Department of Health & Human Services
Office of Inspector General
Cost-Saver Handbook

THE 1996 RED BOOK

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Inspector General

OFFICE OF INSPECTOR GENERAL

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services' (HHS) programs as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components.

OFFICE OF AUDIT SERVICES

The OIG's Office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities, and are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse and mismanagement and to promote economy and efficiency throughout the Department.

OFFICE OF EVALUATION AND INSPECTIONS

The OIG's Office of Evaluation and Inspections (OEI) conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the Department, the Congress, and the public. The findings and recommendations contained in the inspections reports generate rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs.

OFFICE OF INVESTIGATIONS

The OIG's Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil money penalties. The OI also oversees State Medicaid fraud control units which investigate and prosecute fraud and patient abuse in the Medicaid program.

OFFICE OF ENFORCEMENT AND COMPLIANCE

The Office of Enforcement and Compliance (OEC) is responsible for the imposition of mandatory program exclusions, as well as certain permissive program exclusions and civil money penalty and assessment actions not handled by the Office of Litigation Coordination. It develops models for corporate integrity and compliance programs, monitors ongoing compliance agreements and promotes industry awareness of corporate compliance agreements developed by the OIG.

OFFICE OF LITIGATION COORDINATION

The Office of Litigation Coordination (OLC) is responsible for the coordination and disposition of all qui tam and other False Claims Act matters, and other criminal, civil and administrative matters not handled by the Office of Enforcement and Compliance. Activities include all voluntary disclosure actions; liaison with the Health Care Financing Administration and outside entities in global settlement negotiations; and the development of standards governing use of permissive exclusion authority in cases involving the Department of Justice.

INTRODUCTION

The Red Book

What is the Red Book?

The *Red Book* is a compendium of significant Office of Inspector General (OIG) monetary recommendations that have not been substantially implemented. These recommendations may require one of three types of actions: legislative, regulatory, or administrative actions, such as changes to manual issuances. Some complex issues can involve two or all three types of actions.

The Inspector General Act requires that the OIG's semiannual reports to the Congress include "an identification of each significant recommendation described in previous semiannual reports on which corrective action has not been completed." Thus, the OIG highlights significant recommendations in each semiannual report. Because of the abbreviated nature of this list and the potentially significant impact of the OIG's recommendations, however, we prepare the *Red Book* to highlight even further our most significant monetary issues.

Not only does the *Red Book* amplify our OIG reporting requirements for unimplemented recommendations, but it brings together in one document significant cost-saving recommendations for review by Department and Office of Management and Budget (OMB) officials, and the Congress.

Recommendations for proposed legislation remain in the *Red Book* until the law has been enacted. On administrative issues, recommendations are removed when the action has been substantially completed.

Recommendations from draft reports represent the tentative position of the OIG and are subject to change when the final versions of the reports are issued.

Included for each of our proposals are current law, reason for action, resultant savings and status of actions taken.

Full implementation of the recommendations contained in this 1996 edition of the Red Book could produce over $23 billion in annual savings to the Department.

Over the past 5 years, over $37 billion in savings, settlements, fines, restitutions and receivables have resulted from OIG activities and implementation of OIG recommendations.

The HHS Organization

The Department of Health and Human Services (HHS) is the Federal Government's principal agency for promoting the health and welfare of Americans and providing essential human services to persons of every age group. The HHS is comprised of the Health Care Financing Administration (HCFA), Public Health Service (PHS) agencies, the Administration for Children and Families (ACF), the Administration on Aging (AOA)--as well as general departmental management (GDM). The OIG's findings and recommendations relating to these operating divisions and GDM are highlighted in separate sections of this *Red Book*.

The Department touches every aspect of life for each American citizen. Eighty-five (85) percent of the HHS budget provides medical care coverage for the elderly, disabled, and the poor.

INTRODUCTION

The balance of the programs support research into the causes of disease, promote preventive health measures, support the provision of health and social services, and combat alcoholism and drug abuse.

The purpose of each of the Department's operating divisions is:

- The HCFA administers the Medicare and Medicaid programs.
- The PHS agencies promote biomedical research, disease cure and prevention; ensure the safety and efficacy of marketed food, drugs and medical devices; measure the impact of toxic waste sites on health; and conduct other activities designed to ensure the general health and safety of American citizens.
- The ACF provides Federal direction and funding for State-administered programs designed to promote stability, economic security, responsibility and self-support for the Nation's families, and includes a variety of programs that provide social services to American children and families, Native Americans and the Nation's developmentally disabled.
- The AoA serves as an advocate for older persons at the national level.

We believe that this 1996 edition of the *Red Book* will prove to be a useful asset for departmental decision-makers, the Administration and the Congress in their continuing efforts to contain costs and improve program efficiency at HHS.

SUMMARY AT A GLANCE

	OVERALL	HCFA	PHS AGENCIES	ACF	GDM
Red Book Items	61	49	5	5	2
□ **Type of Action Recommended**					
Administrative	14	11	3	0	0
Legislative	42	33	2	5	2
Regulatory	5	5	0	0	0
Total Number	61	49	5	5	2
□ **Savings By Type of Action**					
Administrative	$ 647	$ 610	$37	$ 0	$ 0
Legislative	$22,509	$19,912	$54	$1,635	$908
Regulatory	$ 487	$ 487	$ 0	$ 0	$ 0
Total in Millions of Dollars	$23,643	$21,009	$91	$1,635	$908

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HEALTH CARE FINANCING ADMINISTRATION

HEALTH CARE FINANCING ADMINISTRATION

Introduction

Overview

The Health Care Financing Administration (HCFA) is responsible for administering the Medicare and Medicaid programs.

Medicare Part A provides hospital and other institutional insurance for persons age 65 or older and for certain disabled persons including those with end stage renal disease, and is financed by payroll tax deductions through the Federal Hospital Insurance Trust Fund. Medicare Part B (Supplementary Medical Insurance) is an optional program which covers most of the costs of medically necessary physician and other services, and is financed by participants and general revenues.

The Medicaid program provides grants to States for medical care for approximately 37 million low-income people. Eligibility for Medicaid is, in general, based on a person's eligibility for cash assistance programs, typically Aid to Families with Dependent Children or Supplemental Security Income. State expenditures for medical assistance are matched by the Federal Government using a formula that measures per capita income in each State relative to the national average.

Significant OIG Activities

Over the years, OIG findings and recommendations have contributed to many significant reforms in the Medicare program. Such reforms include implementation of the prospective payment system (PPS) for inpatient hospital services and a fee schedule for physician services; the Clinical Laboratory Improvement Amendments of 1988; regional consolidation of claims processing for durable medical equipment (DME); and new payment methodologies for graduate medical education. The unimplemented OIG recommendations contained in this *Red Book* that relate to HCFA activities could produce billions of dollars in annual savings and recoveries to the Department. The OIG has identified a number of significant Medicare policy issues such as addressing excessive utilization and reimbursement variation among home health agencies, adjustments to graduate medical education costs and reductions in reimbursement for hospital capital costs. Regarding Medicaid, the OIG has recommended promoting Medicaid cost sharing, encouraging use of generic drugs and controlling Medicaid payments to institutions for mentally retarded people.

ADDRESS EXCESSIVE UTILIZATION AND INAPPROPRIATE VARIATION IN REIMBURSEMENT AMONG HOME HEALTH AGENCIES

Current Law:

Section 1861 of Title XVIII of the Social Security Act authorizes Medicare Part A payment for home health care services. Under the home health benefit, providers are reimbursed for the cost of each visit up to limits established by the Department.

Proposal:

The HCFA should: (1) intensify its efforts to scrutinize claims submitted by high cost agencies; (2) explore ways in which to prevent unscrupulous agencies from engaging in abusive practices (strategies might include use of Explanations of Medical Benefits (EOMBs), requiring greater participation by physicians in detecting and reporting unscrupulous behaviors, and developing of more stringent standards for participation in the Medicare home health program); and (3) consider legislation to restructure the benefit to prevent fraud, waste and abuse. The HCFA may wish to limit cost per beneficiary or adopt policies used by other payers, such as setting limits on benefits; moving more intensive and special needs patients to targeted programs; employing case managers; and involving beneficiaries in their own care through EOMBs and copayments.

We support HCFA's longer term efforts to improve the home health benefit, which include the development of outcome measures to assess the performance of individual home health agencies and establishment of a prospective payment system for this benefit.

Legislative	Regulatory	Other Administrative
✓	✓	✓

Reason for Action:

Audits and investigations have identified medically unecessary care and inappropriate fraudulent billing by specific home health agencies (HHAs). Other OIG studies describe extreme variations and broad patterns of billing by HHAs, which raise questions about the appropriateness of some billings. We therefore believe it is necessary to place systematic controls on the home health benefit to prevent abuse.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$500	$1,100	$1,400	$2,100	$2,800

Status:

The HCFA concurred with the recommendations and, among other actions, has advanced a legislative proposal as part of the President's FY 1997 budget.

Report:

☞ A-04-95-01103--Final report--March 1996; A-04-95-01104--Final report--June 1996; A-04-95-01103--Final report--May 1996; OEI-04-93-00262--Final report--September 1995; OEI-04-93-00260--Final report--July 1995; OEI-12-94-00180--Final report--May 1995; OEI-02-94-00170--Final report--June 1995; A-04-94-02087--Final report--June 1995; A-04-94-02078--Final report--November 1994

ASSESS PAYMENT FOR OXYGEN CONCENTRATORS

Current Law:

Section 1861(S)(6) of the Social Security Act prescribes coverage of durable medical equipment (DME) including home oxygen equipment and supplies under Medicare. Medicare covers home oxygen care for beneficiaries who suffer from significant hypoxemia (a deficiency in the amount of oxygen in the blood).

Proposal:

The HCFA should reduce payment coverage for oxygen concentrators.

Legislative	Regulatory	Other Administrative
☐	☐	☑

Reason for Action:

Our work in the area indicated that (1) the Department of Veterans Affairs pays substantially less for oxygen concentrators; and (2) widely varying levels of service are provided to Medicare beneficiaries.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$200	$230	$240	$260	$280

Status:

The HCFA has begun work to assess whether payment policies for oxygen concentrators are reasonable.

Report:

☞ OEI-03-91-01710--Final report--November 1994
OEI-03-91-00711--Management advisory report--August 1991

LIMIT MEDICARE PART B REIMBURSEMENT FOR HOSPITAL BEDS

Current Law:

Medicare Part B allows for the reimbursement of a hospital bed used by a Medicare beneficiary in the home when the bed is prescribed by a physician. Monthly rental payments are made according to a fee schedule established by the Omnibus Budget Reconciliation Act of 1987. Medicare payments are capped at 120 percent of the allowed fee schedule amount over a maximum period of 15 months.

Proposal:

The HCFA should develop a new approach for reimbursing suppliers for hospital beds used by Medicare beneficiaries at home. A new reimbursement methodology should reflect a hospital bed's useful life and the number of times a bed can customarily be rented over that period.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

A review of the use of hospital beds by a sample of beneficiaries in Texas during 1989 disclosed that the current Medicare reimbursement policy allows the supplier of a bed to recover the bed's wholesale cost within approximately 4 months. The majority of rentals in our sample were for periods of less than 6 months. Since the useful life of a hospital bed is 5 years, we estimated that a supplier can recover the wholesale cost of a bed as many as 7.5 times over the life of the bed.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$6.2	$6.2	$6.2	$6.2	$6.2

Status:

Although a past budget of the President contained a proposal that authorized competitive bidding for durable medical equipment, no legislative proposal was included in the President's current budget. The HCFA awarded a demonstration project on this subject in 1996. The project is expected to run in at least 3 sites for 2 cycles of 2 years each beginning in January 1997.

Report:

☞ A-06-91-00080--Final report--May 1993

REVISE MEDICARE PRESCRIPTION DRUG PAYMENT METHODS

Current Law:

Medicare covers prescription drugs under Part B for certain medical disorders, such as end stage renal disease and cancer, and when necessary for the effective use of durable medical equipment (DME). Reimbursement is based on the lower of an estimated acquisition cost or a national average wholesale price (AWP). Payment for drugs under the Medicaid program varies among the States, but generally includes use of a discounted acquisition cost, as well as a federally mandated manufacturers' rebate program.

Proposal:

The HCFA should reexamine its Medicare drug reimbursement methodologies with a goal of reducing payments as appropriate.

Legislative	Regulatory	Other Administrative
✓	✓	✓

Reason for Action:

In a review of payments for three nebulizer drugs for 1994, we found that Medicare and its recipients could have saved substantial amounts by using a discounted AWP reimbursement formula similar to many Medicaid States. By using a manufacturers' rebate program similar to Medicaid, Medicare would realize additional savings.

Savings (in millions):

	FY 1	FY 2	FY 3	FY 4	FY 5
Discounted AWP	$144[1]	$144[1]	$144 [1]	$144 [1]	$144 [1]
Manufacturers' rebate	$122 [2]	$122 [2]	$122 [2]	$122 [2]	$122 [2]

[1] Savings based on applying a formula of AWP minus 10 percent to Medicare's 1994 total drug allowance.

[2] Savings based on applying a manufacturer rebate similar to that obtained by the Medicaid program to 1994 payments for 17 high volume prescription drugs in the Medicare program.

Status:

The HCFA has agreed with our recommendation to examine Medicare reimbursement methodologies to reduce payments. The HCFA is currently in the process of transferring the drug pricing function from the existing multiple contractor pricing model to a single in-house component and expects to reach a decision in 1996 on whether to proceed with a legislative proposal to develop a revision to their current regulations.

Report:

☞ OEI-03-94-00390--Final report--March 1996
OEI-03-95-00420--Final report--May 1996

REDUCE MEDICARE PART B PAYMENT FOR ENTERAL NUTRITION AT HOME

Current Law:

Enteral nutrition therapy is covered under Medicare Part B as a prosthetic benefit, limited to patients unable to eat normally who require enteral therapy as their primary source of nutrition. While the majority of payments are for patients in nursing homes, some patients receive enteral therapy as part of home care.

Proposal:

Reduce payments through competitive acquisition strategies for patients receiving enteral nutrition at home.

Legislative	Regulatory	Other Administrative
☐	☐	✓

Reason for Action:

Payments for enteral nutrition therapy are excessive because reimbursement rates are high and competitive acquisition strategies are not fully used. In our review of other payers of enteral nutrition, we found that payers who negotiated prices, taking advantage of discounts and other competitive acquisition strategies, reimbursed from 17 to 48 percent less than Medicare.

Savings (in millions):

	FY 1	FY 2	FY 3	FY 4	FY 5
Enteral Payments for Non-nursing Home Residents	$15	$15	$ 15	$ 15	$ 15

The savings is based on a 17 percent savings through use of competitive acquisition strategies applied to 34 percent (non-nursing home residents) of the total enteral nutrient expenditure of $330 million in 1994.

Status:

The HCFA concurs that Medicare is paying too much for enteral nutrients and supports the recommendation to reduce payments for enteral therapy administered at home under Part B. A plan for a DME competitive bid demonstration that includes enteral nutrition is underway. Payment changes are likely to be implemented at the same time changes are made in Part B coverage for enteral nutrients for nursing home patients (see page 7).

Report:

☞ OEI-03-94-00021--Final report--April 1996

ELIMINATE SEPARATE ENTERAL NUTRIENT PAYMENTS IN NURSING HOMES

Current Law:

Suppliers may bill Medicare Part B for enteral nutrients delivered to patients in nursing homes, or may furnish such services under arrangements with nursing homes in which the nursing home claims the cost of the service.

Proposal:

The HCFA should eliminate separate payments for enteral nutrients for beneficiaries in nursing homes.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

Medicare allowed $218 million for enteral nutrition in 1994 for beneficiaries in nursing homes. As food, it also duplicates payments already being made to the nursing home. In addition, reimbursement for nutrients exceeds purchase price commonly available to nursing homes by over 40 percent, because separate payment does not take advantage of nursing homes purchasing power.

Savings (in millions):

	FY 1	FY 2	FY 3	FY 4	FY 5
Medicare	$174	$174	$174	$174	$174

(Proposal may result in slight cost-shifting to Medicare Part A and Medicaid.)

Status:

The HCFA concurred with our recommendation. The HCFA believes excluding enteral nutrients from Part B reimbursement when the patient resides in a nursing home will control overutilization. It is considering alternative payment mechanisms and enhanced control of utilization to contain costs while it examines a legislative remedy.

Report:

☞ OEI-06-92-00861--Final report--March 1996

MINIMIZE INCORRECT PAYMENTS FOR DURABLE MEDICAL EQUIPMENT BILLED DURING SKILLED NURSING FACILITY STAYS

Current Law:

Federal law states that durable medical equipment (DME) may only be billed to Part B of the Medicare program if the equipment is provided in the beneficiary's residence. Title VIII, Section 1861(n) further specifies that a skilled nursing facility (SNF) cannot be considered a residence. Thus, DME billed to Part B during a beneficiary stay in a SNF is incorrectly paid.

Proposal:

We recommend that HCFA take action in the following areas to minimize the opportunity for incorrect DME payments:

- improve the place of service coding system;
- improve the supplier knowledge of beneficiary location;
- review the DME regional carriers' processes; and
- improve processes for identifying SNFs for DME reimbursement purposes.

Legislative	Regulatory	Other Administrative
☐	☐	✓

Reason for Action:

We found that approximately $8.9 million in 1991 and $10.8 million in 1992 was incorrectly allowed for DME billed during Part A SNF stays. Medicare allowed $35 million for DME in all nursing homes in 1992. The inability of the suppliers and carriers to accurately determine the beneficiary's location during a SNF stay leads to incorrectly paid DME claims.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$19	$19	$19	$19	$19

Status:

The HCFA concurred with our recommendations to correct incorrect payments to SNFs for DME, and is currently developing a corrective action plan.

Report:

☞ OEI-06-92-00860--Final report--October 1994
OEI-06-92-00862--Final report--March 1996
OEI-06-92-00865--Final report--March 1996

LIMIT PAYMENTS FOR NON-PROFESSIONAL SERVICES IN SKILLED NURSING FACILITIES TO PART A

Current Law:

The Medicare program provides coverage under Part A for stays, of up to 100 days, in a skilled nursing facility (SNF). The intent of this benefit is to shorten hospital stays while still providing coverage for a patient who requires regular nursing and professional intervention. Section 1861(h) of the Social Security Act specifies the covered SNF services provided to an individual in a Part A skilled nursing stay.

Proposal:

Given the current policy allowing Part B payment for Part A covered services, and the additional financial costs of this activity, we suggest that:

- HCFA develop a legislative proposal to prohibit entities other than the SNF from seeking coverage on behalf of persons in Part A covered SNF stays for enteral nutrition, incontinence care, and surgical dressings and limit Medicare coverage of these services to Part A.

- HCFA clarify 42 CFR 483.35 (Dietary Services) to specifically include parenteral and enteral nutrition.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

Our findings indicate that current Medicare policies may inappropriately allow billing of non-professional services to Part B during Medicare covered SNF stays. In 1992, under Part B $102 million was allowed for items such as incontinence supplies, dressings and enteral nutrition on behalf of patients in SNFs. Paying for these services and supplies under Part A could save Medicare money and reduce improper incentives for providers.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
TBD	TBD	TBD	TBD	TBD

Status:

The HCFA concurred with the first recommendation and the President's FY 1997 budget contains a provision to require consolidated billing beginning in FY 1997. The HCFA also believes that it would be prudent to clarify the 42 CFR 483.35 (Dietary Services) to include parenteral and enteral nutrition.

Report:

☞ OEI-06-92-00864--Final report--June 1995
OEI-03-94-00770--Final report--December 1994
OEI-03-94-00772--Final report--December 1994

STOP INAPPROPRIATE PAYMENTS FOR WOUND CARE SUPPLIES

Current Law:

Medicare reimburses wound care supplies which are protective covers or fillers that treat openings on the body caused by surgical procedures, wounds, ulcers, or burns under Part A payments to nursing homes and home health agencies. Medicare Part B reimburses these supplies through payments to suppliers.

Proposal:

Bundle Medicare payments for wound care supplies into the per diem rate paid to nursing facilities under Medicare and Medicaid. As an interim measure, HCFA should target medical review of these supplies and monitor payment levels.

Legislative	Regulatory	Other Administrative
✓		✓

Reason for Action:

Our report found that questionable payments for wound care supplies may account for as much as two-thirds of the $98 million in Medicare allowances from June 1994 through February 1995.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$85	$85	$85	$85	$85

Status:

The HCFA concurred with the recommendations. The HCFA has taken a number of specific actions to target program integrity resources to those areas most vulnerable to abuse. The HCFA is considering proposals to require consolidated billing of services, including wound care supplies, for Medicare payments to nursing homes. The HCFA believes that this may serve as an incentive for nursing homes to more closely monitor the use of wound care supplies.

Report:

☞ OEI-03-94-00790--Final report--October 1995
OEI-03-94-00791--Final report--October 1995
OEI-03-94-00792--Final report--October 1995

ALLOW PAYMENT FOR NONEMERGENCY ADVANCED LIFE SUPPORT AMBULANCE SERVICES ONLY WHEN MEDICALLY NECESSARY

Current Law:

The Social Security Act, section 1861(s)(7), provides for coverage of ambulance service when medically necessary. The limitations for coverage of ambulance services are specified in 42 CFR 410.40, and include the requirement that the services be medically necessary, specifically that other means of transportation would endanger the beneficiary's health. However, HCFA does not make a coverage distinction between advanced life support (ALS) and basic life support (BLS) services which results in payments being based on the type of transportation furnished and not the level of service required by the beneficiary. Effective March 1, 1982, HCFA allowed separate reimbursement rates for BLS and ALS ambulances.

Proposal:

The HCFA should modify its Medicare policy to allow payment for nonemergency ALS services only when the ALS level of service is medically necessary, and instruct carriers to institute controls to ensure that payment is based on the medical need of the beneficiary and closely monitor carrier compliance.

Legislative	Regulatory	Other Administrative
☐	☑	☐

Reason for Action:

From Calendar Years (CY) 1986 to 1989, the number of trips by Medicare beneficiaries in ALS ambulances increased by 131 percent while the number of trips in BLS ambulances increased by only 14 percent. We found that 18 percent of a sample of 400 claims in CY 1989 were for services not medically necessary at the ALS level and where BLS services were available in the same city or town.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$47	$47	$47	$47	$47

Status:

The HCFA agreed with the OIG recommendations. In late 1995 the HCFA prepared a draft regulation that would shift the policy focus away from the type of vehicle used and towards the medical condition of the beneficiary. No final regulation has been issued to date.

Report:

☞ A-01-91-00513--Final report--October 1992

APPLY 190-DAY LIFETIME LIMIT FOR MEDICARE INPATIENT PSYCHIATRIC CARE AND A 60-DAY ANNUAL LIMIT

Current Law:

Medicare limits inpatient care in psychiatric hospitals to 190 days during a beneficiary's lifetime. At the time of the passage of Medicare, inpatient psychiatric care was rendered, for the most part, in State psychiatric hospitals. Congress apparently believed that long-term care of the mentally ill was generally a State responsibility. The delivery of inpatient psychiatric care have expanded beyond the psychiatric hospitals to general hospitals with distinct psychiatric units. The 190-day limit was not extended to these more costly general hospital units.

Proposal:

Develop new limits to deal with the high cost and changing patterns of utilization of inpatient psychiatric services. Apply a 60-day annual and a 190-day lifetime limit to all psychiatric care regardless of the place of service.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

Our study concluded that the Medicare lifetime limit on psychiatric hospital care is no longer effective because of changed patterns of inpatient psychiatric care. Our review found that over 82 percent of the $1.36 billion in program payments for inpatient psychiatric care is being paid to general hospitals--where the lifetime limit does not apply. We found that an annual limit on care, which has congressional precedence in a Department of Defense health care program, may be more acceptable than a lifetime limit. We believe a 60-day annual limit on inpatient psychiatric services will produce significant savings over the current uneven application of the Medicare lifetime limit.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$47.6	$47.6	$47.6	$47.6	$47.6

Status:

The HCFA considered a proposal recommending that the 190-day lifetime limit for psychiatric admissions be extended to general hospitals. However, such a proposal was not included as part of the President's current budget.

Report:

☞ A-06-86-62045--Final report--February 1988

PROVIDE EXPLICIT GUIDELINES ON ALLOWABILITY OF INSTITUTIONAL GENERAL AND ADMINISTRATIVE AND FRINGE BENEFIT COSTS

Current Law:

The HCFA guidelines--Provider Reimbursement Manual (PRM), section 2100--establish the general principle that payments to a provider must be covered under Medicare. The PRM, sections 2102.1, 2102.2, and 2103 expands this principle by explaining factors that affect the allowability of costs such as the reasonableness of cost, their relationship to patient care and the prudent buyer concept.

Proposal:

Revise the PRM to provide explicit guidelines on the allowability of certain general and administrative (G&A) and fringe benefit (FB) costs.

Legislative	Regulatory	Other Administrative
☐	☐	☑

Reason for Action:

We reviewed G&A and FB costs at 19 selected hospitals and 2 home offices nationwide in response to a request from the House of Representatives, Subcommittee on Oversight and Investigations of the Committee on Energy and Commerce. For 16 of the 19 hospitals reviewed, we noted that Medicare participated in approximately $50.7 million of costs that were either unallowable, unreasonable, or not allocable to the Medicare program. Although Medicare's share amounted to approximately $2.1 million, the bulk of the costs were passed on to other health care consumers. We also identified $3.5 million of costs which we have labeled as "costs for concern" because of their tenuous relationship to patient care. We believe that many of the unallowable costs that we identified resulted from the providers' lack of adequate internal controls. However, there are other unallowable costs that we have identified, as well as the "costs for concern" that appear to have resulted from different interpretations of the guidelines contained in HCFA's PRM, which is the principal guideline used by providers to charge costs to the Medicare program.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
TBD	TBD	TBD	TBD	TBD

Status:

The HCFA has published changes to the PRM to clarify the allowability of several of the cost categories identified in our report. The HCFA has not yet clarified the remaining cost categories noted in our report.

Report:

☞ A-03-92-00017--Final report--August 1994

INCREASE
FAIR HEARING THRESHOLD

Current Law:

Section 1842(b)(3)(C) of the Social Security Act, which became effective in FY 1973, imposed a threshold of $100 before an individual qualifies for a fair hearing. A fair hearing is an impartial review of a disputed Medicare claims decision by a carrier employee or subcontractor.

Proposal:

The HCFA should pursue a legislative initiative to increase the fair hearing threshold.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

The $100 threshold for a fair hearing has not been changed in the past 21 years and is low compared to various inflation indices. Accordingly, the threshold is no longer achieving its intended purpose of precluding hearings for negligible dollar amounts. The effect has been a skyrocketing workload.

Savings (in millions):

	FY 1	FY 2	FY 3	FY 4	FY 5
$225 Threshold	$3.8	$3.7	$3.6	$3.5	$3.4
or					
$400 Threshold	$6.0	$5.8	$5.7	$5.5	$5.3

Status:

Proposed legislation to increase the $100 threshold amount for a fair hearing and the thresholds for subsequent levels of appeal was approved by the Department in 1991. However, the proposal has not been submitted to the Congress in subsequent years.

Report:

☞ OEI-07-89-01680--Final report--December 1991

DISCONTINUE USE OF A SEPARATE CARRIER TO PROCESS MEDICARE CLAIMS FOR RAILROAD RETIREMENT BENEFICIARIES

Current Law:

From the inception of the Medicare supplementary medical insurance program (Part B), claims for Railroad Retirement beneficiaries have been processed by a single carrier. This carrier, The Travelers Insurance Company, has a contract with the Railroad Retirement Board (RRB) to process Medicare Part B claims for Railroad Retirement beneficiaries. All other Medicare carriers contract with HCFA to process claims. The authority for this unique contracting arrangement is Section 1842(g) of the Social Security Act, as amended.

Proposal:

Discontinue the use of a separate carrier to process Medicare claims for Railroad Retirement beneficiaries.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

Since 1979, the General Accounting Office, the Grace Commission and HCFA have recommended that the Railroad Retirement beneficiaries be placed under the HCFA carrier system. In following up on these recommendations, we found that cost savings of $9.1 million could be achieved by implementing the proposal. In addition, we concluded that provider billings would be simplified since the providers of service would no longer need to separate and submit RRB claims for payment to the Travelers and other Medicare claims to a different carrier. A further benefit is that beneficiaries would have the assurance that their claims will be processed timely and not routed to the wrong carrier for payment, as has sometimes happened in the past.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$9.1	$9.1	$9.1	$9.1	$9.1

Status:

While HCFA has supported legislation in the past, there is currently no legislative proposal before the Congress.

Report:

☞ A-14-90-02528--Final report--December 1990

RAISE THE MEDICARE ENTITLEMENT AGE TO 67

Current Law:

The Social Security Act and related laws established a number of Federal programs, including Social Security Retirement Insurance benefits and the Medicare program. The Medicare program pays for medical expenses of persons age 65 or older and for the disabled. Historically, Social Security and Medicare have been closely linked. Both established age 65 as their entitlement age. The Social Security Amendments of 1983 increased the age of entitlement for Social Security unreduced benefits from age 65 to age 67 over the transition period 2003 to 2027. This was done as one of several methods to strengthen the solvency of the Social Security Trust Fund. However, the age of entitlement for Medicare has remained unchanged.

Proposal:

Gradually increase the Medicare entitlement age to 67, following the same schedule for the increase in the age of entitlement to unreduced Social Security benefits.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

We analyzed the projected Medicare Hospital Insurance Trust Fund savings that would result if the Medicare entitlement age were gradually raised to age 67 following the same schedule as the Social Security program. We found that: the Hospital Insurance Trust Fund would save three quarters of a trillion dollars over a 30-year period beginning in the year 2003; the Medicare Supplementary Medical Insurance program would also save significant amounts and since the impact of raising the entitlement age on future Medicare beneficiaries is not known, potential negative consequences can be reduced by providing substantial advanced notice of the change. The proposal could help alleviate the Federal deficit and deal with the projected solvency of the trust fund.

Savings:

Potential savings of approximately $60 billion per year in the years immediately after the entitlement age reaches 67 in 2027. In today's terms this amounts to between $4.7 and $14.6 billion per year, depending on the measure used. Savings would first be realized in 2003 and would increase each year until 2027.

Status:

The HCFA currently has no plans to pursue this change.

Report:

☞ OEI-07-91-01600--Report issued--November 1992

MEDICARE SECONDARY PAYER

Current Law:

Medicare is the secondary payer (MSP) to certain group health plans (GHPs) in instances where medical services were rendered to Medicare-entitled employees or to the Medicare-entitled spouses and other family members of employees. Medicare is also the secondary payer in situations involving coverage under Worker's Compensation; black lung benefits; automobile and nonautomobile, no fault; or liability insurance; and Department of Veterans Affairs programs. The HCFA provides administrative funds to Medicare contractors to monitor and collect incorrect primary benefits paid on behalf of Medicare beneficiaries.

Proposal:

The HCFA should: (1) ensure that contractor resources are sufficient and instruct contractors to recover improper primary payments from insurance companies other than the Blue Cross and Blue Shield insurance companies;
(2) implement financial management systems to ensure all overpayments (receivables) are accurately recorded;
(3) develop detailed procedures to properly handle employers that refuse to provide other health insurance coverage information; and (4) resubmit the justification of a legislative proposal, which would require insurance companies, underwriters, and third-party administrators to periodically submit GHP coverage data directly to HCFA.

Legislative	Regulatory	Other Administrative
✓		✓

Reason for Action:

Although agreement was reached to relieve all Blue Cross and Blue Shield plans of past due MSP overpayments and there is a 3-year future plan to identify MSP situations, it only applies to the Blue Cross and Blue Shield plans and not to all other insurance companies. Additional measures continue to be needed to help in the collection of accurate and timely information on other primary payers. This will help to reduce future Medicare overpayments which result from unidentified MSP cases and help the recovery process for overpayments.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
TBD	TBD	TBD	TBD	TBD

Status:

The legislative proposal was not included in the President's current budget. The HCFA is pursuing the recommended administrative actions through improved processes to identify and recover overpayments related to MSP, as well as improved information systems to guard against making improper Medicare payments where the Blue Cross and Blue Shield plans are primary payers. However, we continue to recommend that safeguards are needed to guard against improper payments where insurance companies other than the Blues are primary payers.

Report:

☞ A-09-89-00100--Final management advisory report--March 1990
OEI-07-90-00760--Final report--August 1991
OEI-03-90-00763--Management advisory report--November 1991
A-09-91-00103--Final report--August 1992
A-14-94-00391--Final report--December 1993
A-14-94-00392--Final report--March 1994

EXPAND MEDICARE SECONDARY PAYER PROVISIONS FOR END STAGE RENAL DISEASE BENEFITS

Current Law:

The Omnibus Budget Reconciliation Act of 1981 changed the status of Medicare from primary to secondary payer for beneficiaries with end-stage renal disease (ESRD) for the first 12 months of health benefits. Effective February 1, 1990, Medicare become secondary payer for the first 18 months of Medicare entitlement. After October 1, 1998, Medicare will again be the secondary payer for the first 12 months.

Proposal:

Extend the Medicare secondary payer (MSP) provision to include ESRD beneficiaries without a time limitation.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

The proposed change for ESRD beneficiaries would make MSP provisions consistent with legislation passed by Congress for aged and disabled beneficiaries, which does not restrict the period of time that Medicare is the secondary payer.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$503	$549	$600	$654	$712

Status:

The President's past budget contained a proposal to extend the MSP provision for individuals with ESRD to 24 months. Notwithstanding this proposal, OIG continues to advocate that when Medicare eligibility is due solely to ESRD, the GHP would remain primary until such time as the beneficiary became entitled to Medicare for old age or disability. At that point Medicare would become the primary payer.

Report:

☞ A-10-86-62016--Final report--December 1987

REQUIRE MEDICARE COVERAGE OF ALL STATE AND LOCAL GOVERNMENT EMPLOYEES OR MAKE MEDICARE THE SECONDARY PAYER

Current Law:

The Consolidated Omnibus Budget Reconciliation Act of 1985 established Medicare Part A coverage and payment of hospital insurance contributions for new State and local government employees hired after March 31, 1986. However, employees hired prior to April 1, 1986 are not covered by Medicare Part A unless the government entity has voluntarily agreed to cover groups of its employees under the full Old-Age, Survivors and Disability Insurance (OASDI) program.

Proposal:

Require Medicare coverage and hospital insurance contributions for all State and local employees, including those hired prior to April 1, 1986. If this proposal is not enacted, seek legislation making Medicare the secondary payor for retirees for exempt State and local agencies.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

Retirees from exempt agencies pay significantly less taxes when they qualified for Medicare coverage. We estimate that over a 9-year period (1982-1990) Medicare will have spent about $16.9 billion in benefits for these retirees. However, only an estimated $2.7 billion of taxes, with interest, will have been collected, leaving a shortfall of $14.2 billion to be subsidized by other taxpayers. Most of these retirees qualify for Medicare through other covered employment or as a spouse of a covered worker. Those insured through other employment contributed far less for their coverage than other retirees yet their hospital benefit protection is the same. Furthermore, exempt government agencies which had not paid the employer's share of hospital insurance contributions will have the windfall advantage of Medicare as the primary payor of health costs for retirees over age 65. Both conditions unfairly drain the health insurance trust fund and are inequitable to employees and employers who must contribute.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$1,559	$1,552	$1,521	$1,490	$1,451

Status:

Although a past budget of the President contained a proposal to include under Medicare all State and local government employees hired before April 1, 1986, no legislative proposal was included in the President's current budget.

Report:

☞ A-09-88-00072--Final report--February 1989

CONTINUE MANDATED REDUCTIONS IN HOSPITAL CAPITAL COSTS

Current Law:

Beginning October 1, 1991, HCFA began a 10-year transition period for paying hospital capital costs under a prospective payment system. Final regulations were promulgated August 30, 1991 (56FR43358). The rates are based on historical costs, less a mandated reduction of 7.4 percent (OBRA 1993).

Proposal:

That HCFA seek legislative authority to continue mandated reductions in capital payments beyond FY 1995. The HCFA should determine the extent that capital payment reductions that are needed to fully account for hospitals' excess bed capacity and report the percentage of reduction to the Congress.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

Hospital capital costs soared during the first 5 years of the prospective payment system (PPS), despite low bed occupancy. The Medicare system of reimbursing capital costs on a pass-through basis (i.e., reimbursed outside of diagnosis related group) was a major reason for capital expenditures increasing even though there was excess hospital capacity.

Paying capital costs prospectively, as required by recently implemented regulations, should assist in curbing escalating costs. However, the PPS rates are based on historical costs that are inflated because: (1) excess capacity in the hospital industry has caused more capital costs to be incurred than economically necessary and (2) inappropriate elements such as charges for depreciation on federally funded assets are included in the historical costs.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$820	$950	$1140	$1450	$1840

Status:

The HCFA is seeking public comment on reducing prospective capital rates.

Report:

☞ A-09-91-00070--Final report--April 1992
A-14-93-00380--Final report-April 1993

MORE ACCURATELY REFLECT BASE YEAR COSTS IN PROSPECTIVE PAYMENT SYSTEM'S CAPITAL COST RATES

Current Law:

Under section 1886(d) of the Social Security Act, the Medicare program pays for the operating costs attributable to hospital inpatient services under a prospective payment system (PPS). A PPS pays for care using a predetermined specific rate for each discharge. Public Law 100-203 required the Secretary of Health and Human Services to establish a PPS for capital costs for cost reporting periods beginning in FY 1992.

Proposal:

The HCFA should: (1) consider reducing payment rates by 7.5 percent to more accurately reflect costs of the base year used for the capital cost PPS and (2) continue to monitor the most current data (i.e., closing of unsettled cost reports for 36 percent of hospitals) and make any necessary further adjustments to the base rate.

Legislative	Regulatory	Other Administrative
☐	✓	☐

Reason for Action:

While HCFA took great pains to devise and implement an equitable PPS for capital costs, information now available indicates that HCFA's 1992 estimated base year rate is 7.5 percent higher than current actual costs. A 7.5 percent reduction would also correct all forecasting estimates that HCFA had to make in arriving at an anticipated rate to implement the capital costs PPS. The total effect of overpayments in relation to cost used as the basis for the capital cost PPS will gradually increase from 1996 until the capital cost PPS is fully implemented in 2002.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$249	$284	$319	$354	$388

Status:

In response to our report, HCFA officials stated that they agreed with our analysis that the Federal capital rate reflects a known over-estimation of base year costs. The HCFA also stated that comments from individual hospitals and hospital associations were uniformly opposed to making any of the possible rate reductions that we discussed in the proposed rule. However, the Prospective Payment Assessment Commission (ProPAC) acknowledged that there are legitimate issues about the appropriate level of the rates in light of the current data. The HCFA does not intend to adopt any of the possible approaches at this time, in anticipation of congressional action to realize savings in this area.

Report:

☞ A-07-95-01127--Final report--August 1995

REDUCE THE PROSPECTIVE PAYMENT SYSTEM ADJUSTMENT FACTOR FOR INDIRECT MEDICAL EDUCATION COSTS

Current Law:

Since the inception of Medicare's prospective payment system (PPS), indirect medical education (IME) payments have been paid only to teaching hospitals. The IME payments are designed to alleviate an anticipated adverse effect that PPS would have on teaching hospitals. The IME adjustment factor was determined by HCFA and Congress. Using historical data, HCFA compared costs per case in teaching and nonteaching hospitals using regression analysis and determined that operating costs in hospitals with teaching programs increased approximately 5.79 percent for every 0.1 resident physician per hospital bed as compared to hospitals without teaching programs. Under a congressional mandate, HCFA was required to double the adjustment factor under PPS--increasing it to 11.59 percent.

The Consolidated Omnibus Budget Reconciliation Act of 1985 reduced the IME adjustment factor from 11.59 percent to 8.1 percent for discharges occurring on or after May 1, 1986 and before October 1, 1988. The Omnibus Budget Reconciliation Act of 1987 further modified the IME adjustment by reducing it to approximately 7.7 percent for each 0.1 in the ratio of interns and residents to beds.

Proposal:

Reduce the IME adjustment factor to the level supported by HCFA's empirical data. Initiate further studies to determine whether different adjustment factors are warranted for different types of teaching hospitals.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

Our extensive analytical work showed that teaching hospitals were making excessive profits.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$900	$900	$900	$900	$900

Status:

The President's FY 1997 budget reduces the IME adjustment factor to 6 percent in FY 1999 and thereafter. Our savings estimate has been modified to reflect the President's proposal.

Report:

☞ A-07-88-00111--Final report--September 1989

REVISE GRADUATE MEDICAL EDUCATION PAYMENT METHODOLOGY

Current Law:

Section 9202 of the Consolidated Omnibus Budget Reconciliation Act of 1985 and Section 9314 of the Omnibus Budget Reconciliation Act of 1986 changed the way Medicare reimburses hospitals for the cost of direct graduate medical education (GME). Under the new methodology, GME costs are reimbursed on a "hospital specific" prospective payment basis, which is retroactive to cost reporting periods beginning on or after July 1, 1985.

Proposal:

Revise the regulations to remove from a hospital's allowable GME base year costs any cost center with little or no Medicare utilization. Submit a legislative proposal to compute Medicare's percentage of participation under the former more comprehensive system.

Legislative	Regulatory	Other Administrative
✓	✓	

Reason for Action:

The HCFA has estimated that the new GME regulations will result in substantial Medicare savings. Results of our review indicate that Medicare GME costs under the new reimbursement method may actually increase because of two factors in the new payment methodology. First, the new system allows hospital cost centers with little or no Medicare patient utilization to be given increased importance in the calculation of the GME reimbursement. Second, the Medicare patient load percentage used in the new system to compute Medicare's share of GME costs is based on inpatient data only and is higher than Medicare's overall share of GME costs as determined under the previous method which also included ancillary and outpatient data.

Savings (in millions):

	FY 1	FY 2	FY 3	FY 4	FY 5
Factor (1)	$ 39.2	$ 39.2	$ 39.2	$ 39.2	$ 39.2
Factor (2)	$125.6	$125.6	$125.6	$125.6	$125.6
Combined *	$157.3	$157.3	$157.3	$157.3	$157.3

** Note: When the two proposed changes are handled as one combined calculation, the savings are less than calculating the effect of the changes separately.*

Status:

The President's FY 1997 budget contains proposals to slow the growth in Medicare spending on GME.

Report:

☞ A-06-92-00020--Final report--April 1994

DENY MEDICARE REIMBURSEMENT FOR PATIENTS WHO RECEIVE SUBSTANDARD MEDICAL CARE

Current Law:

Under Medicare, hospitals receive a pre-established payment for each discharge based upon an assigned diagnosis related group (DRG). Each DRG results in an associated payment that represents an average cost for patients having similar diagnoses. Congress established the peer review organizations (PROs) to protect the integrity of the prospective payment system (PPS) and to maintain the quality of care. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) gave PROs the authority to deny Medicare reimbursement for patients receiving substandard medical care defined as medical care clearly failing to meet professionally recognized standards.

Proposal:

Increase efforts to identify and address poor quality care in hospitals by issuing regulations to implement the COBRA 1985 provisions.

Legislative	Regulatory	Other Administrative
☐	✓	☐

Reason for Action:

We found that 6.6 percent of the patients sampled received poor quality of care.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$110	$110	$110	$110	$45.3

Status:

The HCFA issued a notice of proposed rulemaking to give the PROs the authority to deny Medicare reimbursement for patients who received substandard medical care. The HCFA has not yet issued a final regulation.

Report:

☞ OEI-09-88-00870--Final report--July 1989

MODIFY PAYMENT POLICY FOR MEDICARE BAD DEBTS

Current Law:

Under Medicare's prospective payment system (PPS) hospitals are reimbursed for inpatient services rendered to Medicare beneficiaries by a fixed payment amount based on a diagnosis related group (DRG). However, bad debts related to unpaid deductible and coinsurance amounts are reimbursed separately as pass-through (i.e., reimbursed outside of DRG) items under reasonable cost principles.

Proposal:

Seek legislative authority to modify bad debt payment policy. We presented an analysis of four options to HCFA. These included: the elimination of a separate payment for bad debts; the offset of Medicare bad debts against beneficiary Social Security payments; the limitation of bad debt payments to PPS hospitals which are profitable; and the inclusion of a bad debt factor in the DRG rates.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

Our review of HCFA's Hospital Cost Report Information System showed that total Medicare bad debts increased from $159 million during the second year of PPS (FY 1985) to $398 million during the fifth year of PPS (FY 1988). During this same period, hospitals continued to earn significant profits. Our audits also showed that hospital bad debt collection efforts have often been less than adequate since there is little incentive for a hospital to collect the unpaid deductible and coinsurance amounts when Medicare pays these amounts.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$487.7	$487.7	$487.7	$487.7	$487.7

Status:

This proposal was not included in the President's current budget.

Report:

☞ A-14-90-00339--Final report--June 1990

LIMIT PROSPECTIVE PAYMENT SYSTEM REIMBURSEMENT FOR HOSPITAL ADMISSIONS NOT REQUIRING AN OVERNIGHT STAY

Current Law:

Under the prospective payment system (PPS), hospitals are reimbursed for each admission when the patient is discharged based on established rates which are grouped into diagnosis related groups (DRG). Current Medicare instructions provide that an admission occurs when it is expected that the patient will occupy a bed and remain overnight. This applies even if the person is later discharged or transferred to another hospital without actually using a hospital bed overnight.

Proposal:

Seek legislation to pay for covered services related to 1-day admissions without an overnight stay, as outpatient services which are paid on the basis of the lower of the actual costs or the customary charges in a locality.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

Based on Medicare records for 1989, our follow-up review revealed that the Medicare program paid for 179,500 admissions which did not require an overnight stay. Many of these cases related to observations after emergency or outpatient services, to surgeries later canceled or to acute care stays of doubtful necessity. In many cases, documentation revealed that few, if any, services were provided during the period the patient was an inpatient.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$210	$210	$210	$210	$210

Status:

Our follow-up report (A-05-92-00006) indicated that problems still exist with inappropriate admissions and that the volume of 1-day admissions on a national basis had increased approximately 150 percent over 1985 levels.

The HCFA proposes to implement our recommendation through administrative remedies that would designate whether specific services are to be covered and paid for as inpatient or outpatient services. No proposal was included in the President's current budget.

Report:

☞ A-05-89-00055--Final report--July 1989
A-05-92-00006--Final report--January 1992

RECOVER OVERPAYMENTS AND EXPAND THE DIAGNOSIS RELATED GROUP PAYMENT WINDOW

Current Law:

Under the prospective payment system (PPS), Medicare fiscal intermediaries (FI) reimburse hospitals a predetermined amount for inpatient services furnished to Medicare beneficiaries depending on the illness and its classification under a diagnosis related group (DRG). Currently, separate payments for nonphysician outpatient services (such as diagnostic tests and laboratory tests) rendered within 72 hours of the day of an inpatient admission are not permitted (OBRA of 1990, section 4003).

Proposal:

The HCFA should propose legislation to expand the DRG payment window to at least 7 days immediately prior to the day of admission.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

Our review identified about $83.5 million in admission related nonphysician outpatient services rendered 4 to 7 days immediately before an inpatient admission. The FIs cited clerical errors and insufficient or nonexistent edits for improper payments, and the hospitals cited clerical errors and misinterpretation of the regulations.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$83.5	$83.5	$83.5	$83.5	$83.5

Status:

The HCFA agreed to recover the improper billings and to refund the beneficiaries' coinsurance and deductible. Collection of the overpayment is being handled by settlement agreements with the hospitals through the Department of Justice working with HCFA and the OIG. The HCFA did not concur with the recommendation to further expand the payment window. No legislative proposal was included in the President's current budget.

Report:

☞ A-01-92-00521--Final report--July 1994

REDUCE MEDICARE PAYMENTS FOR HOSPITAL OUTPATIENT SERVICES

Current Law:

To bring payments for services in hospital outpatient departments more in line with the payments for services performed in an ambulatory service center (ASC) the Omnibus Budget Reconciliation Act (OBRA) of 1990, Section 4151, reduced Medicare payments for hospital outpatient services by (1) adjusting the payment formula to 58 percent of the ASC rates and 42 percent of the hospital's outpatient costs, and (2) lowered hospital payments made on a reasonable cost basis by 5.8 percent. The OBRA 1993 contains a provision to extend the current 5.8 percent reduction in payments for hospital outpatient department services from FYs 1996 through 1998.

Proposal:

Enact legislation to reduce the current payments for services in outpatient departments to bring them more in line with ASC approved payments. We recommended paying outpatient departments the ASC approved rate or adjust hospital payments by a uniform percentage.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

Our study of hospital outpatient surgeries showed that the current blended rate to hospitals in the aggregate is greater than the payment rate for ASC approved services. We analyzed over 2 million hospital outpatient bills containing ASC approved surgeries from 5,421 hospitals. The disparity between Medicare payments to outpatient departments and ASCs for similar services still exists.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$90	$107	$126	$147	$175

Status:

The HCFA sent a report to Congress on developing a prospective payment system (PPS) for hospital outpatient services. In addition, the President's FY 1997 budget contains a proposal to: (1) eliminate a formula-driven overpayment which allows Medicare to fully deduct beneficiary coinsurance payments received by the hospital before the program makes its payments; and (2) establish a budget neutral PPS for outpatient department services starting in 2002.

Report:

☞ A-14-89-00221--Final report--March 1991
OEI-09-88-01003--Final report--May 1989

PRECLUDE IMPROPER PAYMENTS TO HOSPITALS FOR HOSPICE BENEFICIARIES

Current Law:

When a beneficiary elects hospice care, the Medicare program reimburses the hospice a fixed rate for each day of care. The hospice then assumes fiscal responsibility for all Medicare Part A services related to the beneficiary's terminal illness. A separate Medicare payment to the hospital is not allowable; instead the hospital should bill the hospice and the hospice then receives a higher daily rate for the number of days the hospice beneficiary is hospitalized.

Proposal:

The HCFA should instruct its FIs to recover improper payments from hospitals noted in our review and to review related medical records for the potential inappropriate payments we identified.

Legislative	Regulatory	Other Administrative
☐	☐	☑

Reason for Action:

Our review showed that over $21 million in overpayments should be recovered for Calendar Years 1988-1992. In addition, more effective edits of hospital/hospice claims could result in annual savings of approximately $4 million over the next 5 years.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$4	$4	$4	$4	$4

Status:

The HCFA agreed to recover the overpayments identified and instruct its FIs to review the claims we identified as potential overpayments. We are currently performing additional work assessing the effectiveness of HCFA's common working file edits in regard to hospice/hospital payments.

Report:

☞ A-02-93-01029--Final report--June 1995

TERMINATE MEDICARE DISPROPORTIONATE SHARE ADJUSTMENTS

Current Law:

Since May 1986, Medicare's Prospective Payment System (PPS) has included an adjustment that provides additional payments to hospitals that serve a disproportionately large share of low-income patients. This "disproportionate share adjustment" can be justified in at least two ways. First, it compensates hospitals for higher costs that may be associated with treating low-income patients. Second, it increases revenues, thereby reducing financial distress for hospitals with large shares of low-income Medicare and Medicaid patients. Some of these hospitals treat many other low-income patients who lack insurance and are unable to pay for their care. Both justifications are consistent with the goal of ensuring ongoing access to care for low-income Medicare beneficiaries and for all beneficiaries who reside in areas with substantial low-income populations. In order to qualify for the disproportionate share (DS) adjustment payment, a PPS provider had to meet one of two basic criteria-one based on the hospital's location and bed size and the other based on revenue from State and local governments.

The Omnibus Budget Reconciliation Act of 1987 included amendments to the Social Security Act which resulted in increased DS adjustment payments to PPS hospitals. Specifically, the amendments provided for: (1) eliminating the 15 percent limit on DS adjustment payments to large urban hospitals; (2) increasing from 15 to 25 percent the DS adjustment payments to hospitals qualifying on the basis of net inpatient care revenues received from State and local governments for indigent patients; and (3) extending the expiration date of the DS adjustment.

Proposal:

Terminate DS adjustment payments without redistribution of the funds to PPS hospitals.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

We used HCFA's Hospital Costs Report Information System to compare DS adjustment hospitals to non-DS adjustment hospitals. We found that there was no significant difference between DS adjustment eligible hospitals and non-DS adjustment hospitals in terms of Medicare profit margins, costs per discharge, and durations of patient hospitalization.

In our opinion, these comparisons indicate that DS adjustment payments are unnecessary. Payments under PPS adequately compensate hospitals for services provided to Medicare patients, including low income patients. We are recommending that DS adjustment payments be reduced if not eliminated.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$410	$1,410	$3,940	$5,420	$6,070

Status:

Although the President's past budgets contained proposals to phase down Medicare disproportionate share payments, no legislative proposal was included in the President's current budget.

Report:

☞ A-04-87-00111--Final report--September 1989

ROLL REIMBURSEMENT FOR LABORATORY SERVICES INTO CHARGE FOR PHYSICIAN OFFICE VISITS

Current Law:

Medicare pays the full amount of all clinical laboratory services provided in outpatient and office settings based on fee schedules.

Proposal:

The HCFA should study the feasibility of rolling the reimbursement for laboratory services into the recognized charge for physician office visits (which are subject to beneficiary co-payment) and propose legislation within 2 years.

Legislative	Regulatory	Other Administrative
✓		✓

Reason for Action:

Clinical laboratory claims account for 25 percent of the line items in Medicare bills. Numerous initiatives to limit inappropriate growth have been enacted into law in recent years. Most involve limiting the amount paid for each laboratory service. These initiatives have failed to limit overall spending, however, because they did not reduce the number of tests prescribed. The OIG proposal would eliminate incentives for inappropriate lab tests while still allowing sufficient funds to pay for needed services: Unnecessary tests would decrease as a result of the incentive to control costs; beneficiary coinsurance and deductible provisions would again come into play; and administrative savings would result from the reduction in number of claims processed.

Savings (in millions):

	FY 1	FY 2	FY 3	FY 4	FY 5
Roll-In	$ 700	$1,500	$2,700	$4,100	$6,000
Co-Payment	1,130	1,240	1,370	1,520	1,690
Admin. Savings	210	210	210	210	210
TOTAL	$2,040	$2,950	$4,280	$5,830	$7,900

Status:

The HCFA does not concur with our recommendation but is studying alternative ways to limit laboratory services.

Report:

☞ OEI-05-89-89150--Monograph--October 1990
OEI-05-89-89151--Management advisory report--July 1991

EXPAND NATIONAL LIST OF CHEMISTRY PANEL TESTS

Current Law:

Chemistry tests are clinical laboratory services requested by physicians in order to diagnose and treat patients. Chemistry tests which are commonly performed on automated laboratory equipment are referred to as panel tests and are required by HCFA to be grouped together for payment purposes. In addition, HCFA requires that other chemistry tests available in a carrier's service area and commonly performed on automated laboratory equipment be reimbursed as panel tests.

Proposal:

The HCFA should update its guidelines by expanding the national list of chemistry panel tests to include 10 chemistry tests identified by the OIG audit. The HCFA should also establish a process whereby advances in technology and laboratory practices are periodically reviewed to update the national panel test list.

Legislative	Regulatory	Other Administrative
☐	☐	☑

Reason for Action:

Based upon claims information and responses to questionnaires by hospital and independent laboratories related to 18 tests identified for review, 10 are available in all carrier service areas and are commonly performed on automated equipment. These 10 tests should be paid as panel tests. However, HCFA's guidelines which specify chemistry tests that should be paneled by all carriers have not been updated timely to add tests as technology has advanced.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$130	$130	$130	$130	$130

Status:

The HCFA agreed with 8 of the 10 tests recommended for addition to the list. In November 1995, HCFA updated its carrier manual adding three of the tests recommended in the OIG report. The HCFA has also issued carrier manual instructions that require all tests in an automated profile to be medically necessary.

Report:

☞ A-01-93-00521--Final report--January 1995

TAKE STEPS TO PREVENT INAPPROPRIATE PAYMENTS FOR PHYSICAL THERAPY IN PHYSICIANS' OFFICES

Current Law:

Medicare has detailed coverage guidelines for physical therapy which apply to all outpatient settings, except physicians' offices. While no specific coverage requirements exist regarding physical therapy in physicians' offices, the services like all others, must be reasonable and necessary and not just for palliation. As in any other area in Medicare, in the absence of HCFA national policy, local carriers establish their own policies.

Proposal:

The HCFA should take appropriate steps to prevent inappropriate payments for physical therapy in physicians' offices. The HCFA can use the following approaches to achieve this goal:

- conduct focused medical review;
- provide physician education activities; and
- apply its existing physical therapy coverage guidelines for other settings to physicians' offices.

Legislative	Regulatory	Other Administrative
☐	☐	☑

Reason for Action:

Our findings indicate that 78 percent of procedures which were reimbursed as physical therapy in physicians' offices do not represent true physical therapy services. Forty-seven million dollars was inappropriately paid in 1991. Two-thirds of the carriers have no policies concerning physical therapy in physicians' offices.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$47	$47	$47	$47	$47

Status:

Currently, model guidelines are being drafted for possible use in reviewing claims for physical therapy or related services billed by physicians under the physician "incident to" benefit.

Report:

☞ OEI-02-90-00590--Final report--March 1994

ENCOURAGE PHYSICIANS TO USE PAPERLESS CLAIMS

Current Law:

Physicians may submit claims to Medicare in either paper or electronic form. Seventy-three percent of all physician claims are currently submitted electronically, and 59 percent of Medicare physicians use only paper.

Proposal:

The HCFA should:

- lead a target outreach effort to encourage voluntary conversion to paperless Medicare claim filing by physicians who submit claims on paper and who have a moderate to high level of interest in making the switch.
- begin to plan now for the policy changes that will become necessary to achieve an almost completely paperless environment for processing Medicare claims. These policy changes can include: targeting a date when all physicians will be mandated to submit paperless claims, targeting a date when paperless claims submission will become a condition for Medicare participating physician status, or continuing to accept paper claims but imposing a filing fee to cover the incremental cost of doing so.

Legislative	Regulatory	Other Administrative
✓		✓

Reason for Action:

We found that approximately 65 percent of physicians who now submit Medicare claims only on paper indicate a high or moderate level of interest in switching to paperless claims.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$126	$126	$126	$126	$126

Status:

The HCFA concurred with our recommendations. However, with respect to the policy options suggested, HCFA believes that mandating paperless claims is impractical.

Report:

☞ OEI-01-94-00230--Final report--May 1996
A-05-94-00039--Final report--May 1996

REVIEW MEDICARE INCENTIVE PAYMENTS IN HEALTH PROFESSIONAL SHORTAGE AREAS

Current Law:

Since 1989, physicians who treat Medicare patients in HHS defined health professional shortage (HPSA) areas have been entitled to bonus payments that were designed to improve patient access to care. The current law calls for a 10 percent bonus.

Proposal:

The HCFA should seek to (1) eliminate the Medicare incentive payments entirely, (2) modify the Medicare incentive payment program to target it more effectively to primary care, or (3) channel funds from the Medicare incentive payment program to new or existing mechanisms to improving access to primary care.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

A substantial amount of the Medicare incentive money has gone to physicians who provide little or no primary care. Also, among primary care physicians, Medicare incentive payments apparently have little effect on practice location decisions.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$90.6	$120.8	$161	$214.6	$286

Status:

The HCFA concurred with our recommendation. The HCFA had previously advanced legislation to provide larger bonuses for primary care services and eliminate certain bonuses in urban areas. The HPSA modification is not in the President's current budget, and HCFA has no immediate plans to pursue legislation for this initiative. The United States General Accounting Office has recently made a similar recommendation to ours, based on its review of HPSA definitions.

Report:

☞ OEI-01-93-00050--Final report--June 1994

FURTHER REDUCE MEDICARE'S END STAGE RENAL DISEASE RATES

Current Law:

The Omnibus Budget Reconciliation Act (OBRA) 1981 established a prospective payment system for outpatient dialysis treatments. Under this system, HCFA implemented a composite rate per treatment to reimburse for both freestanding and hospital based facilities.

Proposal:

Reduce the payment rates for outpatient dialysis treatments to reflect current efficiencies and economies in the marketplace.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

In FY 1989, payments under Medicare's end stage renal disease (ESRD) program totaled $2 billion for dialysis treatments. These payments were made to 1,164 freestanding facilities and 666 hospital based facilities. The FY 1989 HCFA data shows that dialysis payments averaged $125.05 per treatment for freestanding facilities and $129.11 for hospitals.

The HCFA, with our assistance, has accumulated cost data for 1985 and 1988 to update the composite rates. The 1985 data showed a median cost, including home dialysis costs, of $108.19 per treatment. Even after considering the effect of home dialysis services included in 1985 data, the in-facility costs have decreased from 1980 to 1985 without a corresponding reduction in the prospective rates. In addition, our audit of the 1988 home office costs of a major chain of freestanding facilities shows that its costs have decreased from $117 per treatment in 1980 to $89 in 1988. Due to the prominence of this chain, their audited costs have a significant impact on the median cost of providing a dialysis treatment. We estimated that, this chain is earning $36 per treatment, a 29 percent profit margin for each treatment in 1988. We believe that both the 1985 and 1988 audited data justifies a decrease in the payment rate.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$22*	$22*	$22*	$22*	$22*

**This savings estimate represents program savings of $22 million for each dollar reduction in the composite rate.*

Status:

The HCFA agreed that ESRD facilities have become more efficient in their operations and that the composite payment rate should reflect the costs of outpatient maintenance dialysis treatment in an efficiently operated facility. While OBRA 1990 prohibited HCFA from changing the ESRD composite rates, it mandated a study to determine the costs, services and profits associated with various modalities of dialysis treatments. The study undertaken by the Prospective Payment Assessment Commission (ProPAC) was presented to Congress in March 1996 and recommended an across-the-board increase to the current rates. The HCFA notes ProPAC's recommendation but expressed concern about such an increase for all renal facilities.

Report:

☞ A-14-90-00215--Final report--March 1991

PRECLUDE IMPROPER END STAGE RENAL DISEASE PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS

Current Law:

Regulations define end stage renal disease (ESRD) and specify when Medicare entitlement based on ESRD ends. Medicare beneficiaries who have been medically diagnosed as having ESRD are prohibited from enrolling in a health maintenance organization (HMO) or a competitive medical plan (CMP). An exception exists for individuals who have ESRD and are commercial members of the HMO/CMP immediately prior to Medicare enrollment in the same plan. An HMO/CMP with a Medicare risk contract receives an additional $3,000 monthly capitation payment for beneficiaries classified as having ESRD.

Proposal:

The HCFA should advise all risk-based HMOs/CMPs that ESRD capitation rates are only effective for beneficiaries who currently are diagnosed as having ESRD; identify and recover all payments to HMOs/CMPs for beneficiaries misclassified as having ESRD including the $35.7 million in overpayments identified through February 1995; and make systemic and procedural changes to prevent future overpayments.

Legislative	Regulatory	Other Administrative
☐	☐	☑

Reason for Action:

Our review showed that between October 1990 and February 1995 approximately $35.7 million in overpayments has been made to HMOs/CMPs on behalf of Medicare beneficiaries inappropriately identified as having ESRD. Our review also indicated that overpayments to the HMOs/CMPs were continuing. These inappropriate classifications were caused by systems weaknesses at HCFA. We found that when an HMO/CMP attempts to enroll a beneficiary who has an active ESRD indicator, the enrollment is (appropriately) automatically denied. However, if a plan advises HCFA that the beneficiary no longer meets the ESRD definition, HCFA staff enrolls the beneficiary but HCFA's systems do not recognize ESRD termination. This results in the HMO/CMP erroneously receiving the higher ESRD capitation payment.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$50.7	$54	$15	$15	$15

Status:

The HCFA agreed with our findings and recommendations. The systems changes are scheduled to be implemented in August 1996 along with the recoupment of improper payments.

Report:

☞ A-04-94-01090--Final report--February 1996

ENSURE THAT CLAIMS FOR AMBULANCE SERVICES FOR END STAGE RENAL DISEASE BENEFICIARIES MEET COVERAGE GUIDELINES

Current Law:

The Medicare Part B benefit for ambulance service has very strict limits. These are explained by HCFA in the Medicare Carriers Manual, Section 2120. The transport is not covered if it fails to meet the medical necessity requirement, even if it meets other requirements.

Proposal:

The HCFA should ensure that claims meet Medicare coverage guidelines.

Legislative	Regulatory	Other Administrative
☐	☑	☐

Reason for Action:

Seventy percent of transports involving dialysis in our sample did not meet Medicare's guidelines for medical necessity. These claims represent an estimated $65.7 million in 1993. Claims did not meet Medicare guidelines because on the date of ambulance services, beneficiaries did not have conditions that contraindicated use of another type of transport. Almost two-thirds of the beneficiaries (63 percent) were clearly not bed-confined.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$65.7	$80.2	$97.9	$119.4	$145.7

Status:

The HCFA prepared a draft regulation in late 1995 that would shift the policy focus away from the type of vehicle used and towards the medical condition of the beneficary. No final regulation has been issued to date.

Report:

☞ OEI-03-90-02130--Final report--August 1994

MODIFY PAYMENT PRACTICES OF AMBULANCE SERVICES FOR MEDICARE END STAGE RENAL DISEASE BENEFICIARIES

Current Law:

Medicare Part B covers ambulances services under certain conditions. Medicare prohibits coverage for ambulance transportation unless the beneficiary is normally bed-confined and has to be transported by stretcher. Ambulance company services and charges are represented by alphanumeric codes which the Medicare program uses to analyze utilization and payments. Persons with end stage renal disease (ESRD) are entitled to Medicare coverage under the 1972 amendments to the Social Security Act.

Proposal:

The HCFA should ensure fairer payment for services rendered and may consider combining two or more of the following strategies: (1) establish a payment schedule for ambulance transport to maintenance dialysis, and set the fee lower than what is paid for unscheduled, emergency transports; (2) negotiate preferred provider agreements with ambulance companies to provide scheduled transportation for ESRD beneficiaries; (3) undertake competitive bidding to establish a price for scheduled transports for ESRD beneficiaries or to select companies who agree to provide such services; (4) establish a rebate program for companies that routinely transport ESRD beneficiaries; and (5) provide an add-on to the composite rate Medicare pays dialysis facilities and allow the facility to negotiate agreements with ambulance companies.

Legislative	Regulatory	Other Administrative
☐	☑	☐

Reason for Action:

The payment system does not take into account the routine, predictable nature of scheduled ambulance transports. The payment system does not take advantage of the lower costs associated with high volume scheduled transports.

Savings (in millions):

	FY 1	FY 2	FY 3	FY 4	FY 5
Lower Estimate	$4.9	$6.0	$7.3	$8.9	$10.9
Upper Estimate $14.7	$18.0	$22.0	$26.8	$32.7	

Note: These savings figures are in addition to and assume full implementation of recommendations from our report, OEI-03-90-02130, which recommends elimination of payments for dialysis transport which do not meet Medicare guidelines.

Status:

The HCFA has established codes for scheduled transport and has required uniform use of national ambulance codes, but no related payment changes have been made. The HCFA prepared a draft regulation in late 1995 that would shift policy focus away from the type of vehicle used and towards the medical condition of the beneficiary. No final regulation has been issued to date.

Report:

☞ OEI-03-90-02131--Final report--March 1994

CHANGE THE WAY MEDICARE PAYS FOR CLINICAL LABORATORY TESTS

Current Law:

The amount the Medicare program pays for most clinical lab tests is based on fee schedules. These fee schedules, effective July 1, 1984, were established by each carrier at 60 percent of the Medicare prevailing rate (the rate most frequently used by all suppliers). The Congress took action in the Omnibus Budget Reconciliation Act (OBRA) of 1990 to pay comparable prices by limiting the annual fee schedule increase to 2 percent for 1991, 1992 and 1993 and reducing the national cap to 88 percent of the median of all the fee schedules. The OBRA 1993 will further reduce the national Medicare fee cap to 80 percent of the median of carrier prices in 1995 and to 76 percent in 1996. The law also calls for no cost-of-living increases for 1994 and 1995.

Proposal:

Require laboratories to identify and bill panels (groups of related tests) at reduced rates whenever they are ordered and study reinstating the beneficiary coinsurance and deductible provisions for laboratory services as a means of controlling utilization.

Legislative	Regulatory	Other Administrative
✓		✓

Reason for Action:

The OBRA 1993, if fully implemented, should reduce the higher profit rates from Medicare billings. However, the OIG found that although prices on individual tests are being reduced by legislation, panels are still generally being billed as individual tests to Medicare. Medicare policies are not sufficient to control the billing of profile tests because there is no requirement that the tests ordered as a panel by the physician be billed only as a panel. The HCFA's guidelines do not address the problem of panels as a marketing mechanism of the laboratory industry nor the problem of the industry billing the contents of the panels individually. In the OIG's opinion, these conditions have contributed to the significant increase in the utilization of laboratory services.

Savings (in millions):

	FY 1	FY 2	FY 3	FY 4	FY 5
Co-Payment	$1,130	$1,240	$1,370	$1,520	$1,690
Profiles	TBD	TBD	TBD	TBD	TBD

Status:

Although the President's past budget included a proposal to reinstitute coinsurance for clinical laboratory services, no legislative proposal was included in the President's current budget. The OBRA of 1993, however, will reduce Medicare fees for clinical laboratory tests to 76 percent of the national average in 1996. In addition, HCFA is profiling physicians' ordering and referring patterns as part of its focused medical review efforts.

Report:

☞ A-09-89-00031--Final report--January 1990
A-09-93-00056--Follow-up report--January 1996

SELECTIVELY CONTRACT FOR CORONARY ARTERY BYPASS GRAFT SURGERY

Current Law:

Medicare pays for coronary artery bypass graft (CABG) surgery costs incurred for physician, hospital, and other services. Payment for hospitals is based on diagnosis related group (DRG) rates and for physician and other services on reasonable charge determinations.

Proposal:

The HCFA should negotiate all-inclusive package payment prices with selected surgeons and medical centers for providing CABG surgery to Medicare beneficiaries.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

Medicare paid over $1.5 billion in 1985 for CABG (DRG codes 106 and 107) surgery performed on about 63,000 beneficiaries. We found that hospitals and surgical teams performing more than 200 CABG surgeries per year had better outcomes in terms of mortality rates, lengths of stay and charges. The reasonable charge allowances for physicians are often inconsistent and inequitable. Similarly, both inconsistent carrier controls/payment guidelines and the revised HCFA procedure coding system have increased the costs to Medicare of CABG surgery. Current legislation does not allow the negotiation of preferred provider and fixed-price packages for CABG surgery for Medicare patients, despite the fact that these practices now save the private sector millions of dollars each year in CABG surgery costs.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$543.9	$543.9	$543.9	$543.9	$543.9

Status:

The HCFA conducted a demonstration and a final report was issued in January 1996. The HCFA is in the process of implementing the recommendation through the Centers of Excellence.

Report:

☞ OAI-09-89-00076--Final report--August 1987

MODIFY FORMULA FOR THE MEDICAID PROGRAM

Current Law:

The Federal Medical Assistance Percentage (FMAP) prescribed in the Social Security Act, determines the Federal share of costs for the Medicaid and various other programs.

Proposal:

The HCFA should consult with the Congress on modifications to the FMAP formula which would result in distributions of Federal funds that more closely reflect per-capita-income relationships. (See a similar proposal for family assistance programs located in the Administration for Children and Families chapter of this *Red Book*.)

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

The FMAP formula does not fully reflect the congressional objective of distributing Federal funds according to a State's ability to share in program costs, as measured by State per-capita-income. Two provisions result in higher-income States receiving significant additional Federal funds beyond amounts the formula would provide if it were based solely on per-capita-income relationships. Changes to these provisions, namely (i) eliminating the program growth incentive of the FMAP and (ii) lowering the current minimum floor to 45 percent (from 50 percent), would result in distributions of Federal funds that more closely reflect per-capita-income relationships. If the formula were changed, higher income States (such as New York and California) would receive a reduced Federal share in program expenditures, while lower income States (such as Mississippi and Arkansas) would receive a greater Federal share. Higher income States could offset the Federal share reduction by reducing their comparatively greater program benefits. However, if a cost-of-living factor were added to the formula, it would help insure that any reductions in Federal sharing would be more equitable.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$4,100	$4,100	$4,100	$4,100	$4,100

Status:

No legislative proposal was included in the President's current budget.

Report:

☞ A-06-89-00041--Final report--August 1991

PROMOTE MEDICAID COST SHARING

Current Law:

Section 1902(a)(14) of the Social Security Act provides that Medicaid may impose "enrollment fees," premiums, or similar charges, and deductions, cost sharing, or similar charges." Children, HMO enrollees, pregnancy services, emergency services, and hospice services provided to residents of nursing facilities or medical institutions are exempt from cost sharing.

Proposal:

The HCFA should promote the development of effective cost sharing programs by:

- allowing States to experiment with cost sharing programs that target new populations and reflect more substantial cost sharing amounts, and/or
- recommending changes to Federal requirements allowing for greater State flexibility in determining exempted populations and services, and allowing for higher recipient cost sharing amounts.
- promoting the use of cost sharing in States that do not currently have programs.

Legislative	Regulatory	Other Administrative
✓		✓

Reason for Action:

We found 27 States use cost sharing in their Medicaid programs. Cost sharing programs save money. States without cost sharing could save between $167 and $335 million annually (of which the Federal share would be $99 to $198 million) by applying cost sharing to just four services - inpatient hospital, outpatient hospital, physician visits, and prescription drugs. States with cost sharing do not report significant impacts on utilization of services or access to care. Cost sharing States have not experienced excessive administrative, recipient, or provider burdens. Federal requirements may hinder States from designing even more effective cost sharing programs.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$121.7	$135.9	$151.8	$169.6	$189.5

Status:

The HCFA provided States with program and administrative flexibility through waivers for Medicaid programs and if a State asks for help, will assist it by soliciting information from States who currently impose cost sharing and would share those experiences.

Report:

☞ OEI-03-91-01800--Final report--July 1993

SUPPORT MEDICAID PAYMENTS OF PREMIUMS FOR EMPLOYER GROUP HEALTH INSURANCE

Current Law:

Effective January 1, 1991, section 1906 of the Social Security Act mandated State Medicaid agencies, when cost effective, to pay premiums for employer group health plan (EGHP) insurance for Medicaid-eligible individuals.

Proposal:

The HCFA should:

- continue to strongly support States implementing Section 1906 of the Social Security Act. They can do so by transferring technology from States that have developed systems and procedures for 1906 programs to States without such systems and procedures.
- propose legislation that allows States to pay EGHP deductibles and coinsurance using Medicaid fee schedules rather than EGHP fee schedules.

Legislative	Regulatory	Other Administrative
✓		✓

Reason for Action:

We found that:

- most States have not purchased EGHP insurance for Medicaid-eligible individuals.
- compliance with current legislation could reduce potential savings resulting from EGHP insurance.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$34.7	$37.6	$40.8	$44.3	$48.1

Status:

The HCFA agreed with our first recommendation and continues to work with regional offices and States to promote implementation by conducting numerous workshops and having discussions with technical advisory groups. The HCFA deferred commenting on our second recommendation because of legislative proposals being considered at that time.

Report:

☞ OEI-04-91-01050--Final report--May 1994

CLOSE LOOPHOLES THAT SHELTER THIRD PARTY LIABILITY SETTLEMENTS AND AWARDS

Current Law:

Some Medicaid recipients who receive settlements and awards from liable third parties as a result of accidents are able to shelter the assets in irrevocable trusts and retain their eligibility for Medicaid. With these trusts, they are also able to prevent Medicaid from being repaid for medical services related to injuries sustained in the accidents.

Proposal:

We recommend that HCFA develop: (1) legislative proposals to close the loopholes in the Omnibus Budget Reconciliation Act of 1993; and (2) guidelines to assist States in strengthening Medicaid's right to recover when trusts are established by third parties.

Legislative	Regulatory	Other Administrative
✓		✓

Reason for Action:

Our national survey of the 51 Medicaid agencies disclosed that in 36 agencies trusts were used by Medicaid and Supplemental Security Income recipients to shelter assets. Although we were unable to determine the financial impact of these trust funds on Medicaid nationally, we concluded that the impact on Medicaid from 25 such trusts studied in California was significant.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$3	$3	$3	$3	$3

Status:

The HCFA agreed that the exception in the law contains loopholes. It indicated that recommendations could be made to Congress to amend the exception limiting the use of trust funds to certain well-defined necessities (e.g. health care that is not covered by Medicaid). The HCFA also agreed to take appropriate action to strengthen Medicaid's right to recover from trusts established from third party settlements.

Report:

☞ A-09-93-00033 -- Final report -- October 1994

ENCOURAGE USE OF GENERIC DRUGS IN MEDICAID PROGRAM

Current Law:

Under Medicaid, reimbursement for drugs is generally based upon ingredient costs plus a reasonable pharmacy dispensing fee. Effective October 29, 1987, Federal regulations limited the amount which Medicaid reimbursed for drugs with available generic drugs to a Federal upper limit price (FULP). However, FULP limits do not apply to drug purchases where prescribing physicians certify in their handwriting on the prescription form that a specific brand is medically necessary.

Proposal:

The HCFA should identify and alert States to methods which would encourage the use of lower priced generic drug products in the Medicaid program. The HCFA should also take a more active role to encourage States to use generic drugs and provide stronger incentives for States to adopt policies that encourage use of generic drugs and monitor the States' efforts to encourage the use of lower priced generic drugs and formally assess those activities.

Legislative	Regulatory	Other Administrative
☐	☐	☑

Reason for Action:

Our review showed that annual cost savings to the Medicaid program could be as much as $46 million for only 37 high volume dispensed brand name drugs, if the reimbursement for those drugs was limited to the amounts set by HCFA for equivalent generic drugs. The cost savings would become even greater in the future as the Federal patents on exclusive drug manufacturing of 60 important highly used drugs with more than $10 billion in sales will expire by 1995.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$49	$49	$49	$49	$49

Status:

The HCFA has provided a copy of our report to States and encouraged them to use lower priced generic products. On February 2, 1996, States were requested to provide a description of any policies adopted by States that encourage use of equivalent generic drugs. This information will be included in the 1995 State drug utilization review annual report due to regional offices by June 30, 1996.

Report:

☞ A-06-93-00008--Final report--July 1994

IMPLEMENT AN INDEXED BEST PRICE CALCULATION IN THE MEDICAID DRUG REBATE PROGRAM

Current Law:

The Omnibus Budget Reconciliation Act of 1990 (OBRA '90) authorized States to collect rebates from drug manufacturers for drug purchases made under the Medicaid program. Rebates are calculated using average manufacturer price (AMP), the manufacturer's best price among other factors. To discourage drug manufacturers from raising AMP amounts, the basic rebate amount is increased by the amount AMP increases over and above the consumer price index for all urban consumers (CPI-U). However, no similar indexing of best price is made, even though best price is part of the basic rebate calculation for brand name drugs.

Proposal:

Best price calculation in the Medicaid drug rebate program should be indexed.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

Drug manufacturers have consistently increased best prices in excess of the CPI-U since the inception of the Medicaid drug rebate program. To determine the potential effect that increases in best price (beyond the rate of inflation) had on rebates, we calculated the difference in rebates that would have resulted from using an indexed best price. We estimate that drug rebates would have increased by about $123 million for the 406 drug products included in our review.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$123	$123	$123	$123	$123

Status:

We are continuing our review of the Medicaid drug rebate program.

Report:

☞ A-06-94-00039--Final report--October 1995

REDUCE NONEMERGENCY USE OF EMERGENCY ROOMS BY MEDICAID RECIPIENTS

Current Law:

States attempting to control nonemergency use of emergency rooms must consider several Federal requirements. Medicaid recipients must have the right to freedom of choice of a health care provider as stated in Section 1902 (a)(23) of the Social Security Act. Before recipients are restricted in choices of providers a waiver under section 1915(b) must be obtained.

Proposal:

The HCFA should encourage States to develop initiatives to review and reduce nonemergency use of emergency rooms by Medicaid recipients and assist them through data analysis instructions, expedited review of waiver applications for managed care, and dissemination of effective emergency room control practices.

Legislative	Regulatory	Other Administrative
☐	☐	☑

Reason for Action:

Seventeen Medicaid directors and managers in nine different States were interviewed about the programs/procedures they have established to control nonemergency use of emergency rooms. In addition, utilization and charge data were obtained from HCFA, the States, and the Medicaid Statistical Information System. From this we found that: heavy nonemergency use of emergency rooms by Medicaid recipients is a continuing problem; substantial Medicaid savings could be realized by redirecting nonemergency visits to more appropriate and less costly care sites; and States have developed controls to improve access to and continuity of care as well as to reduce costs of which managed care/pre-paid programs are the most successful.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$80.5	$103.8	$133.9	$172.7	$222.8

Status:

The HCFA indicated it was concerned that it may not have sufficient resources to encourage States to develop initiatives to review and reduce nonemergency use of emergency rooms, or disseminate annual reports on effective practices, but will assist States with expediting the review of State applications for waivers to implement their efforts to control emergency rooms.

Report:

☞ OEI-06-90-00180--Final report--March 1992

INSTALL EDITS TO PRECLUDE IMPROPER MEDICAID REIMBURSEMENT FOR CLINICAL LABORATORY SERVICES

Current Law:

Clinical diagnostic laboratory tests performed in a physician's office, by an independent laboratory, or by a hospital laboratory for its outpatients are reimbursed on the basis of fee schedules. Medicaid reimbursement for clinical laboratory tests may not exceed the amount that Medicare recognizes for such tests and each Medicare carrier in a respective State will provide its fee schedule to the State agency. For purposes of the fee schedule, clinical diagnostic laboratory services includes laboratory tests, listed in codes 80002 - 89399 of the Current Procedural Terminology Manual. Effective for services rendered on or after July 1, 1984, Federal matching funds are not available for any amount over the amount recognized by Medicare for such tests.

Proposal:

The respective State agencies should install edits to detect and prevent payments that exceed the Medicare limits and billings which contained duplicative tests, recover overpayments for clinical laboratory services identified in each of the reviews, and make adjustments for the Federal share of the amounts recovered by the State agencies.

Legislative	Regulatory	Other Administrative
☐	☐	☑

Reason for Action:

Overall, these reviews disclose that State agencies are reimbursing providers for laboratory services which exceed the Medicare limits or were duplicated for payments purposes. In addition, it was determined that these overpayments are occurring because the State agencies do not have adequate computer edits in place to prevent the payment of unbundled or duplicated claims for chemistry, hematology, or urinalysis tests.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$14	$14	$14	$14	$14

Status:

The HCFA is evaluating our results.

Report:

☞ A-01-95-00005--Final report--January 1996
A-01-96-00001--Final report--February 1996
A-04-95-01108--Final report--December 1995
A-04-95-01109--Final report--April 1996
A-04-95-01113--Final report--February 1996
A-05-95-00035--Final report--February 1996
A-05-96-00019--Final report--March 1996
A-06-96-00031--Final report--December 1995
A-06-95-00078--Final report--November 1995
A-07-95-01139--Final report--September 1995
A-07-95-01147--Final report--October 1995
A-07-95-01138--Final report--March1996
A-09-95-00072--Final report--May 1996
A-10-95-00002--Final report--March 1996

CONTROL MEDICAID PAYMENTS TO INSTITUTIONS FOR MENTALLY RETARDED PEOPLE

Current Law:

Federal Medicaid rules for reimbursing States for the intermediate care facilities/mentally retarded (ICF/MR) are not tailored to ICF/MR operations. "Reasonable costs" or "efficiently and economically operated facility" are not defined in regulation. Each State has considerable discretion in defining these terms and setting ICF/MR payment methodology.

Proposal:

The HCFA should take action to reduce excessive spending of Medicaid funds for ICF/MRs by one or more of the following:

- take administrative action to control ICF/MR reimbursement by encouraging States to adopt controls;
- seek legislation to control ICF/MR reimbursement, such as mandatory cost controls, Federal per capita limits, flat per capita payment, case-mix reimbursement, or national ceiling for ICF/MR reimbursements; and
- seek comprehensive legislation to restructure Medicaid reimbursement for both ICF/MR and home and community-based waiver service for developmentally disabled people via global budgeting, block grants, or financial incentive programs.

Legislative	Regulatory	Other Administrative
✓		✓

Reason for Action:

Medicaid reimbursement rates for large ICF/MRs are more than five times greater in some States than in others. Average Medicaid reimbursement in 1991 for large ICF/MRs ranged among States from $27,000 to $158,000 per resident. This variation was unrelated to the patients' severity of illness, quality of service, facility characteristics, or resident demographics. Lack of effective controls results in excessive spending.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$683	$683	$683	$683	$683

Status:

The HCFA nonconcurred with our recommendation. The HCFA believes Medicaid statutory provisions allow States to establish their own payment systems. This flexibility allows for the variations found among States in their payment rates and the methods and standards used in determining these rates. The HCFA sent copies of our report to State Medicaid Directors for their use.

Report:

☞ OEI-09-91-01010--Final report--June 1993

PUBLIC HEALTH SERVICE AGENCIES

PUBLIC HEALTH SERVICE AGENCIES

Introduction

Overview

The activities conducted and supported by the Public Health Service (PHS) operating divisions represent this country's primary defense against acute and chronic diseases and disabilities. These programs provide the foundation for the Nation's efforts in promoting and enhancing the continued good health of the American people.

These currently independent operating divisions within the Department include: National Institutes of Health (NIH), to advance our knowledge through research; Food and Drug Administration (FDA), to assure the safety and efficacy of marketed drugs, biological products and medical devices; Centers for Disease Control and Prevention (CDC), to combat preventable diseases and protect the public health; Health Resources and Services Administration (HRSA), to support the development, distribution and management of health care personnel, other health resources and services; Indian Health Service (IHS), to improve the health status of Native Americans; Agency for Toxic Substances and Disease Registry (ATSDR), to address issues related to Superfund toxic waste sites; the Agency for Health Care Policy and Research (AHCPR), to enhance the quality and appropriateness of health care services and access to services through scientific research and the promotion of improvements in clinical practice, and in the organization, financing and delivery of services; and the Substance Abuse and Mental Health Services Administration (SAMHSA), to assist States in refining and expanding treatment and prevention services.

Significant OIG Activities

The Office of Inspector General (OIG) concentrates on such issues as biomedical research, substance abuse, acquired immune deficiency syndrome and medical effectiveness. Significant unimplemented monetary recommendations identified by the OIG regarding policy issues relate to instituting and collecting user fees for FDA activities; and changes to OMB Circular A-21 to effect more productive use of Federal research dollars at the Nation's colleges and universities.

INSTITUTE AND COLLECT USER FEES FOR FOOD SAFETY INSPECTIONS

Current Law:

The Food and Drug Administration (FDA) currently imposes user fees for several activities, including color certification and reconditioning of products. The FDA began collecting fees in 1993 for activities covered by the Prescription Drug User Fee Act.

In the absence of specific authorizing legislation, the FDA is precluded by statute from imposing user fees to cover additional functions.

Proposal:

Extend user fees to fund inspections of food processors and establishments.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

The OIG believes that user fees, if properly instituted, represent a legitimate method to recover regulatory costs. Such fees would be consistent with fee systems in other Federal regulatory environments, such as the Environmental Protection Agency, the Federal Communications Commission, the Federal Energy Regulatory Commission, and the Nuclear Regulatory Commission. In addition, user fees would properly reflect the value of discrete benefits enjoyed by manufacturers from FDA's regulatory activities, such as increased consumer confidence in industry's products and protection from unfair competition.

The imposition of user fees for major FDA regulatory functions will not only shift the economic burden of FDA's functions to users but will have the potential added benefits of increasing revenue for needed expansion of services, improving agency tracking of resources, and increasing agency accountability for the costs of regulation.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$44.4	$44.4	$44.4	$44.4	$44.4

Status:

The estimated cost for performing domestic food safety inspections, plus overhead, for FY 1996 was $44.4 million. The President's current budget did not request user fees for food safety inspections.

Report:

☞ OEI-05-90-01070--Final report--August 1991

CAP MEDICAL MALPRACTICE COVERAGE TO COMMUNITY AND MIGRANT HEALTH CENTERS

Current Law:

The Federal Tort Claims Act (FTCA) provides unlimited medical malpractice coverage to Community and Migrant Health Centers (C/MHC). Under FTCA, the Government consents to be sued for claims resulting from any personal injury caused by the negligence of employees who were acting within the scope of their employment. The Federally Supported Health Centers Assistance Act of 1992 (the Act), Public Law 102-501, extended FTCA coverage to C/MHC medical personnel for a 3-year demonstration period beginning January 1, 1993. The Act, slated to expire December 31, 1995, was recently extended indefinitely.

Proposal:

Health Resources and Services Administration (HRSA) consider seeking a legislative change to limit malpractice settlements or judgements involving C/MHCs to $1 million.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

We found that GAO reported in 1993, malpractice insurance with unlimited dollar coverage, such as FTCA currently provides, will generally cost about 50 percent more than coverage limited to $1 million per claim. GAO also reported about 57 percent of policies C/MHCs purchased from private insurers during Calendar Year (CY) 1991 provided coverage up to $1 million per claim. Our actuarial consultant advised us that for this same period, the average limit purchased at that time by C/MHCs was $850,000. The actuarial consultants estimated the Federal Government would incur $30.6 million more over a 3-year period to provide unlimited dollar coverage compared to providing coverage with a limit of $1 million per claim.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$10	$10	$10	$10	$10

Status:

The HRSA agreed to consider a legislative proposal to amend FTCA to include the $1 million limitation.

Report:

☞ A-04-95-05018--Final report--March 1996

IMPROVE INDIAN HEALTH SERVICE'S BILLINGS AND COLLECTIONS FROM PRIVATE HEALTH INSURANCE COMPANIES

Current Law:

The Indian Health Service (IHS) funds health care to American Indians and Alaska Natives through appropriations by Congress and collections from third party resources. Public Law 100-713, the Indian Health Care Amendments of 1988, authorizes the IHS to bill third parties, including private insurance companies, for both inpatient and outpatient services. According to IHS, reimbursements received from private insurance companies for patients in IHS operated facilities are used to implement IHS business offices and purchase medical supplies and equipment.

Proposal:

The IHS should establish the necessary internal controls, assign adequate resources to its business offices, and provide additional training to business office staff to ensure that underbillings of approximately $7 million per quarter are properly filed and collected.

Legislative	Regulatory	Other Administrative
☐	☐	☑

Reason for Action:

We found that IHS had not established the controls necessary to ensure that the amounts billed to private insurance companies were accurate and all covered services were billed. As a result, for the 3-month period tested, we calculated that IHS underbilled private insurers by approximately $7 million.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$28	$28	$28	$28	$28

Status:

The IHS fully concurred with our recommendations and delineated IHS actions to address them. Specifically, IHS is in the process of, or has plans for: (1) implementing an automated system to achieve the necessary internal controls; (2) allocating resources to improve methods for billings and collections; (3) meeting the training needs of business office staff; (4) implementing fee schedules on a timely basis; (5) ensuring adequate accounting and medical records are maintained for each patient; (6) providing adequate resources to carry out claims follow-up; and (7) improving policies and procedures for follow-up of unpaid claims.

Report:

☞ A-06-93-00080--Final report--June 1995

DEVELOP AND CONSISTENTLY BILL UNIVERSITY RECHARGE CENTER COSTS

Current Law:

The Office of Management and Budget (OMB) Circular A-21, "Cost Principles for Educational Institutions," requires billing rates for specialized service funds (recharge centers) to be based on actual costs, designed to recover the aggregate cost of a good or service, and reviewed periodically.

Proposal:

Universities should improve their oversight of recharge centers and should: (1) develop and implement policies and procedures for the operation of recharge centers that are consistent with OMB Circular A-21; (2) establish and maintain adequate accounting and recordkeeping procedures for recharge center; and (3) analyze and adjust billing rates to eliminate deficit and surplus funds.

The Department should work with OMB to revise Circular A-21 to ensure that criteria related to the financial operation of recharge centers is clear.

Legislative	Regulatory	Other Administrative
☐	☐	☑

Reason for Action:

Our review showed that 11 of 12 universities did not maintain adequate accounting systems and records to allow for: (a) the development of billing rates based on actual costs; or (b) the identification of surplus or deficit fund balances. These weaknesses in the internal control structure resulted in some recharge centers: (1) accumulating surplus and deficit fund balances that were not adjusted for in subsequent billing rates; (2) including duplicate or unallowable costs in billing rates; (3) including recharge center costs in the calculation of indirect cost rates; (4) using recharge center funds for unrelated purposes; and/or (5) billing some users at reduced rates. These weaknesses caused billing rates to be overstated, resulting in overcharges of $3.2 million to the Federal Government.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$3.2	*	*	*	*

** Recurring savings would result with circular change.*

Status:

The Assistant Secretary for Management and Budget concurred with our recommendations and has recommended to OMB that Circular A-21 be revised to provide more definitive guidance on the financial operations of recharge centers. However, such a change was not included in the recent Circular revision.

Report:

☞ A-09-92-04020--Final report--January 1994

LIMIT GRADUATE STUDENT COMPENSATION TO THAT PAID FOR SIMILAR WORK

Current Law:

The OMB Circular A-21, "*Cost Principles for Educational Institutions*", requires that tuition remission (the forgiveness by the institution of all or a portion of the tuition costs of the student) and other forms of compensation charged to federally sponsored research to be reasonable.

Proposal:

The Assistant Secretary for Management and Budget (ASMB) should work with OMB to revise Circular A-21 to stipulate a reasonableness standard for graduate student compensation based on assigned responsibilities and not to exceed compensation paid to other individuals of similar experience for similar work.

Legislative	Regulatory	Other Administrative
☐	☐	☑

Reason for Action:

Although OMB Circular A-21 requires that tuition remission and other forms of compensation charged to federally sponsored research be reasonable, it provides unclear guidance, relying on the concepts of the prudent person and arm's length bargaining, in defining "reasonableness." In the absence of a consistent standard, OIG used the salaries of postdoctoral research assistants and equivalent positions as a "fair and reasonable benchmark" for measuring the reasonableness of compensation packages provided to graduate students at four universities.

Based on a statistical sample, the OIG found that three of the four universities it audited charged a total of $5.7 million in unreasonable graduate student compensation to federally sponsored research projects.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$5.7	*	*	*	*

** Recurring savings would result with circular change.*

Status:

The ASMB endorsed the OIG recommendation, concluding that a prudent person would not provide greater compensation to individuals who are less qualified by education and practical experience than others performing similar work, and doubting whether the other three universities engaged in arm's-length transactions. Recommended changes, however, were not included in the recent Circular revision.

Report:

☞ A-01-94-04002--Final report--October 1994

ADMINISTRATION FOR CHILDREN AND FAMILIES

ADMINISTRATION FOR CHILDREN AND FAMILIES

Overview

The Administration for Children and Families (ACF) provides Federal direction and funding for State, local and private organizations as well as for State-administered programs designed to promote stability, economic security, responsibility and self-support for the Nation's families. It also oversees a variety of programs that provide social services to the Nation's children, youth and families, persons with developmental disabilities and Native Americans.

Major types of family support payments to States encompass: Aid to Families with Dependent Children (AFDC), a cooperative program among Federal, State and local governments; the Child Support Enforcement (CSE) program, which provides grants to States to enforce obligations of absent parents and for establishing and enforcing child support orders. The Head Start program provides comprehensive health, educational, nutritional, social and other services primarily to preschool children and their families who are economically disadvantaged. The Foster Care and Adoption Assistance program provides grants to States to assist with the cost of foster care and special needs adoptions, maintenance, administrative costs and training for staff. Other programs include Community Services, Job Opportunities and Basic Skills Training (JOBS), and the State Legalization Impact Assistance Grants program.

Introduction

Significant OIG Activities

The OIG reviews the cost-effectiveness of the ACF social services and assistance programs, including determining whether authorized services are provided to recipients at lowest costs. We identified opportunities to improve the delivery of program services, such as: modifying the Federal Medical Assistance Percentage formula, which would result in a more equitable distribution of federal funds among States; requiring States to develop criteria and implement procedures for assuring that appropriate foster care cases are referred to State child support enforcement agencies; basing child support incentive payments on the States' demonstrated ability to meet Federal requirements and performance objectives; and limiting Federal participation in foster care administrative costs.

MODIFY FORMULA FOR THE AFDC, FOSTER CARE AND ADOPTION ASSISTANCE PROGRAMS

Current Law:

The Federal Medical Assistance Percentage (FMAP) prescribed in the Social Security Act, determines the Federal share of costs for the Medicaid, Aid to Families with Dependent Children (AFDC), Foster Care and Adoption Assistance programs. In addition, four additional programs will use the FMAP as the Federal matching rate for specific types of costs. These programs are Job Opportunities and Basic Skills, Child Care and Supportive Services, Transitional Child Care and At-Risk Child Care.

Proposal:

The Administration for Children and Families (ACF) should consult with the Congress on modifications to the FMAP formula which would result in distributions of Federal funds that more closely reflect per-capita-income relationships. (See a similar proposal for the Medicaid program located in the HCFA chapter of this *Red Book*.)

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

The FMAP formula does not fully reflect the congressional objective of distributing Federal funds according to a State's ability to share in program costs, as measured by State per-capita-income. Two provisions result in higher-income States receiving significant additional Federal funds beyond amounts the formula would provide if it were based solely on per-capita-income relationships. Changes to these provisions, namely (i) eliminating the program growth incentive of the FMAP and (ii) lowering the current minimum floor to 45 percent (from 50 percent), would result in distributions of Federal funds that more closely reflect per-capita-income relationships. If the formula were changed, higher income States (such as New York and California which had average monthly AFDC expenditures per person in poverty in Fiscal Year (FY) 1987 of $809) would receive a reduced Federal share in program expenditures, while lower income States (such as Mississippi and Arkansas which had average monthly AFDC expenditures per person in poverty in FY 1987 of $170) would receive a greater Federal share. Higher income States could offset the Federal share reduction by reducing their comparatively greater program benefits. However, if a cost-of-living factor were added to the formula, it would help insure that any reductions in Federal sharing would be equitable.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$1,100	$1,100	$1,100	$1,100	$1,100

Status:

This proposal was not included in the President's current budget.

Report:

☞ A-06-90-00056--Final report--July 1991

REVIEW RISING COSTS IN THE EMERGENCY ASSISTANCE PROGRAM

Current Law:

The Emergency Assistance (EA) Program is an optional supplement to the Aid to Families with Dependent Children Program. It is a State's discretion whether or not to implement the EA Program. The purpose of the EA Program is to provide temporary financial assistance and supportive services to eligible families experiencing an emergency. House and Senate Committee reports cited several instances of emergencies which include a child's deprivation of food, housing, utilities, and necessary parental support.

Proposal:

The ACF should: (1) support legislation that would either cap the Federal share of EA expenditures or include the Program as part of a block grant; (2) revise or rescind its current policies allowing the shifting of costs to the EA program especially where such costs have been borne traditionally by the States. In this regard, the eligibility period should be limited; and (3) issue policy guidelines requiring States to reimburse hospital care at amounts less than total charges.

Legislative	Regulatory	Other Administrative
✓		✓

Reason for Action:

We found that ACF approved State plan amendments which enabled States to maximize Federal revenue by obtaining EA funding for services traditionally State funded. As a result, the States shift in categorical costs represented a significant portion of the 400 percent increase in EA Program from 1991 to 1994.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
TBD	TBD	TBD	TBD	TBD

Status:

In response to our draft report, the ACF agreed that there is an urgent need to control the rapid escalation of EA expenditures. Further, ACF agreed with our recommendations to support capping EA expenditures. The ACF stated it fully intends to take action to address inappropriate State practices. As such, on September 12, 1995, ACF issued Action Transmittal ACF-AT-95-9 which discontinues Federal financial participation under the EA Program for costs of providing benefits and services to children involved in the juvenile system.

Report:

☞ A-01-95-02503--Final report--October 1995

REDUCE CHILD SUPPORT INCENTIVE PAYMENTS AND BASE THEM ON STATES' PERFORMANCE

Current Law:

The Child Support Enforcement (CSE) program provides States with a Federal cost share of 66 percent for CSE administrative costs. States also receive incentives of 6 to 10 percent of collections from absent parents based on a ratio of collections to costs. Additionally, States receive credit for their share of collections recovered for Aid to Families with Dependent Children (AFDC) families.

Proposal:

Base incentive payments on the States' demonstrated ability to meet Federal CSE requirements and performance objectives. Also, consider OIG recommended options to reduce financial incentives realized by States that would result in a more equitable cost sharing with the Federal Government. These options are: (1) limiting incentives to a break-even point where a State's share of AFDC collections plus incentives equal the State's share of CSE costs;
(2) eliminating incentives to poor performing States; and (3) reducing the Federal share of administrative costs. Require that States use incentive payments for CSE purposes.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

During our review at nine selected States, we noted that incentive payments were used primarily to fund the State or local jurisdictions' share of CSE costs rather than expanding the coverage of the program. Also, a portion of incentive payments either were deposited in State and local general funds for unrestricted non-CSE uses or provided funding for the State or local share of public assistance costs. (The law currently does not restrict how these incentive payments can be used.) Further, in FY 1992, States realized net incentive-related revenue estimated at $463 million. On the other hand, the Federal Government not only did not realize any net revenue in terms of its share of AFDC collections, but actually paid out a net of $626 million. As stated previously, there was little evidence that incentives improved or expanded State CSE programs. Moreover, the legislative intent of having States increasingly share in the costs to motivate cost efficiencies has not been accomplished.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$277	$277	$277	$277	$277

Status:

This proposal was not included in the President's current budget.

Report:

☞ A-09-91-00034--Final report--April 1992
A-09-91-00147--Final report--September 1992

REFER FOSTER CARE CASES TO CHILD SUPPORT ENFORCEMENT AGENCIES

Current Law:

Section 11 of the 1984 Child Support Amendment Act requires States to secure and enforce child support collections on behalf of children receiving foster care maintenance payments under Title IV-E of the Social Security Act "where appropriate".

Proposal:

As a condition of receiving Federal matching funds for foster care administration under Title IV-E, the ACF should require States to develop criteria and implement procedures for assuring that foster care agencies refer appropriate cases to State child support agencies. We believe this would increase child support collections on behalf of foster care children, thus offsetting tax dollars spent for their care and maintenance.

Legislative	Regulatory	Other Administrative
✓		✓

Reason for Action:

Collections are being made on behalf of only 5.9 percent of foster care children in our sample. Few foster care cases are referred to child support agencies for possible collections.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$11	$11	$11	$11	$11

Status:

The ACF is in the process of implementing a strategy to address our recommendation. Specifically, ACF plans to add to the Program Review Instrument of Foster Care (the Instrument) a series of items dealing with State procedures and practices for identification of appropriate foster care cases, referral to child support agencies, follow-up and coordination between Foster Care and child support agencies, and accurate accounting for and crediting of collections. The Instrument will also require reviewers to determine whether a memorandum of understanding exists between the State agencies, and if so how well it is implemented. If no such agreement is in place, the Instrument will probe whether one would be useful for a particular State. The ACF did not agree with our estimate of potential savings.

Report:

☞ OEI-04-91-00530--Final report--May 1992

LIMIT FEDERAL PARTICIPATION IN STATES' COSTS FOR ADMINISTERING THE FOSTER CARE PROGRAM

Current Law:

Title IV-E of the Social Security Act makes Federal funding available to States for costs incurred in providing care and maintenance to children eligible for Foster Care. It also authorizes Federal participation in related administrative and training costs. Placement activities are included in administrative costs.

Proposal:

Limit Federal participation in Foster Care administrative costs through one of the following actions: (1) limit future increases in administrative costs to no more than 10 percent per year, (2) fund administrative activities via a single block grant with future increases based on the consumer price index, (3) limit administrative costs to a percentage of maintenance payments, or (4) restrict, through legislation, the filing period for retroactive claims, namely require States to file claims for Federal participation within 1 year after the calendar quarter in which the expenditure was made. Costs for child placement services should be separated from traditional overhead costs so they can be effectively monitored.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

Legislative action is required to control increases in Foster Care administrative costs. Current "open-ended" legislation has allowed administrative costs to increase from $400 million in FY 1988 to an estimated $1.2 billion in FY 1994 - approximately a 200 percent increase.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
$247	$306	$364	$415	$461

Status:

This proposal was not included in the President's current budget.

Report:

☞ A-07-90-00274--Final report--August 1990

GENERAL DEPARTMENTAL MANAGEMENT

GENERAL DEPARTMENTAL MANAGEMENT

Introduction

Overview

The Office of Inspector General's (OIG) departmental management and Governmentwide oversight role includes reviews of payroll activities, accounting transactions, implementation of the Federal Managers' Financial Integrity Act and the Prompt Pay Act, financial management audits under the Chief Financial Officers (CFO) Act, grants and contracts, the Department's Working Capital Fund, conflict resolution and adherence to employee standards of conduct. The OIG also participates in interagency efforts through the President's Council on Integrity and Efficiency and the President's Council on Management Improvement to prevent losses to and abuses of Federal programs.

The OIG has oversight responsibility for these staff division activities at the departmental level. A related major responsibility flows from the Office of Management and Budget's (OMB's) designation of HHS as cognizant agency to audit the majority of the Federal funds awarded to the major research schools, 104 State and local government cost allocation plans, and separate indirect cost plans of about 1,000 State agencies and local governments. In addition, OIG oversees the work of nonfederal auditors of Federal money at some 6,700 entities, such as community health centers and Head Start grantees, as well as at State and local governments, colleges and universities, and other nonprofit organizations.

Significant OIG Activities

The OIG's work in departmental management and Governmentwide oversight focuses principally on financial management and managers' accountability for resources entrusted, standards of conduct and ethics, and Governmentwide audit oversight, including recommending necessary revisions to OMB guidance. The OIG also reviews the adequacy of States' system(s) to control the growth of administrative/indirect costs claimed for Federal financial participation.

SIMPLIFY ADMINISTRATIVE/INDIRECT COST ALLOCATION SYSTEMS

Current Law:

The Office of Management and Budget (OMB) Circular A-87, *Cost Principles for State and Local Governments*, establishes requirements that State and local governments must follow in preparing and submitting cost allocation plans for Federal approval. State and local governments must adhere to the plans when claiming administrative/indirect costs for Federal financial participation.

Proposal:

Simplify the process for charging administrative/indirect costs to Federal programs through reform of the cost allocation plans. We have identified a range of options, some of which require legislative actions, to reform the cost allocation system. Options for reform include: (1) use of block grant awards; (2) a flat percentage rate for administrative/indirect costs; and (3) negotiation of a nonadjustable rate for a predetermined number of years.

Legislative	Regulatory	Other Administrative
✓	✓	

Reason for Action:

State cost allocation plans annually allocate an estimated $20 billion of administrative/indirect costs to Federal programs. We concluded from a review of 105 statewide cost allocation plans (35 States, plans for each of 3 years) that the system for allocating costs to Federal programs has degenerated into a highly technical accounting and allocation maze. The Federal, State and local governmental communities have struggled to work within a burdensome system instituted over 20 years ago that seeks to equitably share administrative/indirect costs. Prior reform efforts concentrated on individual programs and/or cost principles instead of the system or process and thus were not entirely successful.

Savings (in millions):

FY 1	FY 2	FY 3	FY 4	FY 5
*	*	*	*	*

** Estimated savings resulting from reform of cost allocation plan process. The report of the National Performance Review (NPR), "Creating a Government That Works Better and Costs Less" estimates a 5-year savings of $3.3 billion by reducing intergovernmental administrative costs.*

Status:

Some of our recommendations are cited in the NPR report that calls for reform of the cost allocation process. The OMB's revision of Circular A-87 addressed those recommendations. However, further reform is needed to address the bulk of administrative/indirect costs charged to Federal Government.

Report:

☞ A-12-92-00014--Final report--September 1993

IMPROVE FUNDING SYSTEM FOR WELFARE ADMINISTRATIVE COSTS

Current Law:

The Federal Government pays for half of the administrative costs for most types of administrative activities in the Aid to Families with Dependent Children (AFDC), Food Stamp and Medicaid programs. States have considerable latitude in defining their administrative costs. Costs need only be considered "reasonable and necessary" as outlined in OMB Circular A-87, "Cost Principles for State and Local Governments."

Proposal:

Examine the following alternative options for funding administrative costs in the AFDC, Food Stamp, and Medicaid programs:

- *Reduce Medicaid special match rates to 50 percent*. This option has already been enacted for the AFDC and Food Stamp programs.
- *Block Grant*. Combine the administrative costs of all three programs at a base year level, then provide inflationary increases each year.
- *Standard Cost Per Recipient*. Fund States based on a standard per recipient allocation amount.
- *Cost Per Recipient Cap*. Impose a cap on Federal reimbursement of the cost per recipient.

Legislative	Regulatory	Other Administrative
✓		

Reason for Action:

The current method for reimbursing States for welfare administrative costs is unwieldy, inefficient, and unpredictable. In addition, there is considerable unexplained disparity in administrative costs among States and significant risk of increase in administrative costs overall.

Savings (in millions):

Options	FY 1	FY 2	FY 3	FY 4	FY 5
Reduce Special Match	$236	$273	$ 315	$ 362	$ 415
Block Grant	$248	$817	$1,458	$2,159	$2,940
Standard Cost Per Recipient	$ 69	$180	$ 293	$ 423	$ 562
Capped Cost Per Recipient	$113	$127	$ 144	$ 162	$ 182

Status:

Enhanced matching rates have been reduced to 50 percent in the AFDC and Food Stamp programs; however, not in the Medicaid program.

Report:

☞ OEI-05-91-01080--Final report--January 1995

Internet Address

The 1996 Red Book and other OIG materials may be accessed on the Internet at the following address:

http://www.sbaonline.sba.gov/ignet/internal/hhs/hhs.html