OVERVIEW OF THE HEALTH CARE FINANCING ADMINISTRATION

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OVERVIEW OF THE HEALTH CARE FINANCING ADMINISTRATION

Background

Since early in this century, health insurance coverage has been an important issue for our Nation. The first coordinated efforts to establish government health insurance were initiated at the state level between 1915 and 1920. However, these efforts came to naught. Renewed interest in government health insurance surfaced during the 1930s at the Federal level, but nothing concrete resulted beyond the limited provisions in the Social Security Act that supported state activities relating to public health and health care services for mothers and children.

From the late 1930s on, most people desired some form of health insurance to alleviate the unpredictable and uneven incidence of medical costs. The main issue was whether health insurance should be privately or publicly financed. Private health insurance, mostly group insurance financed through the employment relationship, ultimately prevailed.

Private health insurance coverage expanded rapidly during World War II, as employee fringe benefits were expanded because the government limited direct wage increases. This trend continued after the war. Concurrently, numerous bills incorporating proposals for national health insurance, financed by payroll taxes, were introduced in Congress during the 1940s; however, none was ever brought to a vote.

Instead, Congress acted in 1950 to improve access to medical care for needy persons who were receiving public assistance. This permitted, for the first time, Federal participation in the financing of state payments made directly to the providers of medical care for costs incurred by public assistance recipients. The aged population was also perceived as requiring special attention in order to improve their access to medical care, but views differed regarding the best method for accomplishing the desired objective. Pertinent legislative proposals in the 1950s and early 1960s reflected widely different approaches. When consensus proved elusive, Congress passed limited legislation in 1960, including legislation entitled “Medical Assistance to the Aged” which provided medical assistance for aged persons who were less poor, yet still needed assistance with medical expenses.

NOTES: This article provides brief summaries of complex subjects. It should be used only as an overview and general guide to the Medicare and Medicaid programs. This is not a legal document, nor is it intended to fully explain all of the provisions or exclusions of the relevant laws, regulations, and rulings of the Medicare and Medicaid programs, nor of the relationship between these programs. This article does not render any legal, accounting, or other professional advice, and should not be relied on in making specific decisions. Only original sources should be utilized. Therefore, the views expressed in this article do not necessarily reflect the policies or legal positions of the Department of Health and Human Services (DHHS) or the Health Care Financing Administration (HCFA).

After consideration of various approaches and lengthy national debate, Congress passed

legislation in 1965 establishing the Medicare and Medicaid programs as Title XVIII and Title XIX of the Social Security Act. Medicare was established in response to the specific medical care needs of the elderly (with coverage for certain disabled persons and certain persons with kidney disease added in 1973). Medicaid was established in response to the widely perceived inadequacy of welfare medical care under public assistance. The forerunner of the current DHHS was given overall responsibility for administering the Medicare and Medicaid programs. The programs were managed by the Social Security Administration (SSA) until 1977, when the responsibility was transferred from SSA to the newly formed HCFA.

National Health Care Overview

As a share of the gross domestic product (GDP), health care spending stabilized in 1993-1997 at 13.5 percent. The GDP is the total value of goods and services produced in the United States. National health expenditures (NHE) reached $1.1 trillion in 1997. The 4.8-percent increase in 1997 marks the slowest growth in NHE history and continues a trend of deceleration that began in 1991. For the 278 million persons residing in the United states, the average expenditure for health care in 1997 was $3,925 per person.

Health care is funded through a variety of private payers and public programs. Private funds include individuals' out-of-pocket expenditures, private health insurance, philanthropy and non-patient revenues (e.g., gift shops, parking lots, etc.), as well as health services that are provided in industrial settings. For the years 1974-1991, these private funds paid for 58 to 60 percent of all health care expenditures. But by 1997, the private share of health expenditures had dropped to 53.6 percent of our Nation's total health care expenditures, while the share of health care provided by public spending increased correspondingly over this period.

Public spending represents expenditures by Federal, State, and local governments. Of the publicly funded health care expenditures for our Nation, each of the following account for a small percentage of the total: the Department of Defense health care programs for military personnel; the Department of Veterans Affairs health programs; non-commercial medical research; payments for health care under Workers Compensation programs; health programs under state-only general assistance programs; and the construction of public medical facilities. Other activities which are also publicly funded include: maternal and child health services; school health programs; public health clinics; Indian health care services; migrant health care services; substance abuse and mental health activities; and medically-related vocational rehabilitation services. The largest shares of public health expenditures, however, are for the Medicare and Medicaid programs.

Together, Medicare and Medicaid financed $374 billion in health care services in 1997 — more than one-third of the nation's total health care bill and almost three-fourths of all public spending on health care. Since their enactment, both Medicare and Medicaid have been subject to numerous legislative and administrative changes designed to make improvements, with financial considerations, in the provision of health care services to our Nation's aged, disabled, and

disadvantaged persons.

Medicare

Overview

Title XVIII of the Social Security Act, entitled Health Insurance for the Aged and Disabled, is commonly known as Medicare. As part of the Social Security Amendments of 1965, the Medicare legislation established a health insurance program for aged persons, to complement the retirement, survivors, and disability insurance benefits under Title II of the Social Security Act.

When first implemented in 1966, Medicare covered most persons age 65 or over. In 1973, other groups became eligible for Medicare benefits: persons entitled to Social Security or Railroad Retirement disability cash benefits for at least 24 months, certain persons with End Stage Renal Disease (ESRD), and certain otherwise non-covered aged persons who elect to pay a premium for Medicare coverage.

Medicare consists of two primary parts: hospital insurance (HI), also known as Part A, and Supplementary Medical Insurance (SMI), also known as Part B. A third part of Medicare, sometimes known as Part C, is the Medicare+Choice program which was established by the Balanced Budget Act (BBA) of 1997 (Public Law 105-33) and began providing services on January 1, 1998. Beneficiaries must, however, have both Part A and Part B coverage to enroll in a Part C plan. When Medicare began on July 1, 1966, there were about 19 million people enrolled in the program. In 1998, about 39 million people were enrolled in one or both of Parts A and B of the Medicare program.

Historical information was extracted from the *Social Security Bulletin*, Volume 56, Number 4, Winter, 1993. NHE data and estimates are from the Office of National Health Statistics in the Office of the Actuary (OACT), HCFA. Medicare data are from the national claims history database in the Office of Information Services (OIS), HCFA, with estimates by OACT. Medicaid data are taken from the reports sent by the states to OIS, with estimates and projections by OACT. For more information, data details, and an explanation of the various aspects of health care spending, refer to the Office of National Health Statistics, OACT/HCFA, report entitled "National Health Expenditures, 1996," by Katharine Levit et. al., *Health Care Financing Review*, Fall 1997, Volume 19, Number 1, pages 161-200; and "National Health Spending Trends in 1996," by Katharine Levit et. al, *Health Affairs*, January/February, 1998, Volume 17, Number 1, pages 35-51.

Medicare Coverage

HI is generally provided automatically, and free of premiums, to persons age 65 or over who are eligible for Social Security or Railroad Retirement Board benefits, whether they have claimed

monthly benefits or not. Also, workers and their spouses with a sufficient period of Medicare-only coverage in Federal, State, or local government employment are eligible beginning at age 65. Similarly, individuals who have been entitled to Social Security or Railroad Retirement disability benefits for at least 24 months, and government employees with Medicare-only coverage who have been disabled for more than 29 months, are also entitled to HI benefits. HI coverage is also provided to insured workers with ESRD (and to insured workers' spouses and children with ESRD). HI also covers some otherwise ineligible aged and disabled beneficiaries who can and do pay a monthly premium for their coverage. In 1998, the HI program provided protection against the costs of hospital and specific other medical care to about 39 million people (34 million aged and 5 million disabled enrollees). HI benefit payments totaled $134 billion in 1998. The following health care services are covered under Medicare's HI program:

- *Inpatient hospital* care coverage includes costs of a semi-private room, meals, regular nursing services, operating and recovery rooms, intensive care, inpatient prescription drugs, laboratory tests, X-rays, psychiatric hospitals, inpatient rehabilitation, and long-term care (LTC) hospitalization when medically necessary, as well as all other medically necessary services and supplies provided in the hospital. An initial deductible payment is required, plus copayments for all hospital days following day 60 within a benefit period (described later).

- *Skilled nursing facility* (SNF) care is covered by HI only if it follows within 30 days (generally) of a hospitalization of 3 or more days, and is certified as medically necessary. Covered services are similar to those for inpatient hospital, but also include rehabilitation services and appliances. The number of SNF days provided under Medicare is limited to 100 days per benefit period (described later), with a copayment required for days 21-100. HI does not cover nursing facility care at all if the patient does not require skilled nursing or skilled rehabilitation services.

- *Home Health Agency* (HHA) care, including care provided by a home health aide, may be furnished part-time by a HHA in the residence of a home-bound beneficiary if intermittent or part-time skilled nursing and/or certain other therapy or rehabilitation care is necessary. Certain medical supplies and Durable Medical Equipment (DME) may also be provided. There must be a plan of treatment and periodical review by a physician. Home health care under HI has no duration limitations, no copayment, and no deductible. For DME, beneficiaries must pay a 20-percent coinsurance, as required under SMI of Medicare. Full-time nursing care, food, blood, and drugs are not provided as HHA services.

- *Hospice* care is a service provided to those terminally ill persons with a life expectancy of 6 months or less who elect to forgo the standard Medicare benefits for treatment of the illness, and receive only hospice care for it. Such care includes pain relief, supportive medical and social services, physical therapy, nursing services, and

symptom management. However, if a hospice patient requires treatment for a condition that is not related to the terminal illness, Medicare will pay for all covered services necessary for that condition. For the hospice program, the Medicare beneficiary pays no deductibles, but does pay small coinsurance amounts for drugs and inpatient respite care.

An important HI benefit concept is the benefit period, which starts when the beneficiary first enters a hospital and ends when there has been a break of at least 60 consecutive days since inpatient hospital or skilled nursing care was provided. There is no limit to the number of benefit periods covered by HI during a beneficiary's lifetime; however, inpatient hospital care is normally limited to 90 days during a benefit period, and copayment requirements (detailed later) apply for days 61-90. If a beneficiary exhausts the 90 days of inpatient hospital care available in a benefit period, he or she can elect to use days of Medicare coverage from a non-renewable "lifetime reserve" of up to 60 (total) additional days of inpatient hospital care.

All individuals age 65 or over who are citizens, or aliens lawfully admitted for permanent residence with 5 consecutive years of residence, and all disabled persons entitled to coverage under HI are eligible to enroll in the SMI program on a voluntary basis by payment of a monthly premium. Almost all persons entitled to HI choose to enroll in SMI. In 1998, the SMI program provided protection against the costs of physician and other medical services to about 37 million people. SMI benefits totaled $76.1 billion in 1998.

SMI is often thought of primarily as coverage for physician services (in both hospital and non-hospital settings). However, SMI also covers certain other non-physician services, including: clinical laboratory tests, DME, most supplies, diagnostic tests, ambulance services, flu vaccinations, prescription drugs which cannot be self-administered, certain self-administered anticancer drugs, some other therapy services, certain other health services, and blood which was not supplied by HI.

The expenditures for institutional services in hospital outpatient departments, ambulatory surgical centers, certain other centers, and HHA services are also covered. To be covered, all services must either be medically necessary or be one of several prescribed preventive benefits. Certain medical services and related care are subject to special payment rules, including deductibles (for blood); maximum approved amounts (for Medicare-approved physical or occupational therapy services performed in settings other than hospitals); or higher cost-sharing requirements (such as that for outpatient treatments for mental illness).

It should be noted that some health care services are not provided under any part of Title XVIII. Non-covered services under Medicare include long-term nursing care, custodial care, and certain other health care needs, such as dentures and dental care, eyeglasses, hearing aids, and most prescription drugs. These are not a part of the Medicare program unless they are a part of a Managed Care Plan (MCP) under the Medicare +Choice program.

Medicare+Choice (Part C) is an expanded set of options for the delivery of health care under Medicare. While all Medicare beneficiaries can receive their benefits through the original Fee-For-Service (FFS) program, most beneficiaries in both HI and SMI can choose to participate in a Medicare+Choice plan instead. Organizations that are seeking to contract as Medicare+Choice plans have to meet specific organizational, financial, and other requirements. The primary Medicare+Choice plans are:

- Coordinated care plans, which include health maintenance organizations (HMOs), provider-sponsored organizations (PSOs), preferred provider organizations (PPOs), and other certified coordinated care plans and entities that meet the standards set forth in the law.

- Private, unrestricted FFS plans, which allows beneficiaries to select certain private providers. For those providers who agree to accept the plan's payment terms and conditions, this option does not place the providers at risk, nor vary payment rates based on utilization.

- Medical Savings Account plans which provide Medicare benefits after a single high deductible is met. Medicare makes an annual deposit to the Medical Savings Account, and the beneficiary is expected to use the money in the MSA to pay for medical expenses. Medical SavingsAccounts are currently a test program for a limited number of eligible Medicare beneficiaries.

Except for Medical Savings Account plans, all Medicare+Choice plans are required to provide the current Medicare benefit package, excluding hospice services, and any additional health services required under the adjusted community rate process. There are some restrictions as to who may elect an Medical Saving Account plan even when enrollment is no longer limited in number of participants.

Program Financing, Beneficiary Liabilities, and Provider Payments

All financial operations for Medicare are handled through two trust funds, one for the HI program and one for the SMI program. These trust funds, which are special accounts in the U. S. Treasury, are credited with all receipts and charged with all expenditures for benefits and administration costs. The trust funds cannot be used for any other purpose. Assets not needed for the payment of costs are invested in special Treasury Securities. The following sections describe Medicare's financing provisions, beneficiary cost-sharing requirements, and the basis for determining Medicare reimbursements to health care providers.

Program Financing

The Medicare HI program is financed primarily through a mandatory payroll tax. Almost all employees and self-employed workers in the U.S. work in employment covered by the Medicare HI program and pay taxes to support the cost of benefits for aged and disabled beneficiaries. The HI tax rate is 1.45 percent of earnings (paid by each employee and by the employer for each), and 2.90 percent for self-employed persons. For 1994 and later, this tax is paid on all covered wages and self-employment income without limit. (Prior to 1994, the tax applied only up to a specified maximum amount of earnings.) The HI trust fund also receives income from: (1) a portion of the income taxes levied on Social Security benefits paid to high-income beneficiaries; (2) premiums from certain persons who are not otherwise eligible and choose to enroll voluntarily; (3) from the general fund of the U.S, Treasury reimbursements for the cost of providing HI coverage to certain aged persons who retired when the HI program began and thus, were unable to earn sufficient quarters of coverage (and those federal retirees similarly unable to earn sufficient quarters of Medicare-qualified federal employment); (4) interest earnings on its invested assets; and (5) other small miscellaneous income sources. The taxes paid each year are used mainly to pay benefits for current beneficiaries.

The Medicare SMI program is financed through: (1) premium payments ($45.50 per beneficiary per month in 1999) and (2) contributions from the general fund of the U.S. Treasury. Beneficiary premiums are currently set at a level that covers 25 percent of the average expenditures for aged beneficiaries. Therefore, the contributions from the general fund of the U.S. Treasury are currently the largest source of SMI income. The SMI trust fund also receives income from interest earnings on its invested assets and a small amount of miscellaneous income.

The Medicare Part C program (Medicare+Choice) has rather complex financing, depending upon which plan is chosen. Basically, the funding for the Medicare+Choice program comes from the HI and SMI trust funds in proportion to the relative weights of HI and SMI benefits to the total benefits paid by the Medicare program.

Beneficiary Payment Liabilities

For Parts A and B, beneficiaries are responsible for charges not covered by the Medicare program, and for various cost-sharing aspects of both HI and SMI. These liabilities may be paid: (1) by the Medicare beneficiary; (2) by a third party such as private medigap insurance purchased by the Medicare beneficiary; or (3) by Medicaid, if the person is eligible. The term medigap is used to mean private health insurance which, within limits, pays most of the health care service charges not covered by Parts A or B of Medicare. These policies, which must meet federally-imposed standards, are offered by Blue Cross and Blue Shield (BC/BS) and various commercial health insurance companies.

For hospital care covered under HI, the beneficiary's payment share includes a one-time deductible amount at the beginning of each benefit period ($768 in 1999). This covers the beneficiary's part of the first 60 days of each spell of inpatient hospital care. If continued inpatient care is needed beyond the 60 days, additional coinsurance payments ($192 per day in 1999) are required through the 90th day of a benefit period. Medicare pays nothing after day 90, unless the beneficiary elects to use lifetime reserve days, for which a copayment ($384 per day in 1999) is required from the beneficiary.

For skilled nursing care covered under HI, the first 20 days of SNF care in a benefit period are fully covered by Medicare. But for days 21-100, a copayment ($96 per day in 1999) is required from the beneficiary. After 100 days of SNF care per benefit period, Medicare pays nothing for SNF care. Home health care has no deductible or coinsurance payment by the beneficiary. In any HI service, the beneficiary is responsible for fees to cover the first three pints or units of non-replaced blood per calendar year. The beneficiary has the option of paying the fee or of having the blood replaced.

There are no premiums for most people covered by the HI program. Eligibility is generally earned through the work experience of the beneficiary or that of a spouse. However, most aged people who are otherwise ineligible for premium-free HI coverage can enroll voluntarily by paying a monthly premium, if they also enroll in SMI. For people with less than 30 quarters of coverage as defined by SSA, the 1999 HI monthly premium rate is $309; for those having 30 to 39 quarters of coverage, the rate is reduced to $170. Voluntary coverage upon payment of the HI premium, with or without enrolling in SMI, is also available to disabled individuals for whom cash benefits have ceased due to earnings in excess of those allowed for receiving cash benefits.

For SMI , the beneficiary's payment share includes: one annual deductible (currently $100); the monthly premiums; the coinsurance payments for SMI services (usually 20 percent of the medically-allowed charges); a deductible for blood; charges above the Medicare allowed charge (for claims on assignment); and payment for any services which are not covered by Medicare. For outpatient mental health treatment services, the beneficiary is liable for 50 percent of the approved charge.

For Part C, the beneficiary’s payment share is based on the cost-sharing structure of the specific Medicare+Choice plan selected by the beneficiary, since each plan has its own requirements.

Provider Payments

For HI, before 1983, payments to providers were made on a reasonable cost basis. Medicare payments for most inpatient hospital services are now paid under a reimbursement mechanism known as the prospective payment system (PPS). Under PPS, a specific predetermined amount is paid for each inpatient hospital stay, based on each stay’s Diagnosis Related Group (DRG) classification. In some cases the payment received is less than the hospital's actual cost for providing the HI-covered inpatient hospital services for the stay; in other cases it is more. The hospital absorbs the loss or makes a profit. Certain payment adjustments exist for extraordinarily costly inpatient hospital stays. Payments for inpatient rehabilitation, psychiatric, home health, hospice, and skilled

nursing care are paid under a variety of methodologies, with each service type generally having some payment restrictions and limitations.

For SMI , before 1992, physicians were paid on the basis of reasonable charge. This was initially defined as the lowest of (1) the physician's actual charge, (2) the physician's customary charge, or (3) the prevailing charge for similar services in that locality. Starting January, 1992, allowed charges were defined as the lesser of: the submitted charges, or a fee schedule based on a relative value scale (RVS). Payments for DME and clinical laboratory services are also based on a fee schedule. Hospital outpatient services and HHAs are currently reimbursed on a reasonable cost basis, but the BBA has provided for implementation of a PPS for these services in the future.

If a doctor or supplier agrees to accept the approved rate as payment in full (takes assignment), then payments provided must be considered as payments in full for that service. No added payments (beyond the initial annual deductible and coinsurance) may be sought from the beneficiary or insurer. If the provider does not take assignment, the beneficiary will be charged for the excess (which may be paid by medigap insurance). Limits now exist on the excess which doctors or suppliers can charge. Physicians are participating physicians if they agree before the beginning of the year to accept assignment for all Medicare services they furnish during the year. Since Medicare beneficiaries may select their doctors, they have the option to choose those who do participate.

For Part C, payments to the Medicare+Choice plans are based on a blend of local and national capitate rates, generally determined by the capitation payment methodology described in Section 1853 of the Social Security Act. Actual payments to plans vary based on characteristics of the enrolled population. New risk adjusters are scheduled to be implemented in January, 2000.

Medicare Claims Processing

Prior to 1991, when a Medicare contractor (carrier or Fiscal Intermediary (FI)) received a claim (at that time called a "bill"), it contacted HCFA directly to confirm beneficiary entitlement and benefit status regarding deductibles and coinsurance. Based on information furnished by HCFA, the contractor paid the claim and forwarded a record of the transaction to HCFA. FIs forwarded bill records for all institutional provider claims processed. Carriers submitted payment records for all physician and supplier claims paid by Medicare. Payment records contained summarized physician/supplier claim data. For example, payment records contained the combined provider payment amount for all services on the claim, and the combined reasonable charge for all non-physician items. Place and type of service were determined by the service on the claim with the largest single charge.

This system had several shortcomings including significant time lags in data receipt by HCFA; limited ability to link institutional and physician/supplier data; limited availability of detailed data on physician/supplier services; and a lengthy, potentially error-prone process for payment and data correction. To address some of the shortcomings of the traditional claims processing system, the

Common Working File (CWF) was developed by HCFA and fully implemented in 1991.

The Common Working File System (CWF) Environment

The CWF is a Medicare Part A and Part B benefit coordination and claims validation system. Under CWF, the country is divided into nine distinct processing sectors. Each sector has a designated contractor "host" site and a number of FI or carrier processing contractors. Each beneficiary is assigned to one and only one sector. The host site maintains in a database CWF Health Insurance Master Records (HIMRs) for each Medicare beneficiary in the sector. The records include all Part A and Part B utilization and entitlement data. In addition to maintaining the entitlement and utilization data, the host site performs a number of other functions including checking utilization and consistency, authorizing FIs or carriers to pay claims, and forwarding claims data to the HCFA central office.

FIs and carriers do not send claims directly to HCFA. Instead, they interact with the host site. FIs and carriers process the claims submitted by providers, submit the claims to the host site for prepayment review and authorization, and then act on host site authorization to pay the claim.

A highly simplified description of the CWF claims flow process follows:

- A beneficiary receives a service from a physician, hospital, or other provider of health care services.
- The provider sends a claim to a Medicare carrier when the service was provided by a physician or supplier, or to an FI when the service was provided by an institution.
- The carrier or FI enters the claim information into its claims processing system, calculates the payment amount, and conducts consistency and utilization edits.
- The carrier or FI sends the claim to the CWF host site for edit checks and payment authorization.
- The host site edits the claim for consistency, entitlement, remaining benefits, deductible status, and duplicates of previously processed bills/claims.
- Within 24 hours of receiving the claim, the host site makes one of three payment determinations: pay the claim, reject the claim, or recycle the claim to obtain missing information.
- When the host site authorizes payment, the carrier or FI pays the claim.
- The host site sends daily to the Office of Information Services (OIS) a file of claims

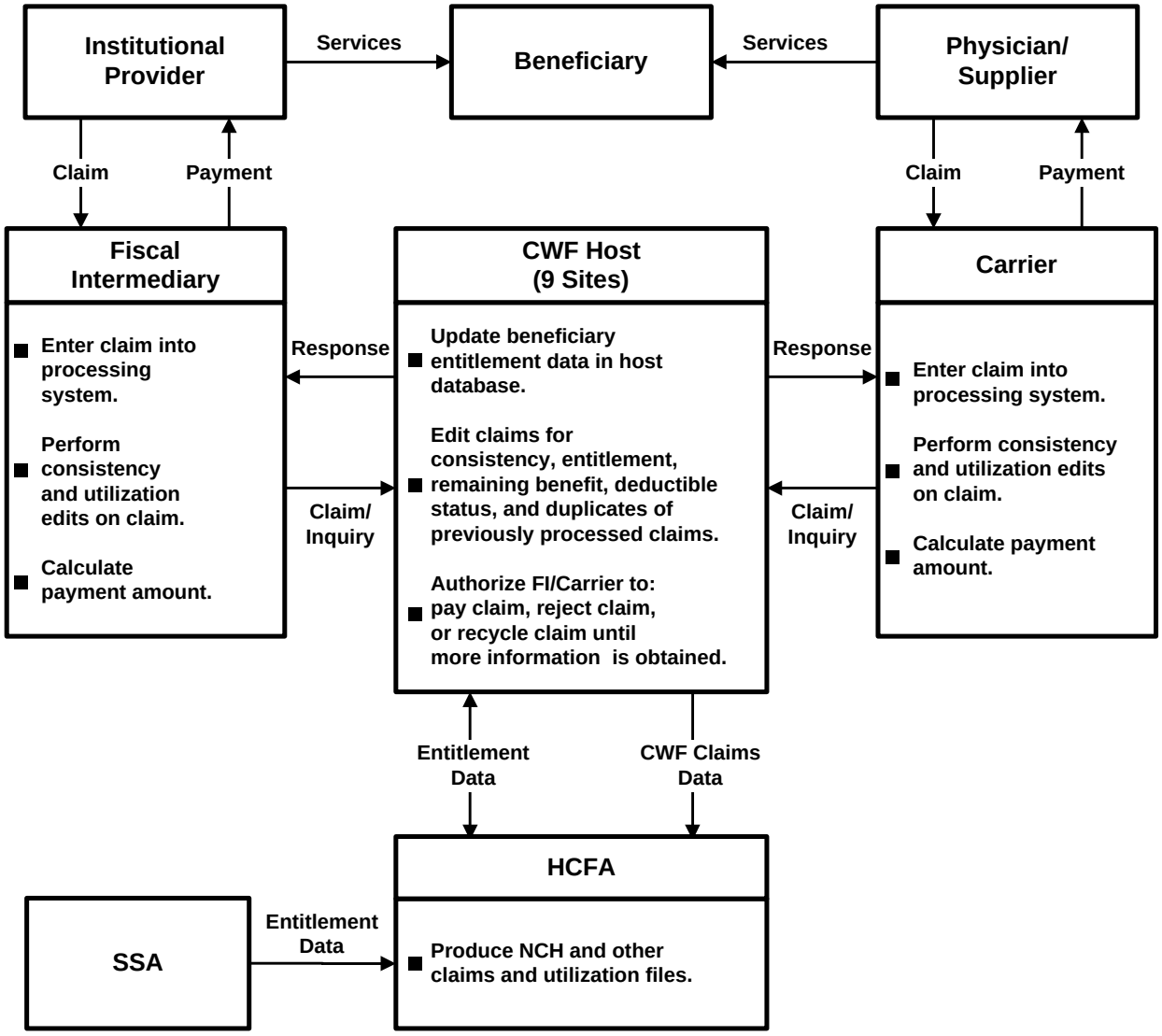
that have been correctly processed and posted to the host database.

- The host site updates the beneficiary's utilization history maintained in a CWF HIMR and transmits the information to OIS.

- The host site updates the beneficiaries enrollment history and transmits the hospice election and Medicare Secondary Payer (MSP) information to OIS.

A diagram of the CWF claims flow process is presented below:

Common Working File System Claims Processing



The CWF offers the following benefits:

- Pre-payment edits that eliminate costly adjustment processing and overpayment recovery activities.
- Enhanced utilization review opportunities because all beneficiary utilization data are maintained on a single file.
- Detection of duplicate claims through the use of a combined Part A and Part B master record for each beneficiary.
- Quick payment determination reply to the FI or carrier (generally within 24 hours of receipt of a claim).
- Improved quality and availability of Medicare payment and utilization data.

Changes in Claim Forms

Claims for Medicare covered services are submitted using claim forms. Different claim forms are submitted for institutional services and physician/supplier services. These forms are described below.

Institutional Claims

From 1984 to 1993, institutional providers recorded claim information on the Uniform Bill 82 (UB82). The UB82 was an improvement over previous claim forms for several reasons. First, the UB82 helped standardize data reporting because it was used by all types of institutional providers. Second, the UB82 allowed reporting of revenue center codes, value codes, and occurrence codes. Revenue center codes provide information on cost centers within facilities. Value and occurrence codes provide information about monetary conditions and events that may affect claim processing and payment. Third, prior to the UB82, diagnostic and surgical information was reported in narrative form for samples of claims. Only one diagnosis and one surgical procedure were recorded.

With adoption of the UB82, hospitals were required to report International Classification of Diseases-9th Revision-Clinical Modification (ICD-9-CM) codes on inpatient hospital claims. Narratives were no longer permitted. Inpatient hospital claims contained codes for the principal diagnosis and up to four additional diagnoses, and for the principal procedure and up to two additional surgical procedures.

Adoption of PPS led to more complete coding of diagnoses and procedures on inpatient claims because they are used to determine the DRG, and hence the payment amount to the hospital.

Beginning April 1985, ICD-9-CM procedure and diagnosis codes were required on all institutional claims. Beginning July 1987, HCFA required providers to use the HCFA Common Procedure Coding System (HCPCS) instead of ICD-9-CM procedure codes to report outpatient surgery. In September 1991, the maximum number of diagnoses and procedures that could be listed on institutional claims increased to ten. Providers were instructed to record the principal diagnosis first. They were then instructed to record up to eight secondary diagnoses and an E-code, which indicates external cause of injury, when applicable.

In October 1993, a new institutional claim form, the Uniform Bill 92 (UB-92 HCFA-1450), became effective. The UB-92 HCFA-1450 is different from the UB82 in several ways. It contains individual fields for a principal diagnosis, eight secondary diagnoses, an admitting diagnosis, and an E-code. The maximum number of procedure codes was reduced from ten to six. The maximum number of condition codes and occurrence codes was increased to 30, value codes to 36, and revenue center codes to 58. Figure 1, at the end of this chapter, is a copy of the UB-92 HCFA-1450 claim form used by institutional providers under the Medicare program.

Physician/Supplier Claims

The HCFA Form 1500 (HCFA-1500) claim reporting form is the source of Medicare physician/supplier claims data. It is submitted to carriers by physicians and suppliers requesting payment for services provided to Medicare beneficiaries. Although precursors to the HCFA-1500 existed, none were used universally by physicians and suppliers. HCFA Form 1490-S was used by beneficiaries who submitted their own Medicare claims until 1990, when providers were required to submit claims on behalf of beneficiaries.

In 1980, HCFA developed the first version of the HCFA-1500, an adaptation of a claim form recommended by the American Medical Association (AMA). In 1981, a Uniform Claim Form Task Force was convened to design a form that could be easily used by all physicians and carriers. The task force was co-chaired by the AMA and HCFA, with input from insurance organizations such as the Blue Cross/Blue Shield Association and the Health Insurance Association of America. A revised HCFA-1500 was approved by the Office of Management and Budget in 1984, and HCFA mandated that the HCFA-1500 be used by all Medicare physicians and carriers.

On the 1984 version of the HCFA-1500, diagnoses and procedures could be recorded using codes or narrative. At the time, ICD-9-CM diagnosis codes and HCPCS procedure codes were not required by all carriers. Some physicians used other coding schemes, and some recorded the diagnosis and procedure in narrative form only.

In addition, the 1984 HCFA-1500 accommodated six line items. Each line item contained information associated with the service or procedure performed, such as the diagnosis, charges, and date, place, and type of service. The name of the referring or ordering physician and the name and Provider Identification Number (PIN) of the physician who provided the services were required. The task force reconvened in 1986 to revise the HCFA-1500. Use of the revised HCFA-1500 was

required by July 1992. One significant change to the form was the elimination of diagnosis and procedure narrative. As ICD-9-CM and HCPCS codes were improved and became more specific, the narrative was no longer needed to describe or clarify the diagnosis or services provided.

Another change to the HCFA-1500 was the addition of a Unique Physician Identification Number (UPIN) for the referring or ordering physician. Each UPIN is assigned to one and only one physician, whereas the same PIN can be used by more than one physician. For example, physicians in a group practice can share a PIN. Performing physicians continue to report a PIN. Carriers, however, are required to record both the PIN and UPIN of the performing physician on claims records they submit to HCFA. Figure 2, at the end of this chapter, is a copy of the HCFA-1500 used by physician/supplier providers under the Medicare program.

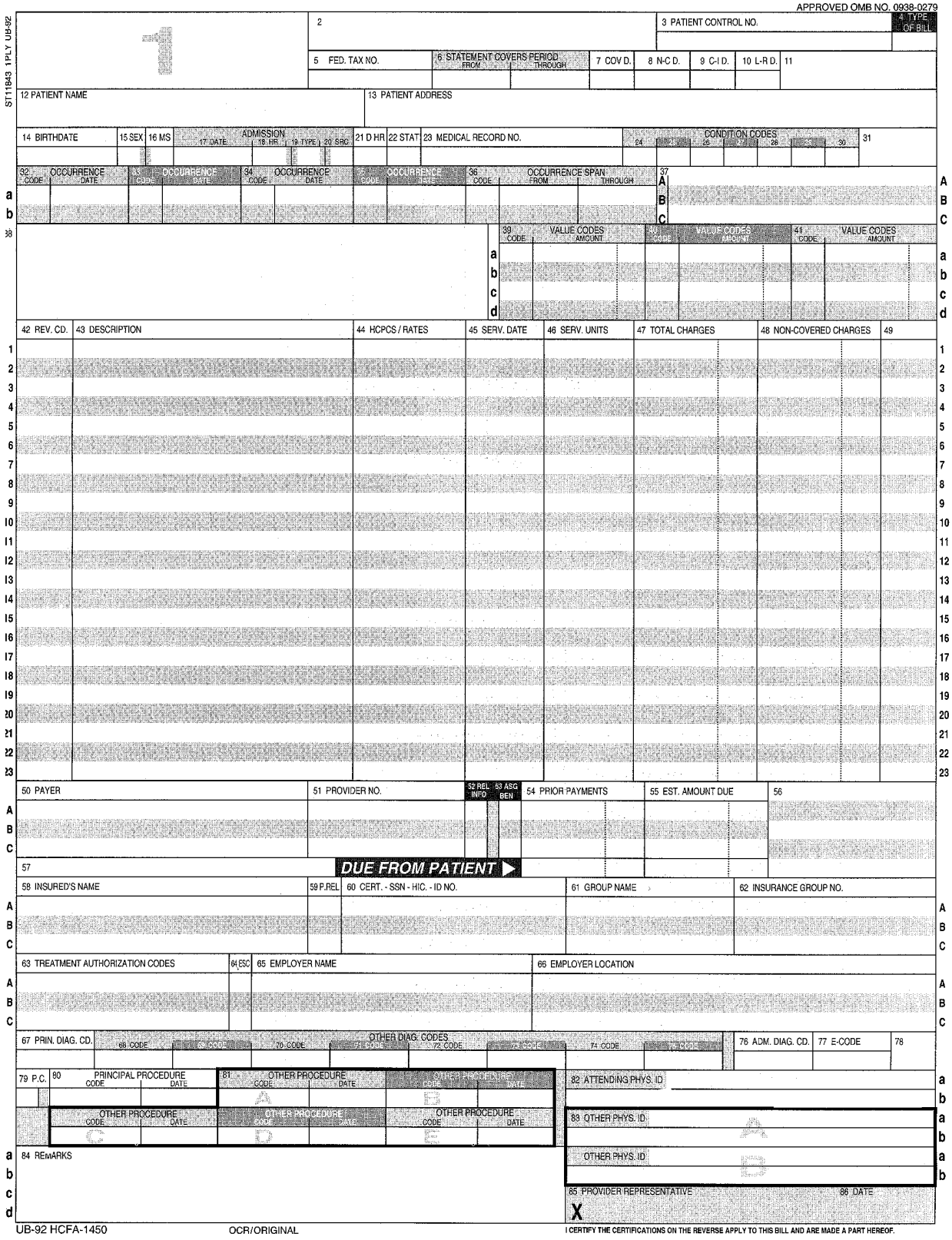


Figure 1a
Front of Form UB-92 HCFA-1450

UNIFORM BILL: **NOTICE: ANYONE WHO MISREPRESENTS OR FALSIFIES ESSENTIAL INFORMATION REQUESTED BY THIS FORM MAY UPON CONVICTION BE SUBJECT TO FINE AND IMPRISONMENT UNDER FEDERAL AND OR STATE LAW.**

Certifications relevant to the Bill and Information Shown on the Face Hereof: Signatures on the face hereof incorporate the following certifications or verifications where pertinent to this Bill:

1. If third party benefits are indicated as being assigned or in participation status, on the face thereof, appropriate assignments by the insured/beneficiary and signature of patient or parent or legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the particular terms of the release forms that were executed by the patient or the patient's legal representative. The hospital agrees to save harmless, indemnify and defend any insurer who makes payment in reliance upon this certification, from and against any claim to the insurance proceeds when in fact no valid assignment of benefits to the hospital was made.
2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.
3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.
4. For Christian Science Sanitoriums, verifications and if necessary re-verifications of the patient's need for sanitorium services are on file.
5. Signature of patient or his representative on certifications, authorization to release information, and payment request, as required by Federal law and regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 thru 1086, 32 CFR 199) and, any other applicable contract regulations, is on file.
6. This claim, to the best of my knowledge, is correct and complete and is in conformance with the Civil Rights Act of 1964 as amended. Records adequately disclosing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.
7. For Medicare purposes:

   If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his medical expenses and he wants information about his claim released to them upon their request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare authorizes any holder of medical and other information to release to Medicare medical and non-medical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, workers' compensation, or other insurance which is responsible to pay for the services for which this Medicare claim is made.
8. For Medicaid purposes:

   This is to certify that the foregoing information is true, accurate, and complete.

   I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State Laws.
9. For CHAMPUS purposes:

   This is to certify that:

   (a) the information submitted as a part of this claim is true, accurate and complete, and, the services shown on this form were medically indicated and necessary for the health of the patient;

   (b) the patient has represented that by a reported residential address outside a military treatment center catchment area he or she does not live within the catchment area of a U.S. military or U.S. Public Health Service medical facility, or if the patient resides within a catchment area of such a facility, a copy of a Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any instance where a copy of a Non-Availability Statement is not on file;

   (c) the patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverages, and that all such coverages are identified on the face of the claim except those that are exclusively supplemental payments to CHAMPUS-determined benefits;

   (d) the amount billed to CHAMPUS has been billed after all such coverages have been billed and paid, excluding Medicaid, and the amount billed to CHAMPUS is that remaining claimed against CHAMPUS benefits;

   (e) the beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,

   (f) any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent but excluding contract surgeons or other personnel employed by the Uniformed Services through personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.

   (g) based on the Consolidated Omnibus Budget Reconciliation Act of 1986, all providers participating in Medicare must also participate in CHAMPUS for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987.

   (h) if CHAMPUS benefits are to be paid in a participating status, I agree to submit this claim to the appropriate CHAMPUS claims processor as a participating provider. I agree to accept the CHAMPUS-determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. I will accept the CHAMPUS-determined reasonable charge even if it is less than the billed amount, and also agree to accept the amount paid by CHAMPUS, combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. I will make no attempt to collect from the patient (or his or her parent or guardian) amounts over the CHAMPUS-determined reasonable charge. CHAMPUS will make any benefits payable directly to me, if I submit this claim as a participating provider.

ESTIMATED CONTRACT BENEFITS

Figure 1b

Back of Form UB-92 HCFA-1450

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ 3. ____

2. ____ 4. ____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

Figure 2a
Front of Form HCFA-1500

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS. SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION

(PRIVACY ACT STATEMENT)

We are authorized by HCFA, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing date sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to HCFA, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (OMB-0938-0008), Washington, D.C. 20503.

Figure 2b
Back of Form HCFA-1500

Administration of Medicare

DHHS has the overall responsibility for administration of the Medicare program, with the assistance of SSA. Within DHHS, responsibility for administering Medicare rests with HCFA. SSA is responsible for the initial determination of an individual's Medicare entitlement, and has overall responsibility for maintaining Medicare data on the master beneficiary record, SSA's primary record of beneficiaries.

A Board of Trustees, composed of two appointed members of the public and four members who serve by virtue of their positions in the Federal Government, oversees the financial operations of the HI and SMI trust funds. The Secretary of the Treasury is the managing trustee. The Board of Trustees reports on the financial and actuarial status of the Medicare trust funds to Congress on or about the first day of April each year.

State agencies (usually state health departments under agreements with HCFA) identify, survey, and inspect provider and supplier facilities and institutions wishing to participate in the Medicare program. In consultation with HCFA, they then certify those that are qualified. The state agency also assists providers as a consultant, and coordinates the various state programs to assure effective and economical endeavors.

Medicare Data Summary

The Medicare program covers 95 percent of our nation's aged population, and many people who are on Social Security because of disability. In 1998, HI covered about 39 million enrollees with benefit payments of $134.0 billion, and SMI covered 37 million enrollees with benefit payments of $76.1 billion. Administrative costs were 1.2 percent of HI and 1.8 percent of SMI disbursements for 1998. Total disbursements for Medicare in 1998 were $213.4 billion.

Medicaid

Overview

Title XIX of the Social Security Act is a Federal-State matching entitlement program that pays for medical assistance for certain individuals and families with low incomes and resources. This program, known as Medicaid, became law in 1965 as a cooperative venture jointly funded by the Federal and State governments (including the District of Columbia and the Territories) in order to assist states in furnishing medical assistance to eligible needy persons. Medicaid is the largest source of funding for medical and health-related services for America's poorest people.

Within broad national guidelines established by federal statutes, regulations, and policies, each state: (1) establishes its own eligibility standards; (2) determines the type, amount, duration, and

scope of services; (3) sets the rate of payment for services; and (4) administers its own program. Medicaid policies for eligibility, services, and payment are complex, and vary considerably among states of similar size or geographic proximity. Thus, a person who is eligible for Medicaid in one state may not be eligible in another state; and the services provided by one state may differ considerably in amount, duration, or scope from services provided in a similar or neighboring state. In addition, Medicaid eligibility and/or services within a state can change during the year.

Basis of Eligibility and Maintenance Assistance Status

Medicaid does not provide medical assistance for all poor persons. Even under the broadest provisions of the federal statute, Medicaid does not provide health care services even for very poor persons unless they are in one of the following designated groups. And low income is only one test for Medicaid eligibility for those within these groups; their resources also are tested against threshold levels (as determined by each state within federal guidelines).

States generally have broad discretion in determining which groups their Medicaid programs will cover and the financial criteria for Medicaid eligibility. To be eligible for federal funds, however, states are required to provide Medicaid coverage for certain individuals who receive federally assisted income-maintenance payments, as well as for related groups not receiving cash payments. In addition to their Medicaid programs, most states have additional state-only programs to provide medical assistance for specified poor persons who do not qualify for Medicaid. Federal funds are not provided for state-only programs. The following enumerates the mandatory Medicaid categorically needy eligibility groups for which federal matching funds are provided:

- Individuals are generally eligible for Medicaid if they meet the requirements for the Aid to Families with Dependent Children (AFDC) program that were in effect in their state on July 16, 1996, or— at state option — more liberal criteria.

- Children under age 6 whose family income is at or below 133 percent of the Federal Poverty Level (FPL).

- Pregnant women whose family income is below 133 percent of the FPL (services to these women are limited to those related to pregnancy, complications of pregnancy, delivery, and postpartum care).

- Supplemental Security Income (SSI) recipients in most states (some states use more restrictive Medicaid eligibility requirements which pre-date SSI).

- Recipients of adoption or foster care assistance under Title IV of the Social Security Act.

- Special protected groups (typically individuals who lose their cash assistance due to earnings from work or from increased Social Security benefits, but who may keep

Medicaid for a period of time).

- All children born after September 30, 1983, who are under age 19, in families with incomes at or below the FPL. (This phases in coverage, so that by the year 2002 all such poor children under age 19 will be covered.)

- Certain Medicare beneficiaries (described later).

States also have the option of providing Medicaid coverage for other categorically related groups. These optional groups share the characteristics of the mandatory groups (that is, they fall within defined categories), but the eligibility criteria are somewhat more liberally defined. The broadest optional groups for which states will receive federal matching funds for coverage under the Medicaid program include:

- Infants up to age 1 and pregnant women not covered under the mandatory rules whose family income is no more than 185 percent of the FPL (the percentage amount is set by each State).

- Children under age 21 who meet what were the AFDC income and resources requirements in effect in their state on July 16, 1996, (even though they do not meet the mandatory eligibility requirements).

- Institutionalized individuals eligible under a special income level (the amount is set by each state — up to 300 percent of the SSI federal benefits rate).

- Individuals who would be eligible if institutionalized, but who are receiving care under home and community-based services waivers.

- Certain aged, blind, or disabled adults who have incomes above those requiring mandatory coverage, but below the FPL.

- Recipients of state supplementary income payments.

- Certain working and disabled persons with family income less than 250 percent of FPL who would qualify for SSI if they did not work.

- TB-infected persons who would be financially eligible for Medicaid at the SSI income level if they were within a Medicaid-covered category (however, coverage is limited to TB-related ambulatory services and TB drugs).

- Optional targeted low-income children included within the Children's Health Insurance Program (CHIP) established by the BBA 1997.

! Medically needy (MN) persons (described later).

The MN program allows states the option to extend Medicaid eligibility to additional qualified persons. These persons would be eligible for Medicaid under one of the mandatory or optional groups, except that their income and/or resources are above the eligibility level set by the state. Persons may qualify immediately, or may spend-down by incurring medical expenses that reduce their income to or below the state's MN income level.

The MN Medicaid program does not have to be as extensive as the categorically needy program, and may be quite restrictive in rules governing coverage and eligibility. Federal matching funds are available for MN programs. However, if a state elects to have a MN program, there are federal requirements that certain groups and certain services must be included: children under age 19 and pregnant women who are medically needy must be covered; prenatal and delivery care for pregnant women, and ambulatory care for children must be provided. A state may elect to provide MN eligibility to certain additional groups, and may elect to provide certain additional services within its MN program. In 1997, 42 states elected to have a MN program, and provided at least some MN services for at least some MN recipients. All remaining states utilize the special income level option to extend Medicaid to the near poor in medical institutional settings.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104-193) — known as the "welfare reform bill"—made restrictive changes regarding eligibility for SSI coverage that impacted the Medicaid program. This law impacts the Medicaid coverage for certain aliens. For legal resident aliens and other qualified aliens who entered the United States on or after August 22, 1996, Medicaid is barred for 5 years. Medicaid coverage for most aliens entering before that date and coverage for those eligible after the 5-year ban are state options; emergency services, however, are mandatory for both of these alien coverage groups. For aliens who lose SSI benefits because of new restrictions regarding SSI coverage, Medicaid can continue only if these persons can be covered for Medicaid under some other eligibility status (again with the exception of emergency services which are mandatory). Although a number of disabled children lost SSI as a result of changes to the Public Law 104-193, their continued eligibility for Medicaid was assured by Public Law 105-3 (BBA 1997).

In addition, welfare reform repealed the open-ended federal entitlement program known as AFDC, and replaced it with Temporary Assistance for Needy Families (TANF), which will provide grants to states to be spent on time-limited cash assistance. TANF limits a family's lifetime cash welfare benefits to a maximum of 5 years, and permits states to impose a wide range of other restrictions as well —in particular, requirements related to employment. However, the impact on Medicaid eligibility is not expected to be significant. Under welfare reform,

persons who would have been eligible for AFDC under the AFDC requirements in effect on July 16, 1996, generally will still be eligible for Medicaid. Although most persons covered by TANF will receive Medicaid, it is not required by law.

Title XXI of the Social Security Act, known as Children's Health Insurance Program (CHIP), is a new program initiated by the BBA. In addition to allowing States to craft or expand an existing state insurance program, CHIP will provide more federal funds for States to expand Medicaid eligibility to include more children who are currently uninsured. With certain exceptions, these are low-income children who would not qualify for Medicaid based on the plan that was in effect on April 15, 1997. Funds from the CHIP also may be used for providing medical assistance to children during a presumptive eligibility period for Medicaid. This is one of several options for states to select for providing health care coverage for more children, as prescribed within the BBA's Title XXI program.

Medicaid coverage may begin as early as the third month prior to application— if the person would have been eligible for Medicaid had he applied during that time. Medicaid coverage generally stops at the end of the month in which a person no longer meets the criteria of any Medicaid eligibility group. The BBA allows states to provide 12 months of continuous Medicaid coverage (without re-evaluation) for eligible children under the age of 19.

Scope of Medicaid Services

Title XIX of the Social Security Act allows considerable flexibility within the states' Medicaid plans. However, some federal requirements are mandatory if federal matching funds are to be received. A state's Medicaid program must offer medical assistance for certain basic services to most categorically needy populations. These services generally include:

- Inpatient hospital services
- Outpatient hospital services
- Prenatal care
- Vaccines for children
- Physician services
- Nursing facility services for persons age 21or over
- Family planning services and supplies
- Rural health clinic services
- Home health care for persons eligible for skilled-nursing services
- Laboratory and X-ray services
- Pediatric and family nurse practitioner services
- Nurse-midwife services
- Federally-qualified health-center (FQHC) services, and ambulatory services of an FQHC that would be available in other settings
- Early and periodic screening, diagnostic, and treatment (EPSDT) services for children under age 21

States also may receive federal matching funds for providing certain optional services. The most common of the 34 currently-approved optional Medicaid services include:

- Diagnostic services
- Clinic services
- Intermediate care facilities for the mentally retarded (ICFs/MR)
- Prescribed drugs and prosthetic devices
- Optometrist services and eyeglasses
- Nursing facility services for children under age 21
- Transportation services
- Rehabilitation and physical therapy services
- Home and community-based care to certain persons with chronic impairments.

The BBA included a state option known as Programs of All-Inclusive Care for the Elderly (PACE). PACE provides an alternative to institutional care for persons age 55 or over who require a nursing facility level of care. The PACE team offers and manages all health, medical and social services, and mobilizes other services as needed to provide preventative, rehabilitative, curative, and supportive services. This care is provided in day health centers, homes, hospitals, and nursing homes, while helping the person maintain independence, dignity, and quality of life. PACE functions within the Medicare program as well as under Medicaid.

Regardless of source of payment, PACE providers receive payment only through the PACE agreement and must make available all items and services covered under both Titles XVIII and XIX without amount, duration or scope limitations, and without application of any deductibles, copayments, or other cost sharing. The individuals enrolled in PACE receive benefits solely through the PACE program.

Amount and Duration of Medicaid Services

Within broad federal guidelines and certain limitations, states determine the amount and duration of services offered under their Medicaid programs. States may limit, for example, the number of days of hospital care or the number of physician visits covered. Two restrictions apply: (1) limits must result in a sufficient level of services to reasonably achieve the purpose of the benefits; and (2) limits on benefits may not discriminate among beneficiaries based on medical diagnosis or condition.

In general, states are required to provide comparable amounts, duration and scope of services to all categorically-needy and categorically-related eligible persons. There are two important exceptions: 1) medically necessary health care services identified under the EPSDT program for eligible children which are within the scope of mandatory or optional services under federal law, must be covered even if those services are not included as part of the covered services in that

state's plan; and 2) states may request waivers to pay for otherwise-uncovered home and community-based services for Medicaid-eligible persons who might otherwise be institutionalized. States have few limitations on the services which may be covered under such waivers as long as the services are cost effective (except that, other than as a part of respite care, they may not provide room and board for such recipients). With certain exceptions, a state's Medicaid plan must allow recipients to have some informed choices among participating providers of health care, and to receive quality care that is appropriate and timely.

Payment for Medicaid Services

Medicaid operates as a vendor payment program. States may pay providers directly, or states may pay for Medicaid services through various prepayment arrangements, such as HMOs. Within federally-imposed upper limits and specific restrictions, each state generally has broad discretion in determining the payment methodology and payment rate for services. Generally, payment rates must be sufficient to enlist enough providers so that covered services are available at least to the extent that comparable care and services are available to the general population within that geographic area. Providers participating in Medicaid must accept Medicaid payment rates as payment in full. States must make additional payments to qualified hospitals that provide inpatient services to a disproportionate number of Medicaid recipients and/or to other low-income or uninsured persons under what is known as the disproportionate share hospital (DSH) adjustment. Excessive use of the DSH adjustment resulted in rapidly increasing federal expenditures for Medicaid. However, under legislation passed in 1991, 1993, and again within the BBA 1997, the state allotments for payments to DSH hospitals have become increasingly limited.

States may impose nominal deductibles, coinsurance, or copayments on some Medicaid recipients for certain services. Certain Medicaid recipients, however, must be excluded from cost sharing: pregnant women, children under age 18, hospital or nursing home patients who are expected to contribute most of their income to institutional care. In addition, all Medicaid recipients must be exempt from copayments for emergency services and family planning services.

The Federal Government pays a share of the medical assistance expenditures under each state's Medicaid program. That share, known as the Federal Medical Assistance Percentage (FMAP) is determined annually by a formula that compares the state's average per capita income level with the national income average. States with a higher per capita income level are reimbursed a smaller share of their costs. By law, the FMAP cannot be lower than 50 percent nor higher than 83 percent. In 1999, the FMAPs varies from 50 percent (in 10 states) to 76.78 percent (in Mississippi). The BBA also permanently raised the FMAP for the District of Columbia from 50 percent to 70 percent, and raised the FMAP for Alaska from 50 percent to 59.8 percent for 3 years. For the children added to Medicaid through the CHIP program, the FMAP average for all States is about 70 percent, compared with the Medicaid average of 57 percent.

The Federal Government also reimburses states for 100 percent of the cost of services provided through facilities of the Indian Health Service; provides financial help to the 12 states that provide the highest number of emergency services to undocumented aliens; and shares in each state's expenditures for the administration of the Medicaid program. Most administrative costs are matched at 50 percent, although higher percentages are paid for certain activities and functions such as development of mechanized claims processing systems.

Except for the CHIP program and the Qualifying Individuals (QI) program (described later), federal payments to states for medical assistance have no set limit (cap); rather, the Federal Government matches (at FMAP rates) state expenditures for the mandatory services plus the optional services that the individual state decides to cover for eligible recipients, and matches (at the appropriate administrative rate) all necessary and proper administrative costs.

Medicaid Summary and Trends

Medicaid was initially formulated as a medical care extension of federally-funded programs providing cash income assistance for the poor, with an emphasis on dependent children and their mothers, the disabled, and the elderly for cash payments. Over the years, however, Medicaid eligibility has been incrementally expanded beyond its original ties with eligibility for cash programs. Legislation in the late 1980s assured Medicaid coverage to an expanded number of low-income pregnant women, poor children, and to some Medicare beneficiaries who are not eligible for any cash assistance program. Legislative changes also focused on increased access, better quality of care, specific benefits, enhanced outreach programs, and fewer limits on services.

Since its inception, Medicaid has had very rapid growth in expenditures. Although the rate of increase has subsided recently, acceleration over the years has been noteworthy. This rapid growth in Medicaid expenditures has been due to several factors. The primary ones include the following:

- The expanded coverage and utilization of services, and the increase in the size of the Medicaid-covered populations (a result of federal mandates, population growth, and the earlier economic recession)

- The DSH payment program, coupled with provider tax and donations programs

- The increase in the number of old and disabled persons requiring extensive acute and/or long term health care and various related services

- The results of technological advances to keep more low birth-weight babies and other critically ill or severely injured persons alive and in need of continued extensive and expensive care

- The increase in payment rates to providers of health care services, when compared with general inflation

As with all health insurance programs, most Medicaid recipients require relatively small average expenditures per person each year. Providing health care coverage for almost 17.5 million children, who otherwise would usually receive little or no medical care, has always been a primary concern of the Medicaid program. The data for 1997 indicate that Medicaid payments for services for these children (who constitute over 51 percent of all Medicaid recipients) averaged about $1,500 per child. However, certain other specific groups comprising far fewer persons have much larger per person expenditures. Regardless of their initial financial situation, their medical needs are so great or continuous that most of these patients must eventually depend upon Medicaid. When expenditures for these high and lower cost recipients are combined, the 1997 payments to health care vendors for 34 million Medicaid recipients average $3,680 per person.

LTC is an important and increasingly utilized provision of Medicaid—especially as our Nation's population ages. Almost 45 percent of the total cost of care for persons using nursing facility or home health services in the U.S. in recent years is paid for by the Medicaid program. A much larger percentage is paid for by Medicaid, however, for those persons who use more than 4 months of such LTC. The data for 1997 show that Medicaid payments for nursing facility (excluding ICF/MRs) and home health care totaled $42.7 billion for more than 3.4 million recipients of these services — an average 1997 expenditure of $12,340 per LTC recipient. With the percentage of our population who are elderly or disabled increasing faster than the younger groups, the need for LTC is expected to increase.

Another significant development in Medicaid is the growth in managed care as an alternative service delivery concept different from the traditional FFS system. Under managed care systems, HMOs, prepaid health plans (PHPs) or comparable entities agree to provide a specific set of services to Medicaid enrollees, usually in return for a predetermined periodic payments per enrollee. Managed care programs seek to enhance access to quality care in a cost-effective manner. Waivers may provide the states with greater flexibility in the design and implementation of their Medicaid programs. Waiver authority under Sections 1915(b) and 1115 of the Social Security Act is an important part of the Medicaid program. Section 1915(b) waivers allow states to develop innovative health care delivery or reimbursement systems. Section 1115 waivers allow statewide health care reform experimental demonstrations for covering uninsured populations and testing new delivery systems without increasing costs. Finally, the BBA 1997 provided states a new option to use managed care.

The number of Medicaid beneficiaries enrolled in some form of managed care program is

growing rapidly. Several states have converted their entire Medicaid programs into managed care arrangements.

Medicaid data as reported by the states indicate that more than 34 million persons received health care service through the Medicaid program in 1997. Total outlays for the Medicaid program in 1997 included: direct payment to providers of $125 billion, payments for various premiums (for HMOs, Medicare, etc.) of more than $20 billion, payments to DSHs of $15 billion, and administrative costs of $6 billion.

The total expenditure for the nation's Medicaid program in 1998 was approximately $170 billion ($96 billion in federal and $74 billion in state funds). With anticipated impacts from the BBA 1997, projections now are that total Medicaid outlays may be $270 billion in fiscal year (FY) 2004, with an additional $6.6 billion expected to be spent for the new CHIP.

Medicaid—Medicare Relationship

Medicare beneficiaries who have low incomes and limited resources may also receive help from the Medicaid program. For persons who are eligible for full Medicaid coverage, the Medicare health care coverage is supplemented by services that are available under their state's Medicaid program, according to eligibility category. These additional services may include, for example, nursing facility care beyond the 100-day limit covered by Medicare, prescription drugs, eyeglasses, and hearing aids. For persons enrolled in both programs, any services that are covered by Medicare are paid for by the Medicare program before any payments are made by the Medicaid program, since Medicaid is always payer of last resort.

Certain other Medicare beneficiaries may receive help through their state Medicaid program. Qualified Medicare Beneficiaries (QMBs) and Specified Low-Income Medicare Beneficiaries (SLMBs) are the best known and the largest in numbers. QMBs are those Medicare beneficiaries who have resources at or below twice the standard allowed under the SSI program, and incomes at or below 100 percent of the FPL. This category includes persons who are eligible for full Medicaid coverage. For QMBs, the state pays the HI and SMI premiums and the Medicare coinsurance and deductibles, subject to limits that States may impose on payment rates. SLMBs are Medicare beneficiaries with resources like the QMBs, but with incomes that are higher, but still less than 120 percent of the FPL. For SLMBs, the Medicaid program only pays the SMI premiums. The Medicare law states that disabled and working individuals who previously qualified for Medicare because of disability, but who lost entitlement because of their return to work (despite the disability), are allowed to purchase Medicare HI and SMI coverage. If these persons have incomes below 200 percent of the FPL, but do not meet any other Medicaid assistance category, they may qualify to have Medicaid pay their HI premiums as Qualified Disabled and Working Individuals

(QDWIs). According to HCFA estimates, Medicaid currently provides some level of supplemental health coverage for 5 million Medicare beneficiaries in the previously mentioned three categories.

The BBA 1997 establishes a capped allocation to states, for each of 5 years beginning January 1998, for payment of all or some of the Medicare SMI premiums for additional Medicare beneficiaries: those with incomes that are above 120 percent and less than 175 percent of the FPL. These income levels exceed those established for QMBs and SLMBs. These beneficiaries are known as QIs. Unlike QMBs and SLMBs, who may be eligible for Medicaid benefits in addition to their QMB/SLMB benefits, the QIs cannot be otherwise eligible for medical assistance under a state plan. The payment of this QI benefit is 100 percent federally funded, up to the state's allocation. This QI program provides financial assistance to additional persons needing help in acquiring adequate health care coverage.

Conclusion

The DHHS, the individual states, and the U.S. Congress continually seek to make improvements in the Medicare and Medicaid programs' coverage of needy individuals, and in the quality, effectiveness, and extent of health care services. However, these programs must function within the various federal and state constraints of serious economic, social, and political factors. As a result, federal and state regulations and laws continue to be reviewed for these expensive, yet vitally important, Medicare and Medicaid programs.

Acknowledgment

The Office of the Actuary and the Office of Strategic Planning would like to express their gratitude to Barbara Klees and Earl Dirk Hoffman for their valuable contributions to this overview article and to Mary Onnis Waid (retired) who diligently prepared this article for many years.

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