

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**INDIAN HEALTH SERVICE
MEDICARE AND MEDICAID PAYMENTS
MANAGEMENT ADVISORY REPORT**



Richard P. Kusserow
INSPECTOR GENERAL

MAY 1991

Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

INDIAN HEALTH SERVICE
MEDICARE AND MEDICAID PAYMENTS
MANAGEMENT ADVISORY REPORT



Richard P. Kusserow
INSPECTOR GENERAL

OEI-07-89-00941

EXECUTIVE SUMMARY

PURPOSE

To assess the appropriateness of retaining or eliminating the Indian Health Service (IHS) multi-year account now that all of the IHS hospital facilities have met the Health Care Financing Administration (HCFA) requirements for participation in the Medicare and Medicaid Programs.

BACKGROUND

Current legislation requires that Medicare and Medicaid payments due to IHS hospitals be held by the Secretary of DHHS in the Secretary's special fund account and used by him exclusively for making improvements in hospital facilities that are necessary to achieve compliance with HCFA's conditions of participation. The legislation provided for the special fund account only until such time that the Secretary certified that substantially all of the IHS facilities have met these conditions and standards. IHS requires that payments due IHS hospital facilities be routed by the Medicare Fiscal Intermediary and the Medicaid State Agencies through IHS Central Office, which in turn "apportions" the funds to IHS area offices for distribution to the individual IHS hospitals.

FINDINGS

- Substantially all of the IHS hospital facilities have met the HCFA conditions of participation since 1981. In fact, at the time of our review, all of them met those conditions.
- The "Indian Health Care Improvement Act" continues to permit Medicare and Medicaid monies to be deposited into the Secretary's special fund account even though all of these facilities have met the HCFA conditions of participation.
- The Secretary's special fund account for Medicare and Medicaid payments is vulnerable to abuse.

RECOMMENDATIONS

- The IHS should phase out the Secretary's special fund account and expeditiously develop methods and procedures by which all IHS hospitals can directly receive and account for the use of Medicare and Medicaid funds.
- The IHS should seek legislation to expand the demonstration program authorized by Public Law 100-713 to a more representative sample of IHS facilities and to modify the restrictions imposed on the use of these funds.

TABLE OF CONTENTS

EXECUTIVE SUMMARY

INTRODUCTION.....1

 Purpose.....1

 Background.....1

FINDINGS3

RECOMMENDATIONS5

DISCUSSION7

COMMENTS.....8

APPENDICES

 APPENDIX A: ASMB Comments..... A-1

 APPENDIX B: HCFA Comments.....B-1

 APPENDIX C: PHS CommentsC-1

INTRODUCTION

PURPOSE

To assess the appropriateness of retaining or eliminating the Indian Health Service (IHS) facilities multi-year account now that substantially all of the IHS hospital facilities have met the Health Care Financing Administration (HCFA) requirements for participation in the Medicare and Medicaid programs.

BACKGROUND

On September 30, 1976, Public Law 94-437, "*Indian Health Care Improvement Act*" was enacted by Congress. This law made an exception to Sections 1395f(c) and 1395n(d), which prohibits payment of Medicare and Medicaid monies for treatment provided in Federally owned hospital and skilled nursing facilities. The law requires Medicare contractors to deposit Medicare and Medicaid funds, which are claimed by IHS facilities, into the Secretary's special fund account which is to be used to make improvements in its facilities. The funds deposited during one fiscal year can be used during that year and during two succeeding years for expenses related to achieving and maintaining HCFA's standards for provider participation. The law further provides under subsection (c) that the restrictions imposed concerning the collection and use of these funds would cease to apply once the Secretary determines and certifies that substantially all of the IHS hospitals and skilled nursing facilities are in compliance with requirements and conditions as specified under Title XVIII and XIX for Medicare and Medicaid participation.

On January 4, 1975, Public Law 93-638, "*Indian Self-Determination and Educational Assistance Act*" was enacted by Congress. Congressional findings, as stated in Section 2(a)(1), are that "the prolonged Federal domination of Indian service programs has served to retard rather than enhance the progress of Indian people and their communities by depriving Indians of the full opportunity to develop leadership skills crucial to the realization of self-government, and has denied to the Indian people an effective voice in the planning and implementation of programs for the benefit of Indians which are responsive to the true needs of the Indian communities."

On November 23, 1988 Public Law 100-713, "*Indian Health Care Amendments of 1988*", was enacted by Congress. This law authorized IHS hospitals to collect treatment charges from private insurance companies. Further, this law authorized the establishment of a demonstration program, beginning in October 1991 and ending September 30, 1995, in which four IHS hospital facilities, operating under contract by Indian tribes or Alaska Native organizations, would directly bill and receive reimbursement from Medicare, Medicaid and third party insurance sources. The goal of this demonstration program is to determine if these IHS hospitals are capable of billing, receiving and accounting for the use of these funds without direct IHS Headquarter's intervention, which is in accordance with the "*Indian Self Determination and Educational Assistance Act*", Public Law 93-638, reauthorized as Public Law

100-472. Upon conclusion of the program, the Secretary will report to Congress concerning whether direct billing and reimbursement should be expanded to other IHS hospital facilities which are operated under contract.

We have conducted discussions with officials of IHS, the Joint Commission on Accreditation of Health Care Organizations (JCAHO), HCFA, and the Fiscal Intermediary for IHS Medicare claims, Blue Cross of New Mexico, concerning the IHS hospitals' certification status, the deficiencies identified in these facilities and the routing of Medicare and Medicaid payments. In addition, previous government reports addressing Medicare and Medicaid funding to IHS hospital facilities were analyzed. We have also contacted Congressional staff to obtain the legislative history of Public Law 94-437 and Public Law 100-713.

FINDINGS

Substantially all of the IHS hospital facilities have met the HCFA conditions of participation since 1981. In fact, at the time of our review, all of them met those conditions.

The General Accounting Office issued a letter report, number B-211198, Subject: "Medicare/Medicaid Funds Can Be Better Used To Correct Deficiencies in Indian Health Service Facilities" (GAO HRD-83-22), dated August 16, 1983. In this document, the GAO advised the Secretary, that as of September 30, 1981, all of the IHS facilities met the Medicare and Medicaid standards, and that the Medicare and Medicaid funds were now being used to correct staffing deficiencies and to fund maintenance of the hospital facilities and equipment.

The IHS records establish that the majority of the IHS hospitals were certified for Medicare and Medicaid participation in 1977, and that the last IHS hospital was certified for Medicare and Medicaid participation in December 1983. All but two of the IHS hospitals are accredited by the JCAHO. The remaining two facilities are certified by the HCFA. It should be noted that IHS does not operate any skilled or intermediate care nursing facilities.

The "Indian Health Care Improvement Act" continues to permit Medicare and Medicaid monies to be deposited into the Secretary's special fund account even though all of these facilities have met the HCFA conditions for participation.

Title 42 U.S.C. 1395qq(a) is an exception to the prohibitions contained in Sections 42 U.S.C. 1395f(c), and 1395n(d), which prohibited the issuance of Medicare and Medicaid payments to Federal facilities. Subsection (c) of this Title directed that Medicare and Medicaid payments be placed in a special fund and used for the exclusive purpose of making any improvements as may be needed to achieve compliance with the applicable Medicare and Medicaid conditions and requirements. This section of the law is operative only until such time that substantially all of the IHS facilities have met these conditions and standards. Once the Secretary determines and certifies that the IHS facilities have met these conditions and requirements, the facilities would then be eligible to receive payments directly from the Medicare and Medicaid programs. These funds would then be available for payment of operating expenses.

However, even though all the IHS facilities meet Medicare conditions and standards, the Secretary has not officially determined and certified that this is the case. As a result, the Medicare and Medicaid funds continue to be deposited into the Secretary's special fund account instead of being sent directly to the IHS hospitals which provided the care and billed the Medicare and Medicaid programs.

The IHS records establish that in Fiscal Year 1989, the Medicare program issued payments for treatments at IHS hospitals totalling \$35,103,789 and Medicaid payments were made which totalled \$39,716,363. The total Medicare and Medicaid reimbursement was \$74,820,152.

The Secretary's special fund account for Medicare and Medicaid payments is vulnerable to abuse.

The Secretary's special fund account is vulnerable to abuse due to the legislative provision that allows the funds to be used over the course of three fiscal years. Evidence of the vulnerability of this fund to abuse was recently uncovered by our office. In one Area Office, we found that in excess of \$2 million of funds appropriated for Indian youth alcoholism programs under Public Law 99-570 were apparently diverted to the Medicare and Medicaid facilities fund for the purpose of carrying over unspent program funds into the next fiscal year. Without this diversion, these funds would have reverted to the Treasury. We have referred this situation to our Office of Audit Services for further review.

RECOMMENDATIONS

The IHS should phase out the Secretary's special fund account and expeditiously develop methods and procedures by which all IHS hospitals can directly receive and account for the use of Medicare and Medicaid funds. This can be accomplished by:

1. The Assistant Secretary for Health developing and implementing appropriate accounting systems at all hospitals to bill, receive and account for the expenditure of Medicare and Medicaid funds.

IHS should initiate action to develop appropriate accounting systems for use by all IHS hospitals. In addition, the IHS should establish appropriate audit controls and oversight to assure that the monies received and expended by the individual hospitals are utilized in accordance with legal requirements.

For those facilities, which are so small that it is not economically feasible to have accounting staff on site to implement this recommendation, an alternative would be to establish the responsibility for accounting and expenditure control at the area office rather than at the hospital facility.

2. The HCFA Administrator, in cooperation with the Assistant Secretary for Health, preparing documents for the Secretary to officially determine and certify that substantially all of the IHS hospital facilities are in compliance with the HCFA conditions for participation in the Medicare and Medicaid programs.

This determination and certification will remove the restrictions on the direct payment and use of Medicare and Medicaid monies by IHS hospital facilities, as contained in Title 42 U.S.C. Section 1395qq(c). With the restrictions removed, individual IHS hospitals could be placed into direct payment when IHS has notified HCFA that appropriate accounting systems and audit controls are in place.

3. The Assistant Secretary for Health, in cooperation with the Assistant Secretary for Management and Budget, eliminating the Secretary's special fund account into which Medicare and Medicaid payments are now deposited. The account could be phased out over several years. As each hospital or area office developed acceptable financial management capabilities, it could directly receive and use for operating expenses those Medicare and Medicaid payments which it collected. However, Medicare and Medicaid funds collected by those hospitals or area offices not yet capable of managing them could be deposited into the Secretary's special fund account to be managed as currently done by IHS. Ultimately all hospitals or area offices would manage their own Medicare and Medicaid funds and the multi year account would be eliminated entirely.

4. In eliminating the Secretary's Special fund account, the carrying-over of funds would be governed by standard GAO financial management principles, which depend on "purpose of use" and carryover procedures (e.g. capital funds can be carried over).

We recommend accomplishing the above four steps within five years.

We believe that the IHS should expeditiously begin implementing the preceding recommendation. However, if this is not possible:

IHS should seek legislation to expand the demonstration program authorized by Public Law 100-713 to a more representative sample of IHS facilities and to modify the restrictions imposed on the use of these funds.

The demonstration program authorized by Public Law 100-713 authorized no more than four IHS facilities to receive direct Medicare and Medicaid reimbursement and to utilize these funds for facility improvements in order to meet and maintain HCFA's conditions for participation. This demonstration program could be expanded to include facilities of various bed sizes and to determine the type of accounting system and audit controls that are best suited for use in smaller and larger facilities.

The demonstration project could be expanded to include IHS facilities that participate in either the Medicare and/or the Medicaid program. Further, the demonstration program should be modified to allow the use of Medicare and Medicaid funds for facility operating expenses other than those related to maintaining HCFA's conditions for participation. This would be in line with payments made to other federally supported providers such as community health centers and migrant health centers.

DISCUSSION

The proposal:

- *is consistent with the goals of the Indian Self Determination and Educational Assistance Act;*
- *would provide an incentive for IHS hospital facilities to aggressively pursue collection of Medicare, Medicaid, and third party payments since they would be allowed to retain and use these funds;*
- *would eliminate an accounting structure which is vulnerable to abuse; and,*
- *would promote the development of financial management systems and expertise necessary for IHS hospitals to achieve greater management effectiveness.*

The proposal would allow funds now being exclusively targeted to maintain Medicare and Medicaid certification requirements to be used for operating expenses. This would not jeopardize the certification of the hospitals, since the Service Unit Director would be responsible for ensuring that within annual funds available, including reimbursements, maintaining Medicare and Medicaid program accreditation would be his or her first priority. Funds needed for this purpose would be requested through the normal appropriations process and would be subject to the usual oversight of the Departmental, OMB, and congressional budget processes. This would likely result in greater accountability and promote more effective certification programs.

Overall, we believe that the Secretary's special fund for receipt of Medicare and Medicaid payments has served its original purpose of bringing IHS facilities up to Medicare certification standards. Now IHS is faced with new challenges in its hospital program. Among them are: the effective collection of third party payments (including both private insurance and Medicare and Medicaid payments); the development of effective financial management and accounting systems in the hospitals and area offices; and promoting self determination of Indian tribes. The financial management structure established for past years' problems is inappropriate to tackle the new ones.

COMMENTS

We received comments to the draft of this report from the Assistant Secretary for Management and Budget (ASMB), the Assistant Secretary for Health (ASH), and the Administrator for the Health Care Financing Administration (HCFA). Based on these comments, we have made appropriate changes to this report. These comments are included in Appendices A-C of this report.

The ASMB supported the OIG findings, but recommended that we expand our description of the proposal (page 6) to clarify that our proposal would allow funds now being exclusively targeted to maintain Medicare and Medicaid certification requirements to be used for other operating expenses. They also suggested we clarify that the Service Unit Director of the facility would continue to be responsible for assuring that the IHS facility met and maintained Medicare and Medicaid program accreditation.

We agree with their comments and have incorporated this language in the report.

The HCFA fully supports the OIG recommendations of this report, but noted that they would need additional funding to cover the costs associated with the certification, audit and other administrative costs for HCFA and Medicare contractors to perform needed reviews of IHS hospital facilities.

The PHS did not concur with the OIG recommendations.

PHS believes that the present system, in which Medicare and Medicaid funds are returned to the Areas that provided the services and are earmarked only to eliminate deficiencies in each health care facility, has worked well and they see no clinical or administrative advantage to changing the system. They estimate that implementation of our recommendations would require at least 10 additional employees at each hospital to perform financial and certification functions.

The PHS also believes that the recommendations would create accounting difficulties. They cite that the process of billing and collection is continuous. Collections received late in the fiscal year, if not expended, would revert to Treasury and would not be available to meet payroll costs for those staff funded by this activity. Since this is a cash account, adequate funds must be carried forward into the next fiscal year to meet payroll costs for at least three pay periods.

The PHS also did not concur with our recommendation to expand demonstration programs. They point out that the demonstration program was designed for the express purpose of allowing tribally contracted programs to directly bill and receive payments. These tribal contract programs have accounting systems and other fiscal controls in place. On the other hand, IHS facilities (operated by the Service Units) do not have separate accounting functions and cannot meet Treasury and GAO requirements. PHS believes it would be counterproductive and not cost effective to install these accounting functions and fiscal controls at local IHS-operated hospitals and facilities.

OIG RESPONSE TO PHS COMMENTS

We continue to support our recommendations.

The current system which permits normal appropriations to IHS and provides for a Secretary's special fund account breeds artificial distinctions which impair the implementation of sound accounting, recordkeeping and management practices.

Restrictions that are imposed on the use of the Secretary's special fund account hampers the ability of PHS to plan and manage its programs. These restrictions make it difficult for PHS to utilize these funds to respond to shortfalls in IHS health programs. For example at the FY 1990 Select Committee on Indian Affairs Budget Hearing, the Director of the Indian Health Service testified that the IHS projected a shortfall for the IHS in FY 1989. Based on this testimony, Congress provided \$14 million above the President's budget recommendation. At that time (FY 1990), the Secretary's special fund had a carryover of \$12,698,360.

We believe that flexibility is needed in the use of Medicare and Medicaid reimbursements so that IHS can fulfill their mission of providing health care to Native Americans.

As far as accounting capabilities are concerned, the PHS corrective action for the *"High Risk Area: Management of the Indian Health Service (PHS-89-01-HR)"* cited in the *"Federal Managers Financial Integrity Act Report to the President and Congress"* dated December 1990, item 7, (pages 18-19), appears to agree with our position that accounting functions and fiscal controls should be implemented at the local hospital level. IHS appropriations for FY 1991 included \$2 million to implement this policy.

APPENDIX A

ASMB COMMENTS

Washington, D.C. 20201

OCT 25 1990

MEMORANDUM TO THE INSPECTOR GENERAL

Attn: Alan Levine

From : Kevin E. Moley *Kevin E. Moley*
Assistant Secretary for Management and BudgetSubject: OIG Management Advisory Report: "Indian Health Service
-- Medicare and Medicaid Payments," OEI-07-89-00941

We have reviewed the OIG Management Advisory Report on IHS Medicare and Medicaid Payments and fully support the findings, with one exception. We would propose that the first paragraph in the Discussion section (page 6) be revised to read:

The proposal would allow funds now being exclusively targeted to maintain Medicare and Medicaid certification requirements to be used for other operating expenses. This would not jeopardize the certification of hospitals, since the Service Unit Director would be responsible for ensuring that within annual funds available, including reimbursements, maintaining Medicare and Medicaid program accreditation would be his or her first priority.

We support removing the current restrictions imposed on Medicare and Medicaid funds, however, we believe we should extend flexibility on the use of all funds -- both appropriations and reimbursements -- rather than imposing a different set of restrictions, as the OIG is proposing. Currently, approximately \$65 million of Medicare and Medicaid collections are used annually to fund staff positions, equipment, and some facility structural improvements which are considered essential to maintaining accreditation standards. We believe that the way the management report proposal is drafted, all funds necessary for maintaining accreditation would be interpreted by the IHS and the Tribes as coming solely from annual appropriations.

We prefer to lift administrative limitations. This should permit Service Unit Directors to manage health care delivery within a combined annual budget allocation, including direct appropriations and reimbursements. Since collections would be retained by the billing facility, a strong incentive would exist for maintaining accreditation so as not to lose the ability to bill Medicare, Medicaid, and other third party insurers for services. After meeting and maintaining standards of participation, any remaining funds could be used by a Service Unit Director to expand programs and services to its service population without jeopardizing accreditation, or quality of care.

APPENDIX B

HCFA COMMENTS



DEC 3 1990

Memorandum

Date Gail R. Wilensky, Ph.D. *grw*
From Administrator
Subject OIG Management Advisory Report: "Indian Health Service--Medicare and Medicaid Payments", OEI-07-89-00941
To The Inspector General
Office of the Secretary

We have reviewed the subject report which concerns the appropriateness of retaining or eliminating the Indian Health Service (IHS) facilities' multi-year account now that substantially all of the IHS hospital facilities meet the Health Care Financing Administration (HCFA) requirements for participation in the Medicare and Medicaid programs.

The report recommends that the HCFA Administrator, in cooperation with the Assistant Secretary for Health, prepare documents for the Secretary to officially determine and certify that substantially all of the IHS hospital facilities are in compliance with the HCFA conditions for participation in the Medicare and Medicaid programs. HCFA concurs with this recommendation. HCFA also encourages IHS to establish a review system immediately upon the adoption of any phase-in plan of direct payment to IHS hospitals to ensure that funding is still used to maintain the certification status of the IHS facilities during the OIG's 5-year plan.

Should the recommended action be implemented, the IHS hospitals would be subject to the same audit and reimbursement guidelines currently in effect for other Medicare hospitals. Additional funding to cover the certification, audit and other administrative costs for the IHS hospitals has not been included in our budget requests to date, and would require additional funds for the Medicare contractors involved.

Thank you for the opportunity to review and comment on this final report. Please advise us whether you agree with our position on the report's recommendation at your earliest convenience.

APPENDIX C

PHS COMMENTS

Memorandum

FEB 4 1991

Date

From Assistant Secretary for Health

Subject: PHS Comments on Office of Inspector General (OIG) Management Advisory Report "Indian Health Service--Medicare and Medicaid Payments"

To Inspector General, OS

Attached are the PHS comments on the subject OIG management advisory report.

We do not concur with the report's recommendations that the IHS should (1) phase out the multi-year facilities account and develop methods and procedures by which all Indian Health Service (IHS) hospitals can directly receive and account for the use of Medicare and Medicaid funds, and (2) seek legislation to expand the demonstration program authorized by Public Law 100-713 to a more representative sample of facilities and modify the restrictions imposed on the use of these funds.

With regard to the first recommendation, the DHHS Health Accounting System and its subsystems, currently in place, greatly facilitate the fund control between hospitals and IHS Area Offices and meets the requirements of Office of Management and Budget Circular A-34, "Instructions on Budget Execution." Medicare and Medicaid funds are deposited into the multi-year special account in accordance with appropriate statutes and appropriation acts. All funds collected from Medicare and Medicaid are returned to the IHS Area Office which collects them and are generally expended by the Service Unit that provided the services.

Regarding the second recommendation, the demonstration program was designed to allow tribally contracted programs to directly bill and receive payments. Programs that are contracted under the authority of Public Law 93-638 have accounting systems and other fiscal controls in place which are adequate for a proper stewardship of Federal funds. IHS facilities which are operated by IHS do not have separate accounting systems and cannot meet the requirements of the Treasury and General Accounting Office to handle funds and comply with other financial management requirements. We believe it would be counterproductive and not cost effective to institute this program at the local IHS operated hospital or facility.

RECEIVED

FEB 11 1991

OFFICE OF
INSPECTOR GENERAL
Attachment

James O. Mason
James O. Mason, M.D., Dr.P.H.

PUBLIC HEALTH SERVICE COMMENTS ON
THE OFFICE OF INSPECTOR GENERAL'S MANAGEMENT ADVISORY REPORT
"INDIAN HEALTH SERVICE-MEDICARE AND MEDICAID PAYMENTS"
OEI-07-89-00941

General Comments

The recommendation to have the Secretary determine that all Indian Health Service (IHS) hospitals are in substantial compliance with the requirements and conditions of Title XVIII and Title XIX of the Social Security Act, while on the surface a positive step for the IHS, may not be in the best interest of the Agency. The determination of substantial compliance of IHS hospitals will remove the restrictions on the direct payment and use of Medicare and Medicaid monies by IHS facilities, as contained in Title 42 U.S.C., section 1395cc(c). With the restrictions removed, it is possible that some Medicare and Medicaid funds would be diverted to other IHS programs or that the IHS annual appropriation would be reduced accordingly. Under the present system, Medicare and Medicaid monies collected by IHS are utilized to correct deficiencies and maintain each hospital at the highest level of clinical and administrative excellence. All funds collected from Medicare and Medicaid are returned to the Area which collected them and generally expended in the Service Unit that provided the services.

The recommendation to phase out the multi-year facilities account and develop methods and procedures by which all IHS hospitals can directly receive and account for the use of Medicare and Medicaid funds will (1) result in the loss of funds collected late in the fiscal year, and (2) require the abandonment of the present accounting system that has worked extremely well. All IHS hospitals currently use the IHS Health Accounting System which is one of the most sophisticated and flexible systems in use, to correctly bill and collect Medicare and Medicaid funds. These funds are deposited in a multi-year account in accordance with law and regulation and prevent collections received late in the fiscal year, if not expended, from reverting to the Treasury.

We believe the present system, in which Medicare and Medicaid funds are promptly and accurately collected and returned to the Areas that provided the services and are earmarked only to eliminate deficiencies in each health care facility, has worked well and we see no clinical or administrative advantage to changing the system.

Because there seems to be a very significant difference of opinion, we would be pleased to meet with appropriate OIG staff and PHS/IHS staff to discuss and elaborate on the PHS position on these very important issues.

OIG Recommendation

THE IHS SHOULD PHASE OUT THE MULTI-YEAR FACILITIES ACCOUNT AND EXPEDITIOUSLY DEVELOP METHODS AND PROCEDURES BY WHICH ALL IES HOSPITALS CAN DIRECTLY RECEIVE AND ACCOUNT FOR THE USE OF MEDICARE AND MEDICAID FUNDS. THIS CAN BE ACCOMPLISHED BY:

1. The Assistant Secretary for Health developing and implementing appropriate accounting systems at all hospitals to bill, receive and account for the expenditure of Medicare and Medicaid funds.

The IHS should initiate action to develop appropriate accounting systems for use by all IHS hospitals. In addition, the IHS should establish appropriate audit controls and oversight to assure that the monies received and expended by the individual hospitals are utilized in accordance with legal requirements.

For those facilities which are so small that it is not economically feasible to have accounting staff on site to implement this recommendation, an alternative would be to establish the responsibility for accounting and expenditure control at the area office rather than at the hospital facility.

PHS Comments

We do not concur. The IES operated hospitals currently use the HHS Health Accounting System. This system with its subsystems is one of the most sophisticated and flexible systems in use. Over \$20 billion a year in HHS obligations and expenditures are currently being processed. This system has been used to correctly bill and collect nearly \$75 million of Medicare and Medicaid funds in FY 1989. The recommendation that IES initiate action to develop appropriate accounting systems for use by all IHS hospitals is, therefore, neither necessary nor cost effective.

The recommendation states that each hospital should receive and disburse the receipts. In order to comply with current Treasury and General Accounting Office (GAO) regulations, additional positions would be required for additional finance officers and certifying officers. These additional positions combined with the mandated internal controls would be required for a proper separation of duties. The Division of Fiscal Services, Health Resources and Services Administration, estimates that up to 10 full-time employees would be required to perform the required services at each hospital that are now being performed at the Area Offices.

We believe this is unnecessary because Area Offices presently perform the oversight and have in place the audit controls to assure any funds received are expended in accordance with legal requirements. The HHS Health Accounting System and its subsystems, currently in place, greatly facilitate the fund control between hospitals and Area Offices and the oversight of this part of financial management at hospitals, clinics and Area Offices. The system meets the requirements of the Office of Management and Budget (OMB) Circular A-34 "Instruction on Budget Execution".

OIG Recommendation

2. The HCFA Administrator, in cooperation with the Assistant Secretary for Health, prepare documents for the Secretary to officially determine and certify that substantially all of the IHS hospital facilities are in compliance with the HCFA conditions for participation in the Medicare and Medicaid programs.

This determination and certification will remove the restrictions on the direct payment and use of Medicare and Medicaid monies by IHS hospital facilities, as contained in Title 42 U.S.C., section 1395cc(c). With the restrictions removed, individual IHS hospitals could be placed into direct payment when IHS has notified HCFA that appropriate accounting systems and audit controls are in place.

PHS Comments

We do not concur. The Director, IHS has the delegated authority for the management and operation of the Medicare and Medicaid portions of Sections 401 and 402 of the Indian Health Care Improvement Act and, as such, is the official authorized to make the determination of substantial compliance with the Act. Because of this delegation, the Director, IHS, is the appropriate official to prepare any documentation for the Secretary, HHS, that would certify substantial compliance as defined in Sections 401 and 402 of P.L. 94-437, Indian Health Care Improvement Act. Therefore, we do not agree that the Administrator of the Health Care Financing Administration (HCFA) should prepare documents to formally certify that IHS facilities are in compliance with the conditions for participation.

In order to better understand the PHS position regarding the issue of determining that IHS facilities are in substantial compliance, the following information is submitted:

(1) Legislative Background

- P.L. 94-437 - Indian Health Care Improvement Act authorized IHS to bill and collect from Medicare and Medicaid.
- Funds collected are to be placed in a special fund to be used for the purpose of improvements necessary to achieve compliance with conditions and requirements of Titles 18 and 19.
- The special fund shall cease to apply when the Secretary, HHS, determines that substantially all hospitals and skilled nursing facilities are in compliance.
- The statute states that any payments received shall not be used in determining appropriations for health care and services to Indians.
- P.L. 94-437 states that reimbursements from Medicare and Medicaid shall be used to supplement and not supplant appropriations.
- House Report 94-1026, page 5, states "... and continued participation in Medicare would be contingent on meeting the standards - the amendment requires medicare payments to be earmarked for use in meeting and maintaining medicare standards."
- Senate Report 100-508, page 22, states "Given past Administration attempts to offset IHS program decreases with amounts collected from Medicare and Medicaid reimbursement, the Committee wishes to make clear that the authority to collect reimbursements from the Medicare and Medicaid programs is conditioned upon such funds being used only for the purpose authorized in the Act, that is to achieve and maintain compliance with accreditation standards."

(2) Joint Commission on the Accreditation of Healthcare Organizations

IHS was directed by the Congress to seek Joint Commission accreditation rather than rely upon HCFA certification. At the outset only 22 IHS hospitals:

were accredited. Through a long process, IHS has attained accreditation of all its hospitals except one. At the present time there are 42 hospitals accredited and one that is certified by ECFA.

The IHS is justly proud of this accomplishment. It has been no small task to accomplish this feat. It is an accomplishment that is a direct result of the targeted and directed use of the funds contained in the Secretary's special fund.

Joint Commission standards are on a continuum of oversight, assessment and direct actions relative to patient care standards for all aspects of direct inpatient and outpatient care. This includes the various ancillary (laboratory, pharmacy) and support services (biomedical services, fire safety code enforcement). This also includes daily quality controls and committees which meet regularly to identify problems, prepare studies, review results, and implement actions required to correct the cited deficiencies. The accreditation process is not a single event, but rather a dynamic process in which there is a constant uncovering of deficiencies which in many ways reflect changing epidemiology, standards of care and their applications in practice. IHS hospitals, as all other accredited hospitals in this country, have many cited Type One deficiencies which require correction before the next survey by the Joint Commission.

Failure to correct Type One deficiencies can result in loss of Joint Commission accreditation which would then cause the facility to lose its Medicare and Medicaid provider status and thus lose its ability to be paid for the services provided. At the present time, all Medicare and Medicaid monies collected are earmarked and utilized to correct these deficiencies and maintain each hospital at the highest level of clinical and administrative excellence. As stated earlier, if IHS hospitals are determined to be in substantial compliance with the requirements and conditions of Title XVIII and Title XIX of the Social Security Act, it is possible that some Medicare and Medicaid funds could be diverted to other IHS programs, or that the IHS annual appropriation would be reduced accordingly.

Standards are dynamic and ever changing, representing changes in the delivery of health care. These changes must be addressed if IHS facilities are to

retain their accredited status. Loss of the directed nature of the Medicare and Medicaid funding would have an untoward effect on the IHS health care delivery system.

We agree that substantially all IHS facilities have met the HCFA conditions for participation in Medicare or accreditation by the Joint Commission since 1981 and that all 43 hospitals now meet these conditions. Forty-two hospitals are accredited by the Joint Commission and one is certified by HCFA. However, while we are justly proud of our facilities' accreditation status, we must acknowledge the fact that they must maintain the accredited status if they are to continue participation in both the Medicare and Medicaid programs. The maintenance of the accredited status is mandatory if the facilities are to continue to receive payments from each program.

As we have stated in past budget documents and also in congressional testimony, this accomplishment is one of great importance to the IHS and also to the Department of HHS. The record of the accreditation status of IHS facilities is a feat of which IHS is extremely proud and justifiably so. This feat has been accomplished as a direct result of the targeted and directed use of the Medicare and Medicaid funds.

The IHS has grave concern that if the Secretary's special fund is abolished, the funds will be directed to general operating expenses. This action, while creating flexibility, would deprive the clinical managers of the one tool that they have to meet the special funding needs to correct deficiencies and maintain accreditation of the facilities. The accreditation of the facilities and maintenance of Medicare standards is one of the best indications to assure that the highest quality of health care is being rendered. To do less would be not meeting the IHS goal and mission. It is for these reasons that we believe that abolishing the Secretary's special fund is not in the best interest of IHS.

OIG Recommendation

3. The Assistant Secretary for Health, in cooperation with the Assistant Secretary for Management and Budget, eliminating the multi-year facilities account into which Medicare and Medicaid payments are now deposited.

The account could be phased out over several years. As each hospital or area office developed acceptable financial management capabilities, it could directly receive and use for operating expenses those Medicare and Medicaid payments which it collected. However, Medicare and Medicaid funds collected by those hospitals or area offices not yet capable of managing them could be deposited into the multi-year account to be managed as currently done by IHS. Ultimately hospitals or area offices would manage their own Medicare and Medicaid funds and the multi-year account would be eliminated entirely.

We recommend accomplishing this within 5 years.

PHS Comments

We do not concur. There are practical reasons to maintain this authority. As stated in the PHS response to recommendation 1, this would be costly and counterproductive. The additional numbers of staff and attendant costs would far outstrip any appreciable savings. The costs incurred would require additional appropriations to the existing base. The additional staff would have to be hired and trained before any activities could be undertaken. To accomplish this task, an additional 400 to 500 total staff would be required. The total dollars to support these additional staff would be approximately \$15 million.

Recommendation 3 does not recognize the fact that over the past 4 years most funds collected for Medicare and Medicaid have been made available to the hospital providing the billed services. Regardless of which account the funds are deposited (split year or single year) they must be apportioned through the budget process by CMS. To obligate and expend funds before legally apportioned is a violation of the "Anti-deficiency Act." These requirements may be found in CMS Circular No. A-34 "Instruction on Budget Execution."

The elimination of multi-year authority for the expenditure of funds will result in the loss of funds collected late in each fiscal year. For those funds collected within the last 30 to 60 days of the fiscal year, the process of depositing the funds, then requesting and receiving an apportionment, and the allocation of funds to Areas and Service Units will most certainly result in the loss of funds if all funds must be spent in the fiscal year in which they are collected. The Congress recognized this issue and established the multi-year accounts. IHS does not wish to lose any funds. Medicare and Medicaid funds collected must have, at a minimum, the ability

to be used for one-full fiscal year beyond the year in which they were collected.

The process of billing and collection is continuous. Collections received late in the fiscal year, if not expended, would revert to Treasury and would not be available to meet payroll costs for those staff funded by this activity. Since this is a cash account, adequate funds must be carried forward into the next fiscal year to meet payroll costs for at least three pay periods. This buffer is important because the costs of payroll are fixed and the flow of collections is variable. A disruption of health care would be the inevitable result of a furlough or termination of staff caused by a lack of funds to meet payroll costs.

Medicare and Medicaid funds are deposited into the multi-year special account in accordance with the statute and appropriation acts. The OMB apportions this authority to IHS as called for by the public law appropriating the funds for the operations of the IHS. All funds collected from Medicare and Medicaid are returned to the Area Office which collects them and are generally expended by the Service Unit that provided the services.

OIG Recommendation

THE IHS SHOULD SEEK LEGISLATION TO EXPAND THE DEMONSTRATION PROGRAM AUTHORIZED BY PUBLIC LAW 100-713 TO A MORE REPRESENTATIVE SAMPLE OF IHS FACILITIES AND TO MODIFY THE RESTRICTIONS IMPOSED ON THE USE OF THESE FUNDS.

PHS Comments

We do not concur. We question the appropriateness of seeking legislation to expand the demonstration program authorized by P. L. 100-713. The demonstration program was designed for the express purpose of allowing tribally contracted programs to directly bill and receive payments. Programs that are contracted under authority of P. L. 93-638 have accounting systems in place and have other fiscal controls which meet all requirements. IHS facilities (those operated by the Service Unit) do not have separate accounting functions and cannot meet the requirements of the Treasury and GAO to handle funds and do other accounting functions. As we have stated elsewhere in these comments, it would be counterproductive and not cost effective to institute this action at the local IHS-operated hospital or facility.