5-1975

Medicare: Problems Involved with Cost Allocation, Utilization, and Redisbursment

Gerald A. Forgit

MEDICARE: PROBLEMS INVOLVED WITH COST ALLOCATION, UTILIZATION, and REIMBURSEMENT

by

Gerald A. Forgit

Bachelor of Business Administration, University of Massachusetts 1969

An Independent Study

Submitted to the Faculty

of the

University of North Dakota

in parital fulfillment of the requirements

for the degree of

Master of Science

Grand Forks, North Dakota

May

1975

TABLE OF CONTENTS

CHAPTER ONE

INTRODUCTION TO THE MEDICARE PROGRAM

Program Inception and Authority:

Medicare is a two part program enacted by the Social Security Amendments of 1965, Public Law 89-97, although it did not become effective until July 1 of 1966. The first part, which is largely financed through hospital insurance taxes imposed by the Internal Revenue Code and provides protection against hospital and related health care costs is titled "Hospital Insurance benefits for the Aged and Disabled" but is known as "Basic Medicare" or "Part A Medicare." It is the basic plan and is referred to as Hospital Insurance.[1] The second part is called "Supplemental Medical Insurance Benefits for the Aged and Disabled," but is more commonly known as "Medical Insurance Program" or "Part B Medicare." This program covers the costs of physicians services and other health items not covered under the basic program. The medical or voluntary insurance program is paid for by those enrolled and by matching funds from the Federal Government.

Requirements for Receiving Coverage:

There are four methods of becoming eligible for hospital insurance benefits. One method, which effects the majority of those reaching 65, applies to persons who are entitled to monthly social security retirement benefits or survior benefits or who are "qualified railroad retirement beneficiaries." To be entitled to Social Security a person must file an application, but even if he continues to work, he is eligible for Basic Plan Benefits. Since July 1, 1973 the second method allows social disability beneficiaries at any age, who have received disability benefits for at least 24 consecutive months to be covered under the Basic

Plan.[2] A "qualified railroad retirement beneficiary" means that the individual is entitled to an annuity or a pension under the Railroad Retirement Act.[3] The third method, a transitional provision, applies only to those who are not eligible for monthly social security or railroad retirement benefits but who either reached 65 before 1968 or after 1967 and have a minimum of three quarters of coverage. Someone reaching age 65 in 1974 would need 20 quarters of coverage. This entitles those 65 or over to benefits if they enroll and pay a monthly premium of $36 for the period of July 1974 until June of 1975 at which time it increases to $40 monthly. Finally, starting July 1973, protection under the hospital insurance program includes persons under age 65, who are entitled to monthly cash payments under either social security or railroad retirement programs because they are disabled. Entitlement for protection under the hospital insurance programs begins after they have been entitled to disability for at least 24 consecutive months.

As proof of right to protection under hospital insurance benefits and/or supplementary medical insurance, the Social Security Administration issues to each beneficiary and "Health Insurance Card," Form 55A-1966. This card displays beneficiaries name, sex, claim number, extent of his entitlement, and the effective dates(s) of his rights. This card should be shown whenever services are required.

Generally, Medicare's hospital insurance helps pay for three kinds of care. They are (1) inpatient hospital care; and when necessary after hospital stay, (2) inpatient care in a skilled nursing facility, and (3) home health care. The hospital insurance ("Part A" Medicare) covers almost all medical costs except for the first $92 (increased from $89 in 1974 because of increased medical costs) and a charge of $23 a day for the 61st through 90th day in a hospital in any benefit period.[4] A benefit period is technically known as "spell of illness" and begins with the first day the beneficiary is eligible for Medicare and is furnished

hospital or extended care services and ends when he has been out of a hospital or skilled facility for 60 consecutive days. The beneficiary pays the deductible of $92 only once in each "benefit period." There is a charge of $46 a day (up from $42 in 1974) for each of the 60 reserve days used. Reserve days are not renewable like the 90 hospital days in each benefit period. Since there are only 60 reserve days in a beneficiaries life time, he can decide himself when he wants to utilize them. If the patient does not want to make use of his reserve days after his allotted 90 has passed, then he must notify the hospital in writing ahead of time. Otherwise, the reserve days will automatically be deducted from the current total.

Hospital insurance does not cover physician's services even though received in a hospital unless he is a student intern or resident in training. Physician services are covered under Medicare's Medical Insurance ("Part B" Medicare). The following services are covered under hospital insurance: (1) semiprivate room (2 to 4 beds in a room) or private room if medically required. (2) all meals, including special diets. (3) regular nursing services. (4) intensive care unit costs. (5) drugs furnished by hospital. (6) lab tests and x-rays. (7) medical supplies. (8) operating and recovery room costs and, (9) rehabilitation services. Medicare's hospital insurance will not pay for personal convience items, private duty nurses and the first three pints of blood you receive in a benefit period.

The benefits can be received in tuberculosis hospitals, psychiatric hospitals, Christian Science Sanatoriums and general hospitals, but psychiatric hospitals benefits are limited to a lifetime use of 190 days.

Hospital insurance benefits can be applied for the beneficiary if all of the following requirements are met: (1) a doctor prescribes impatient care, (2) illness requires the kind of care that can be only provided in a hospital, (3) the hospital is participating in Medicare, and (4) the Utilization Review

Commitee does not disapprove the stay.

Post hospital extended care can be provided in a "skilled nursing facility," which is a facility having staff and equipment necessary to provide skilled nursing care or rehabilitation services. Generally qualification for admission requires at least 3 consecutive days in a hospital, transfer to a facility within 14 days after discharge from the hospital and that a doctor certifies that skilled nursing or rehabilitation is needed on a daily basis. Coverage can be received for up to 100 days in any benefit period. The beneficiary pays $11.50 a day for each day over 20 in each benefit period.[5] Usually only those costs furnished to a hospital inpatient are covered during a stay in a "skilled nursing facility."

After discharge from a hospital in which the stay was at least three days, or from a skilled nursing facility, hospital insurance covers the costs of up to 100 home health visits, if they occur before the start of a new benefit period. They must be under a plan established by a doctor within 14 days of discharge and must occur within one year of discharge. The services must be provided at home, except when specialized equipment is necessary.

Complete coverage is not available under the health or hospital insurance program. The insurance ("Part B" Medicare) was designed to supplement the coverage provided by the hospital plan. Under this plan the Federal Government usually pays 80% of the reasonable costs of charges for services extended to the beneficiary. Once again there is a deductible that must be paid by the patient. It is a medical insurance deductible and is the first $60 of covered expenses in each calender year. There is a special carry over rule applicable to the $60 deductible. If the beneficiary has covered medical expenses in the last three months of a year that can be counted toward the $60 deductible for the next year.[6]

Medical insurance extends coverage for doctors services, outpatient hospital care, outpatient physical therapy and speech patholgy, home health care, and other

services not supplied by Medicare's hospital insurance.

The preceding paragraphs described the two basic insurance plans, and leaves a brief paragraph on how medical insurance payments are made. Under Medicare's medical insurance program payment can be made to the doctor, called assignment, or to the beneficiary. The assignment method can be used only if both the physician and beneficiary agree to it. If the doctor agrees to it, he is also agreeing to accept the reasonable charge set by Medicare. Payment made to the patient is 80% of reasonable charges, after subtracting any part of $60 deductible that is applicable.

Use of an Intermediary or Carrier:

Adminstration of the hospital insurance and supplementary medical insurance programs is the responsibility of the Secretary of Health, Education, and Welfare. This extensive program requires the aid in administration from both state and private agencies. The Secretary is also authorized to use separate organizations for services such as auditing or cost analysis.

Responsibility for the administration of medicare is further broken down by the Secretary of HEW to the Social Security Adminstration and specifically to the Bureau of Health Insurance. The law provides for considerable participation of private organizations in the actual adminstration of both the hospital insurance and medical insurance plans. Medicare payments are generally handled by private entities under contract with the government. Those handling claims from hospitals, skilled nursing facilities and home health agencies are referred to as intermediaries. Carriers work with claims from doctors and other suppliers of services under the medical insurance program. Intermediaries and their role will be discussed first, then the duties of carriers will be explained. In dealing with intermediaries, the Blue Cross Association will be discussed.

The hospital insurance plan allows groups of providers to nominate national,

state, or local public or private agencies to function as an intermediary between themselves and the federal government. It is expected and is usually the case that a private organization is nominated. In the majority of cases a local Blue Cross Association is selected. After selection by the providers an agent contracts with the government under which the intermediary determines the amount of payment to be made and distributes the reimbursement to the provider. Also, it is not unusual for the intermediary to provide consultation services in order for the provider to perform as required under the Basic Plan. It's other duties are to act as a chain of command between Secretary and provider, and to audit the providers records. The Secretary advances funds to the intermediary for payment of providers services, and agrees to pay adminstrative costs to the agent. If unsatisfactory results are the result of the agreement between the intermediary and the Secretary then either side can terminate the relationship, the only stipulation is that the government must give 120 days notice to public and providers, while the intermediary must give 180 days notice to the same plus the Secretary.

Generally the role of administering the medical insurance plan is assigned to carriers. They are non-governmental agencies appointed by the Secretary. A carrier can be any entity experienced in the health insurance field. The contract between the Secretary and the carrier is for operation of the Basic Plan and requires the government to reimburse the agent for administrative costs involved in the program. A normal contract is for at least one year and can be automatically renewable. It is interesting that these contractors are selected by the government, unlike the intermediary, and that competitive bidding for the contract is not required. The law requires certain duties which the carrier is obligated to perform and typically requires the following:[7]

(1) To determine the reasonable charges for services furnished; if a provider is involved it's reimbursement must be on a reasonable cost basis;

after the date of notice.

END NOTES TO CHAPTER ONE

[1]P-H Social Security and Unemployment Compensation. para. 32 901.

[2]Ibid., para. 30, 747-A.2.

[3]Commerce Clearing House, Inc., 1974 Social Security and Medicare Explained (Chicago: 1974), para. 605.1.

[4]P-H Social Security and Unemployment Compensation, Report Bulletin 15, October 16, 1974, para. 15.1

[5]Ibid.

[6]U.S. Department of Health, Education, and Welfare, Social Security Administration, Your Medicare Handbook. HEW Pubn. No. (SSA) 74-10050 (1974), p.20.

[7]P-H Social Security and Unemployment Compensation. para. 32, 949.

[8]Ibid., para. 31, 680.2.

CHAPTER TWO

THE BASIC REIMBURSEMENT FORMULA

What Services are Reimbursed:

This chapter will cover the subject of reimbursement. It will begin with some discussion on what services are reimbursed and will explore more deeply how they are reimbursed.

Basically there are two bases for reimbursement or payment under the Medicare program. These are denoted as "reasonable cost" and "reasonable charge." Both terms will be defined as the two independent plans of Medicare are discussed. Generally any amount paid to a provider of services-i.e. hospital, skilled nursing home, home health agency- for services rendered to a beneficiary is, after adjustment for the deductible portion, the "reasonable cost" of the services. A provider is reimbursed for services on basis of "reasonable cost" whether the applicable plan is the hospital insurance program or the medical insurance plan.

Generally, reimbursement for physician services, medical and other health services under the medical insurance program is based on the "reasonable charge" for the service. One noted exception to this rule is that an organization that provides medical and other health services on a prepayment basis may elect to be paid on the basis of "reasonable cost" as opposed to reimbursement on the "reasonable charge" method.[1]

Reimbursement under the hospital insurance plan requires the use of a "reasonable cost" in it's determination. Basically, "reasonable costs" are current costs, both direct and indirect, including standby costs, that are

necessary expenses of the institution in providing services to beneficiaries, rather than costs of a past period or a fixed rate. The share of total hospital costs to be accepted by the program is related to the care given beneficiaries in order that no cost of their services will be borne by patients not covered by the hospital insurance plan.

A provider of services is usually reimbursed on the basis of "reasonable cost" as noted before, but such costs cannot exceed the providers customary charges for such services. In the case of services provided free of charge or at nominal charge, the reimbursement is determined on the basis of items included in the determination of reasonable cost which will provide "fair compensation" for such services. It was the Social Security Amendments of 1972 that authorized the use of customary charges or fair compensation where applicable but did not become effective until accounting periods beginning after 1973.[2]

Under new rules, effective for cost reporting periods beginning Jan. 1, 1974, reimbursements are limited to customary charges to the community at large when those charges fall below the providers reasonable cost. When the provider is a public institution that furnishes care free or for a nominal fee, reimbursement will be at reasonable costs.[3]

The law provides that a reasonable cost is determined under acceptable methods established by regulations. These methods will be explained in the next few paragraphs covering the hospital insurance plan. Considerations must be given to principles developed and generally applied by national organizations, such as AMA and Blue Cross Association, when developing acceptable methods used in computing reimbursement to providers. Determination of cost of services may be based on a per diem, per unit, per capital, or other basis. It may provide for using different methods in different circumstances, and for the use of cost estimates. It may also provide for the use of charges or a percentage of charges where this method reasonably reflects the costs. The regulations must also

provide for making retroactive corrective adjustments where the total reimbursement proves to be either inadequate or excessive.[4] The above requirements were part of the original law and it has since been amended to include a specific provision for recognition of a reasonable return, not to exceed 1½ times the average rate of interest on obligation issued by the Federal Hospital Insurance Trust Fund, on equity capital including necessary working capital invested in the facility.[5]

The 1972 Amendments to the Social Security Act excluded in the computation of "reasonable costs" any cost in excess of what was actually incurred and more important any "cost found to be unnecessary in the efficient delivery of needed health services." This is not to conflict with higher or differing costs because of a difference in providers because of size, nature, and scope of services provided, type of patient treated, location of hospital, and other factors. However reimbursement of reasonable costs for inefficiency in operation or excessive services will not be provided. There would be no denying of services greater than generally provided to a beneficiary, but Medicare will not pay for that service.

Reimbursement on the basis of reasonable costs as long as they do not exceed customary charges became effective with the 1971 Amendments. Customary charges were defined in the House Ways and Means Committee as:

> (1) the charge listed in the established charge schedule (if the institution has only a single set of charges applied to all patients), or (2) the most frequent or typical charge imposed (if institution uses more than one charge for a single service). However, in order to be considered to be the "customary charge," a charge would have to be one that was actually collected from a substantial number of individuals.[6]

The Committee went further with this idea and allowed a carry forward for certain differences between the two costs.

> Your Committee recognizes the desirability of permitting a provider that was reimbursed under Medicare, Medicaid and Child health Programs on the basis of charges in a fiscal period to carry unreimbursed

> allowable costs for that period forward for perhaps two succeeding fiscal periods. Should charges exceed costs in such succeeding fiscal periods, the unreimbursed allowable costs carried forward could be reimbursed to the provider along with current allowable costs up to the limit of current charges.[7]

The Social Security Adminstration has put together regulations controlling the principles of reimbursement on a reasonable cost basis. What will follow will be a look at some of the more important principles that have been adopted. The principles of reimbursement not only give coverage to direct costs as to room and board but also to indirect costs as those to be discussed next.

There is allowable an appropriate amount for all depreciable assets used in the services of aiding beneficiaries. The depreciation allowed is basically on a historical cost amount except for those institutions with inadequate records of assets acquired before 1966. There is an optional allowance given in place of depreciation. All assets procured after 1965 must use historical cost. The assets actually used in service for beneficiaries are covered even if they have been fully depreciated for other purposes. Also, assets acquired before August 2, 1970 can be depreciated using accelorated methods allowed by income tax laws. Those purchased after that date are required to use the straight line method. There is an important point here concerning the funding of depreciation. Although not required, funding is recommended for two reasons. First it is recognized as a method to insure asset replacement and secondly it is not used as an offset against the interest expense allowable as a program cost. Under the 1972 Amendments, reimbursement will not be allowed for capital costs, such as depreciation, that are inconsistent with state or local facility plans.

Allowable costs include an amount for interest on both current and captial debts. The stipulation is that the interest must be on funds needed to satisfy a financial need, and also for a purpose closely related to patient care. The interest must be within the relevant range that a prudent borrower would have incurred in a arm's length transaction. There is also the requirement

here that interest must be on capital costs consistent with state or local health facilities.

The category of charity, courtesy discounts, and bad debts has mixed application. Charity and courtesy discounts are reductions in charges made by a provider and are not allowable as reasonable costs. Bad debts are not permissable as a reimbursable expense unless the beneficiary is negligent in paying the deductible or coinsurance amounts.

Costs of educational activities are allowable if they meet three requirements. The activity must be: (1) intended to improve the quality of health care or administration; (2) if necessary, licensed by state law; and (3) if license is not required, approved by the recognized professional organization for that particular activity. These educational activities are approved if there are formal and/or planned programs of study used by staff members of the institution. The costs of this type of program include both direct and general service costs minus amounts received from grants, tuition, etc.

Research costs that are incurred with and as a part of patient care are allowable. However, any costs involved in research that do not apply to patients is not reimbursable. As with educational activities, the costs are only paid if not covered by grants.

There are two situations with grants, gifts, and endowments. Any such income to the provider that is unrestricted is not deducted from operating costs in arriving at a reimbursement amount. But income designated by the donor for covering specific costs must be deducted.

The provider receives a major benefit from the use of volunteer or nonpaid workers. The value of services performed by them, if they work more than 20 hours per week in full time positions other than a religious order, is allowable as an operating expense. The applicable amount must be present in the records of the provider as a legal obligation. There is a stipulation that the nonpaid workers

must be a member of an organization of nonpaid workers that has an arrangement with the institution.

All purchase discounts, allowances, and refunds are reductions in cost and providers are expected to take advantage of these reductions. An intermediary has the authority not to reimburse excess costs because of an institutions failure to utilize such discounts.

Owners of certain provider organizations often render services as managers, administrators, or in other ways. The provider is allowed a reasonable amount of compensation for services to owners if the services provided are a necessary function. The amount allowed for services provided by partnerships or sole providers is determined as the reasonable value of services rendered. It is intersting to note that this cost is allowed whether there are actual distribution of profits or not. The operating profit (loss) does not effect the allowance of compensation for the owners services. With corporations, unless the compensation is paid (cash or in kind), within 5 days of the cost period, to the employee or officer holding stock and rendering service the unpaid compensation is not included in the reimbursable amount, either when paid or in the period earned.[8]

Another includable cost is the value of services, supplies, or facilities furnished the provider by related organizations. They are includable as an allowed cost at their cost to the related organization, but cannot exceed the price of comparable services or supplies purchased elsewhere.

Through the use of an "inpatient routine nursing salary cost differential," the more costly care generally received by medicare patients is recognized. The reason behind this allowance is that on the average, aged patients receive more costly care and Medicare patients are an intregal part of this group.

How Reimbursable Costs are Determined for Hospitals:

At this point the major principles controlling reimbursement have been explained. Generally, however, the Medicare program requires that all payments

to providers be based on a reasonable cost of services covered by the program and be related to patient care of beneficiaries. The includability of costs is subject to regulations prescribing the treatment of specific items and will not be discussed other than to list a few as examples. Specific treatment is given for: costs of television and telephone service, costs of billing, parking lot costs, costs of emergency room services, oxygen costs, and start-up costs, franchise fees, and organization costs.

Once allowable costs are determined the next step is to apportion the amount of such costs attributable to Medicare beneficiaries. This area of cost apportionment including cost data and cost finding is the next area of concern. The two acceptable methods for cost periods after 1971 are the Departmental Method and the Combination Method. Before discussing the two methods the terms routine services and ancillary services will be defined. Routine services means room, dietary, and nursing services, minor medical and surgical supplies, and the use of facilities and equipment for which a separate charge is not ordinarily made. Ancillary services are other services for which separate charges are usually made in addition to routine services.

Any hospital or hospital-skilled nursing facility complex with 100 or more beds is required to use the Departmental Method. Using this method, the ratio of beneficiary charges to total patient charges for the services of each ancillary department is applied to the cost of the department.[9] Added to this is the cost of routine services for beneficiaries, determined on the basis of separate cost per diem for general routine patient care sections.[10] Also, in hospitals, a separate average cost per diem for each intensive care unit, coronary unit, and other special inpatient units is added.

The following is an example of the Departmental Method taken from 20CFR 405 (Medicare) Federal Health Insurance for the aged (para. 405,452 c (2) (u)). It illustrates the apportionment on the average cost per diem for general

routine services taking into account an inpatient routine nursing salary cost differential. It apportions ancillary services cost on the ratio of beneficiary charges to total charges applied to department cost for reporting periods beginning after December 31, 1971.

The total reimbursable cost is computed in two steps. The first $88,000 is the total of the separate departmental costs arrived at by applying the applicable ratio (charges of program beneficiaries to total charges) to total costs for each department. The second amount is found by multiplying the applicable average per diem cost for the service by the beneficiary inpatient days. The separate costs of each department and service are shown in Illustration 1 and when totalled equal $300,000.

ILLUSTRATION I

DEPARTMENTAL METHOD[11]

Department	Charges to program beneficiaries	Total charges	Ratio of beneficiary charges to total charges	Total cost	Cost of beneficiary services
operating rooms	$20,000	$70,000	28 4/7	$77,000	$22,000
delivery rooms	$0	$12,000	0	$30,000	$0
pharmacy	$20,000	$60,000	33 1/3	$45,000	$15,000
x-ray	$24,000	$100,000	24	$75,000	$18,000
laboratory	$40,000	$140,000	28 4/7	$98,000	$28,000
others	$6,000	$30,000	20	$25,000	$5,000
totals	$110,000	$412,000		$350,000	$88,000

	Total inpatient days	Total cost	Average cost per diem	Program inpatient days	Cost of beneficiary services
general routine	30,000	$630,000	$21	8,000	$168,000
coronary care unit	500	$20,000	$40	200	$8,000
intensive care unit	3,000	$108,000	$36	1,000	$36,000
	33,500	$758,000		9,200	$212,000
					88,000
Total cost reimbursable					$300,000

The other method is the Combination Method and it is required for any hospital or hospital-nursing complex with less than 100 beds. Illustration 2 shows that by using this method the cost for routine services is found on the basis of a separate average cost per diem for the routine patient care sections. This amounts to $150,000 in the illustration. Hospitals then add a separate average cost per diem for the aggregate of coronary care, intensive care, and other special care units which in this case is $28,000. Also added is the cost of ancillary services used by beneficiaries ($64,000), determined by apportioning the total cost of those services (delivery room costs are excluded) on the basis of the ratio of beneficiary charges for ancillary services to total patient charges for such services.

The cost of general routine services provided to beneficiaries would be added to the $242,500 figured in the following illustration plus an inpatient routine nursing salary cost differential adjustment.

ILLUSTRATION 2

COMBINATION METHOD[12]

Financial Data:

Total inpatient days for all patients - general area	$30,000
Total inpatient days for all patients - special care units	$2,500
Inpatient days applicable to program beneficiaries - general	$7,500
Inpatient days applicable to program beneficiaries - special care	$750
Total allowable costs - general inpatient routine area	$600,000
Total allowable costs - special care units	$95,000
Inpatient ancillary services -- total allowable cost excluding delivery room	$320,000
Inpatient ancillary services- total charges excluding delivery room	$400,000
Inpatient ancillary services -charges for services to beneficiaries	$80,000

Cost Computation Applicable to Program:

Average cost per diem for general routine services:

$600,000 ÷ 30,000 = $20 per diem

Cost of general routine services to beneficiaries:

$20 per day x 750 days= $150,000

Average cost per diem for special care units:

$95,000 ÷ 2.500 = $38 per diem

Cost of services to beneficiaries:

$38 per diem x 750 days = $28,500

Ratio of beneficiary charges to total charges for all ancillary services excluding delivery room

$80,000 ÷ $400,000 = 20%

Cost of ancillary services to beneficiaries:

20% x $320,000 =	$64,000
Total cost of services provided to beneficiaries.	$242,500

The two methods illustrated are approved for hospitals and usually the hospital-nursing facility complex. There are temporary or interm methods of cost apportionment but they require approval before application. To a certain extent they depend on the facility and its size so consequently they will not be discussed in this paper.

Provider Cost Allocation Methods:

Principles of reimbursement require that providers receiving payment on basis of reimbursable cost maintain adequate financial records and cost data. The records must be such that they can be based on an approved method of cost finding and usually on the accrual basis of accounting. Government institutions operating on a cash basis of accounting are permitted to use the cost data on such basis subject to appropriate treatment for capital expenditures. The basic accounting rule of consistency applies in order not to impair comparability. Cost reports are required on an annual basis determined by the providers accounting year.

Generally, either the "Step-Down" Method or the "Double Apportionment" Method must be followed in determining the actual costs of services during the accounting period. A more sophisticated method may be used with approval of the intermediary. For reporting periods beginning after December 31, 1971, those using the Departmental Method of apportionment must use the Step-Down method or the Double-Apportionment Method. Those providers using the Combination Method are required to use the Modified Cost Finding Method. Each method will be explained in the following paragraphs.

The Step-Down Method is basically the same as that used by many companies

allocating costs of service departments to other service departments and production departments. It recognizes that services of non-revenue-producing departments (service departments) are used by other non-revenue departments as well as by revenue-producing departments. All costs of non-revenue centers are allocated to all centers they serve, whether they produce revenue or not. The usual method is to begin with the non-revenue center serving the greatest number of other centers. Once the cost of a non-revenue center is apportioned, that center is "closed." This applies even though it may have received service from a center that apportions its costs at a later time.

Similar to the Step-Down Method is the Double-Apportionment Method, which also recognizes that non-revenue centers service other non-revenue centers as well as revenue-producing centers. With this method, the non-revenue centers are not "closed" after preliminary allocation of their costs. They accumulate a portion of the costs of all other centers from which services are rendered. The preliminary allocation is followed by another or final apportionment of expenses involving the allocation of all costs left in the non-revenue-producing centers directly to the revenue-producing centers.

The final method discussed is the Modified Cost Finding Method used by providers following the Combination Method of cost apportionment. This method differs from the Step-Down Method in that services provided by non-revenue-producing centers are allocated directly to revenue-producing centers even though the services may be used by other non-revenue centers. Applying this method requires the costs of non-revenue centers having a similar basis of allocation be combined. The resultant total is then distributed to revenue centers. All the non-revenue centers having large percentages of cost in relation to total costs are allocated in this manner. The total costs of remaining non-revenue centers will be allocated to revenue centers in the pro-

portion that each bears to total costs already allocated. The basis to be used and the centers to be combined are not optional, but are identified in the cost report forms for this method. The skilled-nursing facilities generally use the methods approved for hospitals, while home health agencies have additional approved cost finding methods such as; The National League for Nursing Methods I and II and The Combined Public Health Service-National League for Nursing Method.

The last item of discussion before prospective reimbursement is payment to providers. The requirement is for payment of the reasonable cost of services provided for the beneficiaries. However since actual costs are not determined until the end of a reporting period, an interim rate, attempting to approximate actual costs, is fixed by the intermediary with each provider and is paid regularly. The intermediary will make a tenative adjustment after receiving the cost report. The final settlement will be made after auditing the providers records and reaching an agreement on the total allowable cost due. Under certain circumstances "accelorated payments" are made. Interim payments can be made, usually weekly, without regard to individual billings. This program is referred to as "Periodic Interim Payment" (PIP) and is elected by hospitals meeting certain requirements.

Prospective Reimbursement:

Concern about inadequacies of retroactive reasonable cost determinations and the escalation of health care costs, caused concern about the subject of prospective reimbursement. It would involve the use of a prospective rate and would require that the rate of payment be set in advance of the period to which it would apply. If actual costs are less than the prospective rate, the provider would retain all or part of the savings. If actual costs exceed the rate, the provider would have to begin cost saving measures to stay within the reim-

bursable rate. Possible prospective rates of reimbursement would include a study of negotiated rates, formulas and budget review. Deficiencies in cost data, lack of current methods of comparability among providers, measuring health care output, and estimating costs necessary for efficient delivery of health services are problems in attempting to apply a prospective rate.

Theoretically the prospective reimbursement method could be incentive for the provider of services to institute cost saving measures. But control must be adequate enough to prevent the savings in cost to be the result of a drop in services or their quality.[13]

In concluding the section of this chapter on provider reimbursement, the Amendments of 1972 concerning limits on recognized costs will be outline. First, the Secretary can act prospectively rather than retroactively, enabling the provider to know in advance the limits on costs that will be recognized. This is basically the section previously discussed. Second, the relatively high costs that can not be justified as reasonable for the results obtained will not be reimbursed. Third, since limits would be set in advance, it would enable a provider to charge the beneficiary for the costs of services in excess of those that are considered to be necessary in the efficient delivery of health care. However, the beneficiary must be specifically advised of the type and amount of such charges before admission.

Determination of Reimbursable Amounts For Physicians:

Payment for services under the supplemental medical insurance program furnished by a physician and others, not including a provider of services, is made on a basis of "reasonable charge." The special case of provider based-physcian will be discussed briefly here and more extensively in the next chapter.

The cost of provider based-physician services which are indirectly related to medical or surgical service provided to patients, such as teaching, admini-

stration, and supervision, are an allowable cost to the provider. However, those costs of service which are directly related to identifiable medical services are reimbursed under the medical insurance plan on the basis of reasonable charge.

The law controlling the determination of "reasonable charge" requires the administering carrier to insure that the charge will be reasonable and not higher than the charge applicable, for a comparative service under comparable conditions, to the carriers policyholders. It also requires that the determination of "reasonable charge" take into consideration the customary charge for similar services generally made by a physician in the locality.

The Amendments of 1972 expanded the original requirements so that no charge may be determined to be reasonable unless it meets the following definition:

> in the case of bills submitted or requests for payment made under this part after December 31, 1970, if it exceeds the higher of (i) the prevailing charge recognized by the carrier and found acceptable by the Secretary for similar services in the same locality in administering this part on December 31, 1970, or (ii) the prevailing charge level that, on the basis of statistical data and methodology acceptable to the Secretary, would cover 75 percent of the customary charges made for similar services in the same locality during the last preceding calendar year. . . In the case of physician services the prevailing charge level determined for purpose of clause (ii) of the preceding sentence for any fiscal year beginning after June 30, 1973, may not exceed (in the aggregate) the level determined under such clause for the year ending June 30, 1973, except to the extent that the Secretary finds, on the basis of appropriate economic index data, that such higher level is justified by economic changes.[14]

There has been much controversy over the criteria applied in making determinations of reasonable charge. Most of the controversy surround the requirement that the charge cannot be "higher than the charge applicable, for a comparable service and under comparable circumstances, to the policy holders of the carrier." The Senate Finance committee in a report on "Medicare and Medicaid" believed that the above provision was intended to limit medicare payments to the amounts in local Blue Shield fee schedules, no matter what the difference was between actual charges and the fee schedules. However, the Social Security Ad-

Administration felt that this limitation applied only where Blue Shield fee schedules were intended as payment in full for physician services. Again the Amendments of 1972 were needed for clarification. It is required that in a locality where a significant number of payments are made under Blue Shield or other insurance contracts and to the extent that these payments are accepted as full payment by physicians, they should be appropriately reflected in the charge information used in determining reasonable charges.

Reasonable charge determinations in general are under Administrative regulations. There are two criteria in the law for determining reasonable charges. They are (1) the customary charges of a physician for similar services and (2) the prevailing charges locally for similar services. Obviously, there are no uniform fee schedules applicable to all physicians, or to all in a locality. The law requires an individual determination based on charges of the particular physician and others in the area. Application of the criteria by carriers requires them to exercise considerable judgment on the data in order that reasonable charge determinations are equitable.

The Social Security Administration does not review every determination by the carrier. It will review and evaluate the general procedures and performance of duties by the carriers. The Administration hopes that application of the principles of determination will result in over-all consistency among carriers.

Customary charge refers to an amount most frequently charged by a physician for a specific medical service in a particular area. Token charges for charity patients and below normal charges for welfare and other low income patients are not included in the determination. If, in a particular case, the physican charges the patient less than his customary charge, the reasonable charge must not exceed the actual charge. The carrier is not to consider the income of a patient beneficiary in determining the amount that is a reasonable charge. There

is no provision for a carrier to evaluate the reasonableness of a charge after considering a beneficiary's economic status. The reasonable charge cannot exceed the physicians customary charge unless unusual circumstances such as medical complications arise. But there is another stipulation that the additional charge for complications must be general practice in that area. As previously stated, the carrier is expected to exercise judgment particularly when a physician varies his charges for a specific medical procedure or service. In such a case, the carrier would use the median or midpoint of charges, but only if a sufficient number of charge data is available. Within the data any clustering of charges in a certain range should indicate the point from which the customary charge should be taken. Using relative value scales in arriving at a decision is acceptable under the above circumstances. The relative value scales are also applied when there is insufficient volume of material to pick a median of charges or even simply because the carrier does not have enough information on a particular physician.

Customary charges are not static. They are subject to change because of a physicians increased charges to the public in general. The customary charge resulting from a revised charge to patients should be recognized as the new customary charge, if it is not above the limit of the prevailing charge range. The newly determined customary charge should be acceptable in judging the reasonableness of charges when future service is provided under the medical insurance program.

The prevailing charge is defined as that charge which falls within a range of charges most frequently utilized in an area for a particular medical service or procedure. The top of the range establishes a limit that a carrier will find acceptable for a given service. It is the pattern of charges in a particular locality that determine the prevailing charge. There are acceptable variations in the range of prevailing charges. These ordinarily apply to

specialists and can lead to the development of more than one range of prevailing charges that are considered reasonable. Being they are not static, carriers are expected to re-evaluate and adjust, if necessary, the determinations of prevailing charges in a locality.

In each locality, the carrier is expected to take into account the differences in population, its density, economic levels, and other factors possibly affecting charges.

In order to tie in the idea of customary and prevailing charges in the determination of what is reasonable, the following illustration is given.

> The prevailing charge for a specific procedure ranges form $80 to $100 in a locality, Dr. A's bill is for $75 although he customarily charges $80.
> Dr.B's bill is his customary charge of $85.
> Dr.C's bill is his customary charge of $125.
> Dr.D's bill is for $100, although customarily it's $80, and there are no special circumstances.
> The reasonable charge for Dr. A would be limited to $75, since reasonable charge can not exceed actual, even if lower than customary and below prevailing rate.
> The reasonable charge for Dr. B would be $85.
> The reasonable charge for Dr. C could not be more than $100, the top of the prevailing range.
> The reasonable charge for Dr. D would be $80, because that is his customary charge. Even though his actual charge of $100 falls within the range of prevailing charges, the reasonable charge cannot exceed his customary charge in the absence of special circumstances.[15]

Conclusion:

Chapter Two has dealt primarily with the principles of reimbursement, specifically the area of cost data and cost finding. Included in the cost data were descriptions of applicable methods of allocation such as the Step-Down and Double Apportionment Methods. The use of these methods in conjunction with either the Departmental or Combination Methods of cost finding in determination of the "reasonable cost" as a basis of reimbursement for providers and "other" institutions were given in detail.

Not only were applicable hospital methods disclosed, but the use of a reason-

able charge, and its determination, was given considerable coverage in dealing with physician reimbursement provided by the voluntary medical insurance plan or Part B Medicare as it is known.

The discussion and illustrations have shown the complications that the Medicare program has created for health care institutions and individuals. The law is exacting and yet it leaves, what seems to be, a great deal of judgment to the intermediary in the determination of what is a reasonable charge or cost. This is especially noticeable if the differences of locality and economic level are considered.

END NOTES TO CHAPTER TWO

[1]Commerce Clearing House Inc., 1974 Social Security and Medicare Explained (Chicago: 1974), para. 678.

[2]Ibid., para. 679.

[3]P-H Social Security and Unemployment Compensation. Report Bulletin 4, May 15, 1974, para. 4-2.

[4]Commerce Clearing House Inc., para. 679.

[5]Ibid.

[6]U.S. Congress, House, Social Security Amendments of 1971, Report of the Committee on Ways and Means on H.R.1. 92nd Cong., 1st sess., 1971, p. 102.

[7]Ibid.

[8]P-H Social Security and Unemployment Compensation. para. 31, 664.25 (d) (2).

[9]Ratio of beneficiary charges to total charges means the ratio of inpatient charges to beneficiaries of the health insurance program for services of a revenue-producing department to inpatient charges to all patients for the department during an accounting period. Once the revenue-producing center's ratio is determined, the cost of services rendered to beneficiaries of the program is computed by applying the ratio for the center to the cost of related center for the year.

[10]The average cost per diem for general routine services means the amount computed by dividing the total allowable inpatient cost for routine services (not counting the cost of services of intensive care, coronary, and other special care units as well as nursery units) by the total number of inpatient days of care (excluding the same as above) provided by the institution in the accounting period.

[11]P-H para. 31, 664.51 (c) (2) (u).

[12]P-H para. 31, 664.51 (c) (3) (iii).

[13]U.S. Congress, House, Social Security Amendments of 1971, Report of the Committee on Ways and Means on H.R.1. p. 80.

[14]Social Security Amendments of 1972, Statutes at Large 86, Sec. 224(a), (1972).

[15]P-H para. 31, 665.4.

CHAPTER THREE

REIMBURSEMENT PROBLEMS

Hospital Requirements For Participation:

This chapter will look at the definition of a hospital and the conditions necessary for its participation in the hospital insurance plan (Part A Medicare). Along with this, will be a discussion on the reimbursement problems of the hospital-based physician. The passage of PL 92-603 has several interesting changes and they will be noted. The last area of concern is the use of an economic index as a measure of the effects of inflation on reimbursement.

Section 1861 (e) of the Social Security Act defines "hospital" (including skilled-nursing facility) as an institution that is:

(1) ordinarily engaged in providing to inpatients, usually under the care of a physician, diagnostic and theraputic services, treatment and care of the disabled, sick, or injured,

(2) maintains clerical records,

(3) has bylaws effective for a staff of physicians,

(4) has a requirement that the patient must be under care of a physician, and

(5) provides 24-hour nursing service supervised or given by a registered nurse, and has one on duty at all times; except this requirement may be waived by the Secretary until January 1, 1976.

The above are the basic requirements since enactment of the Act. For fiscal years after March 1973 it has been a requirement that hospitals have a written overall plan and budget reflecting an annual operating budget and a capital expenditures budget as a condition for participation.[1] This operating budget must include all expected income and expenses determined by using generally accepted

accounting principles. Capital expenditures must show a three year plan including the applicable operating budget year. For capital expenditures of more than $100,000, a detailed plan for sources of financing and expenditure objectives is required.[2] These plans and budgets are expected to be reviewed and revised annually. Preparation of the plan by the hospitals' governing body must include medical as well as administrative staff.[3]

The conditions for participation are extremely numerous and that in itself causes problems. For example, there are separate conditions for most departments. There are applicable conditions for physical facilities, medical staff, dietary department, pharmacy room, laboratories, and cooking facilities. The conditions for every separate component can be found in the regulations, specifically Subpart J of the Medicare regulations, 20 CFR Part 405.

Hospital-Based Physician:

There seems to be a particular problem for providers in receiving maximum reimbursement for the services of the hospital-based physician. This is not for services furnished to individual patients, but rather costs that are generally borne by the hospital insurance program as stated previously.

Not only are the types of services performed by physicians numerous but the method of compensating them is left, to a great extent, to an agreement between the provider and physician. Generally, compensation is either on a salary basis, a percentage of the gross income received from the patients for a particular service (from the anathesiology department), or a percentage of net income re-received from patients (possible a percentage with a guaranteed amount).[4] No matter how the billing is accomplished or what method is used to distribute the proceeds between physicain and hospital, it is almost always charged to the patient as a single sum. The problem arises because in order to receive payment for services, it is necessary for the hospital to distinguish between the medical

services of the physician and the hospital services (including the physician services for the hospital).

The Medicare program has brought about a great deal of controversy regarding reimbursement of the hospital-based physician. A factor contributing to the controversy has been the lack of information at both the hospital and intermediary level. The primary reason is believed to be a misunderstanding of the principle for hospital-based physician reimbursement. What will follow is a description of the fundamental principle and a description of how, using the same principle, maximum reimbursement can be received.

The principle requires a reimbursement for medical and surgical services be on the basis of reasonable charge. Hospital services through a physician under the hospital insurance plan are on a reasonable cost basis. The distinction between charges and costs is important if the physician is paid on a percentage of gross income (collections). This situation is the result of an agreement between the two to have the provider deduct a percentage of the physicians charges to cover billing costs. This possibly could have been an attempt to have the physician share in the allowance for charity, courtesy, or bad debts, but the term billing costs were used. If the terms of the actual agreement are not known, the provider should estimate costs of billing and determine if the reduction in the physician's fee is actually a reimbursable billing costs.

Possibly the most frequently used method for compensation is to record the net fees paid to the physician as a charge to the specific cost center, radiology or anesthesiology for example. The provider usually credits accounting expenses when the physician reimburses the provider for billing costs. With this method of accounting for physician fees, the provider is under-reimbursed for costs incurred in providing the service. What is actually occurring is the non-Medicare patient is paying for the costs incurred by the Medicare patient.

Using Illustrations 3&4, the typical method providers utilize for reimbursement will be explained. First, the following assumptions are listed for both Illustrations:

(1) Three patients are receiving service; Medicare, Non-Medicare, and Charity.

(2) All three receive the same procedures required of a physician.

(3) Compensation for the physician is 50% of net collections.

(4) The charge is $200 per procedure, $100 is cost and the other $100 is for the physician.

(5) Fifty percent of physician's fee is the professional component and 50% is the providers component.[5]

ILLUSTRATION 3

UNDERREIMBURSEMENT[6]

Part A and B Costs:

Patients	Collections	Total Costs	Physician Fees	Other Costs
Medicare	$200	$200	$100	$100
Non-Medicare	$200	$200	$100	$100
Charity	-0-	$100	-0-	$100
	$400	$500	$200	$300

Total costs	$500
Less Professional Part B costs (50% of physician fees)	$100(1)
Net Part A costs	$400(2)

Part A Reimbursement:

	Total Charges	Medicare Charges	Total Costs(2)	Medicare Costs
Cost Center	$600	$200	$400	$133.33

Part B Reimbursement:

			Fees(1)	
Physician	$600	$200	$100	$33.33

Part A	$133.33
Part B	33.33
Total Reimbursement	$166.66

Illustration 3 shows that only $166.66 is reimbursed when actually the cost incurred in treating the patient is $200. The underreimbursement is figured by multiplying the allowances (charity) assumed by the physician ($100) times the total costs to total charges ratio resulting in the deficiency. To arrive at the maximum payment, the provider need only charge the gross fees to the applicable cost center (anesthesiology, etc.), and offset allowances by the allowances assumed by the physician. Using this method does not reduce either special service costs or general and administrative costs. Illustration 4 shows the effect if this change is made.

ILLUSTRATION 4

MAXIMUM REIMBURSEMENT[7]

Computation of Part A and B Costs:

Patient	Collections	Total Costs	Physician Fees	Other Costs
Medicare	$200	$200	$100	$100
Non-Medicare	$200	$200	$100	$100
Charity	-0-	$200	$100	$100
	$400	$400	$300	$300

Total Costs	$600
Less Professional Part B (50% of physician fees)	$150(1)
Part A Costs	$450(2)

appeal a "field auditors" decision to the auditors boss (the local Blue Cross plan if Blue Cross is the selected intermediary). If unsatified at this level, then it could only appeal to a higher Blue Cross Association level. The passage of 92-603 brought some hope of changes to the appeal prodecure.[9] Specifically it is Section 243 and it created the Provider Reimbursement Review Board.

The frustration associated with appeal activity was increased by the strenuous resistance of the government to allow judicial review of disputed cases. The government's argument was centered on the fact that courts had no jurisdiction in Medicare matters except for two areas not concerned with reimbursement. Unfortunately, the courts generally agree with the government and have refused to hear cases. There have been several attempts, but few have met with lasting success. The last case of significance was in 1973 and involved the question of whether or not a contribution was restricted (and therefore offset against allowable costs) or not restricted (and therefore not off). The government presented its position of lack of jurisdiction by the court; but the court ruled otherwise.

This environmental pressure had an important part in the creation of the Provider Reimbursement Review Board. It will have five members who must be knowledgeable in cost reimbursement. Two members must be provider representatives and one must be a certified public accountant. Most importantly , the law expressly provides for the right of judicial review whenever the Secretary overturns an appeal boards position of supporting a provider.

There may be problems with this new phase. In fact, there is the possibility that the status quo will be retained. This is particularly true when it is considered that the CPA does not have to be an independent party; that is, he could be one of the two members representing the provider. This would leave three members to come from the Social Security Administration.

Although the new legislation is not as helpful as first thought, it is a new device available to providers in fighting reimbursement problems. It is definitely

an improvement over the previous procedures.

Use of an Index to Measure the Effects of Inflation:

Chapter Three has discussed a few of the Social problems facing the provider in its attempt to maximize Medicare reimbursement. There are more, but many of them are local problems between a provider and his intermediary. The last section in this chapter deals with the use of an economic index as an aid against rising costs of services. An exact index to measure inflation will not be proposed but rather the attempt by both parties to measure the results of inflation will be explored.

It might be appropriate at this time to mention a few items that are considered major factors for the increase in hospital costs. They are considered a type of product cost and were a major contributor to the increase in hospital costs since the introduction of Medicare. The passage of Medicare created a very noticeable demand for hospital care by making it available to those, who before, were not in a financial position to demand extensive, or in some cases minimal coverage. One factor in this increase has been the rise in the standard of liviing, bringing with it or causing an increase in hospital wages. To some extent this was a result of pressure being exerted to change the minimum wage. The increase in labor costs was very noticeable because it grew at a faster rate than wages in other industries.[10] There was an attempt to "catch-up".

Another inflationary cost for hospitals has been the rise in prices for non-labor items, such as supplies, plant faclities, and equipment. Particularly for plant and equipment, the increasing cost of capital has had a dual effect. First, the cost of capital itself has increased and second, the demand for more and higher quality service has increased the need for greater capital expenditures.

Hospitals responded to the increase in demand for services with major advances in hospital care, measured by more and better quality labor and non-labor

items. These advances have increased at an annual level substantially greater than that of the pre-medicare period. Although these reasons for increasing costs don't fully explain why, they at least make one aware of some of the causes.

In order to measure the effect inflation has on hospital costs, reimbursable costs in particular, some type of index must be used to quantify the inflationary increases. There are various approaches used to develop such an economic index, but only one will be discussed in the following paragraphs. There will be no attempt to show how such an index was specifically developed or how it is used. Rather, its purpose, determination, and some of the constraints and assumptions made concerning it will be considered.

Massachusetts, as one of the leading states in the field of Medicare developments, has recently completed a novel approach to controlling or measuring hospital costs. Blue Cross and the certain hospitals in Massachusetts have negotiated the Hospital Reimbursement Agreement.[11] An integral part of that agreement is a composite index used to measure the effects of inflation on hospital costs. The index will be used to establish lower limits for cost increases without decreasing the quality of health care services. This primary purpose will establish thresholds based on the unique character of each hospital with the idea that reimbursement for cost increases greater than this limitation will require justification.

The composite index will not attempt to measure cost increases due to population growth, improvements in quality, or increased availability of care services, but only to inflation. Hopefully the index will enable responsible people to separate the impact of inflation and measure its effect on reimbursable costs. It will be used to measure the effect of inflation on hospital costs at year end in connection with the reimbursement settlement between Blue Cross and the provider. Additionally, it will be used as a control in identifying cost elements

that are increasing at a rate higher than inflation. This will hopefully allow for immediate corrective action. It is also proposed that the index be used to forecast the impact of inflation on hospital costs during the year. This last use is questionable considering rate at which inflation has recently increased.

The index was developed by separating hospital costs into categories common to both hospitals and other purchasing institutions. If this had not been done, the general economic indicatbrs of inflation could not have been used to assess the effects of inflation on hospital costs. Generally, the economic indicators used for the composite index are national indicators of economic activity. They are prinarily based on price-level data supplied by the Bureau of Labor Statistics. Specifically, the Consumer Price Index and Wholesale Price Index are examples of sources. The index has been developed to measure the rate of change in costs due to inflation for all the labor, services, supplies, utilities, and other factors involved in providing quality health care.

There are 2 major factors contributing to the increased cost of hospital care. They are inflation and adjustments. What the composite index does is measure the rate of inflation and the Agreement provides for full reimbursement for these cost increases. The adjustments are things such as a legislation, regulations, new facilities, disasters, changes in volume of services, increases in insurance premiums, etc. which the index does not attempt to measure. It is interesting to note that these adjustments result in increased reimbursable costs only if they are reasonable and justified.

The Massachusetts plan uses 20 reimbursable cost categories (see Illustration 5) for which annual changes in cost due only to price level changes can be measured. Each of these categories has an economic change indicator that appropriately measures the annual rate of inflation with the elements of each category. To illustrate this point the cost category "Food" will be used. Let's

assume that the price level change for food is accounted for by a single economic change indicator, the yearly percent change in the processed food component of the Wholesale Price Index. If there was an 8% rise in this indicator and assuming that for this particular hospital food is 2% of total costs, then component of the cost limitng factor due to inflation in the Food category is 16%.[12] This procedure is used for the remaining 19 categories and the sum of the components gives the expected change in costs caused by inflation. This percentage would be used in reimbursement as a limit on increased costs. Anything greater than this amount would have to be justified.

To summarize, the composite index is intended to measure only those cost increases caused by price-level changes. It was developed by separating total hospital costs into categories common to hospitals and other institutions so that general economic indicators could be used. It is not the only method that can be applied to measure inflation but it's a forward step taken by independent hospitals and an intermediary without the prodding of federal regulation or control. Hopefully it will be a starting point for others attempting to combat rising costs and reimbursement problems.

Conclusion:

In conclusion, this chapter has discussed certain hospital reimbursement problems. The particular problem of the hospital-based physician was mentioned and a recommended alternative to present accounting methods was suggested. Another area of concern was the development of the Provider Reimbursement Review Board through passage of P.L. 92-603. This Board will hopefully give hospitals an appeal procedure that could justifiably increase their reimbursement for services. The results of this section of the new law will not be known until it is tested by specific hospitals requesting judicial review. The last area of concern was inflation. The effect of it on Medicare and on Medicare costs was touched upon.

The idea of an economic index was suggested. The composite index used in Massachusetts was described as an attempt by hospitals and intermediaries to develope a measure of inflation. These are only a few of the problems hospitals face in receiving reimbursement. The solution to them will only be settled by cooperation between the provider and the intermediary.

ILLUSTRATION 5

REIMBURSABLE COST CATEGORIES

1. Professional/Managerial Salaries, Wages, and Fees
2. Nursing Salaries and Wages
3. Skilled Employee Salaries and Wages
4. Other Employee Salaries and Wages
5. Fringe Benefits
6. Food
7. Drugs and Pharamaceuticals
8. Films and Photographic Supplies
9. Printing, Stationery, and Office Supplies
10. All Supplies not accounted for in (9) above
11. Telephone/Telegraph
12. Electricity
13. Gas
14. Petroleum
15. Purchsed Services from Outside Organizations
16. Buildings and Fixed Equipment
17. Major Movable and Leased Equipment
18. Interest
19. Free Care and Bad Debts
20. Reimbursable Costs not Categorized Elsewhere

END NOTES TO CHAPTER THREE

[1]P-H Social Security and Unemployment Compensation., para. 30, 747-A.32.

[2]Capital expenditures generally include (1) acquisition of land (2) building and land improvements and (3) modernization of equipment and facilities.

[3]P-H para. 30, 747-A52a.

[4]Ibid., para. 31,664.79.

[5]Nicholas S. Grubbs, "How To Maximize Reimbursement For Hospital-Based Physicians Services," Hospital Financial Management, V. 27, March 1973, p. 10.

[6]Ibid.

[7]Ibid., p. 12.

[8]James P. Tyler, "Brace Yourself for Phase III," Hospital Financial Management, V. 27, July 1973, p. 15, possim.

[9]James F. Hughes, "Medicare Reimbursement Review Board: ray of light from PL 92-603?" Hospital Financial Management, V. 28, February 1974, p. 12.

[10]Kenneth E. Raske, "Components of Inflation," Hospitals, V. 48, July 1, 1974, p. 68.

[11] Harbridge House Inc., Measuring Hospital Inflation (Boston: 1974), p. 3.

[12]Ibid., p. 13.

CHAPTER FOUR

CONCLUSION

Is Medicare Coverage Adequate?

The question of adequate Medicare coverage can be discussed from two view points. The first is from the beneficiaries point of view. Medicare has not solved all the health problems of the aged, but it has been a major step in that direction. Most people can find coverage under one of the two plans at an age when they are particularly succeptable to expensive health care. It provides them with a certain amount of assurance and self-sufficiency.

For example, protection is provided for services at hospitals, skilled-nursing facilities, home health agencies, physicians, diagnostic laboratories, amublance firms, and physical therapists. The beneficiaries have the possibility of being a member of the prepayment plan if they choose and can appeal any reimbursement decision they feel is not adequate. And basically the only stipulation is that persons or organizations they choose to provide the services must be approved for Medicare participation. Generally, the coverage provided beneficiaries is adequate and can only improve, especially with the passage of some sort of national health bill.

However, the other point of view is that of the providers and others that perform services under one of the Medicare programs. Providers, in general, feel that they are not always adequately reimbursed. This is particularly true because of rising costs and because of the increased need for more and better services since the inception of Medicare. There has been considerable controversy since the Social Security Amendments of 1972. The amendments have been bene-

ficial but have also left the outcome of many areas in doubt. This questionable area will be discussed in the next section.

Are Hospitals Adequately Reimbursed?

Assessing the impact of the Social Security Amendments of 1972 (PL 92-603) is difficult because, although the bill was passed into law on October 30, 1972, many of the implementing regulations have not been written yet. The main objectives of the law that concern this paper are the proposals to improve methods of computation and reimbursement and to decrease costs of medical services. The first proposals involved the use of prospective reimbursement methods and these were mentioned in Chapter Two. Section 237 authorizes states to become involved in developing methods of reimbursement of reasonable costs. So far nothing of substance has been done other than giving them authorization. As previously discussed, a Provider Reimbursement Board was established. The final proposal for inprovement of computations was authorization by the Secretary to experiment with designs to increase the efficiency and economy of providers operations. But this also has not resulted in any substantial recommendations.

The proposal of PL 92-603 to decrease the cost of medical services will seemingly have an adverse effect on the adequacy of hospital reimbursement. Some of the proposals, such as the limitation on capital expenditures and payment of the lesser of customary charges or reasonable costs, were dealt with in previous chapters. The regulations will contain limits on routine services and "hotel-type" services such as room, board, and laundry. The idea is to limit reimbursement to costs that are reasonable and incurred by prudent management. In effect, what will probably happen will be a reduction in reimbursements for all the proposals mentioned because they will cause a cutback of services.[1] The result is a decrease in reimbursements over the long run, bring with it financial problems. The effect may be to put more emphasis on financial

planning. This is particularly true when you consider that medical costs have risen more than most other types of costs.

The law will and has had a significant impact on hospitals concerned with Medicare costs. Not only has it clarified some areas but it also has created new management. The question of adequate reimbursement cannot be answered at this time. There will be no real answer until effective methods of prospective reimbursement, until an index for measuring inflation, and until improved agreements between provider and intermediary are developed. The next five years and the proposals developed within that time should give an affirmative answer to the question of adequate hospital reimbursement.

Future Outlook:

There are several new programs that could have a beneficial effect on Medicare. One of these is the proposed National Health Insurance Bill. Although Congress has not agreed on final regulations and although it is unlikely that it will be effective until the later part of 1975, it deserves mention here. So far the House Ways and Means Committee's efforts to draft the bill have met with disagreement. This nonconformity of opinion centers on how to finance the catastrophic insurance; whether to make employer purchases of basic insurance mandatory; and who should provide the insurance-- private insurers, Social Security Administration, or a new Federal Agency.[2] The Catastrophic Insurance would cover most people with the Federal Government paying all family expenses above $6,000. The Employer Plan requires employers to provide comprehensive health insurance for employees to cover the first $6,000 of medical expenses. Those not eligible for the Employer Plan would be protected under the State-Administered Alternate Plan.

The goal of the national health program coincides with that of Medicare. With the national Health Bill, Medicare would be retained as a separate plan with

BIBLIOGRAPHY

American Hospital Association. Cost Finding and Rate Setting for Hospitals, Chicago, 1968.

American Institute of Certified Public Accountants, Inc. Medicare Audit Guide, New York, 1969.

Blue Cross Association. Modification of Cost Reporting Forms to Reflect 1972 Regulation Changes for Providers with 100 or more Total Beds. Special Programs-Operations, February 1973.

Blue Cross and Blue Shield of North Dakota. You Are Now Eligible for Medicare-Extended, Pubn. A10.0006. Rev. 1-75.

Commerce Clearing House Inc., 1974 Social Security and Medicare Explained, Chicago, 1974.

Commerce Clearing House Inc., Social Security Benefits Including Medicare, Chicago, 1974.

Grubbs, Nicholas S. "How to Maximize Reimbursement for Hospital-based Physician Services." Hospital Financial Management, V.27, March 1973, p.8-12.

Harbridge House Inc., Measuring Hospital Inflation, Boston, 1974.

Harris, Percy G. "How We've Cut our Medicare Claims Denials in Half." Medical Economics, V. 51, February 4, 1974, p. 183-9.

Hughes, James F. "Medicare Reimbursement Review Board: ray of light from PL 92-603?" Hospital Financial Management, V.28, February 1974, p.12-14, 16.

Langford, Edwin D. "Questions on Reimbursement Topics." (Medicare Topics) Texas CPA, V.46, April 1974, p.37-9.

P-H Social Security and Unemployment Compensation.

Raske, Kenneth E. "Components of Inflation." Hospitals, V.48, July 1, 1974, p.67-70.

Social Security Amendments of 1972, Statutes at Large, Vol. 86 (1972).

Touche Ross & Co., 1974 Review of Hospital Operations, August 1974.

Tyler, James P. "Brace Yourself for Phase III." Hospital Financial Management, V. 27, July 1973, p.8-26, passim.

BIBLIOGRAPHY

U.S. Congress. House. Social Security Amendments of 1971, Report of the Committee on Ways and Means on H.R.1, 92nd Cong., 1st sess., 1971.

U.S. Department of Health, Education, and Welfare. Social Security Administration, Your Medicare Handbook, DHEW Pubn. No. (SSA) 74-10050 (1974).