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### Coding Corner

#### Billing for Multiple Surgical Procedures in the Same Operative Session

This topic has received heightened attention from the OIG in 2003. Multiple surgeries are separate procedures performed by a physician on the same patient at the same operative session. Regulations require when multiple surgical procedures are performed, only the highest-paying procedure is reimbursable at the full payment rate. The second through the fifth procedures are reimbursable at 50% the normal payment rate.

Medicare has stated that they do not want providers appending the 51 modifier (multiple procedures) on their claims. (Refer to the Medicare General Surgery Billing Guide page 10) They will append the modifier and make the adjustment to the charge once they receive the claim. Appending the 51 modifier yourselves may cause an additional cut to your reimbursement.

To properly bill for multiple procedures take note of the steps in the following example. A physician performs a closed treatment of a humeral shaft fracture without manipulation and during the same operative session also sutures a complex laceration on the other arm which is 3.5 cm and then he makes an intermedi-

ate repair of a 2.5 cm laceration on the patient's right leg. First, list all the procedure codes reflective of the services performed during the operative session; 24500, 13121, and 12031. Make sure the services are not bundled. List all procedures on the same claim. List the highest reimbursable procedure code as the first procedure with the second highest code down through the lowest. The claim for this example would look as follow:

- **24500** - \$ Charge Amount (reimbursed at the Massachusetts Rate of \$354.30)
- **13121** - \$ Charge Amount (reimbursed at the Massachusetts Rate of \$333.71)
- **12031** - \$ Charge Amount (reimbursed at the Massachusetts Rate of \$179.64)

Upon receipt of the bill, Medicare will see that multiple procedures were done by the same physician on the same day and will automatically apply the 51 modifier to procedure code 13121 and 12031 reducing the fee to 50% of the fee schedule amount.

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# Value ~ Added

A Publication of the Feeley & Driscoll, P.C. Health Care Services Group

## Medicare Hospital Fund Will Run Dry in 2026

It has become an annual rite of spring over the past thirty-eight years – just as the swallows return to San Juan Capistrano every year, and the Red Sox return to Fenway Park – the Medicare Board of Trustees reports to Congress on the financial operations and actuarial status of the Medicare program. Play ball!

These detailed annual reports evaluate the near-term and longer-term financial status of the Medicare program under a range of possible future conditions over the next 75 years. This spring, for the first time in five years, the Trustees have lowered their estimate for the sustainable life of the Hospital Insurance trust fund.

Under the Trustees' "intermediate" set of economic and demographic assumptions (i.e. the "middle-case" or "best guess" scenario), the HI trust fund is now expected to become depleted just 23 years from today – in 2026 – which is four years earlier than the previous estimate (and who-knows-who-much earlier than the Olde Towne Team is expected to win their next World Series).

According to the Trustees, the significant decline in the Medicare program's life expectancy is attributed primarily to lower than expected revenues and somewhat higher hospital spending. The bump in spending is the result of increases in inpatient admissions and more complex patient cases.

## Structure of the Medicare Program

The Medicare program is comprised of two distinct parts, of course –

- *Hospital Insurance* (i.e. Medicare Part A) helps pay for hospital, home health, skilled nursing facility, and hospice care for the

## Medicare Hospital Fund Will Run dry in 2026 (continued)

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*Medicare Hospital Fund Continued from Page 1...*

aged and disabled. The largest category of HI expenditures is inpatient hospital services.

- Supplementary Medical Insurance (i.e. Medicare Part B) pays for physician, outpatient hospital, home health, and other services. The largest SMI expenditure category is physician services.

The two funds are financed in very different ways. The HI trust fund is financed primarily by payroll taxes paid by workers and employers. Currently, employers and employees each pay 1.45% of their earnings to Medicare. (The self-employed pay 2.9%). Other HI revenue sources include a portion of the federal income taxes that people pay on their Social Security benefits, and interest paid on the US Treasury securities held in the HI trust fund.

In contrast, the SMI trust fund is financed primarily by transfers from the general fund of the US Treasury, which cover about 75% of total SMI expenditures, and by monthly premiums paid by beneficiaries, which cover the remaining 25% of expenditures.

**Hospital Insurance Trust Fund**

In this year's 158-page annual report, the Medicare Trustees indicate that total HI fund income in calendar year 2002 was \$178.6 billion (up \$4.0 billion from CY 2001, or +2.3%), but total expenditures were \$152.5 billion (up \$9.1 billion, or +6.3%). Although growth in expenditures did outpace growth in revenues during the twelve-month period, CY 2002 still represented the fifth consecutive period that the fund experienced a positive cash flow. As of December 31, 2002, the fund had \$234.8 billion in assets (up \$26.1 billion, or +12.5%).

However, the Trustees estimate that Medicare Part A spending will outpace tax revenues after 2012; deficits in total income over expenditures will occur beginning in 2018; and the HI fund will run out of cash in 2026, four years earlier than predicted in the previous annual report. (Last year's report had extended the life of the fund by one year over the preceding estimate. Before that, the 2001 report had extended the life of the program by four years.)

Report Year	Estimated Depletion of HI Trust Fund
003 (based on 2002 data)	2026 (-4)
002 (based on 2001 data)	2030 (+1)
001 (based on 2000 data)	2029 (+4)
000 (based on 1999 data)	2025

In comparison, the Social Security trust fund is now expected to be exhausted by 2042, which is one year later than earlier estimates. In the past two years, the estimated sustainable life of Social Security has been extended by four years.

**Supplemental Medical Insurance Fund**

SMI fund income in CY 2002 was \$106.2 billion (up +7.7%), but total expenditures were \$113.2 billion (up +11.6%). As of December 31, 2001, the fund had a balance of \$34.3 billion (down -16.9%).

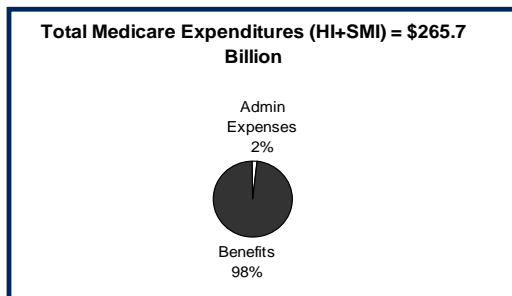
SMI expenditures have increased faster than HI expenditures in most years and are expected to continue to do so for a number of years in the future. However, unlike the HI trust fund, the SMI fund is expected to be adequately financed "into the indefinite future," but only because current law provides that general revenue contributions and beneficiary premiums are automatically adjusted annually to cover the expected costs for the upcoming year.

SMI solvency comes at a price, however. According to the Trustees, Medicare Part B general revenues in 2002 accounted for approximately 7.8% of personal and corporate Federal income taxes (up +1.7% from 2001). If taxes remained at current levels relative to the national economy, then SMI general revenues would account for about 32% of total income taxes by 2077.

**What Can Be Done to Save Medicare?**

As for the impending exhaustion of the HI trust fund, the Trustees estimate that in order to bring fund into "actuarial balance," outlays would have to be reduced by 42% or income would need to be increased by 71%. To increase revenue to necessary levels, the current 2.90% payroll tax would have to be immediately increased to 5.30%. Of course, to any extent that program-saving efforts are delayed or gradually phased-in, the magnitude of the adjustments required would increase.

Congress and the President are unlikely to come to terms on such drastic expenditure reductions or tax increases, however, and both the House and Senate continue to look at even more costly Medicare benefit enhancements, especially coverage for prescription drugs, which could cost a minimum of \$400 billion over the next decade.



## Compliance Corner

An update on recent activity by the Department of Health and Human Services Office of Inspector General (HHS-OIG)

The OIG is responsible for conducting audits, evaluations, and both criminal and civil investigations for all HHS agencies. These functions are performed by the OIG's Office of Audit Services (OAS), Office of Evaluation and Inspections (OEI), and Office of Investigations (OI), respectively.

**Medicaid Payments for School-Based Health Services** - The OIG has produced a number of reports concerning this subject. In 2003, 6 audits have been performed in Massachusetts alone. The objective of these audits was to determine whether costs claimed for school-based health services by the school districts through the Commonwealth of Massachusetts were reasonable, allowable, and adequately supported in accordance with the terms of the state Medicaid plan and applicable Federal regulations.

The OIG found inadequate controls in all 6-school audits. The most common errors being; billing Medicaid when students were absent and / or rendering services to students who were not prescribed to receive school-based health services; and not keeping adequate documentation.

To read the most recent report for Boston Public Schools, go to:  
<http://www.oig.hhs.gov/oas/reports/region1/10200001.pdf>

**Comparing Medicare Physician Payments to Private Payers** – The OIG issued a final report describing relative differences in physician payment amounts between Medicare and the private sector found through an analytic data mining technique. Data mining is a relatively new field in analysis that utilizes a number of tools to better understand and describe very large data sets. The report states that 217 procedure codes out of 681 (30%) were identified with consistent and substantial differences in relative values. The reasons for these differences are unclear and may be attributable to errors within the relative values themselves, or to population differences.

To read the full report, go to:  
<http://oig.hhs.gov/oei/reports/oei-06-00-00570.pdf>

**Review of Outlier Payments Made to the Baystate Medical Center Under the Outpatient Prospective Payments for the Period August 1, 2000 through June 30, 2001** – The objective of this audit was to determine whether outpatient claims with outlier payments were billed in accordance with

Medicare laws and regulations. The OIG reviewed a sample of 38 such claims, totaling \$145,736 and found that 37 claims were incorrectly billed. Specifically, the billing errors primarily included claims with incorrect ambulatory payment classification codes (APCs), as well as claims with incorrect units and clerical errors. As a result, the OIG identified both overpayments and underpayments resulting in a net Medicare overpayment to the Hospital of \$7,939.

There has been quite a lot of recent OIG activity in the Northeast region concerning outlier payments under the still relatively new Outpatient Prospective Payment System. This topic first appeared in the OIG's Work Plan for Fiscal Year 2002, and continues to be an area of focus for regulators. The OIG's vulnerability assessments have found that these types of outlier payments pose a "high risk" of being inaccurate.

The OIG is particularly concerned that significant overpayments can result if providers submit claims with clerical errors that result in overstated charges for services. Pilot reviews at several hospitals have indeed uncovered some overpayments. The OIG plans to expand this review initiative nationwide based on data analysis identifying high-risk providers. So we expect the high volume of reports on this issue to continue for the foreseeable future.

To read the full report, go to:  
<http://oig.hhs.gov/oei/reports/region1/10200528.pdf>

## Contact Feeley & Driscoll

Please visit [www.fdcpa.com/healthcare.htm](http://www.fdcpa.com/healthcare.htm) to receive the latest health care news and the dates and agendas of our upcoming Reimbursement Roundtables for Hospitals and Long Term Care Providers

If you have any questions or would like to discuss further any of the issues discussed in Value Added with one of our health care specialists, please contact us at (617) 742-7788 or

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## CMS Program Memorandums - March 2003

### **Clarification of 3-Day Payment Window vs. 1-Day Payment Window for Hospitals Excluded from Inpatient Prospective Payment System (IPPS)**

*Agencies:* Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)  
*Action:* 2-3-03, Transmittal No. A-03-008, Change Request 2537.

Long-term care hospitals (LTCHs) and inpatient rehabilitation hospitals (IRFs) are not subject to the 3-Day Payment Window (72-hour rule) for pre-admission services. Hospitals excluded from IPPS are subject to the 1-Day Payment Window (24-hour rule) for pre-admission services, even though these types of facilities are now under their own prospective payment system (PPS). With the implementation of IRF PPS, it was mistakenly assumed that because they were coming under a PPS, the 72-hour rule would apply. Due to current edits within the Common Working File (CWF), IRFs and LTCHs are currently subject to the 72-hour rule. In summary, only acute inpatient hospitals are subject to the 3-day payment window. LTCHs and IRFs are only subject to the 1-day payment window.

### **Correct Payment of January and February 2003 Physician Services**

*Agencies:* Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)  
*Action:* 2-3-03, Transmittal No. B-03-011, Change Request 2549.

### **Identifying the Primary Payer Amounts to Send to the Medicare Secondary Payer Pay Module (MSPPAY) and the Shared Systems When There Are Multiple Primary Payers on Electronic and Hardcopy Claims**

*Agencies:* Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)  
*Action:* 2-3-03, Transmittal No. AB-03-011, Change Request 2050.

### **Durable Medical Equipment Regional Carriers (DMERCs) – New Modifier Needed to Invoke Advanced Beneficiary Notice (ABN) Logic for Hardcopy and Electronic Claims**

*Agencies:* Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services  
*Action:* 2-3-03, Transmittal No. B-03-009, Change Request 2048.

### **Use of the National Drug Code (NDC) for Drug Claims at the Durable Medical Equipment Regional Carriers (DMERCs)**

*Agencies:* Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)  
*Action:* 2-7-03, Transmittal No. B-03-012, Change Request 2339.

### **Single Drug Pricer**

*Agencies:* Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)  
*Action:* 2-7-03, Transmittal No. AB-03-014, Change Request 2544.

### **Implementation of the Financial Limitation for Outpatient Rehabilitation Services**

*Agencies:* Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)  
*Action:* 2-7-03, Transmittal No. AB-03-018, Change Request 2183.

Section 4541 (a)(2) of the Balanced Budget Act (BBA) (P.L. 105-33) of 1997, which added §1834(k)(5) to the Social Security Act (the Act), required payment under a prospective payment system for outpatient rehabilitation services. Outpatient rehabilitation services include the following services:

- Physical Therapy (PT) (which includes outpatient speech-language pathology); and
- Occupational Therapy (OT).

Section 4541 (c) of the BBA required application of a financial limitation to all outpatient rehabilitation services (with the exception of outpatient departments of a hospital) of an annual per beneficiary limit of \$1500 for all outpatient PT services (including speech-language pathology services) and a separate \$1500 limit for all OT services. The \$1500 limit is based on incurred expenses and includes applicable deductible (\$100) and coinsurance (20 percent). The annual limitation does not apply to services furnished directly or under arrangement by a hospital to an outpatient, or to a hospital inpatient who is not in a covered Part A stay. The BBA provided that the \$1500 limits be indexed by the Medicare Economic Index (MEI) each year beginning in 2002. This indexed amount is \$1590 for 2003.

### **The Report of Benefit Savings (RBS)**

*Agencies:* Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)  
*Action:* 2-14-03, Transmittal No. A-03-012, Change Request 2557.

### **Minimum Number of Pricing Files That Must Be Maintained On-line for Medicare Physician Fee Schedule (MPFS) Services**

*Agencies:* Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)  
*Action:* 2-3-03, Transmittal No. B-03-007, Change Request 2460.

### **Clarification of the Allocation of Initial Claim Entry Activities Where the Claim is Paid Secondary by Medicare**

*Agencies:* Department of Health and Human Services (DHHS) and Centers for Medicare and Medicaid Services (CMS)

*Action:* 2-28-03 , Transmittal AB-03-024, Change Request 2074.

**3-Day Payment Window Refinements Under the Short-Term Hospital Inpatient Prospective Payment System**

*Agencies:* Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)

*Action:* 2-14-03, Transmittal No. A-03-013, Change Request 2573.

**Implementation of the Modifications (4010A1) to Transactions and Code Set Standards for Electronic Transactions Adopted Under the Health Insurance Portability and Accountability Act (HIPAA)**

*Agencies:* Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)

*Action:* 2-21-03, Transmittal No. AB-03-026, Change Request 2385.

**Update the Medicare Secondary Payment Module (MSPPAY) to Apportion Prospective Payment System (PPS) Outlier Amounts to all Service Lines With Medicare Reimbursement That are PRICER Related and Potential Outlier Service Lines**

*Agencies:* Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)

*Action:* 2-3-03, Transmittal No. A-03-006, Change Request 2053.

**Additional Documentation Request (ADR) Requirements for Ordering Providers of Laboratory Services**

*Agencies:* Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)

*Action:* 2-14-03, Transmittal No. AB-03-021, Change Request 2504.

**Remittance Advice Remark and Reason Code Update**

*Agencies:* Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)

*Action:* 2-3-03, Transmittal No. AB-03-012, Change Request 2546.

**Changes in Payment for Certain Services Provided by Outpatient Physical Therapy (OPT) Providers Under the Medicare Physician Fee Schedule (MPFS)**

*Agencies:* Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)

*Action:* 2-14-03, Transmittal No. A-03-011, Change Request 2366.

**Medicare Fee for Service Contractor Guidance of the HIPAA Privacy Rule**

*Agencies:* Department of Health and Human Services (DHHS) and Centers for Medicare and Medicaid Services (CMS)

*Action:* 2-28-03 , Transmittal AB-03-034, Change Request 2484.

**Durable Medical Equipment Regional Carriers (DMERCs) and Part B Carriers on the VMS Standard System – Short Descriptions of National Modifiers on the Healthcare Common Procedure Coding System (HCPCS) Tape**

*Agencies:* Department of Health and Human Services (DHHS) and Centers for Medicare and Medicaid Services (CMS)

*Action:* 2-28-03 , Transmittal B-03-019, Change Request 2343.

**Payment For Services To Be Paid On A Fee Schedule But For Which There Is No Price**

*Agencies:* Department of Health and Human Services (DHHS) and Centers for Medicare and Medicaid Services (CMS)

*Action:* 2-28-03 , Transmittal A-03-017, Change Request 2541.

**Notice of Interest Rate for Medicare Overpayments and Underpayments**

*Agencies:* Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)

*Action:* 2-11-03, Transmittal No. AB-03-019, Change Request 2430.

**Feeley & Driscoll, P.C.  
Health Care Roundtable Seminars**

As you know, Feeley & Driscoll, P.C. is hosting a series of complimentary roundtables designed to help you and your staff stay abreast of breaking issues impacting your institution's financial position.

Each roundtable will include discussions lead by a combination of experts from Feeley & Driscoll's Healthcare Services Group and outside agencies, payors and regulators.

We encourage you to send a member (or members) of your team to participate in these valuable, timely and informative sessions. All meetings will be held at F&D's Training Center, 200 Portland Street, Boston, MA 02114. Please call Scott Cavallo at (617)742-7788 x369 or e-mail ScottC@fdcpa.com to find out more about these programs. We look forward to seeing you.

Visit our web site at [www.fdcpa.com/seminars.asp](http://www.fdcpa.com/seminars.asp) for the 2003 schedule of Reimbursement Roundtables!

## New Compliance Resource for Health Care Boards of Directors

The explosive expansion of healthcare industry regulations and compliance enforcement should be of critical importance to the Board of Directors or Trustees of every healthcare organization. While Directors are not expected to serve as deputized compliance officers, they are expected to oversee the management in charge of the corporate compliance program. Directors must fully understand the risks associated with any gaps in compliance efforts. Maintaining the momentum of an effective and efficient corporate compliance strategy requires the proactive engagement of your Board, as well as vigilant efforts to continuously update your Board's knowledge of new and emerging compliance issues.

The Department of Health and Human Services Office of the Inspector General and the American Health Lawyers Association recently collaborated to publish a new educational resource to assist Directors to carry out their important oversight responsibilities. This brief, ten-page document is intended to arm Board members with some general background, and a series of questions addressing the compliance issues facing the organizations that they serve. The objective is to help corporate Directors establish, and affirmatively demonstrate, that they have followed a reasonable compliance oversight process.

The main theme highlighted throughout the *OIG-AHLA Corporate Responsibility and Corporate Compliance* is the principle of "duty of care." Duty of care refers to the fiduciary obligation of Directors to exercise the proper amount of care in decision-making and policy-shaping.

Embedded within the duty of care principle is the notion of "reasonable inquiry." It is the responsibility of each Director to make knowledgeable and appropriate inquiries to obtain the most accurate available information needed to uphold their duty of care. Directors should be more than just passive recipients of information. They need to be active players in the oversight process. A Director's failure to reasonably oversee compliance activities may put the organization at risk, and under "extraordinary circumstances," may expose individual Directors to personal liability.

You can download a copy of the *OIG-AHLA Corporate Responsibility and Corporate Compliance: A Resource for Health Care Boards of Directors* and the Massachusetts not-for profit corporations *Attorney General's Guide for Board Members of Charitable Organizations* from the Feeley & Driscoll web site at:

<http://www.fdcpa.com/healthcare.newsletters.htm>

## Notice of Interest Rate for Medicare Overpayments

The Centers for Medicare and Medicaid Services (CMS) recently issued a Program Memorandum (PM), updating the applicable interest rate for Medicare overpayments and underpayments to Medicare providers and suppliers.

Medicare regulations provide for the assessment of interest at the higher of the private consumer rate (PCR) or the current value of funds rate (CVF). PCR is fixed by the Secretary of the Treasury after taking into consideration prevailing private consumer rates of interest. The PCR is published quarterly in the Federal Register by the Department of Health and Human Services (HHS). At the beginning of February 2003, the Secretary of the Treasury notified HHS that the PCR had been changed to 10.75%. The CVF is published annually in the Federal Register by the Secretary of the Treasury, subject to quarterly revisions. The CVF for calendar year 2003 is 2%.

The PCR being more than five times the CVF, the PCR will remain in effect at least until a new rate change is published.

Period	Interest Table
October 24, 2000 - February 6, 2001	13.875 %
February 7, 2001 - April 25, 2001	14.125 %
April 26, 2001 - August 6, 2001	13.750 %
August 7, 2001 - October 30, 2001	13.250 %
October 31, 2001 - January 31, 2002	13.250 %
February 1, 2002 - May 7, 2002	12.625 %
May 8, 2002 - August 7, 2002	11.750 %
August 8, 2002 - November 18, 2002	12.625 %
November 19, 2002 - February 10, 2003	11.250 %
<b>February 11, 2003</b>	<b>10.750 %</b>

Interest begins to accrue from the date of a "final determination," and will either be charged on the overpayment balance or paid on the underpayment balance for each 30-day period that payment is delayed. Examples of a final determination include when a Notice of Amount of Program Reimbursement (NPR) is issued and a written demand for payment or a written determination of an underpayment is made by the intermediary after a cost report is filed.

### **Baby Boomer Bust**

Considerable doubts remain whether the Medicare program is adequately prepared to deal with the impending wave of retiring Baby Boomers born between 1945 and 1965. By 2030, as the last of the Boomer generation become eligible for Medicare, program enrollment is expected to nearly double from 41.1 million to 79.0 million beneficiaries (up approx. +2 million from last year's estimate).

Medicare expenditures (HI + SMI) as a percentage of the Gross Domestic Product (GDP) are projected to increase rapidly, from 2.6% in 2002 to 5.3% by 2035, and then to 9.3% by 2077 (presuming the program survives that long). The Trustees note that growth of this magnitude would place a substantially greater strain on the nation's workers, whose payroll taxes support the program. Today, there are nearly four US workers for every Medicare beneficiary. By 2030, that ratio will drop to 2.4 workers per beneficiary. This trend would continue until there are only 2.0 workers per beneficiary by 2077.

### **Medicare Board of Trustees**

The Medicare Board of Trustees is composed of six members, four of whom serve by virtue of their positions in the Federal government:

- John W. Snow, Secretary of the Treasury, who is the Managing Trustee
- Elaine S. Chao, Secretary of Labor
- Tommy G. Thompson, Secretary of Health and Human Services
- Jo Anne B. Barnhart, Commissioner of Social Security

The other two members of the Board are appointed by the President and confirmed by the Senate to serve as public representatives. The current public Trustees were nominated by President Clinton and began serving their four-year terms in October 2000. Dr. John L. Palmer, Ph.D is a professor of economics and public administration and Dean of the Maxwell School of Citizenship and Public Affairs at Syracuse University. Dr. Thomas R. Saving, Ph.D is a professor of economics at Texas A&M University and Director of the Private Enterprise Research Center.

While a potential risk exists for the Trustees to try to manipulate the Board's projections to suit partisan political agendas, the assumptions and projection methodology are subject to periodic review by independent panels of expert actuaries and economists.

*A copy of the 2003 Annual Report of the Boards of Trustees of the Hospital Insurance and Supplementary Medical Insurance Trust Funds is available at <http://www.cms.hhs.gov/publications/trusteesreport>.*

## **Federal Register Summary - March 2003**

### **Provider Bad Debt Payment**

2-10-03 (Vol. 68, No. 27, Pages 6682-6687)

*Agencies:* Centers for Medicare & Medicaid (CMS),HHS

*Action:* Proposed Rule.

This proposed rule would remove the cap on allowable Medicare bad debt for end-stage renal disease (ESRD) facilities and expand the application of a 30 percent reduction in bad debt reimbursement for hospitals to other Medicare providers or entities currently eligible to receive bad debt reimbursement. In addition, this proposed rule would clarify that bad debts are not allowable for entities paid under proposal, with respect to bad debt payment, is to achieve a consistent bad debt reimbursement policy for hospitals and other providers or entities currently eligible to receive payments from Medicare for bad debt.

### **Third-Party Recoveries**

2-10-03 (Vol. 68, No. 27, Pages 6617-6621)

*Agency:* Office of the Secretary, DoD

*Action:* Final Rule.

### **Substance Abuse and Mental Health Services**

#### **Current List of Laboratories Which Meet Minimum Standards To Engage in Urine Drug Testing for Federal Agencies**

2-3-03 (Vol. 68, No. 2, pages 382-384)

*Agency:* Substance Abuse and Mental Health Services Administration, HHS

*Action:* Notice.

### **Office of Inspector General, HHS**

#### **Program Exclusions: February 2003**

2-14-03, (Vol. 68, No. 31, pages 7567-7569)

*Agency:* Office of Inspector General, HHS

*Action:* Notice of program exclusions.