

# Components of Medicare reimbursement

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Most Americans are surprised to learn that the health insurance industry began just over 50 years ago. Before the end of World War II, a simple fee-for-service system of healthcare was in place in the United States. At that time the consumer was responsible for the use of his or her own resources.

In an attempt to control inflationary tendencies of wartime economy, the government placed caps on wages. In response to these caps, business owners sought a competitive edge to attract skilled workers. Since benefit packages were considered a legal supplementation of wages with no intrinsic value, companies began providing workers with health care coverage. Group health insurance plans soon proliferated offering larger and more attractive packages to prospective employees.

To manage increasing costs while maintaining profits, insurance companies began altering benefits and services covered under policy contracts. As workers retired and were eliminated from employer-sponsored insurance coverage, the number of uninsured in the nation grew. In response, President Johnson created the "Great Society" in the mid-1960's to provide health insurance to the disabled, the poor, and the elderly. His solution would become known as Medicare

**Abstract:** The history of the Medicare reimbursement system, how it works, and issues related to fraud and abuse are discussed.

The statutory charge of Medicare is to ensure adequate reimbursement through a Prospective Payment System (PPS) to cover the costs for providing a given service to Medicare beneficiaries. The PPS was introduced as a way to change hospital behavior through financial incentives that encourage cost-efficient management of resources. The system utilizes a rate of payment in which a hospital is paid a fixed amount that is expected to cover the costs of care while treating a typical patient in a particular diagnosis-related group (DRG). The PPS uses DRGs as payment categories and Major Diagnostic Categories (MDCs) for classifying the DRGs into similar groupings. One of the first steps in DRG assignment is identification of the principal diagnosis represented by an International Classification of Diseases, 9th Revision, Clinical Modification

(ICD-9-CM) code. The secondary diagnoses (referred to as complications or comorbidities), presence or absence of surgery, age of the patient, and discharge status are the other pieces of information making up assignment of a specific DRG to a patient. A basic knowledge of the Medicare program will help in the understanding of how hospitals will be reimbursed for patient care, as well as how changes in Medicare payment may affect reimbursement.

Medicare is one of the largest health insurance providers in the United States. A basic understanding of the Medicare system will provide valuable insights into Medicare reimbursement and the influence it has on a hospital's bottom line.

**Index terms:** Crime; Diagnosis related groups; Economics; Fraud; Health benefit programs; History; Hospitals; Patient care; Reimbursement

**Am J Health-Syst Pharm.** 2003; 60(Suppl 6):3-7

and Medicaid. When the president signed Medicare and Medicaid into law he said, "No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings that have so carefully been put away over a lifetime so that they might enjoy dignity in their last years."<sup>1</sup> Originally, the idea of providing care to the elderly population

sounded fair and feasible to many people. Some believed most elderly would not live long enough to use a great amount of health care resources, offering a solution at a seemingly bargain price.<sup>2</sup> The idea of Medicare was attractive to many voters, as well; it gave them a "free ride" by meeting their health care demands and putting the debt onto future generations.<sup>2</sup>

In 1965 the Social Security Act

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This article was supported by an unrestricted educational grant from Eli Lilly and Company.

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was revised to include Title XVIII and Title XIX establishing Medicare and Medicaid, respectively. Medicare began as a government-sponsored health insurance program and provided equitable access and lower cost of coverage to all American citizens aged 65 and over regardless of race, disability, and income. In 1972, Medicare was extended to the disabled on Social Security Disability Insurance and those with end-stage renal disease. The financial burden was also reduced for those Medicare recipients who could no longer work. Medicare's aim to ensure beneficiary access to care without unwarranted financial burden to beneficiary or taxpayer remains noble; however, with the increased complexity and change in the population case mix, this goal has become increasingly difficult to achieve. Medicare reimbursement was originally based on the hospitals' costs, yet in October of 1983 the Medicare Prospective Payment System (PPS) was implemented through an amendment to the Social Security Act, and Diagnosis Related Groups (DRGs) were introduced as the basis for the Medicare PPS.

Medicaid is a program that provides health care coverage and long-term care to low-income families and disabled people. Medicaid became law in 1965 as a jointly funded venture between the federal and state governments to assist states in providing adequate medical care to eligible needy persons. The Medicaid program varies from state to state due to the fact that the states establish their own eligibility standards; determine the type, amount, duration, and scope of services; set the rate of payment for services<sup>1</sup> and administer their own programs. Medicaid also typically reimburses inpatient hospital care based on DRGs.

### Medicare today

Medicare was the nation's largest health insurance program in the United States until recently, when

federal and state Medicaid enrollment and expenditures surpassed Medicare.<sup>3</sup> Approximately 40 million Americans received health care services through Medicare in 2001, and that number is expected to grow with the aging of America to 77 million by 2030.<sup>4</sup> Recipients of this coverage include individuals who are 65 years of age or older, disabled persons, and those with permanent kidney failure. Current coverage includes Part A, which covers inpatient, home health, nursing home, and hospice services; and Part B, which covers supplies, physician services, services by other health care providers, other services such as clinical lab tests, diagnostic tests, and non-self-administered prescription drugs.

The primary sources for Medicare reimbursement are two insurance trust funds, each associated with one component of coverage. The Medicare Hospital Insurance (HI) Trust Fund finances services covered under Part A while the Supplementary Medical Insurance (SMI) Trust Fund finances those services provided under Part B. A board of six trustees manages the two funds. The managing trustee is the Secretary of the Department of Treasury. Employees and employers finance the HI Trust Fund primarily through Social Security payroll tax contributions. There is no fail-safe mechanism to ensure that the HI program has enough money to continue operating. Each year the trustees report on the HI funds' current status and projected condition over the next 75 years. Whether Medicare can continue in its current form through the approaching enrollment of the baby-boom generation continues to be debated. Currently, the trustees have projected that the HI Trust fund will remain solvent until somewhere between 2008 (intermediate estimate) and 2030 (using optimistic assumptions).<sup>5</sup>

### Reimbursement

The reimbursement objective of

Medicare is to set payment rates consistent with an efficient hospital's costs.<sup>6</sup> The federal and state governments influence reimbursement by acting as a third-party payer and regulating the health care environment. The federal government acts as a third-party payer for Medicare, Medicaid, the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA), the Civilian Health and Medical Program of the Uniformed Services (TRICARE), and the Veterans Administration (VA). Of these programs, Medicare and Medicaid are the largest, with expenditures continually increasing. Estimated Medicare expenditures rose from \$37 billion in 1980 to \$224 billion in 2000, while Medicaid estimates showed an increase in spending from \$26 billion to \$202 billion over the same time period, with both Medicare and Medicaid predicted to exceed \$400 billion in expenditures by the end of 2011.<sup>6</sup>

### Prospective Payment System

In 1972 the Department of Health, Education, and Welfare (HEW) applied limits (referred to as the Section 223 limits) to hospitals above which Medicare would not pay for routine hospital services. In 1982, Congress extended the Section 223 limits from routine hospital costs to encompass total hospital costs. This was part of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) which also called for the Department of Health and Human Services (HHS) to begin development of a system of prospective reimbursement for hospitals. In 1983 President Reagan signed into law an amendment to the Social Security Act replacing the cost-plus system with the currently employed PPS. It was argued that the cost-plus system encouraged overspending since hospitals could increase revenues by raising costs. Critics of this payment system noted that hospital costs had increased by about 13 percent in 1982, which was three times the rate of inflation.<sup>1</sup>

The PPS was introduced as a way to control costs. The PPS utilizes a pre-set payment schedule in which a hospital is paid a fixed amount to provide treatment based on the patient's principal diagnosis at discharge. The fixed amount is expected to cover the costs of care while treating a typical patient in a specified DRG. Because payment is based on an adjusted average payment rate, some payments will be in excess of costs while others will not. The PPS was designed to encourage hospitals would have to provide efficient treatment (due to prospectively determined payments) while maintaining high quality care.

The PPS uses DRGs as payment categories (to determine hospital reimbursement), and Major Diagnostic Categories (MDCs) for classifying the DRGs into similar groupings. The MDCs are critical in determining the correct DRG. MDCs were formed as a way of ensuring that DRGs were clinically coherent, thus no final DRG could contain patients in different MDCs. The MDCs were generally constructed to correspond to a single organ system (e.g., respiratory system, circulatory system, nervous system). Each of the 25 MDCs is organized into either a surgical or medical division. Patients are considered surgical if there is a surgical procedure performed which utilizes an operating room. The surgical patients are then divided by the surgical procedure performed and the medical patients by the primary reason for admission into the hospital. The surgical and medical divisions are further stratified by over 500 DRGs.

### Assignment of a DRG

A series of decisions (through a decision-tree approach) utilizing diagnoses and procedures leads to a DRG assignment. One of the first steps in the decision-tree approach is identification of the principal diagnosis (by the DRG GROUPER

software) represented by an International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) code. All possible diagnoses are divided into the MDCs. The MDC is then separated into a surgical or medical case. As previously discussed, the surgical patients are further divided based on the surgical procedure performed, and the medical patients are divided based on the principal diagnosis. Because a patient can have more than one surgical procedure during a hospital stay, a hierarchy of surgical procedures within each MDC allows the most resource-intensive procedure to be used for DRG assignment. The secondary diagnoses (referred to as complications or comorbidities), age of the patient, and discharge status are other pieces of information necessary for DRG assignment.

GROUPER software has been developed to assist hospitals in applying the decision-tree logic. The GROUPER software compiles the ICD-9-CM diagnosis and procedure codes and assigns an appropriate DRG. The GROUPER software is used with encoder software, which provides a means by which codes can be assigned online before grouping occurs.

The following steps describe the calculation for DRG-adjusted payments:

1. The hospital submits a bill utilizing the Uniform Billing Form rev 92 (UB-92) for each Medicare patient to the Medicare fiscal intermediary. The fiscal intermediary is a private insurance company contracted by Medicare to carry out operational functions of the Medicare program. The patient case is assigned a DRG based on the information submitted on the bill.
2. The base payment rate, a standardized amount (divided into labor-related and non-labor share), is multiplied by the DRG relative weight. The labor-related share is adjusted by the wage index applicable to the area

where the hospital is located. If the hospital is located in Hawaii or Alaska, the non-labor share is adjusted by a cost of living factor. DRG classifications and relative weights must be adjusted at least annually. These adjustments are published in the Federal Register and become effective October 1, the first day of the federal fiscal year. Adjustments made to DRG classifications and relative weights must be made in such a way that aggregate payments to hospitals are not affected.<sup>7</sup> This means that DRG payment changes at the national level are made in a "budget-neutral" manner. How these changes affect an individual hospital varies and may not be "budget-neutral" since the numbers of patients falling into the adjusted DRGs are different in each hospital.

3. If the hospital is recognized as serving a disproportionate share of low-income patients, it will receive a percentage add-on for each case paid through the PPS. This payment is applied to the DRG-adjusted base payment rate and any outlier payments received. (Outlier cases are those that exceed the average costs.)
4. If the hospital is an approved teaching hospital, it receives a percentage add-on payment for each case paid through the PPS. This percentage will vary depending on the ratio of residents to beds.
5. The costs incurred by the hospital for the patient case are evaluated to determine possible eligibility for additional payments as an outlier case. Under the PPS, hospitals have a financial incentive to avoid extremely costly patients. To counter this and promote access to care for medically complex patients, Medicare makes additional payments called outlier payments. This additional payment is designed to protect the hospital from large financial losses due to additional resources consumed. By law The Centers for Medicare and Medicaid Services (CMS) caps outlier payments equal to approximately 5% of the to-

tal projected PPS payments for that year.<sup>8</sup> CMS-established criteria must be met to be considered an outlier. The point where the criteria begin to be met is referred to as the “threshold,” which is updated periodically. The fixed loss threshold (FLT) has increased substantially from \$11,100 in 1999<sup>9</sup> to \$33,560 in 2003.<sup>10</sup> This means that a hospital’s charges for a case, adjusted to cost, must exceed the payment rate for any given DRG by \$33,560 to be considered an outlier. The additional payment received is equal to 80% of the difference between the hospital’s entire cost for the stay and the threshold amount. Once the outlier payment is calculated, it is added to the DRG-adjusted base payment rate.

Although fraud and abuse will be discussed in detail in a later section, it is appropriate to note recent issues related to fraud and abuse in outlier payments now. The Office of Inspector General (OIG) has been investigating the potential overinflation of hospitals’ gross charges to increase outlier payments. Outlier payment calculations rely on the cost-to-charge ratio from the most recent cost report, which can be up to three years old. Therefore, a hospital that rapidly increases charges would likely receive higher outlier payments. On December 3 and 20 2002, CMS issued program memoranda on this topic aimed at exposing hospitals with high outlier payments and directing fiscal intermediaries to audit these records.

It is important to remember that payment responsibility resides with Medicare and the Medicare beneficiary. The Medicare beneficiary payment amount is derived from the co-insurance and deductible. Medicare payment is achieved through the use of private health insurance company contractors (fiscal intermediaries). CMS uses approximately 41 fiscal intermediaries to administer Medicare Part A and pay hospitals within a

specific geographic area. The intermediaries perform various functions including claims processing, determining reasonable costs for covered items and services, and guarding against unnecessary use of covered services.

### Legislative changes

In 1997 it was predicted that approximately five years remained until insolvency of the HI Trust Fund occurred. The Balanced Budget Act (BBA) was enacted to slow the growth of Part A spending between 1998 and 2002 by reducing payments to hospitals, thus extending the period of HI Trust Fund solvency. A review of recently enacted legislation follows.

The BBA of 1997 made extensive changes to the Medicare program, including limited annual payment increases to hospitals; expanded coverage of preventative benefits; created new home health, skilled nursing facility (SNF), inpatient rehabilitation, and outpatient hospital Prospective Payment Systems (PPSs); and established Medicare+Choice, which offers a variety of managed care and other health plan choices.

Since many hospitals experienced devastating reimbursement reductions as a result of the BBA, Congress enacted the Balanced Budget Refinement Act (BBRA) in 1999 which increased payments relative to the BBA payment reductions.

Another important piece of legislation was the passage of the Medicare, Medicaid, and State Children’s Health Insurance Programs (SCHIP) Benefits Improvement and Protection Act (BIPA) of 2000. Medicare, Medicaid, and SCHIP were impacted through a number of provisions. Through BIPA Medicare outlays will increase by approximately \$36 billion over five years, of which \$12 billion would occur in hospitals.<sup>11</sup> The act also required that a report be submitted to Congress by October 1, 2001 on ways to more expeditiously incorporate new services and tech-

nologies into the DRG system under the hospital inpatient PPS.

### Fraud and Abuse

Fraud and abuse have been found to exist in the present PPS. It has been estimated that the government pays \$13 billion in fraudulent or inappropriate Medicare payments each year.<sup>12</sup> Medicare defines fraud as “the intentional deception or misrepresentation that an individual knows to be false or does not believe to be true and, makes knowing that the deception could result in some unauthorized benefit to himself/herself or some other person.”<sup>13</sup>

The Office of Inspector General (OIG) is responsible for protecting the integrity of the Department of Health and Human Services (which administers the Medicare program) through its various offices by conducting audits, investigations, and inspections. From 1994 to 1999, the number of criminal convictions related to health care fraud dramatically increased more than fourfold,<sup>14</sup> and the amount of money collected by the government for fraud cases increased accordingly. In the year 2000, for example, the Federal government collected more than \$1.2 billion from health care fraud cases, which included a \$745 million settlement with Columbia HCA.<sup>15</sup> The reason for this dramatic jump can be traced back to 1996, when the Health Insurance Portability and Accountability Act (HIPAA) was enacted to establish a program to combat health care fraud. The act made health care fraud a federal crime, meaning the government would become more involved with the prosecutions through the new responsibilities granted to the OIG. Monies from the Health Care Fraud and Abuse Control Grants established under HIPAA and various other sources have been put into the Health Care Fraud and Abuse Control Account. These monies pay for the fraud and abuse investigations, audits, inspections, prosecutions,

and consumer education. HIPAA also allocated significant dollars towards combating health care fraud.

An increasing importance placed on the Whistleblower Statute has also increased the number of health care fraud cases. This law allows individuals to sue on behalf of the government when one becomes aware of fraudulent activities. The “whistleblower” can usually receive anywhere from 15-30% of the amount collected by the government.<sup>16</sup> The government has even asked for help from private citizens (the American Association of Retired Persons) in detecting Medicare fraud. In part due to the Whistleblower Statute and HIPAA, the government estimated that overpayments were cut in half from 1996 through 1998.<sup>17</sup>

Increased awareness of more common types of fraud found under the Medicare system—including billing for services not furnished, misrepresenting the diagnosis to justify payment, receiving kickbacks, and billing for a service not furnished as billed (upcoding)—is extremely important. It is imperative to distinguish fraud (knowingly disregarding the truth) from negligence (inadvertent error). An oversight is not generally considered at the same level of violation as fraud, unless a pattern of oversights or errors occurs which increases the likelihood of fraud liability.

As a result of the increased crack-down on health care fraud, many health systems have created Corporate Compliance Programs (CCPs). These programs outline the corporation's efforts to comply with the various laws and regulations and generally

designate a corporate compliance officer to oversee the program. Under the program, detailed plans specifically address areas that present the health system with significant liability concerns (e.g., the billing department), are put in place.

Potential benefits of CCPs include providing health systems with a more accurate view of their employees' behaviors; identifying and ferreting out criminal and unethical conduct; creating a compliance plan for efficient dissemination of information relating to changes in government requirements; and establishing a structure that encourages employees to report concerns internally rather than externally, possibly reducing the risk of government investigations.<sup>18</sup>

The OIG continues to crack down on fraud and abuse in the Medicare system. With the continued search for monies to support Medicare, the government will only strengthen its efforts to curtail fraud and abuse. An effective CCP can offer many benefits to a health system, including the potential reduction in penalties from fraud and abuse violations.

Increased funding and the emphasis placed on curtailing fraud and abuse by the Attorney General's Office have resulted in an increased interest by those receiving health care reimbursements to abide by the rules designated by the various third party payers.

### Conclusion

A basic knowledge of the Medicare program will help hospital decision-makers and pharmacy managers understand how hospitals will be reim-

bursed for specific patients' care and how changes to Medicare may affect reimbursement.

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