40 public and not-for-profit general, acute care hospitals sold or leased between January 1980 and December 1982 in the seven states. (See app. I.) Of these transactions (sales and leases), 30 involved acquisition by for-profit firms and 10 by voluntary, not-for-profit organizations. While we may not have identified all of the public and not-for-profit hospitals acquired in the HHS Atlanta region during this 3-year period, we believe that these 40 provide an accurate representation of the effect of an acquisition on hospital costs and charges in that region.

A major segment of our fieldwork related to determining the effect of an acquisition on hospital costs and charges. For each of the 40 hospitals we obtained, when available,

- the Medicare cost report for the period immediately preceding the sale or lease (usually these reports were for less than a year),
- the last full-year cost report submitted before the acquisition,
- the first cost report submitted after the acquisition (these reports also usually covered less than a year), and
- the first full-year cost report submitted after the acquisition.

These cost reports covered periods ranging from about 2-1/4 to 4 years.

We identified changes in hospital costs and ancillary charges by comparing the pre-acquisition and the post-acquisition cost report data. We used the cost or charge per patient discharge as a standard unit of measurement. For example, to calculate the pre-acquisition administrative and general (A&G)[5] cost per discharge for each hospital, we totaled and combined A&G costs for the full cost reporting year and any partial year before the acquisition. This amount was then divided by the total number of discharges included in the same cost reports. This provided the average cost per discharge for the period before acquisition. Post-acquisition A&G costs per discharge were calculated in the same manner using post-acquisition cost reports. These pre- and post-acquisition A&G

[5] A&G costs are for activities that support overall hospital operations, such as business office, data processing, insurance, public relations, and personnel office expenses

costs per discharge values were then compared to determine the dollar change that occurred after acquisition.

Because some of the increases in the hospitals' costs and charges would reflect "inflation" between the pre- and post-acquisition periods, we computed an inflation index for each hospital. To do this, we used HCFA's hospital market basket index, which is designed to measure changes in the costs of goods and services bought by hospitals. We computed the average index for the midpoints of the pre- and post-acquisition periods and compared these to determine the change in hospitals' costs as reflected in the market basket index. We used this change in the hospital market basket as an indicator of how much of the change in a hospital's costs and charges is explained by inflation. According to HCFA officials, this was the best available methodology to calculate the effect of inflation for each hospital.

We evaluated capital costs, A&G costs, and ancillary costs and charges to patients. We looked at capital costs because they historically have increased after an acquisition because the purchaser usually pays more than the former owner's book value for the hospital (historical cost less accumulated depreciation). We evaluated the changes in A&G costs for two reasons: (1) hospital chains maintain they can control such costs by centralizing management-type services, such as data processing and accounting, and (2) chains allocate home office costs to member hospitals, which could increase overall hospital costs. We assessed ancillary charges because of indications that these were often increased after hospital acquisitions.

In addition to reviewing cost reports of 40 hospitals, we conducted additional audit work at 11 of these hospitals. Three were located in Alabama, four in Florida, and four in Georgia. Table 1.1 shows these 11 hospitals, their locations, purchasers or lessees, and acquisition dates.

Table 1.1: Hospitals Where GAO Performed Additional Audit Work

Name of hospital and type of acquisition	Location	Number of beds	Date of acquisition	Purchaser/Lessee
Public hospitals acquired by for-profits:				
Brookwood Medical Center	Eufaula, Ala	74	Jan 1981	Brookwood Health Services, Inc
Clarke	Jackson, Ala	35	Apr 1982	Gilliard Health Services, Inc
Fairview Park	Dublin, Ga	190	Mar 1981	Hospital Corporation of America
Henry County	Abbeville, Ala	48	Dec 1982[a]	Health Care Management Corp
Humana/Newnan	Newnan, Ga	144	Dec 1982	Humana, Inc
Marion Memorial	Buena Vista, Ga	30	Mar 1982[a]	Health Care Management Corp
Riverside	New Port Richey, Fla	102	July 1982	American Health Care Enterprises, Inc
Public hospitals acquired by not-for-profits:				
East Pasco Medical Center	Dade City, Fla	53	June 1981[a]	Adventist Health Systems
Watkins Memorial	Ellijay, Ga	41	Jan 1982	Georgia Baptist Medical Center
Voluntary hospitals acquired by for-profits:				
Ormond Beach	Ormond Beach, Fla	81	July 1981	Southern Health Services of Kentucky, Inc
East Pointe	Lehigh Acres, Fla	88	July 1981[a]	Hospital Corporation of America

[a]Date hospital was leased

We judgmentally selected these 11 hospitals to review in detail a mix of hospital ownership characteristics. This mix included hospitals

- purchased by national hospital firms,
- purchased by regional or smaller hospital firms,
- leased instead of purchased, and
- acquired by voluntary, not-for-profit hospital firms.

The detailed work in these 11 hospitals generally included determining

- why the public or voluntary not-for-profit owner decided to sell or lease the hospital,
- whether local authorities were satisfied with the hospital's operations after the acquisition,
- whether any improvements in facilities and services were made by the acquiring firm, and
- the effect of the acquisition on hospital costs and charges and on Medicare reimbursement.

Because of a lack of comparable data for 10 of the 11 hospitals, we could not determine the amounts of indigent care provided before and

after the changes in control. We did determine what arrangements the former operators had made for indigent care to be provided by the new operators through inclusion of provisions in the purchase or lease agreements.

The fieldwork for these hospitals involved interviewing local officials, such as hospital governing board members, hospital administrators and employees, physicians, elected city and county officials, county family and children services and county health department officials, involved citizens, and Legal Services Corporation representatives. For each hospital, we also analyzed related documents, such as financial statements, Medicare cost reports for periods both before and after acquisition, purchase or lease agreements, various inspection or survey reports by outside public or private agencies, hospital board records, and available records relating to providing indigent care. We also contacted officials of nearby hospitals and of the acquiring firms. We discussed hospital acquisitions and reviewed available records at federal and state offices. These offices included HHS' Atlanta region as well as state health planning and development agencies and state licensure and certification offices in Alabama, Florida, and Georgia.

We also contacted other organizations familiar with issues discussed in this report, reviewed these matters with them, obtained their views, and analyzed and incorporated information they provided, as appropriate. For example, we used information generated by the state of Florida's Hospital Cost Containment Board, which was established by the Florida legislature to review hospital financial activities. We also contacted the North Carolina Center for Public Policy Research, Inc., a statewide, not-for-profit organization that was analyzing these financial issues. Blue Cross-Blue Shield of North Carolina provided a 1983 study that analyzed for-profit hospital charges to its subscribers. We also contacted the National Association of Public Hospitals and the Georgia and Alabama Hospital Associations. Finally, we contacted the Georgia and Alabama State Boards of Medical Examiners to obtain their comments regarding for-profit corporations' recruiting of physicians.

Our fieldwork was performed from October 1983 through July 1985 in accordance with generally accepted government auditing standards.

Financial Problems Led to Hospitals' Sale or Lease

The primary reason for the sale or lease of the 11 public and voluntary, not-for-profit hospitals we visited was that they were losing money. Compounding these hospitals' financial problems was the fact that many of them needed substantial renovation or modernization and the authorities operating them were unable or unwilling to raise the necessary capital to pay for the improvements. Moreover, the acquiring for-profit and voluntary, not-for-profit hospital entities aggressively pursued the acquisition of the financially distressed hospitals and promised to correct many of the problems they would inherit. Faced with the hospitals' financial problems and the offers to acquire them, hospital authorities found sale or lease to be an attractive alternative to the continued operation of hospitals that were losing money and in need of capital infusions.

Substantial Operating Losses and Low Occupancy Rates

Table 2.1 shows (1) the operating experience of the 11 hospitals during the two cost reporting periods immediately before their sale or lease and (2) the occupancy rates during the year immediately before the change in control. Of the 11 hospitals, 9 experienced operating losses during either one or both of the prior periods. The losses ranged from $43,141 to $914,717. In some instances, the local governments were unable to fully fund the deficits, which officials told us resulted in a degradation of services and facility maintenance. The two hospitals that had not sustained operating losses (Fairview Park and East Pointe) needed to be replaced with new facilities. The owners said that they could not afford to do so because virtually all of their revenues were needed for operating expenses.

Relatively low occupancy rates contributed to the hospitals' financial problems. Hospitals prefer to have relatively high occupancy rates. For example, average occupancy rates between 80 and 90 percent normally would provide a cushion of beds for peak demand periods yet permit hospitals to maintain relatively low charges and still cover costs. However, as shown in table 2.1, only 1 of the 11 hospitals had an occupancy rate over 80 percent and 5 had rates below 50 percent, which means that over half their beds were usually empty.

Table 2.1: Operating Losses and Occupancy Rates Before Change in Control

Name of hospital and type of acquisition	Period	Operating losses: Second year before acquisition: Amount	Operating losses: Second year before acquisition: As a percent of revenues	Operating losses: First year before acquisition: Amount	Operating losses: First year before acquisition: As a percent of revenues	Occupancy rate—first year before acquisition (percent)
Public hospitals acquired by for-profits:						
Brookwood Medical Center	10/1/78–9/30/80	$133,691	5 2	$171,685	5 4	67 5
Clarke	10/1/79–9/30/81	287,152	17 3	274,104	16 8	60 7
Fairview Park	10/1/78–9/30/80	[a]	[a]	[a]	[a]	71 4
Henry County	10/1/80–9/30/82	287,993	19 7	89,853	7 3	24 0
Humana/Newnan	10/1/80–9/30/82	436,955	5 7	848,930	10 4	45 9
Marion Memorial	7/1/79–6/30/81	191,644	23 2	43,143	3 9	37 9
Riverside	10/1/79–9/30/81	[a]	[a]	614,289	8 3	68 4[b]
Public hospitals acquired by not-for-profits:						
East Pasco Medical Center	10/1/78–9/30/80	561,182	26 3	535,998	18 7	35 7[b]
Watkins Memorial	10/1/79–12/31/81	291,284	13 0	914,717	31 7	49 9
Voluntary hospitals acquired by for-profits:						
Ormond Beach	3/1/79–2/28/81	[a]	[a]	63,383	0 9	86 6[b]
East Pointe	7/1/79–6/30/81	[a]	[a]	[a]	[a]	68 0

[a]No operating losses were experienced during the indicated period

[b]The occupancy rate is for an annual period that differs by a few months from the year before acquisition

In addition to the low occupancy rates experienced by most of these hospitals, many also had problems in collecting payment from their patients. Table 2 2 shows the bad debt expenses incurred by each hospital for the 2 years before the changes in control. At eight hospitals the bad debt expenses accounted for all or most of the hospitals' operating losses for the last year it was operated by the former owners.

Table 2.2: Bad Debt Expense Before Change in Control

Name of hospital and type of acquisition	Bad debt expense: Second year before acquisition — Amount	Second year before acquisition — As a percent of revenues	First year before acquisition — Amount	First year before acquisition — As a percent of revenues
Public hospitals acquired by for-profits:				
Brookwood Medical Center	$ 80,630	3 1	$ 97,682	3.1
Clarke	225,000	13 6	232,900	14 3
Fairview Park	410,525	6 3	414,168	4 7
Henry County	488,185	33 4	95,524	7 8
Humana/Newnan	353,000	4 6	475,000	5 8
Marion Memorial	35,874	4 4	76,572	6 9
Riverside	1,159,259	16 3	932,579	12 5
Public hospitals acquired by not-for-profits:				
East Pasco Medical Center	502,122	23 5	338,048	11 8
Watkins Memorial	[a]	[a]	[a]	[a]
Voluntary hospitals acquired by for-profits:				
Ormond Beach	185,434	3 2	423,396	6 3
East Pointe	67,624	1 6	94,462	1 9

[a]Data not available because the applicable hospital records were destroyed by previous owner

Table 2.3 shows accounts receivable for the last 2 years before the change in control for the nine hospitals where comparable data were available. Although accounts receivable are not reflected as operating losses until they are written off as bad debts, sizable amounts of accounts receivable can cause cash flow problems. Accounts receivable had increased as a percentage of revenue at four of the nine hospitals and in absolute dollars at eight.

Table 2.3: Accounts Receivable Before Change in Control

Name of hospital and type of acquisition	Accounts receivable: Second year before acquisition — Amount	Percent of revenues	First year before acquisition — Amount	Percent of revenues
Public hospitals acquired by for-profits:				
Brookwood Medical Center	$ 609,584	23 4	$ 736,312	23 6
Clarke	398,866	24 1	462,117	59 0
Fairview Park	1,860,744	28 6	2,284,430	25.9
Henry County	822,323	56 2	622,988	50 7
Humana/Newnan	1,515,775	19 9	1,704,718	20 9
Marion Memorial	110,118	13 4	226,400	20 3
Riverside	1,425,849	20 0	2,095,943	28 2
Public Hospitals acquired by not-for-profits:				
East Pasco Medical Center	[a]	[a]	146,588	5 0
Watkins Memorial	[b]	[b]	[b]	[b]
Voluntary hospitals acquired by for-profits:				
Ormond Beach	831,598	14.4	966,734	14 4
East Pointe	420,751	10 1	441,804	8.9

[a]Data not reported for this period

[b]Data not available because hospital records were destroyed by previous owner

Lack of Money for Capital Improvements and Plant Maintenance

The 11 hospitals were from 15 to 29 years old and, according to the former owners, were in need of extensive modernization, renovation, or replacement at the time officials decided to sell or lease them. At most of the hospitals all revenues were needed to cover operating expenses, and none of the operators had funded depreciation[1] to provide for capital improvements. Many of the public hospitals had difficulty maintaining supplies, services, or the physical facilities at acceptable levels. For example, seven of the hospitals (Clarke, East Pasco Medical Center, East Pointe, Marion Memorial, Ormond Beach, Riverside, and Watkins Memorial) were inspected by their state hospital licensure and certification offices within 3 years preceding their acquisition. These inspections identified deficiencies at all seven hospitals (see p. 28) that required money to correct. These deficiencies included

- patient rooms, bathrooms, and hallways needed painting,
- plumbing needed repairing,

[1]A technique used by hospitals whereby funds are set aside in an interest-earning fund to be used for replacement or renovation of capital assets

- carpet needed replacing, and
- service, patient, and parking areas needed expanding.

Sources of money for capital improvements were limited. Hill-Burton funds partially financed the construction of nine of the hospitals (all except Ormond Beach and East Pointe). However, the Hill-Burton grant and loan assistance programs have not been available since 1976.

The only federal financial assistance available since 1976 for construction and rehabilitation of public and voluntary, not-for-profit hospitals has been the Department of Housing and Urban Development's Section 242 Mortgage Insurance Program. This program offers reduced interest rates to qualifying hospitals—both not-for-profit and for-profit—but because of strict credit worthiness criteria, hospitals experiencing severe financial problems do not qualify for this insurance.

Local county officials and taxpayers did not favorably view the prospect of increasing taxes or issuing bonds for capital improvements. For example, for 2 of the 11 hospitals (East Pasco Medical Center and Riverside), officials told us that voters rejected bond referendums to provide funds for upgrading the hospitals and making them more competitive with the newer and better equipped for-profit hospitals in the area. Further, county hospital governing boards or county commissioners refused to assess additional taxes in three other counties where this action was considered as one of the alternatives to selling the hospitals (Brookwood Medical Center, Fairview Park, and Humana/Newnan).

Acquiring Firms Offered to Deal With Financial Problems

The companies that acquired the financially distressed public hospitals had aggressively pursued the acquisitions by offering to resolve their financial problems and make necessary capital improvements Many of the acquiring companies were large, with nationwide or regional operations. For example, 22 of the 40 hospitals were acquired by national hospital chains. In addition, 11 of the other 18 were purchased by regional firms or firms that owned a chain of hospitals. Many of the purchasers had substantial assets and were in sound financial condition, which enabled them to obtain long-term financing. Also, in some instances, acquisitions and/or capital improvements were financed from available corporate funds.

When the for-profit corporations and some voluntary, not-for-profit organizations contacted the operators of financially distressed public hospitals, they often made attractive offers, such as

- paying cash for the facility,
- assuming the hospital's outstanding liabilities,
- providing uncompensated medical services for the indigent,
- paying property taxes in the local community,
- renovating the existing facility, or
- building a new facility.

Summary

Nine of the 11 hospitals we visited were losing money at the time they were sold or leased and also were in need of capital improvements. The two hospitals that were not losing money needed to be replaced with new facilities, and the previous owners could not or would not raise the necessary funds. Because the new operators offered a way out of the financial difficulties and also promised to improve or upgrade the existing facilities, the previous owners decided to sell or lease them.

New Operators Modernized Hospitals, Expanded Services, and Increased Charges

To satisfy sale or lease agreements and to make the facilities more attractive to potential patients and their physicians, the new operators at 6 of the 11 hospitals we visited had spent at least $77.7 million for building new facilities, expanding or renovating the hospitals, and adding new equipment. Four others had renovated the facilities and/or added or expanded services, but we were unable to determine the amounts spent on such improvements. The new operator at the remaining hospital (Riverside) had made no improvements in the facility or its services.

In an effort to attract more patients and thus improve occupancy rates, the new operators at all 11 hospitals aggressively recruited additional physicians for their medical staffs. However, because of a national trend toward fewer hospital admissions, increased occupancy levels were generally not realized; all but three of the hospitals had lower occupancy rates several years after the acquisition than before the changes. Also, to improve the hospitals' financial positions, the new operators increased the charges for ancillary services, such as operating rooms, laboratory and X-ray services, and drugs. Also, for at least two hospitals the average amount of ancillary services provided patients significantly increased after the changes in control without a corresponding increase in the relative complexity of Medicare cases being treated.

Facilities and Services Improved

County and hospital officials at the nine public hospitals generally characterized the overall condition of the facilities as poor before they were sold or leased. They said that hospital facilities and equipment were not modern, or in some instances were inadequately maintained, due to lack of money. According to these officials, as a result of the hospitals' poor condition they were unable to attract physicians for their medical staffs and to maintain the desired quality of services. The former owners of the two not-for-profit hospitals acquired by for-profit firms said that although they lacked money for needed capital improvements, operating revenues were generally sufficient to maintain the facilities and provide quality services.

Recognizing these deficiencies, the sale or lease agreements provided for the new owners to replace 3 and renovate 2 of the 11 hospitals. Table 3.1 shows the amounts that the new owners have spent in meeting these commitments as well as the improvements made by the new operators at five other hospitals. The sale agreement with the new for-profit operator at Riverside Hospital in New Port Richey, Florida, did not require

and the new owner did not make improvements to the facility or its services after its purchase in July 1982; however, the hospital was resold in December 1983 to another for-profit firm that planned to spend about $1 million to improve the facility. Also, if the hospital obtains a certificate of need from the state to increase its capacity from 102 to 152 beds, the second owner planned to build a replacement hospital at a cost of about $15 million.

Table 3.1: Summary of Improvements by New Operators

Dollars in millions

	Cost	Date completed	Added or expanded services[a]
Built new facility:			
Fairview Park	$26 1	12/82[b]	
East Pasco Medical Center[c]	15.5	1/85[b]	
East Pointe[c]	15 1	12/83[b]	Expanded hours of operation of emergency room
Expanded or renovated:			
Humana/Newnan	5 3	3/85[b]	Added cardiology and upgraded emergency room
Watkins Memorial	d	d	Added outpatient clinic and expanded laboratory and pharmacy services
Ormond Beach	14 0	10/85[b]	Not available
Added new equipment:			
Brookwood Medical Center	1 7	N/A[b]	Added physical therapy, fetal monitoring systems, and portable X-ray machines.
Changed services:			
Clarke			Renovated pharmacy and X-ray rooms and opened a new intensive care unit
Henry County[c]			Added special care unit and expanded pharmacy and radiology services
Marion Memorial[c]			Added respiratory therapy and cardiac monitoring system
No change:			
Riverside			

[a]These are examples and may not be all inclusive

[b]Required by lease or sale agreement

[c]Leased

[d]Patient rooms, lounge areas, and air-conditioning system were renovated, cost data not available

Inspections by Hospital Accrediting and Licensing Agencies Also Reflected Improvements

As an indication of whether the improvements by the new operators tended to upgrade the overall quality of the 11 hospitals, we reviewed the results of any surveys or inspections made by the Joint Commission on Accreditation of Hospitals (JCAH)[1] and state licensing agencies before and after the sale or lease. The results of this comparison are summarized in table 3.2, which shows that in at least three instances, the improvements by the new operators were favorably reflected in the results of the JCAH or state agency inspections.

Table 3.2: Comparison of Inspections Before and After Sale or Lease

	Results of JCAH accreditation survey		Deficiencies identified by state agency	
Name of hospital and type of acquisition	**Before acquisition**	**After acquisition**	**Before acquisition**	**After acquisition**
Public hospitals acquired by for-profits:				
Brookwood Medical Center	Conditional	Full[b]		
Clarke	No survey	No survey	Yes	Yes
Fairview Park	Full	Full		
Henry County[a]	Full	Full		
Humana/Newnan	Full	Full		
Marion Memorial[a]	No survey	No survey	Yes	No[b]
Riverside	No survey	Survey but not accredited	Yes	Yes
Public hospitals acquired by not-for-profits:				
East Pasco Medical Center[a]	No survey	Full	Yes	No[b]
Watkins Memorial	No survey	No survey	Yes	Yes
Voluntary hospitals acquired by for-profits:				
Ormond Beach	Full	Full	Yes	Yes
East Pointe[a]	Full	Full	Yes	[c]

[a]Leased

[b]Improvement reflected by the JCAH or state report

[c]Not surveyed by state after acquisition

[1]JCAH makes surveys at federal and nonfederal hospitals Hospitals seek JCAH accreditation to demonstrate quality of services and to attract physicians If a hospital meets standards on building and grounds safety, medical records, medical staff privileges, and radiology, laboratory, and other hospital services, JCAH will fully accredit it for periods up to 3 years. If serious problems are identified, JCAH will not accredit the facility (Until 1982 JCAH sometimes gave "conditional" 1-year accreditations) Accreditation by JCAH is accepted by Medicare and Medicaid as proof of meeting most of the programs' conditions for participation State licensure agencies also inspect or survey hospitals for compliance with fire safety and other standards for facility operation and maintenance.

Recruitment of Physicians to the Medical Staffs to Improve Occupancy

One method used by hospitals to increase occupancy rates was increasing the number of physicians practicing at the hospital to increase the number of admissions. All the new operators initiated recruiting programs aimed at adding physicians to the hospitals' medical staffs. Some officials who had sold public hospitals told us that for-profit and not-for-profit hospital firms are more effective at recruiting and retaining physicians than are public hospitals. They attributed this greater effectiveness to their ability to offer more financial incentives. For example, one for-profit firm offered a first year physician a guaranteed annual income of $70,000 plus free office space, a fully equipped laboratory, and secretarial and nursing assistance.

The results of the recruiting activities, along with a comparison of the occupancy rates both before and after the changes in control, are shown in table 3.3. Because these recruiting activities are aimed at achieving both short- and long-term improvements in occupancy levels, we made our comparisons generally for the first full year immediately before the changes in control with (1) the first year after the changes and (2) calendar year 1984, which was 2 to 4 years after the changes.

Table 3.3: Increases in Physicians on the Medical Staff After Changes in Control as Compared to Changes in Occupancy Rates

Name of hospital and type of acquisition	Increase in physicians on staff[a]	Percent	Occupancy rates (percent): Before acquisition	After acquisition: First year	After acquisition: Calendar year 1984	Percentage point change: First year	Percentage point change: 1984
Public hospitals acquired by for-profits:							
Brookwood Medical Center	6	60	67 5	66 5	48 5	−1 0	−19 0
Clarke	0	0	60 7	71 0	39 0	+10 3	−21 7
Fairview Park	5	15	71 4	70 8	69 8	−0 6	−1 6
Henry County	3	150	24.0	33 7	32 0	+9 7	+8 0
Humana/Newnan	23	53	45 9	46 2	41 5	+0 3	−4 4
Marion Memorial	1	33	37 9	57 1	40 0	+19 2	+2 1
Riverside	24	83	68.4	58 0	45 9	−10 4	+22 5
Public hospitals acquired by not-for-profits:							
East Pasco Medical Center	15	75	35.7	53 6	61 5	+17 9	+25 8
Watkins Memorial	1	33	49.9	50.3	30 2	+0 4	−19 7
Voluntary hospitals acquired by for-profits:							
Ormond Beach	1	3	86.6	76 9	51 4	−9 7[b]	−35 2[b]
East Pointe	12	38	68 0	53 3	52 3	−14.7	−15 7

[a]As of June-August 1984 Some hospitals actually recruited more physicians, but some were replacements for those who left after the changes in control

[b]Reduction in occupancy rates partially due to disruptions during extensive renovations made by new owner

As indicated by the comparisons in table 3.3, adding physicians to the hospitals' medical staffs did not always result in increased occupancy rates. However, we believe that in the two cases where the occupancy rates improved most dramatically over the short term (Marion Memorial and East Pasco Medical Center), the improvements were mainly attributable to the hospitals' physician recruitment efforts.

In explaining the decline in occupancy rates from the year before acquisition to 1984, we were told by hospital officials that this was the result of (1) Medicare's new prospective payment system, which encouraged shorter lengths of stay, thus reducing occupancy and (2) the nationwide decline in hospital admissions.

One for-profit firm (Health Care Management Corporation) recruited physicians for Henry County and Marion Memorial hospitals who had previously lost hospital privileges and were practicing with restricted licenses. Of the six physicians added to the staffs of these two hospitals (including two replacements), three had previously lost privileges at the

hospitals. Two of three physicians were practicing with restricted licenses at the time of the acquisitions, and the other's license was restricted 19 months after the acquisition.[2] Hospital officials stated that they added these physicians to the hospital staffs because they were local doctors who were immediately available and the firm needed to increase the occupancy levels in both hospitals. The officials stated that during 1984, after they were acquired by another for-profit firm, the hospitals were more selective.

According to officials of the Georgia and Alabama State Boards of Medical Examiners and two hospitals' chiefs of medical staffs familiar with the situations discussed above, some for-profit firms add physicians to their medical staffs regardless of their qualifications to increase hospital occupancy and, thereby, improve profits. Officials of another for-profit firm strongly disagreed with that contention. They noted that, at one hospital we visited, the firm had removed a physician from the medical staff even though he admitted more patients than any of the other doctors. This was one of the physicians who had lost hospital privileges before the acquisition and had been readmitted to the staff after the acquisition.

Increased Charges for and Use of Ancillary Services

In addition to attempting to improve hospitals' financial condition by increasing occupancy rates, the new operators at all 11 hospitals increased their charges for ancillary services. These services are in addition to room, board, and general nursing care and include the use of operating rooms for surgery, X-rays, laboratory tests, drugs, and supplies. Histórically, ancillary service charges represent about 60 percent of the total charges for a hospital stay. Table 3.4 shows the overall increase in the average ancillary charges per discharge at the 11 hospitals after the changes in control.

[2]One physician's license was restricted whereby he could perform surgery only in an emergency, the second physician had restrictions related to prescribing controlled substances, and the third physician could not provide obstetrical or newborn pediatric services.

Table 3.4: Increases in Ancillary Charges per Discharge

Name of hospital and type of acquisition	Ancillary charges per discharge: Before acquisition	After acquisition	Increase	Percent increase
Public hospitals acquired by for-profits:				
Brookwood Medical Center	$ 830 54	$1,372 28	$541 74	65 2
Clarke	788 93	1,068 03	279 10	35 4
Fairview Park	676 57	861 60	185 03	27 3
Henry County	889 03	1,671 18	782 15	88 0
Humana/Newnan	1,219.93	1,557 44	337 52	27 7
Marion Memorial	704 16	1,342 94	638 78	90 7
Riverside	2,168 11	2,871 49	703 38	32 4
Public hospitals acquired by not-for-profits:				
East Pasco Mèdical Center	1,080 84	1,402 91	322 07	29 7
Watkins Memorial	1,092 28	1,419 57	327.29	30 0
Not-for-profit hospitals acquired by for-profits:				
Ormond Beach	1,836.90	2,383 80	546 89	30 0
East Pointe	1,493 75	2,098 98	605 23	40 5
Weighted average	1,159 31	1,529 27	369 96	32 0

Although the weighted average increase in ancillary charges per discharge for the 11 hospitals was 32 percent, the post-acquisition increases in charges per discharge were substantially higher (65 to 91 percent) at 3 hospitals. Therefore, to determine whether increases in the utilization of ancillary services (in addition to increases in charges) contributed to these increases, we compared various workload indicators for selected ancillary services before and after the changes in control. The services selected were the number of surgical, laboratory, and X-ray procedures and drug costs per discharge because these services generated substantial revenues and utilization data were readily available. This comparison is given in table 3.5, which shows that the two hospitals with the highest increases in the ancillary charge per discharge (Henry County and Marion Memorial) also had the highest increases in number of or amounts of ancillary services per discharge.

Officials at two hospitals (Brookwood Medical Center and Marion Memorial) told us that the utilization of ancillary services had increased

because they were treating a larger percentage of patients with complicated illnesses. Therefore, we obtained Medicare's case mix indexes[3] for periods before and after acquisition to see whether this had occurred for Medicare patients. This information, also shown in table 3.5, indicates that, for these two hospitals, the increased ancillary services cannot be accounted for by treating more complicated Medicare cases.

Table 3.5: Changes in Ancillary Services per Discharge by Type of Service

Name of hospital and type of acquisition	Percent change in use of selected ancillary services per discharge: Surgical procedures	Laboratory procedures	X-ray procedures	Drug-related costs	Percent change in case mix index
Public hospitals acquired by for-profits:					
Brookwood Medical Center	−14[a]	[b]	+26	+60	−5
Clarke	−15	+26	0	+28	+1
Fairview Park	0	+15	0	+30	+1
Henry County	+118	+3	+14	+238	+8
Humana/Newnan	−6	−24	[c]	−4	+9
Marion Memorial	+267	+109	−36	+93	−19
Riverside	−6	+23	−11	+47	−5
Public hospitals acquired by not-for-profits:					
East Pasco Medical Center	+90[d]	+12[d]	+10[d]	+15[d]	+5
Watkins Memorial	[c]	[c]	[c]	+20	+7
Voluntary hospitals acquired by for-profits:					
Ormond Beach	+29[d]	−11[d]	+5[d]	+249[d]	−3
East Pointe	+70[d]	+68[d]	+18[d]	+14[d]	+14

[a]Reflects loss of hospital's full-time surgeon shortly after acquisition

[b]Data before and after acquisition not comparable

[c]Not available

[d]The new operators did not have workload data for periods before the change in control, and the increases or decreases reflect changes in services for discharges for two successive annual reporting periods after acquisition

[3]For most hospitals participating in Medicare, HCFA maintains a statistical index to measure the relative complexity of the types of illnesses being treated for Medicare patients This case mix index was used to adjust payments to hospitals under the reimbursement limits established by section 101 of the Tax Equity and Fiscal Responsibility Act of 1982 and to compute Medicare's prospective payment rates for hospitals (See p 12)

Ancillary Charges Generally Increased After Acquisition

Usually increases in hospital charges for ancillary services do not directly affect the amounts paid by Medicare because this program's payments are based on costs, not charges.[4] However, the increases do affect health insurance companies and individual patients that pay for services based on hospital charges.

Our analysis of cost report data for the 40 hospitals before and after acquisition showed that in every case average ancillary charges per discharge increased. This information, which is presented in detail in appendix II, is summarized in table 3.6.

Table 3.6: Pre- and Post-Acquisition Ancillary Charges per Discharge for 40 Hospitals

	Average ancillary charge per discharge				Percent increase in ancillary costs
	Before acquisition	After acquisition	Increase	Percent increase	
Weighted average for 30 hospitals acquired by for-profit firms	$ 844 84	$1,263 24	$418 40	50	39
Weighted average for 10 hospitals acquired by not-for-profit firms	1,019 44	1,409 64	390 20	38	32
Weighted average for the 40 hospitals	882 16	1,288 12	405 97	46	37
Weighted average for the 11 hospitals visited by GAO	1,159.31	1,529 27	369 76	32	31

Table 3.7 lists for ancillary services the average cost-to-charge ratio for the pre- and post-acquisition periods for the 40 hospitals. The cost-to-charge ratio is the total costs of ancillary services at a hospital divided by the total charges for these services. Medicare used the ratio for each ancillary department to convert charges for Medicare patients into the costs of those services that Medicare paid. For example, if Medicare patients had been charged $500,000 for laboratory services by a hospital and the cost-to-charge ratio for the laboratory department was 0.50, Medicare would have paid the hospital $250,000.

[4]Before implementation of the Medicare hospital prospective payment system, increasing the quantity of ancillary services would increase Medicare payments to a hospital However, under the prospective payment system, the amount of ancillary services provided does not affect the payment a hospital receives

Table 3.7 shows that on the average, under the new operators of the hospital, the charges for ancillary services per discharge increased substantially. Also, the cost-to-charge ratio decreased slightly, which in turn means that the hospitals' gross profit margin (charges minus costs) increased somewhat. The combination of these two factors means that, for payors who pay based on charges, the hospitals substantially increased their gross profits per discharge from ancillary services.

Table 3.7: Pre- and Post-Acquisition Ancillary Service Margins for Charge Payors on an Average per Discharge Basis

	Pre-acquisition ancillary services		Post-acquisition ancillary services		
	Average cost-to-charge ratio	Average per discharge margin	Average cost-to-charge ratio	Average per discharge margin	Change in per discharge margin
Weighted average for 30 hospitals acquired by for-profit firms	0.57	$360	0.53	$590	$230
Weighted average for 10 hospitals acquired by not-for-profit firms	53	475	51	689	214
Weighted average for the 40 hospitals	56	385	53	607	222
Weighted average for the 11 hospitals visited by GAO	52	561	51	745	184

That a hospital has a positive margin on ancillary services does not mean that it makes a profit. The hospital may lose more on room and board and through bad debts than it gains on ancillary services. This is illustrated by the fact that 9 of the 11 hospitals we visited were losing money before acquisition although they had positive margins on ancillary services.

Blue Cross-Blue Shield of North Carolina Study of Hospital Charges

Blue Cross-Blue Shield of North Carolina also reported on changes in hospital charges after a hospital's sale. In July 1983, this organization studied average charges for services provided to its 1981-82 subscribers. This study concluded that care in a for-profit facility was usually much more expensive than care in a similar-sized, not-for-profit hospital. Pharmacy and medical/surgical supply charges primarily accounted for these higher charges. The study also found that in some hospitals, charges increased rapidly for several years following a sale to a for-profit organization.

Summary

The new operators at 10 of the 11 hospitals we visited had built new facilities, expanded and renovated existing ones, and/or bought new equipment. In six instances, the improvements were required by the sale, lease, or associated agreements.

To improve the hospitals' financial condition, the new operators (1) recruited more physicians for their medical staffs in order to increase the number of patients admitted and (2) generally increased the charges for ancillary services. However, in only two instances did the former strategy appear to result in significant increases in occupancy rates. By 1984 the occupancy rates for the other nine hospitals were about the same as or lower than they were before the acquisitions. For two of the hospitals with the largest increases in ancillary charges per discharge, the average amount of services provided also increased substantially. These volume increases did not appear justified by changes in the Medicare case mix of the hospitals.

Comments by Interested Parties

The Federation of American Health Systems, an association of proprietary hospitals and health systems, questioned whether our data support the inference that acquiring proprietary hospitals raises charges more than acquiring not-for-profit hospitals. The Federation said that our study does not compare matched pairs of hospitals so it cannot be said what a not-for-profit would have done under similar circumstances. According to the Federation, hospitals with above average increases in charges may, for example, have upgraded their technology base more than others, and such an upgrade would have to be taken into account to get a true picture of increased charges relative to the level of services offered.

We did not imply that hospitals acquired by proprietary firms raised charges more than those acquired by not-for-profits. Rather, we reported that this was the case for the hospitals we reviewed. While we did not attempt to compare matched pairs of hospitals, we did include in our data base all of the changes of ownership that occurred between 1980 and 1982 in seven of the eight states in the HHS Atlanta region. The reviewed hospitals were basically smaller hospitals in rural areas. Regarding the upgrading of technology, we discuss this in some detail for the 11 hospitals we visited and point out that both proprietary and not-for-profit acquirers generally made substantial improvements (see pp. 26 and 27).

The Federation also said that the hospital market today is different from the "charges are no object" days of the early 1980's and that competition is driving realized charges closer to costs for all hospitals. While increases in hospital charges have moderated in the last few years, as measured by the Consumer Price Index, they are still higher than the overall increase in the index. Also, most of the hospitals in our review were rural hospitals without nearby competing hospitals.

The National Association of Public Hospitals, which represents primarily larger publicly owned hospitals, said that this report was a valuable contribution to the debate on the sale or lease of public hospitals and that the report carefully weighs both the possible advantages and disadvantages of the transfer of ownership of public and not-for-profit hospitals. According to the Association, its observations of numerous other transfers of ownership follow similar patterns of the causes and results of transfers.

HHS said that it had reviewed the report and had no comments.

Lack of Data on Changes in Uncompensated Care Provided to Indigents

We could not make a pre- and post-acquisition comparison of the amount of free health care provided by 10 of the 11 hospitals we visited because of the lack of comparable data on the number of indigents treated and the cost of services provided during the post-acquisition periods. The nine public hospitals we visited had received Hill-Burton financial assistance and before the changes in control were providing indigents with free hospital care using Hill-Burton criteria for determining eligibility for and the amount of such care.

The sale, lease, or associated agreements for the nine public hospitals included either specific or general provisions to the effect that the new owners or lessees would continue to provide indigents with free hospital care. Only one of the agreements specifically provided for the payment of related physician services provided to indigents. The two voluntary, not-for-profit hospitals selected for detailed review had not received Hill-Burton assistance, and the sale or lease agreement with the for-profit firms that acquired them did not include provisions addressing indigent care.

Despite the contractual provisions for indigent care services, the hospitals generally did not have records to document the number of indigents treated or the cost of services provided them, nor did the local governments monitor the hospitals to insure that the specific levels of services agreed upon had been provided. The new operators of the nine former public hospitals and the two former voluntary, not-for-profit hospitals generally limited indigent care to persons who were diagnosed by a physician on the medical staff as seriously ill or requiring emergency services.

Although we were unable to make pre- and post-acquisition comparisons for 10 of the 11 hospitals we visited, other data we reviewed indicated that for-profit and not-for-profit hospitals provide lower levels of free care to indigents than public hospitals.

Who Provides for Indigent Care?

Responsibility for providing health care to the nation's poor population has traditionally been shared by all levels of government and various nongovernment entities. The federal government participates by (1) requiring hospitals that received financial assistance under the Hill-Burton program to provide uncompensated services to indigents and (2) sharing in the costs of the states' Medicaid programs. However, the number of Hill-Burton-assisted facilities under obligation to provide free

care to indigents is declining, and the states' Medicaid programs do not cover all the indigent population.

Some states in the HHS Atlanta region have enacted legislation making the counties the responsible governmental entity for providing health care to indigents not covered by Medicaid. These states often have not provided money to pay for these services; instead they have left the funding responsibility to the option and ability of the individual counties. For example, in Alabama and Florida, the counties depend on public hospitals to provide care for the indigent. To the extent that the costs for these services are not covered under hospitals' revenues from operations, local taxpayers have financed the deficits.

Federal Hill-Burton Program

Between 1946 and 1974 the Hill-Burton program provided federal grants for the construction of public and voluntary, not-for-profit hospitals and other health facilities. In addition, from 1970 to 1976 the federal government made direct construction/renovation loans to public health facilities and guaranteed loans made by commercial lenders to voluntary, not-for-profit health facilities. Through September 1981, the amount of Hill-Burton financial assistance provided for the construction and modernization of health care facilities was about $5.9 billion—$4.4 billion in construction grants, $1.3 billion in guaranteed loans, and $0.2 billion in direct loans.

As a condition for receiving a Hill-Burton grant or loan, the facility agreed to provide a reasonable volume of services to persons unable to pay.[1] Normally, the period of obligation was 20 years under the grant program and until the loan was repaid under the loan program. If within the obligated period the facility's status changes to something not eligible for Hill-Burton funds at the time of application (e.g., sale or lease to a for-profit firm), the federal government may recover the total amount of federal assistance regardless of the amount of free services already provided. On the other hand, when such a change in status occurs, the facility is no longer obligated to provide free care to indigents.

[1]The reasonable volume of services to be provided annually is the lower of 3 percent of the facilities' annual operating costs less reimbursement from Medicare and Medicaid or 10 percent of the federal assistance received adjusted for inflation

If a facility under Hill-Burton obligation denies a request for uncompensated services, it must give the applicant a written dated statement containing the reasons for denial. Requests for services may be denied if the applicant does not meet the federal poverty guidelines, the facility's compliance level has been met for that fiscal period, or the requested services are not offered at the facility. Other than the above exceptions, requests for services may not be denied simply because they are nonemergency. The uncompensated services may be provided to persons whose income is below the poverty guidelines or at reduced charges if income is greater than but not double the guidelines Under the Hill-Burton obligation, uncompensated services include only hospital services; physicians' charges are the patients' responsibility.

Because the Hill-Burton grant and loan programs ended by 1974 and 1976, respectively, the number of facilities under obligation to provide uncompensated services is decreasing. For example, the total number of hospitals and other health care facilities aided by Hill-Burton funds and obligated to provide uncompensated services was 6,900; as of January 1984, about 5,000 of the facilities still had such an obligation, a decrease of about 28 percent. In May 1982 testimony on the Hill-Burton program before the Subcommittee on Health and the Environment, House Committee on Energy and Commerce, we pointed out that the number of facilities with uncompensated service obligations was decreasing. We projected that by 1990 over 50 percent of the then currently obligated facilities may have completed their obligations.

Some of the decrease in the number of facilities with Hill-Burton uncompensated service obligations resulted because of their takeover by for-profit firms. As discussed in chapter 2, many public hospitals are experiencing financial problems and appear to be prime targets for takeover by for-profit firms.

Apparently in response to the decreasing number of hospitals under obligation for uncompensated services, section 2381 of the Deficit Reduction Act of 1984 (Public Law 98-369) authorized HHS to waive the recovery of the Hill-Burton financial assistance if the acquiring for-profit firm sets up a trust fund, in an amount computed in accordance with the statute's criteria, to provide free care to persons unable to pay. HHS had not issued regulations implementing this provision as of February 1986. This waiver provision may, when implemented, give for-profit buyers of Hill-Burton facilities an incentive to provide more uncompensated care to the indigent.

Federal-State Medicaid Programs

Medicaid, authorized by title XIX of the Social Security Act, is a federal grant in aid program designed to assist the states in providing health care to the poor However, eligibility for Medicaid is linked to eligibility for cash assistance under the federal Supplemental Security Income (SSI) program for the aged, blind, and disabled and the federal-state Aid to Families with Dependent Children (AFDC) program, which generally covers families with minor children deprived of parental support. Thus, single adults and childless couples under age 65 are ineligible for Medicaid unless they are blind or disabled. Also, other low-income persons cannot meet Medicaid income eligibility levels.

According to a March 1983 report by the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research,[2] only about half of those classified as poor under the federal poverty definition are covered by Medicaid The income eligibility limits for Medicaid are related to state welfare standards, which are generally more restrictive than national poverty level guidelines.

Although the Medicaid program can provide benefits to many low-income persons who fall under the categories covered by SSI and AFDC (such as those with very large medical expenses who become eligible for Medicaid once their income minus medical expenses drops below the eligibility standard), as of April 1984, 20 states did not have a "medically needy" program.

County Government Role

Information obtained from Alabama, Florida, and Georgia and the counties that we visited in these states shows that the counties are generally responsible for providing health services to the indigent population. Both the Alabama and Florida constitutions require that the counties provide maintenance for the poor. How well the responsibility is carried out in each county depends upon the number of eligible applicants and the availability of money.

The director of Georgia's Health Planning and Development Agency told us that there is no state constitutional requirement or law saying who is responsible for indigent care. However, the state uses the certificate of need approval process to persuade purchasers of public hospitals and the counties to agree on a plan for the continued provision of health care to indigents. This persuasion normally results in the purchaser agreeing

[2] Securing Access to Health Care A Report on the Ethical Implications of Differences in the Availability of Health Services

to a provision in the hospital sale or lease agreement to the effect that the purchaser or lessee will agree to accept any patient diagnosed by a member of its medical staff as seriously ill or needing emergency services, without regard to the patient's ability to pay. However, neither the state nor counties monitor the hospitals' activities to ensure compliance with such provisions.

Alabama has not required certificate of need approvals on hospital acquisitions since 1981. Thus, the effect of the sale or lease of public hospitals on the cost or the availability of care for the indigent is not considered under the certificate of need process.

Florida law was amended in 1979 to include certificate of need reviews on hospital acquisitions. However, the review is required only if the purchaser plans to change the facility's bed capacity or services The community medical facilities supervisor of the state's Department of Health and Rehabilitative Services said that because most acquisitions do not involve changes in bed capacity or services, such transactions are usually exempt from certificate of need review

Recent State Initiatives

To help relieve the counties of some of the indigent care costs,[3] Florida enacted legislation in May 1984 to expand Medicaid coverage, except for nursing home services, to new eligibility groups. These groups include children under 21 and in "intact" families meeting AFDC income and resource standards, unemployed parents and their children under 18 in families meeting AFDC standards, and the medically needy in these categories. This legislation also provided for the state acquiring more information on the issue of indigent care by requiring a determination of (1) the amount of indigent care costs included in bad debt expenses of the state's hospitals, (2) current methods of paying for the care, and (3) alternative financing methods. Florida legislation also appropriated up to $10 million to establish a program for primary care for low-income persons in county public health unit programs, beginning on July 1, 1984.

Under legislation enacted by North Carolina in July 1984, agreements for sale or lease of public hospitals to for-profit firms must require the firms to provide the same or a similar range of services to indigents as

[3]In a March 1984 report, the Florida Task Force on Competition and Consumer Choice in Health Care stated that Florida counties had spent $119 4 million on indigent health care during the period October 1978-September 1979 and had budgeted $145 million for such care from October 1982 through September 1983

previously provided and prohibit the firms from using financial admission policies that would deny services because of a patient's immediate inability to pay for them. The agreements also must require the for-profit firms to prepare annual reports showing compliance with these requirements.

Contractual Arrangements for Continuing Care to Indigents

Each of the nine public hospitals in our review received financial construction assistance under the Hill-Burton program and was obligated to provide free or low-cost hospital care to indigents—normally for 20 years Eight of the nine were still under obligation at the time they were acquired Seven of the hospitals were acquired by for-profit firms and, as a result, no longer have a federal obligation to provide indigent care. HHS has recovered or is seeking to recover outstanding federal Hill-Burton financial assistance from these seven hospitals. The other two public hospitals were acquired by voluntary, not-for-profit organizations. HHS is not seeking to recover the amounts of Hill-Burton obligations because the transferees are not-for-profit entities, and as such were eligible to continue providing uncompensated care as repayment for Hill-Burton financial assistance.

The new owners or lessees of the nine former public hospitals we visited were required under these sale, lease, or associated agreements to provide care to indigents. Five of the agreements included specific commitments or arrangements in terms of the number of inpatient days to be provided or dollar value of services, whereas the other four were less specific. Only one of the agreements specifically included paying for related physician services provided in the hospital to indigents

Table 4.1 summarizes the commitments and arrangements for the nine former public hospitals visited and for the two voluntary, not-for-profit hospitals acquired by for-profit firms

Table 4.1: Commitments and Arrangements for Providing Care to Indigents

Name of hospital and type of acquisition	Hill-Burton free care obligation	Specific commitment or arrangement	Other commitments
Public hospitals acquired by for-profits:			
Brookwood Medical Center	Yes	500 days a year of free care plus another 500 days at half price for 3 years[a]	
Clarke	Yes	The greater of 2 5 percent of gross annual revenue or $62,000	Hospital will not deny emergency services due to inability to pay
Fairview Park	[b]	None	Services to persons diagnosed by staff physician as seriously ill or requiring emergency services without regard to the ability to pay
Henry County[c]	Yes	Up to $180,000 of needed (as opposed to elective) services to indigent residents of the county with county paying up to $120,000 for additional care	To provide needed (as opposed to elective) services to any resident of the county without regard to indigent status
Humana/Newnan	Yes	County to reimburse hospital 88 percent of the charges for a maximum of $500,000 a year for care of indigent county residents	
Marion Memorial[c]	Yes	Hospital to provide care to indigents (as defined by Hill-Burton guidelines) with 1 5 percent of gross revenues established as the minimum amount	
Riverside	Yes	None	Purchaser agrees to provide needed care at no cost to the county to any indigent persons
Public hospitals acquired by not-for-profits:			
East Pasco Medical Center[c]	Yes	None	Hospital agrees to provide needed care at no cost to the county to any indigent person
Watkins Memorial	Yes	None	Hospital agrees to accept county's responsibility to provide care to indigents[d]
Not-for-profit hospitals acquired by for-profits:			
Ormond Beach	No	None	Hospital will provide emergency services
East Pointe[c]	No	None	Hospital will provide emergency services

[a]Pursuant to a separate joint stipulation for dismissal of a lawsuit, the hospital agreed to provide $500,000 in free medical care to indigent persons, and the county agreed to provide up to $150,000 in free medical care over a 3 year period

[b]Twenty year obligation completed before sale

[c]Leased

[d]County paid $16,000 to this hospital for providing indigent care services in calendar year 1984

Lack of Data on the Amounts of Uncompensated Indigent Care Provided by New Operators

The new owners or lessees of 10 of the 11 hospitals we visited did not maintain data on the number of indigents treated and the associated cost of services provided. Only Riverside Hospital in Florida provided us with reliable data on the number of indigents treated and cost of services provided to them for periods before and after the acquisition. The data for Riverside show that indigent admissions decreased by 57 percent (77 to 33) and the cost of services for indigents decreased by about 49 percent ($248,000 to $127,000) from the last year that the county operated the hospital to the first year that the for-profit firm operated the hospital.

For the other 10 hospitals, the costs of indigent care after the changes in control were usually included in the bad debts account, and hospital officials were unable to identify the specific amounts or to provide reliable statistics supporting the number of indigents treated or the related costs. Therefore, we could not make pre- and post-acquisition comparisons of the amount of free care provided to indigents at these facilities. Further, where there were specific commitments or arrangements, the local government entities did not monitor the hospitals to ensure that the services agreed upon were actually provided—even in instances where the counties paid for such services.

For example, on the basis of a billing, Coweta County in Georgia paid Humana/Newnan Hospital about $479,000 for indigent services provided during its first year of operation (Dec. 1982-Nov. 1983). Our review at the hospital showed that no records were maintained to support the billings and that the county had not attempted to verify that services it paid for were actually provided or that they were provided to indigent patients.

Coweta County officials said that they had neither the money nor the staff to monitor Humana/Newnan Hospital's indigent care program and verify whether billed services were actually provided. An official in another county said that the only monitoring possible was through complaints from indigent persons denied care.

County officials at the sites visited, however, said that they were generally satisfied with the for-profit hospitals' provision of indigent care. In only one county in Florida did officials say they were dissatisfied with the treatment of indigents by the for-profit operator of the former county hospital (Riverside Hospital). The county officials gave us several examples of the hospital's unsatisfactory performance, which

involved (1) agreeing to provide hospital care but not the related physicians' services (which was not required under the agreement) and (2) initially refusing to admit an indigent patient for childbirth.

Other Studies Indicate That Private Hospitals Have Historically Provided Less Indigent Care Than Public Hospitals

Although providing health care to the poor is a responsibility shared by both public and private hospitals, historically public hospitals have provided proportionately more uncompensated care. Statistics from the American Hospital Association, presented in table 4.2, show that this situation continues.

Table 4.2: Levels of Uncompensated Care by Hospital Ownership

Dollars in billions

	Expense for uncompensated care[a]		Uncompensated care as a percent of total expenses	
Hospital ownership	**1982**	**1984**	**1982**	**1984**
Public	$1 61	$2 21	8 1	9 9
Nonprofit	3 09	4 25	4 0	4 7
Proprietary	0 28	0 44	3 5	4 3
Total	**$4.98**	**$6.90**	**4.8**	**5.6**

[a]Expenses for charity care plus bad debt

Source American Hospital Association

The data show that proprietary and not-for-profit hospitals provide about the same level of uncompensated care, measured as a percent of total expenses, and that the public hospitals' level is about twice that of other hospitals. In absolute dollar terms, not-for-profit hospitals (the largest group, representing about 70 percent of the nation's hospital beds in 1984) provided the largest amount—about 62 percent of total expenses in 1984. Public hospitals (with about 20 percent of the beds) provided about 32 percent of the uncompensated care, and proprietary hospitals (with about 10 percent of the beds) provided about 6 percent of the care.

The American Hospital Association also reports data on "unsponsored care"; that is, uncompensated care less state and local tax appropriations. Unsponsored care at public hospitals was 4.8 percent of expenses in 1984, or about the same level as not-for-profit hospitals (4.6 percent) and proprietary hospitals (4.3 percent). In other words, state and local

taxes were used to cover 5.1 percent ($1.13 billion) of the uncompensated care provided by public hospitals.

Also, some available data show that some private hospitals that provide emergency services to persons unable to pay transfer such patients to nearby public hospitals as soon as the patients are stabilized. A research group of the University of California at Berkeley studied 458 consecutive patient transfers from 14 private hospitals to a public hospital's emergency room during January through June 1981.[4] Of these 458 patients, 289 (63 percent) had no medical insurance at the time of transfer, 96 (21 percent) had Medicaid coverage, 60 (13 percent) had Medicare coverage, and 13 (3 percent) had private health insurance. The medical charts of 103 transferees classified as "high risk" were also studied. The study was designed to identify reasons for the transfers and any adverse effects on the patients. The study showed that:

- Of the 458 transferred patients, over half (272) were admitted to the public hospital as inpatients, 22 of whom required intensive care; 32 (7 percent) were referred to the hospital's department of psychiatry; 9 (2 percent) were taken into custody by judicial authorities; and 27 (6 percent) were transferred to other institutions for further care.
- Few patients were transferred for medical reasons. Of 103 patients' charts reviewed, only 1 patient was explicitly transferred for a medical indication—a service not available at the original hospital. In no case did a physician or nurse accompany the patient during transfer. In 11 cases physicians indicated that the patient was transferred because of inability to pay.
- The Berkeley study group judged that the health of many patients was jeopardized by transfer. Of 103 patient charts reviewed, the transfer was judged to have jeopardized the health of 33 patients (32 percent). Six patients were transferred in unstable condition due to cardiac or neurological disorders, four of whom were at risk of life-threatening heart problems during transit. Two had neuro-medical emergencies requiring immediate care, which was delayed by transfer.

Added to the public hospitals' burden of providing the indigent with health care is the fact that fewer such hospitals are available to share this uncompensated patient care workload. For example, during our review we identified 30 public and voluntary, not-for-profit hospitals in the HHS Atlanta region that were sold or leased to for-profit firms during

[4] Dave U. Himmelstein, M.D , et al., "Patient Transfers: Medical Practice as Social Triage," American Journal of Public Health, May 1984, pp. 494-497

calendar years 1980, 1981, and 1982. To further illustrate this, information developed by Florida's Hospital Cost Containment Board showed that the mix of that state's acute care general hospital beds shifted. There was an 11-percent increase in for-profit hospital beds, a 14-percent decrease in public hospital beds, and a 2-percent decrease in voluntary, not-for-profit hospital beds between 1979 and 1983. Table 4.3 shows these changes.

Table 4.3: Shift in Florida Acute Care Hospital Bed Mix

	Number of beds		Percentage
Hospital type	**1979**	**1983**	**change**
For-profit	14,249	15,819	11
Government	12,506	10,815	−14
Voluntary, not-for-profit	23,040	22,513	−2
Total	**49,795**	**49,147**	−1

Summary

The nine former public hospitals we visited had included in the sales, lease, or associated agreements a provision requiring or arranging for the new owners or lessees to provide needed care to indigents. In five instances the arrangements were expressed in specific terms, such as a number of inpatient days or specific percentages of gross revenues; however, the local governments did not monitor the hospitals for compliance with these commitments. In the other four instances, the new operators' commitments were expressed in more general terms. At only one of the nine former public hospitals could we identify comparable information about how much uncompensated indigent care was actually provided in accordance with these commitments. At that facility the number of indigent admissions and associated costs decreased after acquisition by a for-profit firm.

In our opinion, the principal issues involve (1) the lack of information on the amount of uncompensated care being provided to indigents and (2) the extent that firms that acquire public hospitals are meeting the commitments in their sales or lease agreements to provide such care.

Two states in the HHS Atlanta region have addressed one or both of these issues. In May 1984, Florida enacted legislation aimed at acquiring better information on the amounts of uncompensated indigent care and how it is paid. In July 1984, North Carolina enacted legislation providing that public hospitals sold or leased to for-profit firms must include in their agreements provisions that would require the same or a

similar range of services to indigents as previously provided. The legislation also requires that annually the new operators must show compliance with these requirements, which should also provide information on the amount of uncompensated care provided.

Comments by Interested Parties

All three hospital associations suggested that we use more recent data relating to the extent of indigent care provided by various types of hospitals. We have incorporated the newer data provided by the American Hospital Association in the report on page 46.

The Federation of American Health Systems believed that the reader could get the impression that proprietary hospitals provide less uncompensated care than not-for-profit hospitals and transfer to public hospitals more patients unable to pay for care than not-for-profit hospitals. We stated that proprietary and not-for-profit hospitals provide about the same level of uncompensated care when measured as a percentage of revenues. However, the American Hospital Association data on uncompensated care mentioned above make it clearer that proprietary and not-for-profit hospitals provide about the same level of uncompensated care as a percentage of expenses. These data show, however, that public hospitals provide a disproportionate share of uncompensated care.

The American Hospital Association commented that the study of patient transfers we discuss on page 47 does not document the inappropriate transfer of medically unstable patients for financial reasons. While there are a number of studies dealing with transfers of patients from private to public hospitals, we chose this study because it considered both the financial and medical condition of the transferred patients. While this study does not show the national extent of this issue, it does indicate that a problem may exist. The Federation of American Health Systems stated that there is no evidence that proprietary hospitals account for a disproportiate share of patient transfers. We are not aware of any such evidence either.

Increases in Capital Costs, Return-On-Equity Payments, and Administrative and General Costs

Hospital acquisitions resulted in significant increases in hospitals' capital costs, return-on-equity payments from Medicare, and administrative expenses. Because these three items accounted for about 67 percent of the total cost increases per discharge for the 30 hospitals acquired by the for-profit firms and about 40 percent of the total cost increases for the 10 hospitals acquired by the not-for-profit firms, this chapter focuses on the extent of and the reasons for such increases.

Increases in Capital Costs

Capital costs include interest, depreciation, and lease expenses. Excluding three hospitals that were replaced shortly after their acquisition, the average increase in capital costs per discharge for the 37 hospitals acquired by the for-profit and not-for-profit firms are shown in appendix IV and summarized in table 5.1. These average increases were derived by combining data from the two individual cost reporting periods before acquisition and comparing this pre-acquisition average to the similarly combined post-acquisition average (including 2 years where cost reports were available). We excluded the three new hospitals that were built after acquisition because these cost increases would have distorted our comparisons and because the costs of building new hospitals were not necessarily a prerequisite of the acquisitions.

Table 5.1: Summary of Pre- and Post-Acquisition Capital Costs per Discharge

	Average capital costs per discharge			
	2 years before acquisition	2 years after acquisition	Increase	Percent increase
Weighted average for 27 hospitals acquired by for-profit firms	$70.49	$157 81[a]	$87 32	123
Weighted average for 10 hospitals acquired by not-for-profit firms	67 90	104 27[b]	37 67	54
Weighted average for 37 hospitals	69.80	145 90	76 10	109

[a]Includes second year data for only 18 hospitals because cost reports for the second year after acquisition were not available for 9 hospitals

[b]Includes second year data for three hospitals

Public Law 98-21, the Social Security Amendments of 1983, provided for Medicare payments for hospital inpatient services under a prospective payment system, rather than a reasonable cost basis. Essentially, Medicare payments are made at a predetermined rate for each discharge. However, hospitals' capital costs (those associated with furnishing buildings and equipment necessary to provide patient care) are treated

separately under Medicare's prospective payment system These costs continue to be passed through; that is, reimbursed on an actual, reasonable cost basis. Thus, Medicare continues to pay the percentage of capital costs that reflects the ratio of Medicare utilization to total hospital utilization.

About $2.9 billion, or about 7 percent, of Medicare's total 1984 hospital payments was for capital costs, such as depreciation, interest, and lease payments. In addition, increases in capital costs also continue to be passed through for Medicaid reimbursement in most states.

Because Medicare continues to reimburse hospitals for their capital costs, the acquisitions of these 37 hospitals increased the amounts claimed[1] for Medicare reimbursement by a total of $3.8 million during the first 12 months after the changes in control. The 27 hospitals acquired by the for-profit firms accounted for about $3.4 million (or 88 percent) of the increase in the amounts claimed.

Public Law 98-21 required HHS to make proposals to the Congress by October 1984, along with proposals for legislation, by which capital costs could be included in the existing prospective payment system. The HHS report was issued in March 1986. HHS plans to incorporate capital costs in the prospective payment rates in October 1986.

Capital Costs for Hospitals Acquired by For-Profit Firms Continued to Increase in Later Years

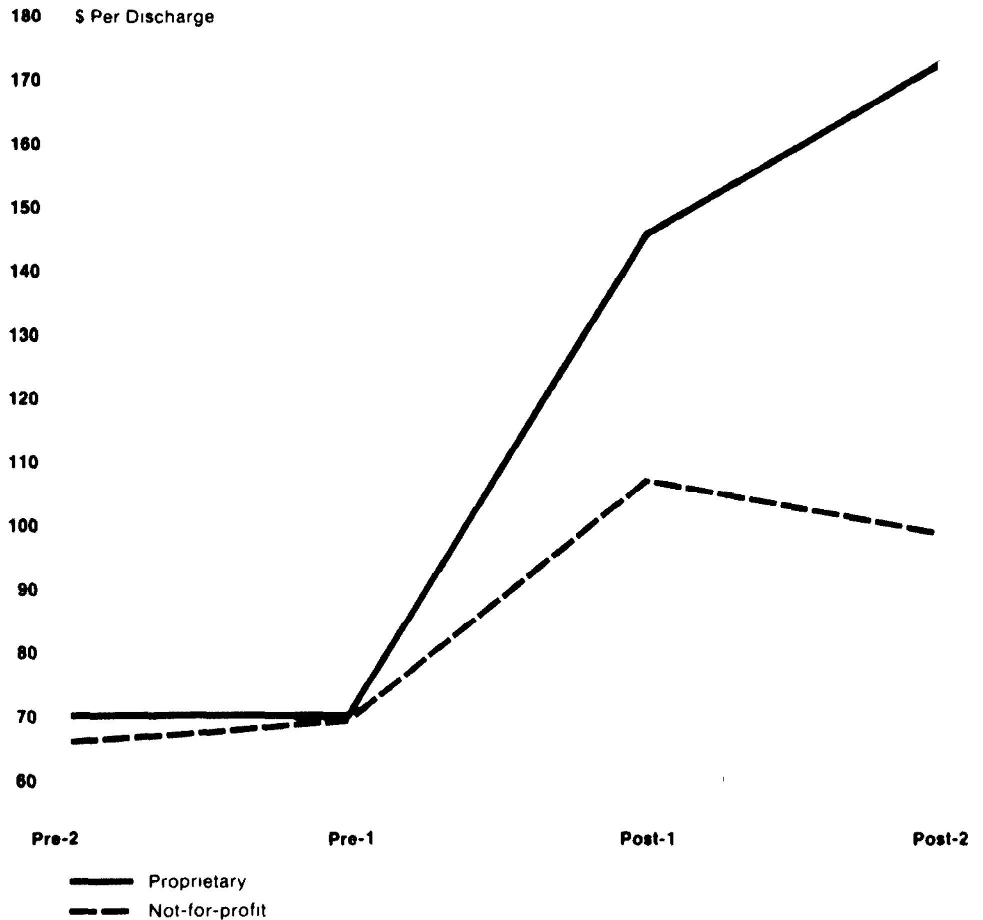
The data shown in appendix IV and summarized in table 5.1 are combined, generally for the two cost reports before and the two after the changes in control. Our analysis showed that capital costs for the hospitals acquired by the for-profit firms continued to increase in later years but those for hospitals acquired by the not-for-profit firms tended to level off.

As shown in figure 5.1, for the 27 acquisitions by for-profit firms, the average capital costs increased from $70 to $146 per discharge, as reported in these hospitals' first cost reports after acquisition. The 10 not-for-profit hospitals' average capital costs increased from $70 to $107 per discharge. For the 18 available second cost reports after acquisition, for-profit hospitals' capital costs continued to increase to $174

[1] The cost reports from which we extracted the data generally had not been audited by Medicare's claims paying agents Therefore, the final Medicare payments may differ from the amounts claimed on the reports

per discharge. We believe capital costs increased primarily because of the acquisition of new equipment or renovations of the hospitals.

Figure 5.1: Annual Changes in Pre- and Post-Acquisition Capital Costs per Discharge



Reasons for Increase in Capital Costs at the 11 Hospitals Visited

The pre- and post-acquisition capital costs for the 11 hospitals we visited are shown in table 5.2. As in table 5.1 and appendix IV, these average increases were derived by combining data from the two cost reporting periods before acquisition and, where available, the two cost reporting periods after.

Table 5.2: Pre- and Post-Acquisition Capital Costs per Discharge for Specific Hospitals

		Capital costs per discharge			
Name of hospital and type of acquisition	**Date of acquisition**	**Before acquisition**	**After acquisition**	**Increase**	**Percent increase**
Public hospitals acquired by for-profits:					
Brookwood Medical Center	Jan 1981	$ 47 34	$ 56 84	$ 9 50	20
Clarke	Apr 1982	91 24	138 33	47 09	52
Fairview Park	Mar. 1981	32 36	33 43	1 08	3
Henry County	Dec 1982[a]	108 44	224 41	115 97	107
Humana/Newnan	Dec 1982	160 42	228 76	68 34	43
Marion Memorial	Mar 1982[a]	56 27	91 46	35 19	63
Riverside	July 1982	100 49	522 98	422 49	420
Public hospitals acquired by not-for-profits:					
East Pasco Medical Center	June 1981[a]	83 63	186 80	103 17	123
Watkins Memorial	Jan 1982	89 59	229 34	139 75	156
Voluntary hospitals acquired by for-profits:					
Ormond Beach	July 1981	129 32	526 13	396 81	307
East Pointe	July 1981[a]	132 98	317 10	184 12	138
Weighted average cost per discharge		81 75	197 31	115 56	141

[a]Date hospital leased

According to hospital officials, the capital cost increases for the 11 hospitals generally resulted from the four following reasons:

- Assets were revalued after the sale.
- New equipment was purchased, and improvements were made.
- Lease payments for leased hospitals exceeded the pre-acquisition depreciation and interest expenses.
- Interest expenses on loans used to finance the purchase were allocated to capital costs.

Asset Revaluations

The capital assets of the acquired hospitals had net book values less than the purchase price paid by the acquiring entity. Thus, after the sale, the purchasers revalued hospital assets.[2] For example, the asset value of Ormond Beach Hospital increased from $3.8 million to $11.9 million about a year after the sale. This was one reason for the increase in the hospital's capital costs of $397 per discharge, or 307 percent, after acquisition. Humana/Newnan Hospital's asset value for the full

[2]For a detailed discussion of issues related to asset revaluation after acquisition, see Hospital Merger Increased Medicare and Medicaid Payments for Capital Costs (GAO/HRD-84-10, Dec 22, 1983)

fiscal year before the sale was $7.4 million. This had risen to $12.3 million by the first post-acquisition cost report, filed 9 months after the sale. This was one factor in the hospital's $68 per discharge, or 43-percent, increase after acquisition.

Continuing turnover of ownership can also result in continuing increases in capital costs. By January 1984, a second change of ownership had occurred at 5 of the 11 hospitals (Brookwood Medical Center, Henry County, Marion Memorial, Ormond Beach and Riverside). For instance, Riverside Hospital was sold for $15 million in July 1982. In December 1983, it was sold again—for $17.5 million. The effects of this second sale are not included in tables 5.1 or 5.2, figure 5.1, or appendix IV. According to officials of the Alabama and Georgia state health planning and development agencies, for-profit organizations routinely bought and sold hospitals to take advantage of the asset revaluation allowed under Medicare's capital cost reimbursement policy. Further, according to Florida's Hospital Cost Containment Board's 1983-84 Annual Report, of 62 changes in hospital ownership in Florida between 1978 and 1982, 44 (or 71 percent) were acquisitions of for-profit hospitals by another for-profit firm.

To assure that such revaluations will not result in Medicare paying for assets more than once, section 2314 of the Deficit Reduction Act of 1984 (Public Law 98-369) effective July 18, 1984, set limits for establishing an appropriate Medicare allowance for depreciation, interest on capital indebtedness, and if applicable, a return on equity for hospitals changing ownership. Public Law 98-369 provided that the valuation of the asset shall be the lesser of (1) the allowable capital cost of the owner of record on the date of enactment of the law or (2) the acquisition cost of the new owner.

Equipment Purchases and Other Improvements

New equipment purchases and other improvements made after the acquisition also increased capital costs. Such increased costs are not affected by the provisions of section 2314 of Public Law 98-369. As discussed in chapter 3, hospitals usually increased or improved services after acquisition by purchasing new equipment or improving facilities. According to Medicare reimbursement regulations, these costs can be depreciated. Moreover, they should result in improvements in the hospitals' capability to provide quality health care. For example, from July 1981 through March 1984, Brookwood Medical Center spent about $1.2 million in property and equipment additions, which the hospital could

depreciate. This contributed to a post-acquisition increase in this hospital's capital costs of $10 per discharge, or 20 percent. Humana/Newnan Hospital officials estimated that about $1 million in new depreciable equipment was purchased in the 14 months after the sale. This contributed to post-acquisition capital cost increases.

Renovations and purchases of new equipment that increased capital costs should have improved health care in the hospitals. According to several hospital authority members, severe financial problems under public ownership prevented hospitals from undertaking needed capital projects. After acquisition, such necessary improvements were often made. Because the construction of new facilities and the major renovation of existing ones had not been completed during the post-acquisition periods covered by our data, the related depreciation expenses are not always included in table 5.2.

Lease Payments

Lease payments exceeded pre-acquisition depreciation and interest expenses for the four leased hospitals (East Pasco Medical Center, Henry County, East Pointe, and Marion Memorial). Generally, after a hospital is leased, the assets are still owned by the lessor. Thus, the lessee corporation cannot claim depreciation and interest for existing assets. However, the leasing corporation can claim lease payments instead of depreciation and interest. For example, at Henry County Hospital, depreciation and interest expenses for the annual period before the lease totaled about $3,000 a month. However, after the lease, lease payments totaled about $22,000 a month. This was a major factor that resulted in the hospital's $116 per discharge, or 107-percent, capital cost increase, shown in table 5.2. East Pointe Hospital incurred an increase in capital costs of $184 per discharge, or 138 percent, after the lease. This was basically because Hospital Corporation of America paid $1,074,000 to lease the building for 30 months. This was amortized at about $36,000 a month, which was much higher than the pre-acquisition depreciation and interest expense of about $14,700 a month.

The Congress also intended that HHS establish cost limits for hospital leases. Although not specifically identified in the statute, according to the conference report, the conferees expected that HHS would determine the reasonableness of lease amounts, taking into account the new limitations on the revaluation of assets. HHS expected to publish implementing regulations in 1986. According to an official of Health Care Management Corporation (the firm that leased Henry County and Marion Memorial hospitals), if HHS' implementing regulations do not address leases, firms

will simply begin to lease, rather than buy, hospitals in order to avoid the constraints of the new law.

Interest Expenses

Capital costs also increased because of interest expenses on loans used to finance the purchase. Allowable debt for Medicare purposes was based on the revalued cost of the assets acquired (less investment), and interest expense on this amount was allocated to capital costs, as allowed under Medicare regulations. For example, Florida Hospital Cost Containment Board cost reports covering the 9-month period after the initial sale of Ormond Beach Hospital showed that long-term debt increased from about $1.2 million to $4.3 million. This was a major contributor to the $397 per discharge, or 307-percent, increase in the hospital's capital costs shown in table 5.2. Also, after this hospital's second sale, which is not reflected in tables 5.1 and 5.2, figure 5.1, or appendix IV, the long-term debt increased from $4.1 million to $10.2 million. At Riverside Hospital, after the July 1982 sale, long-term debt increased from $272,000 to $4.9 million. This was a major factor that contributed to the hospital's $422 per discharge, or 420-percent, increase in capital costs.

Increases in Amounts Claimed for Return on Equity

Under Medicare regulations, for-profit hospitals are allowed a return on equity. This increased the amounts claimed from Medicare after acquisition. As with capital costs, return on equity is treated separately under Medicare's prospective payment system and continues to be reimbursed on a reasonable cost basis. About $200 million, or 0.5 percent, of Medicare's total 1984 payments to hospitals was for return-on-equity payments.

Equity capital is defined as the provider's investment in plant, property, and equipment related to patient care plus net working capital maintained for necessary and proper operation of patient care activities. At the time of the acquisitions covered by our review, Medicare paid for-profit providers a rate of return-on-equity capital equal to 1-1/2 times the rate earned on funds invested by Medicare's Hospital Insurance Trust Fund. The Social Security Amendments of 1983 changed the rate of return for inpatient hospital services so that effective April 1983, it was reduced to the rate earned by the Trust Fund. We identified the amount of return-on-equity capital that the for-profit providers began claiming on their Medicare cost reports after acquiring the public and voluntary, not-for-profit hospitals included in our review.

For the 27 for-profit hospitals, return-on-equity claims amounted to about $101 per Medicare discharge, as shown in appendix V. This totaled about $2.9 million annually in amounts claimed for return on equity for these 27 for-profit hospitals. Because return-on-equity payments were not allowed for these 27 public and voluntary, not-for-profit hospitals before acquisition, this $2.9 million reflects additional annual amounts claimed for Medicare cost reimbursement as a result of the acquisitions.

Increases in Administrative and General Costs

Administrative and general costs are for services supporting hospital operations. They include such costs as business office expenses, automatic data processing, insurance, public relations, and home office allocations. These costs are no longer directly reimbursed as with the previous cost reimbursement system, but are included in the prospective payments. Thus, if A&G costs increase as a percentage of total costs after fiscal year 1983, either profits or patient care costs must make up for the cost increases.

A&G costs for cost reporting periods ended in fiscal year 1981 were used in determining specific diagnosis related group payment rates. Thus, any increases in a hospital's A&G costs before fiscal year 1982 resulted in higher prospective payment system payment rates. In addition, because Medicaid is still a cost-based system in many states, increases in A&G costs continue to be paid under Medicaid reimbursement.

The average increase in A&G costs for the hospitals acquired by the for-profit and not-for-profit firms are shown in appendix VI and summarized in table 5.3. As with the data in table 5.1, these average increases were derived by combining data from the two individual cost reporting periods before acquisition and comparing this average to similarly combined post-acquisition averages.

Table 5.3: Summary of Pre- and Post-Acquisition Administrative and General Costs per Discharge

	Average cost per discharge			
	Before acquisition	After acquisition	Increase	Percent increase
Weighted average for 30 hospitals acquired by for-profit firms	$154 38	$287 07[a]	$132.69	89
Weighted average for 10 hospitals acquired by not-for-profit firms	187 96	274 39[b]	86 44	46
Weighted average for 40 hospitals	161 56	284 92	123 36	76

[a]Includes second year data for only 18 hospitals because cost reports for the second year after acquisition were not available for 9 hospitals

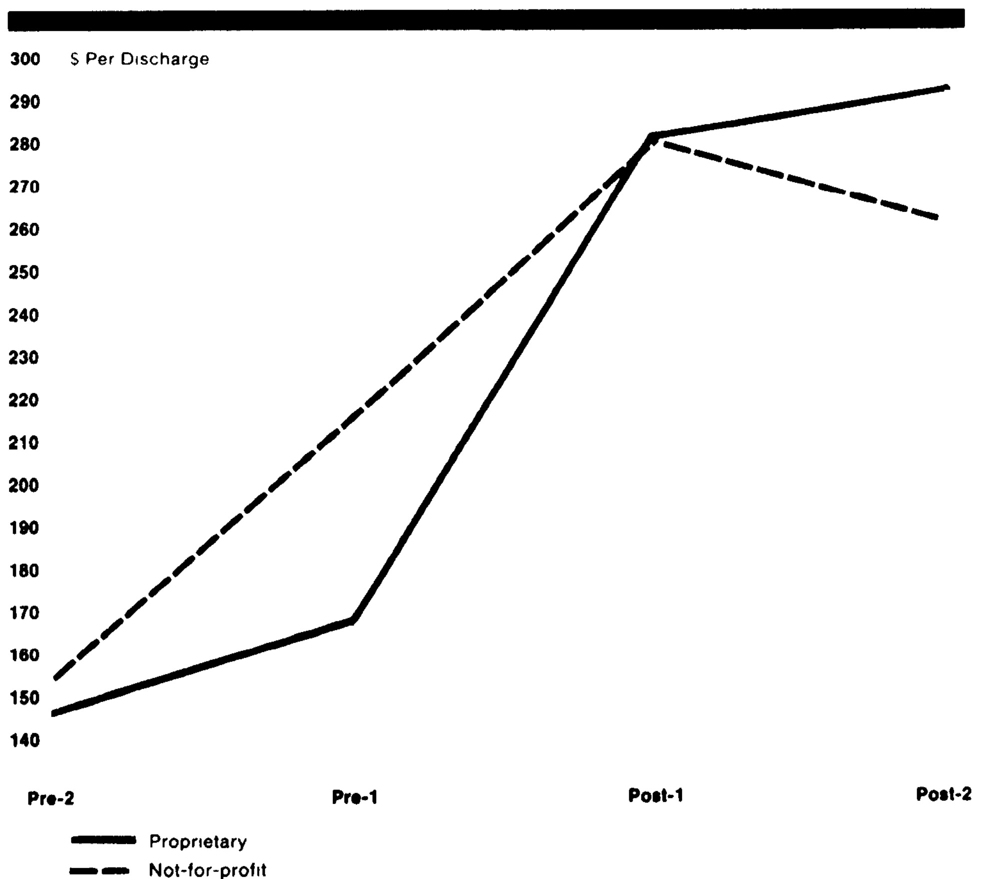
[b]Includes second year data for three hospitals

Increases in A&G Costs for Hospitals Acquired by For-Profit Firms Continued in Later Years

For-profit firms often claim that they can reduce hospitals' A&G costs because of their efficiency. However, A&G costs significantly increased after acquisition, especially for the 30 hospitals acquired by for-profit firms.

As shown in figure 5.2, average A&G costs for for-profit hospitals increased from $167 to $282 per discharge, according to these hospitals' first cost reports after acquisition. Not-for-profit hospitals' average A&G costs increased from $216 to $280 per discharge. For the available second cost reports after acquisition, for-profit hospitals' average costs per discharge continued to increase to $293, while not-for-profit hospitals' average costs decreased to $261. Because of the varying acquisition dates and cost report periods, these figures were not adjusted for inflation. However, appendix VI compares each hospital's A&G cost increases to the change in the market basket index for the hospital's pre- and post-acquisition cost report periods.

Figure 5.2: Annual Changes in Pre- and Post-Acquisition Administrative and General Costs per Discharge



Reasons for Increases in A&G Costs at the 11 Hospitals

The pre- and post-acquisition A&G costs for the 11 hospitals we visited are shown in table 5.4. As with table 5.3 and appendix VI, the average increases were derived by comparing the combined data from the two cost reporting periods before acquisition and, when available, to the two cost reporting periods after.

Table 5.4: Pre- and Post-Acquisition Administrative and General Costs per Discharge for Specific Hospitals

Name of hospital and type of acquisition	A&G costs per discharge Before acquisition	After acquisition	Change	Percent change
Public hospitals acquired by for-profits:				
Brookwood Medical Center	$155 50	$364 68	$209 18	135
Clarke	124 23	156 76	32 53	26
Fairview Park	53 41	111 67	58 26	109
Henry County	186 98	339 98	153 00	82
Humana/Newnan	226 03	744 77	518 74	229
Marion Memorial	126 88	254 48	127 60	101
Riverside	264 03	433 02	168 99	64
Public hospitals acquired by not-for-profits:				
East Pasco Medical Center	238 30	303 33	65 03	27
Watkins Memorial	189 09	180 71	−8 38	−4
Voluntary hospitals acquired by for-profits:				
Ormond Beach	400 54	730 88	330 34	82
East Pointe	400 53	512 81	112 28	28
Weighted average cost per discharge	184 02	336 73	152 72	83

The A&G costs for 10 of the 11 hospitals visited increased, generally for two reasons. The major reason was that significant home office costs[3] were added to hospital expenses without offsetting decreases in other A&G costs. For example, in the full-year period before acquisition, a hospital management firm was paid about $104,000 to manage Barbour County Hospital in Alabama (Brookwood Medical Center). This accounted for 21 percent of total A&G costs of $487,000. However, in the full-year cost report after acquisition, the hospital paid American Medical International, Inc., the purchasing corporation, about $362,000 for regional and home office costs. This accounted for 30 percent of total A&G costs of $1,213,000. This was a major reason why Brookwood's A&G costs increased by $209 per discharge, or 135 percent, as shown in table 5.4. At Henry County Hospital and Marion Memorial Hospital, home office-related costs added after acquisition accounted for 33 and 27 percent, respectively, of each hospital's net A&G costs. No such home office payments existed before the leases. After Ormond Beach Hospital's first sale in July 1981, annualized home office costs amounted to about $359,000, or about 25 percent of hospital administrative costs. This was the major factor for the hospital's $330 per discharge, or 82-percent,

[3]Multihospital chains normally incur costs at their corporate headquarters and/or regional offices that are allocated to the individual hospitals

increase in A&G costs. After this hospital's second sale, this annual allocation amounted to about $479,000 for calendar year 1983, or about 54 percent of the hospital's administrative costs.

The addition of automatic data processing services also increased A&G costs, but to a much smaller degree. After acquisition, purchasing firms sometimes automated hospitals' accounting and other management information systems. While this did improve services, additional costs were incurred. For example, at Brookwood Medical Center the business office manager estimated that new data processing services cost about $100,000 a year. Also, at Henry County Hospital, we estimated such costs increased by about $15,000 a year.

At the two not-for-profit hospitals we reviewed, A&G costs after acquisition increased by 27 percent at East Pasco Medical Center and decreased by 4 percent at Watkins Memorial Hospital. A major factor for East Pasco Medical Center's lower A&G cost increase may have been that its pre-acquisition A&G cost per discharge was higher than most other hospitals. The decrease at the not-for-profit Watkins Memorial Hospital was primarily due to a reduction of interest payments allocated to A&G because a short-term operating loan was paid off. In addition, virtually no home office costs were added to the hospital's A&G costs after acquisition.

Summary

Several causes of the increases in capital costs, such as the revaluation of assets and lease costs substantially exceeding pre-acquisition interest and depreciation costs, have been addressed by the Congress for the Medicare and Medicaid programs. The increases in capital costs for new equipment and other improvements were appropriate because, at the hospitals we visited, such improvements were needed.

The increases in A&G costs after fiscal year 1981 do not directly affect the Medicare program because, under its prospective payment system for inpatient hospital services, these costs are included in prospective payment rates and are not passed through on the basis of reasonable costs. However, the increases in 1981 (the base year for computing prospective payment rates) probably resulted in higher rates for future years. To the extent that the state Medicaid programs continue to pay hospitals on a cost basis, these increases would directly affect the reimbursements under these programs.

Comments by Interested Parties

The American Hospital Association commented that our analysis of cost increases after acquisition implies that the costs increased excessively or inappropriately. The Association said that changes in investment can affect the level of capital costs per discharge. That is why we extensively discussed in chapter 2 the improvements in facilities and equipment that the new operators made. However, as pointed out in this chapter, a major reason for increased capital costs was that the new operators' book values were higher because they paid more for facilities than the prior operators' book values and thus had higher interest and depreciation costs for the same assets than the prior operators. We excluded from the analysis hospitals that were replaced by new facilities so that they would not distort the averages.

The Association said that the increase in administrative costs could be justified if the prior operators were spending too little in this area. Theoretically, this could be the case. But, as noted in the chapter, the primary reason administrative costs increased was the addition of "home office costs" of the acquiring organization to the hospitals' own administrative costs.

The Association also commented that because we use costs per case and because hospital occupancy could have been temporarily affected by the change in operators, the changes in costs per case could have been temporary and we should relate changes in costs to changes in occupancy. Chapter 2 discusses changes in occupancy rates. Also, we used data for 2 years after the change in operators to account for temporary dislocations in occupancy rates. As noted in this chapter, costs generally continued to increase in the second year after change in operators.

Identification Codes for Hospitals

Acquiring organization	Name of hospital	Code
Hospital Corporation of America	Community Hospital of Andalusia, Andalusia, AL	A
	East Pointe Hospital, Lehigh Acres, FL	B
	Fairview Park Hospital, Dublin, GA	C
	Meadowview Regional Hospital, Maysville, KY	D
	John Graves Ford Hospital, Georgetown, KY	E
	Springview Hospital, Lebanon, KY	F
	Bourbon General Hospital, Paris, KY	G
	Vicksburg Medical Center, Vicksburg, MS	H
	Edgecomb General Hospital, Tarboro, NC	I
	Colleton Regional Hospital, Walterboro, SC	J
	Chesterfield General Hospital, Cheraw, SC	K
American Medical International, Inc.	Northwest Alabama Medical Center, Hamilton, AL	L
	Brookwood Medical Center of Eufaula, Eufaula, AL	M
	Barrow Medical Center, Windor, GA	N
	Central Carolina Hospital, Sanford, NC	O
	Piedmont Medical Center, Rock Hill, SC	P
Health Care Management Corporation	Henry County Hospital, Abbeville, AL	Q
	Terrell County Hospital, Dawson, GA	R
	Wheeler County Hospital, Glenwood, GA	S
	Marion Memorial Hospital, Buena Vista, GA	T
Gilliard Health Services, Inc.	Clarke Hospital, Jackson, AL	U
Sunbelt Health Care of Clarke Co.	Thomasville Hospital, Thomasville, AL	V
Southern Health Service of Sumter Co.	Sumter Memorial Medical Center, Livingston, AL	W
Basic American Medical, Inc.	Georgiana Community Hospital, Georgiana, AL	X
American Health Care Enterprises, Inc.	Riverside Hospital, New Port Richey, FL	Y
Southern Health Services of Kentucky, Inc.	Ormond Beach Hospital, Ormond Beach, FL	Z
Healthcare Management Group, Inc.	Morgan Memorial Hospital, Madison, GA	AA
American Healthcare Management, Inc.	Marymount Hospital, London, KY	BB
U.S. Health Corporation	Community Hospital of Calhoun County, Pittsboro, MS	CC
Humana, Inc.	Humana Hospital-Newnan, Newnan, GA	DD

Acquiring organization	Name of hospital	Code
Rush Health Systems, Inc.	Rush Hospital-Butler, Butler, AL	EE
	Rush Hospital-Newton, Newton, MS	FF
Baptist Medical Centers (Alabama)	Baptist Medical Center- Cherokee County, Centre, AL	GG
	Baptist Medical Center- Chilton County, Clanton, AL	HH
Georgia Baptist Medical Center	Watkins Memorial Hospital, Ellijay, GA	II
Sisters of Charity Health Care System	Our Lady of the Way Hospital, Martin, KY	JJ
Methodist Health Systems, Inc.	Biloxi Regional Medical Center, Biloxi, MS	KK
Baptist Memorial Health Systems, Inc.	Baptist Memorial Hospital, Booneville, MS	LL
Mississippi Baptist Medical Center	West Scott Baptist Hospital, Morton, MS	MM
Adventist Health System	East Pasco Medical Center, Dade City, FL	NN

Pre- and Post-Acquisition Ancillary Charges per Discharge

Hospital	Pre-acquisition charges per discharge	Post-acquisition charges per discharge	Increase in charges per discharge	Percent change	Market basket index change
Acquisitions by for-profits					
A	$ 669.67	$ 888.09	$218 42	33	22
B	1,493 75	2,098 98	605.23	41	15
C	676.57	861 60	185 03	27	15
D	571.51	1,025.82	454.32	79	16
E	693 73	941 32	247.59	36	10
F	282.53	436 61	154 09	55	17
G	453.57	650 57	197 00	43	17
H	965 81	1,560.78	594 97	62	7
I	892 02	1,426.03	534.01	60	15
J	1,158.40	1,334 86	176 46	15	11
K	822.37	846.74	24 37	3	15
L	852.12	1,396.94	544.82	64	18
M	830 54	1,372 28	541 74	65	18
N	869 46	1,464 80	595 35	68	15
O	498 69	1,302 09	803 40	161	22
P	711 80	1,343 47	631.68	89	26
Q	889.03	1,671 18	782 15	88	8
R	460.17	700 61	240 44	52	15
S	832 21	1,692 97	860.76	103	19
T	704.16	1,342 94	638 78	91	14
U	788.93	1,068 03	279 10	35	12
V	1,168.15	1,542 59	374.44	32	10
W	502 46	1,032 83	530 36	106	15
X	815.64	851 11	35 47	4	8
Y	1,836.90	2,383.80	546 89	30	13
Z	2,168 11	2,871 49	703.38	32	14
AA	792.70	1,316 61	523 90	66	9
BB	546 33	792.26	245 93	45	8
CC	544.66	745 74	201.08	37	13
DD	1,219 93	1,557 44	337 52	28	7
Average for 30 for- profits	$844 84	$1,263.24	$418.40	50	

Hospital	Pre-acquisition charges per discharge	Post-acquisition charges per discharge	Increase in charges per discharge	Percent change	Market basket index change
Acquisitions by not-for-profits					
EE	$ 711.70	$1,267.87	$556 17	78	12
FF	643.86	683.98	40 11	6	7
GG	1,201 98	1,444 04	242.06	20	12
HH	848 49	1,173 60	325 11	38	13
II	1,092.28	1,419.57	327 29	30	11
JJ	622 22	870.41	248.18	40	14
KK	1,633 09	2,067 29	434.20	27	11
LL	988.17	1,350 78	362 61	37	13
MM	485 83	814.72	328.89	68	8
NN	1,080 84	1,402 91	322 07	30	14
Average for 10 not-for-profits	$1,019 44	$1,409 64	$390 20	38	
Overall average for 40 acquisitions	$882.16	$1,288 12	$405 97	46	

Pre- and Post-Acquisition Ancillary Costs per Discharge

Hospital	Pre-acquisition cost per discharge	Post-acquisition cost per discharge	Increase in cost per discharge	Percent change	Market basket index change
Acquisitions by for-profits					
A	$ 407 92	$ 480 02	$ 72 10	18	22
B	979 93	1,330 32	350 39	36	15
C	297 49	378 40	80 91	27	15
D	356 50	638 14	281 64	79	16
E	476 41	592.29	115 88	24	10
F	225 25	307 89	82.65	37	17
G	339 80	509 55	169 74	50	17
H	584 35	785 30	200 95	34	7
I	611 65	756 39	144 73	24	15
J	629.39	790 06	160 67	26	11
K	579 72	620 12	40 40	7	15
L	381 60	567 12	185 52	49	18
M	450 75	681 97	231 22	51	18
N	429 50	658 41	228 91	53	15
O	307.00	788 31	481 32	157	22
P	499 35	665 50	166 15	33	26
Q	575 22	800 17	224 95	39	8
R	255 74	456 97	201 23	79	15
S	392 59	677 47	284 88	72	19
T	412 71	710 54	297 83	72	14
U	399 11	521 63	122 51	31	12
V	475 68	716 24	240 56	50	10
W	341 00	667 37	326 38	96	15
X	427 23	618 96	191 73	45	8
Y	1,008 61	1,340 04	331 42	33	13
Z	975 24	1,308 17	332 93	34	14
AA	477 66	701 50	223 84	47	9
BB	409 41	442 52	33 11	8	8
CC	346 90	599 01	252 11	73	13
DD	744 69	895 45	150 76	20	7
Average for 30 for-profits	$ 484 38	$ 672 75	$188 37	37	

Hospital	Pre-acquisition cost per discharge	Post-acquisition cost per discharge	Increase in cost per discharge	Percent change	Market basket index change
Acquisitions by not-for-profits					
EE	$ 261 76	$ 488 94	$227 18	87	12
FF	310 99	390 85	79 86	26	7
GG	572 51	822 04	249.53	44	12
HH	436 58	576 38	139 81	32	13
II	645 04	789 38	144 33	22	11
JJ	444 00	612 00	168 00	38	14
KK	856 42	1,080 31	223 90	26	11
LL	512 62	583 55	70.92	14	13
MM	302 14	482 61	180 47	60	8
NN	587 63	793 94	206 32	35	14
Average for 10 not-for-profits	$544 66	$720 43	$175 78	32	
Overall average for 40 acquisitions	$497 26	$680 86	$183 59	37	

Pre- and Post-Acquisition Capital Costs per Discharge

Hospital	Pre-acquisition cost per discharge	Post-acquisition cost per discharge	Increase in cost per discharge	Percent change
Acquisitions by for-profits				
A	$ 67 84	$123 60	$ 55 97	83
B	132 98	317 10	184 12	138
C	32 36	33 43	1 08	3
E	59 85	66 35	6 50	11
F	35 76	43 53	7 78	22
G	31 20	221 81	190 61	611
H	56 22	155 33	99 10	176
I	67 18	82 52	15 35	23
J	86 90	202.42	115 52	133
K	33 42	210 83	177 41	531
L	54.20	79 86	25.66	47
M	47 34	56 84	9 50	20
N	53 99	132 74	78 75	146
Q	108 44	224 41	115 97	107
R	38 89	74 17	35 28	91
S	82 70	97 35	14 65	18
T	56 27	91 46	35 19	63
U	91 24	138 33	47 09	52
V	66 23	334 36	268.14	405
W	147 81	477 98	330 17	223
X	31 51	100 56	69 05	219
Y	129 32	526 13	396 81	307
Z	100 49	522 98	422 49	420
AA	33 34	78 02	44.68	134
BB	59 75	95 72	35 97	60
CC	343 53	135 47	−208 06	−61
DD	160 42	228 76	68 34	43
Average for 27 for- profits	$ 70 49	$157 81	$ 87 32	124

Hospital	Pre-acquisition cost per discharge	Post-acquisition cost per discharge	Increase in cost per discharge	Percent change
Acquisitions by not-for-profits				
EE	$ 43.70	$ 74.45	$ 30 75	70
FF	48 22	48 31	09	0
GG	31.83	49.85	18 02	57
HH	50.78	71 21	20 43	40
II	89 59	229 34	139 75	156
JJ	69.52	174 55	105 03	151
KK	61 96	83.37	21 41	35
LL	86 44	99 37	12 93	15
MM	151 45	159 74	8 30	5
NN	83.63	186.80	103.17	123
Average for 10 not-for-profits	$67 90	$104 27	$36 37	54
Overall average for 37 acquisitions	$69.80	$145.90	$76 10	109

Pre- and Post-Acquisition Medicare Return-On-Equity Payments per Discharge[a]

Hospital	Pre-acquisition cost per discharge	Post-acquisition cost per discharge
Acquisitions by for-profits		
A	0	$194 36
B	0	151 10
C	0	96 80
E	0	84 35
F	0	117 10
G	0	107 39
H	0	18 29
I	0	220 24
J	0	108 54
K	0	121 91
L	0	75 72
M	0	131 75
N	0	66 17
Q	0	19.30
R	0	3.25
S	0	19 70
T	0	26 13
U	0	00
V	0	00
W	0	00
X	0	00
Y	0	4 30
Z	0	2 25
AA	0	00
BB	0	96 20
CC	0	62 92
DD	0	355.15
Average for 27 for-profits	0	$101 16

[a]Only acquisitions by for-profit entities are shown because not-for-profit entities do not qualify for Medicare return-on-equity payments

Pre- and Post-Acquisition Administrative and General Costs per Discharge

Hospital	Pre-acquisition cost per discharge	Post-acquisition cost per discharge	Increase in cost per discharge	Percent change	Market basket index change
Acquisitions by for-profits					
A	$ 95 70	$143.16	$ 47.46	50	22
B	400 53	512 81	112 28	28	15
C	53 41	111 67	58 26	109	15
D	155.71	216.97	61.26	39	16
E	227 96	270 17	42 22	19	10
F	91 45	166 52	75 08	82	17
G	124 90	224.83	99 93	80	17
H	168 49	234.96	66 47	39	7
I	206 19	298 20	92 01	45	15
J	168 42	225 31	56 89	34	11
K	152 35	218.19	65.83	43	15
L	107 60	302 84	195.24	181	18
M	155 50	364 68	209 18	135	18
N	168.54	297.38	128.85	76	15
O	86 42	443 57	357 15	413	22
P	168.85	260 76	91 90	54	26
Q	186.98	339 98	153 00	82	8
R	80 66	166 85	86 20	107	15
S	122 43	230 57	108 14	88	19
T	126 88	254 48	127.60	101	14
U	124 23	156 76	32 53	26	12
V	234 13	446.54	212.41	91	10
W	141 18	334 67	193 49	137	15
X	155.47	313.85	158.38	102	8
Y	400 54	730 88	330 34	82	13
Z	264 03	433.02	168 99	64	14
AA	215 96	337.43	121 47	56	9
BB	116 14	237 07	120 94	104	8
CC	136 79	342 19	205 40	150	13
DD	226 03	744 77	518 74	229	7
Average for 30 for-profits	$154 38	$287 07	$132.69	86	

Hospital	Pre-acquisition cost per discharge	Post-acquisition cost per discharge	Increase in cost per discharge	Percent change	Market basket index change
Acquisitions by not-for-profits					
EE	$183.03	$201 63	$ 18 60	10	12
FF	167.99	275 77	107 78	64	7
GG	237 89	386 24	148 36	62	12
HH	197.09	278 64	81 55	41	13
II	189.09	180 71	−8 38	−4	11
JJ	142 72	153 88	11 17	8	14
KK	233.16	373.30	140 14	60	11
LL	138 08	221 68	83 61	61	13
MM	87.39	163.28	75 90	87	8
NN	238 30	303 33	65 03	27	14
Average for 10 not-for-profits	$187 96	$274.39	$ 86 44	46	
Overall average for 40 acquisitions	$161 56	$284 92	$123 36	76	

Advance Comments From the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D C 20201

MAR 31 1986

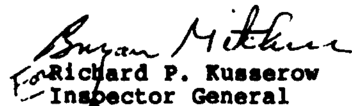
Mr. Richard L. Fogel
Director, Human Resources
Division
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Fogel:

The Secretary has asked me to respond to your draft report, "Public Hospitals: Sales Lead to Better Facilities But Increased Patient Costs." Department officials have reviewed this report with interest and have no comments to make at this time.

Thank you for the opportunity to respond to your report before its publication.

Sincerely yours,



Richard P. Kusserow
Inspector General

Advance Comments From the National Association of Public Hospitals

NATIONAL ASSOCIATION OF PUBLIC HOSPITALS 1426 Twenty-First Street N W Suite 10 Washington D C 20036 (202) 861-0434

Denver General Hospital
Boston City Hospital
District of Columbia General Hospital
Harris County Hospital District (Houston)
University of Medicine and Dentistry of New Jersey University Hospital
Grady Memorial Hospital (Atlanta)
Cleveland Metropolitan General Hospital
Santa Clara Valley Medical Center (San Jose)
The Los Angeles County Hospitals
Parkland Memorial Hospital (Dallas)
Truman Medical Center (Kansas City)
San Francisco General Hospital
Bellevue Hospital Center
Bronx Municipal Hospital
Cook County Hospital
Contra Costa County Health Services Department
Brackenridge Hospital (Austin)
Wishard Memorial Hospital (Indianapolis)
Chope Community Hospital (San Mateo)
Worcester City Hospital
Alameda County Health Care Services Agency (Oakland)
Westchester County Medical Center
Milwaukee County Medical Complex
Nassau County Medical Center
Regional Medical Center at Memphis
Pacific Medical Center (Seattle)
University of New Mexico Hospital
Harborview Medical Center University of Washington
Fresno County Valley Medical Center
General Hospital Ventura County
R E Thomason General Hospital (El Paso)
Kern Medical Center (Bakersfield)
University of Cincinnati Hospital
University of Texas Medical Branch
Queens Hospital Center
Hurley Medical Center (Flint)
San Bernardino County Medical Center
San Joaquin General Hospital (Stockton)
Riverside General Hospital University Medical Center
Oregon Health Sciences University Hospital
Spartanburg General Hospital (Spartanburg SC)
Harlem Hospital Center
Charity Hospital of Louisiana
Maricopa Medical Center (Phoenix)
St Louis County Hospital
Memorial Medical Center (Savannah GA)
Amarillo Hospital District
Jackson Memorial Hospital (Miami)
Pontiac General Hospital (Pontiac MI)
Clinton Memorial Hospital (Wilmington OH)
Earl K Long Memorial Hospital (Baton Rouge)

March 25, 1986

Richard L. Fogel, Director
Human Resources Division
U.S. General Accounting Office
Washington, D.C. 20548

Dear Mr. Fogel:

Thank you for giving me the opportunity to review your draft report on the sale or lease of public hospitals. In general, I believe this report is a valuable contribution to the current debate on this often-emotional subject, carefully weighing both the possible advantages and disadvantages of the transfer of ownership of both public and non-profit hospitals. Your analysis of the impact of such transfers on hospital charges and costs, and especially capital costs, is particularly enlightening.

I cannot comment on any of the specific examples you have analyzed, as I have no direct knowledge of any of those hospitals. However, I have observed both the causes and results of the transfers you describe in numerous other situations, and most of them appear to follow similar patterns--even including the unfortunate inability to record differences in the provision of indigent care. In that regard, I do note, however, that you have limited your analysis for the most part to smaller hospitals in rural areas or smaller SMSAs. Where reorganization or transfer of public or non-profit hospitals has occurred in larger metropolitan areas, my experience has been that indigent care has been both more predominant to begin with and more accurately tracked following the change. There are several such examples available in the area of the county you were particularly interested in, although some of them involve transfer of a public hospital to a newly organized, locally controlled non-profit corporation, rather than the "sale" to a third party. For your future reference,

Mr. Richard L. Fogel
March 25, 1986
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those hospitals include the Memorial Medical Center of Savannah, the Regional Medical Center at Memphis, University Hospital of Louisville and Manatee County Hospital District and the University of Florida Hospitals in Florida.

Finally, I would like to call your specific attention to just one or two sections of your report where I might recommend changes:

Now on p 2

- At page i, you note that public hospitals provide "over 90% of the uncompensated care to the medically indigent." We have never seen any analysis to indicate that the proportion is this large, although we agree it is significant. We suggest that you use instead the Urban Institute's recent data, which indicated that of $12.6 billion in indigent care recorded by hospitals in our 100 largest SMSAs, $9.2 billion was provided by state or locally owned facilities.

- At page 46, please note that our organization is the "National Association of Public Hospitals" (NAPH). Also, the $6.4 billion referred to, I believe, represents our own members' total budgets in 1982. I am not otherwise familiar with those members -- as indicated above, the total amount of indigent care and the private sector contribution noted there appear too small. Please feel free to call our Director of Research, Dennis Androlis, at 861-0434, to discuss these statistics.

Sincerely,

Larry S. Gage

Larry S. Gage

Advance Comments From the American Hospital Association

American Hospital Association

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Suite 500
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Telephone 202 638 1100
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April 14, 1986

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

Dear Mr. Fogel

On behalf of its 6100 member institutions and 35,000 personal members, the American Hospital Association would like to express its appreciation for this opportunity to comment on the draft report on hospital acquisitions recently prepared by the General Accounting Office. On the whole, the report presents an interesting perspective on a complex issue. However, several aspects of the report merit comment.

First, the data presented in the report on the amount of uncompensated care provided by public and other hospitals does not tally with data compiled by the American Hospital Association and used by nearly every organization with an interest in the subject. The report states that over 90 percent of all uncompensated care is provided by public hospitals, and cites several statistics in support of this statement. The figures available to the American Hospital Association, which are derived from more than 4,000 responding hospitals, tells a somewhat different and more complex story.

The figures cited in the report will differ somewhat for several reasons, although the absence of a citation in the report makes any direct comparison impossible. The figures which follow describe uncompensated care (i.e., bad debt plus charity care) in terms of expense, and not charge, dollars. As such, they are a better indicator of the resources consumed in meeting the needs of the medically indigent than the figures included in the draft report. In addition, the following statistics include both uncompensated care and unsponsored care (i.e., uncompensated care less state and local tax appropriations). The uncompensated care figures are an indicator of the role of the hospital in meeting the needs of the medically indigent, whereas the unsponsored care figures are an indicator of the impact of providing care to the medically indigent on the hospital's privately insured patients. In interpreting the following tables, the data should be treated circumspectly because of relatively lower rates of response among investor owned hospitals as contrasted to voluntary not-for-profit and public hospitals.

As these figures indicate, public hospitals provided a disproportionate amount of uncompensated care, although the level of unsponsored care provided by public hospitals was only slightly higher than the level of unsponsored care provided by voluntary not-for-profit and investor owned hospitals. However, the majority of uncompensated and unsponsored care is provided by voluntary not-for-profit hospitals. These data do not indicate, of course, the uneven distribution of both uncompensated and unsponsored care, but it is important to recognized that, depending upon the community, hospitals of all types may serve as the principal source of care for the medically indigent. Nevertheless, it is true that hospitals providing high levels of unsponsored or uncompensated care are more likely to be publicly owned.

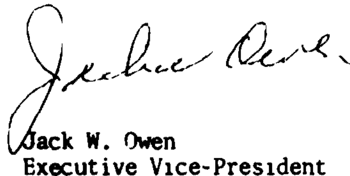
	1982	1984
UNCOMPENSATED CARE (in billions)		
PUBLIC	$1.61	$2.21
VOLUNTARY	$3.09	$4.25
INVESTOR	$0.28	$0.44
TOTAL	$4.98	$6.90
UNCOMP CARE %		
PUBLIC	8.1%	9.9%
VOLUNTARY	4.0%	4.7%
INVESTOR	3.5%	4.3%
TOTAL	4.8%	5.6%
UNSPONSORED CARE (in billions)		
PUBLIC	$0.71	$1.08
VOLUNTARY	$3.04	$4.21
INVESTOR	$0.28	$0.44
TOTAL	$4.04	$5.73
UNSPONSORED CARE %		
PUBLIC	3.6%	4.8%
VOLUNT RY	4.0%	4.6%
INVESTOR	3.4%	4.3%
TOTAL	3.8%	4.6%

A second comment on the draft report conerns the use that is made of the study on patient transfers conducted by Himmelstein, et. al.. In light of the foregoing statistics, it is apparent that an extremely large volume of uncompensated care is provided by voluntary not-for-profit hospitals. This study, as used in the draft report, leaves the impression that private hospitals are not a significant factor in providing care to the medically indgent. The primary limitation of this study is its failure to examine the actual volume of such care actually provided by non-public hospitals. Furthermore, the study is used to support a tentative conclusion concerning for-profit hospitals, even though the ownership of the hospitals included in the study was not described by its authors. Although there is little question that some public hospitals provide substantial and disproportionate amounts of care to the medically indigent, and although the inappropriate transfer of medically unstable patients for financial reasons is to be deplored if and when it occurs, the Himmelstein, et. al., study documents neither condition.

Finally, the report relies heavily on the rate of change in certain categories of expenses following acquisition. Although never clearly stated, the implication of using a rate of change is that these costs increased "excessively" or "inappropriately". In presenting the data, however, it is impossible to evaluate the appropriateness of the rate of change without first evaluating the level of expenses before the acquisition. Capital expenses per case, for example, will clearly rise sharply following a major capital investment, but will then decline relative to operating costs. This pattern is produced by the nature of capital expenditures. Similarly, the rapid rate of increase in administrative costs may be a reflection of an inadequate investment in administrative resources. Finally, it should be noted that the draft report relies on cost-per-case, but does not present any information on changes in the number of admissions. If, as a result of the acquisition, admission volumes temporarily declined, the increase in per-case costs may be spurious. It would be most useful to present all of the information needed by a reader to assess the significance of the reported trends.

In conclusion, a more complete presentation of the data underlying the conclusions would be of great assistance to the reader who wishes to examine independently the evidence underlying the conclusions. In addition, either this or future reports should examine the effect on the services available to "private" patients at the acquired hospitals. By presenting only information on costs, the report tends to leave the impression that acquisition provided few benefits to the communities served by these hospitals. If AHA can be of further assistance, please contact Jim Marrinan at 202.638.1100 in this office, or Henry Bachofer in our office of Public Policy Analysis at (312)280-6599.

Sincerely



Jack W. Owen
Executive Vice-President

Advance Comments From the Federation of American Health Systems

Federation of American Health Systems

March 21, 1986

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202-833-3090

Michael D Bromberg, Esq
Executive Director

Richard L. Fogel
Director
U.S. General Accounting Office
Human Resources Division
Washington, D.C. 20548

Dear Mr. Fogel:

Thank you for letting us review your draft report on the causes and effects of acquisitions of public (government and not-for-profit (NFP) hospitals by hospital systems -- both for-profit and NFP. We have no quarrel with the information you present, but believe that some points need to be presented in a different context in order to be as fair and meaningful as possible.

Here are our specific comments:

1) It may be appropriate to point out that the sample of acquisitions studied may not be representative of the entire population of acquisitions, especially acquisitions by not-for-profit hospital systems.

2) We question whether the data support the inference that acquiring for-profit hospitals raise charges more than acquiring NFP hospitals, all other things equal. The study does not compare matched pairs of hospitals so one cannot say what a not-for-profit would have done under similar circumstances. You may say that the findings are suggestive of a tendency of for-profit hospitals to raise charges more in the period covered by the study, but we think the reader should be told that the findings are not necessarily conclusive. Hospitals with above average increases in charges, for example, may have upgraded their technology base more than others. This upgrade would have to be taken into account to get a true picture of the increase in charges relative to the level of services offered.

3) Most readers will conclude that the cost to a community for its hospital care will be higher under investor-owned (I-O) ownership. This is not necessarily true. Taxes paid by I-Os (but not by NFPs) need to be taken into account.

March 21, 1986

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4) To assure topicality, you might want to mention that the hospital market today is much different from the "charges are no object" days of the early 1980s. Competition is driving realized charges closer to costs for all hospitals.

5) The subhead on page 46 and following text give a misleading impression that I-O hospitals provide less indigent care than NFP hospitals. According to the American Hospital Association, in 1984 government-owned hospitals' bad debt and charity care accounted for 13.8% of gross patient revenues; the comparable ratios for private NFP and for-profit hospitals were 4.6% and 3.6% respectively. Furthermore, we think that the AHA's ratio for investor-owned hospitals is low; less than 30% of I-O hospitals respond to the AHA survey. Almost 70% respond to our survey and we report I-O charity and bad debt at 5.1% of gross patient revenues.

You state on page 47 that "...some data are available which show that some for-profit hospitals that provide emergency services to persons unable to pay transfer such patients to nearby public hospitals as soon as the patients are stablilzed." This is a misleading statement; it implies that there is differential "dumping." <u>There is no evidence whatsoever that for-profit hospitals account for a disproportionate share of patient transfers.</u> We feel strongly that this point must be stated explicity.

We appreciate the opportunity to respond and would be pleased to provide whatever additional detail you may wish.

Sincerely,

Michael D. Bromberg
Executive Director

MDB/res

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