DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date NOV 4 1992

From Bryan B. Mitchell
Principal Deputy Inspector General

Subject Exception Policy for Reimbursement of New Physicians in Medical Groups (A-09-91-00097)

To William Toby, Jr.
Acting Administrator
Health Care Financing Administration

The attached final report summarizes the results of our review of a reimbursement exception policy made by the Health Care Financing Administration (HCFA) for new physicians who join medical groups. The objective of our review was to determine whether the exception policy was authorized by the Congress.

We concluded that the exception policy was not authorized by the Congress and that HCFA should not have provided the exception. As a result, intended savings may not have been realized.

The Congress provided, effective April 1, 1988, that the customary charges of first-year physicians be limited to 80 percent of the prevailing charges of the established physicians in the same locality. The Congress subsequently amended the law to cover physicians and other health care practitioners in their second, third, and fourth years of practice by providing limits of 85, 90, and 95 percent, respectively.

The HCFA provided for an exception that allowed carriers to use the Medicare group customary charges rather than applying the percentage limits to new physicians in the groups.

Representatives of HCFA explained that they provided the exception because physicians did not have unique national identification numbers. They reasoned that without unique numbers the carriers would be unable to identify and apply the limits to new physicians who practice in group settings. Other options were not discussed or analyzed.

On January 1, 1992, a national fee schedule system for physicians' services replaced the previous reasonable charge system. Payment amounts under the new system are computed on the basis of relative values for all services, adjusted by geographical factors and a nationally uniform dollar

conversion factor. In effect, the conversion factor transforms adjusted relative values into payment amounts.

After we completed our field work, corrective action was taken, according to HCFA. It advised us that the conversion factor for physician payments was revised. The revision will reportedly reduce payments by $50 million annually. Documentation supporting the revision was not provided to us, and, therefore, we were unable to verify that the corrective action was sufficient. We have no further recommendation to make to HCFA on this issue at this time.

Please advise us, within 60 days, on actions taken or planned on our recommendations. If you have any questions, please call me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits at (410) 966-7104. Copies of this report are being sent to other interested top Department officials.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

EXCEPTION POLICY FOR REIMBURSEMENT OF NEW PHYSICIANS IN MEDICAL GROUPS

OCTOBER 1992 A-09-91-00097

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date NOV 4 1992

From Bryan B. Mitchell
Principal Deputy Inspector General

Subject Exception Policy for Reimbursement of New Physicians in Medical Groups (A-09-91-00097)

To William Toby, Jr.
Acting Administrator
Health Care Financing Administration

This final report presents the results of our review of the Health Care Financing Administration's (HCFA) granting of a Medicare exception to congressionally mandated payment limits for new physicians who practice in group settings. The objective of our review was to determine whether the exception was authorized by the Congress.

We found that the exception was not authorized by the Congress and that HCFA should not have provided it. As a result, savings intended by the Congress may not have been completely realized because of the unauthorized exception.

Since 1975, there have been various Medicare cost constraints imposed on physicians' charges. Because physicians beginning their medical practices do not have their own historical charges, some of the Medicare constraints on physician charges did not apply to them. As a result, reimbursement for a given service rendered by first-year physicians sometimes exceeded that of established physicians.

To remedy the condition of new physicians' being paid too much, the Congress provided in Public Law 100-203 that, effective April 1, 1988, first-year physicians' customary charges be limited to 80 percent of the prevailing charges of established physicians in the same localities. This legislation was subsequently amended to cover physicians and other health care practitioners in their second, third, and fourth years of practice by providing limits of 85, 90, and 95 percent, respectively.

Rather than fully complying with the congressional mandate, HCFA's instructions to carriers included an exception for physicians practicing in medical groups. The exception allowed carriers to use the groups' customary charges instead of applying the appropriate percentage limits.

According to HCFA representatives, the exception was provided because individual physicians practicing in medical groups did not have unique physician identification numbers (UPIN). Medical groups bill Medicare carriers using one group provider number. Without UPINs for new physicians, carriers would be unable to identify and apply the limits to only new physicians in medical groups. The representatives said that the exception would be removed when the national UPIN system was established. Since the national UPIN system was not operational at the time, HCFA should have considered other alternatives to achieve compliance with the legislation.

After we completed our audit field work in June 1991, HCFA stated that corrective action on the exception policy was taken with the conversion of physician payments under the reasonable charge system to a fee schedule system on January 1, 1992. The HCFA advised us that it reduced the conversion factor used to compute payment amounts under the new system and that this reduction would reduce payments by $50 million annually. Documentation supporting the revision was not provided to us and, therefore, we were unable to verify that the adjustment was sufficient or whether the estimated savings were valid. We have no further recommendation to make to HCFA on the issue at this time.

BACKGROUND

Physicians submit claims for payment to carriers which are typically insurance companies under contract to process Medicare claims. Under the reasonable charge system, Medicare generally paid 80 percent of physicians' reasonable charges, with enrollees responsible for the remaining 20 percent.

Carriers were responsible for ensuring that charges were reasonable. Reasonable charges were generally limited to the lower of physicians' actual charges, customary charges, or the prevailing charges of all physicians for the same service. The customary charge was the physician's median charge for the same service during a prior 12-month period. Prevailing charges were set at the 75th percentile of the customary charges of all physicians in the defined area for the same service during a prior 12-month period.

Because first-year physicians, estimated by the American Medical Association (AMA) to have numbered about 19,000 in 1987, do not have histories of customary charges, their customary limits had historically been set at the 50th percentile of the weighted customary charges for all other physicians in the same localities. Under this long-standing Medicare policy of using the 50th percentile,

new physicians had received about 80 percent of the reimbursement of more experienced physicians.

Over the years, reimbursement for a given service performed by a first-year physician increased more than the same service performed by an established physician. Since 1975, the Congress imposed various cost constraints on physicians' charges. The constraints, however, generally did not apply to physicians in their first year of practice; thus, new physicians were beginning to receive higher payments for a given service than physicians with several years of experience.

To correct this reimbursement disparity, the Congress sought to restore the original new physician/experienced physician payment relationship by limiting first-year physicians' charges to 80 percent of the prevailing charges of more experienced physicians. The Congress enacted Public Law 100-203, which provided in section 4047 that, effective April 1, 1988, customary charges of physicians without at least 3 months of actual charges be limited to 80 percent of the prevailing charges of other physicians. This limit was to apply until prevailing charges were updated annually each January 1.

The Congressional Budget Office (CBO) estimated that the imposed law would save $280 million during Fiscal Years (FYs) 1988 through 1990. Since the limit on first-year physicians remained in effect after 1990, the savings would have continued. The CBO, however, did not estimate savings after 1990.

In subsequent legislation (Public Law 101-239, section 6108), the Congress amended the prior law by retaining the first-year payment limit and extending the limit to a physician's second year of practice, effective April 1, 1990. The new law also limited physicians' customary charges in the second year to 85 percent of prevailing amounts. The CBO estimated savings relative to this law of $35 million for FYs 1990 and 1991. Again, the savings would have continued, but CBO did not estimate the savings after 1991.

Yet another amendment was made, effective January 1, 1991. In Public Law 101-508, section 4106, the Congress extended the payment limits further. Limits for first, second, third and fourth-year physicians are now based on factors of 80, 85, 90, and 95 percent, respectively. This legislation also expanded payment limits to other types of health care practitioners, such as physician assistants, certified nurse-midwives, psychologists, and physical therapists. The law also required that the limits would

apply to any future fee schedule reimbursement system. Savings of $580 million were estimated by the CBO for FYs 1991 through 1995 for the amendments in Public Law 101-508. This amount included $55 million for FY 1991.

In implementing Public Law 100-203, section 4047, HCFA issued instructions to carriers explaining the reimbursement limits for new physicians. However, it provided an exception for new physicians who practiced in medical groups. For these physicians, HCFA instructed carriers to use the groups' customary charges and not limit their reimbursement to the applicable percentages of prevailing charges.

The instructions, in section 5010.4, subsection D of the Medicare Carriers Manual, Part 3 - Claims Process, directed that the carriers should:

> "...apply the group customary charge screen in determining reasonable charges for all services the new physician renders as a member of a medical group that has established the custom of charging uniform fees without regard to which member of the group provides the service."

The HCFA revised this manual section in April 1991 to implement Public Law 101-508. The revision deleted instructions to the carriers concerning how to determine the customary charges of new physicians in medical groups. In effect, this revision continued the previous policy until new instructions could be provided to the carriers pertaining to how they were to determine customary charges for new physicians who practice in group settings.

A national fee schedule system for physicians' services replaced the previous reasonable charge system on January 1, 1992. It will be phased in over a 5-year period. Payment amounts under the new system are computed on the basis of relative values for all services, adjusted by geographical factors and a nationally uniform dollar conversion factor. In effect, the conversion factor transforms adjusted relative values into payment amounts.

Federal law requires the fee schedule to be budget neutral in 1992. The law also provides that the conversion factor will be updated annually for each subsequent calendar year.

SCOPE

The objective of our review was to determine whether HCFA's exception policy for new physicians practicing in group settings was authorized by the Congress.

We reviewed the pertinent parts of three laws: (1) Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203), (2) Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239), and (3) Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508). We also reviewed the legislative histories of the three laws, as well as HCFA's instructions in the Part B Carriers Manual (HCFA Publication 14) on the reimbursement limits and the exception policy.

To gain an understanding of the development and implementation issues of the policy, we met with HCFA representatives in the Bureau of Policy Development (BPD) and the Office of the Actuary (Baltimore, Maryland). We also interviewed staff from HCFA's Office of Legislation and Policy (Washington, D.C.).

We did not review HCFA's internal controls over changes to the Part B Carriers Manual as this step was not required to satisfy our limited audit objective.

We discussed the estimated savings from the three laws with representatives from the CBO. We did not, however, verify the accuracy or reliability of CBO's estimates of expected savings. We attempted but were unable to develop a valid estimate of the reduction in savings due to the exception policy.

In addition, we obtained information from the AMA about the total number of new physicians and the percentage that practice in medical groups. We did not verify the accuracy or reliability of this data.

To consider possible alternatives to the exception policy, we talked with representatives from HCFA's Bureau of Program Operations (Baltimore, Maryland) and with representatives from one of the carriers located on the west coast.

Our review was conducted in accordance with generally accepted government auditing standards by the Office of Audit Services in Sacramento, California. We performed our field work from April 1991 to June 1991.

After we completed our field work, corrective action was taken to reduce the conversion factor to account for the limits on new physicians in medical groups, according to HCFA. It estimated the downward adjustment would produce

annual savings of $50 million. We asked for documentation to support the conversion factor reduction, but it was never provided. Therefore, we were unable to verify that the adjustment was sufficient or whether the estimated savings were valid.

RESULTS OF REVIEW

We found that legislation on payment limits for new physicians did not authorize an exception for physicians in medical groups. In all three laws, the Congress provided for only two exceptions.

Public Law 100-203 excluded primary care services and all services in rural underserved areas. Primary care services include, for example, office, emergency room, and nursing home visits. The HCFA estimated that about 15 percent of all physician services were primary care services and about 6 percent were rendered in rural underserved areas. The Congress adopted these two exceptions because of its concern that these particular types of services were undervalued.

When the law was revised to include, effective April 1, 1990, physicians in their second year of practice, the Congress retained the two exceptions for primary care services and services rendered in rural areas.

In the last revision, it again expanded the application of limits to more physicians but retained the two exceptions. Thus, over a period of 3 years, the Congress passed these three laws and specifically provided for only two exceptions. It did not include an exception for physicians practicing in group settings.

As previously indicated, the three laws were expected to save Medicare considerable funds. For example, the CBO estimated $280 million in 3-year savings (FYs 1988 through 1990) from the original legislation. It estimated additional savings for FYs 1990 and 1991 of $35 million as a result of extending the limits to the second year of a physician's practice. Savings of $580 million were estimated for FYs 1991 through 1995 for the amendments in the latest law. However, with HCFA's exception policy for physicians in medical groups, the intended savings for FYs 1988 through 1991 may not have been completely realized.

Savings May Not Have Been Completely Realized

According to an AMA sample[1] of 5,865 physicians who were in their second through fifth year of practice in the United States, an average of 37 percent of physicians in their second through fourth years of practice were in group settings. An additional 23 percent were employees of medical schools, hospitals, health maintenance organizations (HMOs), and State and local governments. Many of the physician employees of medical schools, hospitals, HMOs, and State and local governments could have billed Medicare for at least some of their Medicare patients using their employers' group billing numbers and thus would have been excluded from the special reimbursement limits.

The AMA study did not report on the relative level of reimbursement received by physicians in the various categories. If, however, the number of Medicare services billed by physicians in group settings are proportional to services not in group settings, then the level of savings intended by the Congress for FYs 1988 through 1991 may not have been achieved.

HCFA's Reason for the Exception Policy

The exception policy was granted because the UPIN system had not been established, according to HCFA representatives. They reasoned that without unique numbers available under the UPIN system, carriers' computerized claims payment processes could not identify and, therefore, apply limits to physicians practicing in group settings. Physicians in groups bill Medicare using billing numbers for the groups as a whole, instead of using their own unique numbers.

Unique national numbers for all physicians were mandated by the Congress under the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272). This law, signed by the President on April 7, 1986, required the implementation of unique numbers for all physicians by

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[1]Reference the AMA study titled "Study of the Practice Patterns of Young Physicians," dated July 26, 1989, chapter 3, page 14. The AMA had selected for interview 11,081 physicians who were in practice more than 1 year but less than 6 years. For various reasons, the study was able to actually interview only 5,865 of the 11,081 physicians. Data on the total universe of physicians who were in their second through fifth year were not available.

July 1, 1987. However, numerous delays occurred before the UPIN system was implemented on January 1, 1992.

Because the UPIN system was not yet operational, HCFA should have considered other alternatives to comply with the legislation. However, staff from BPD advised us that other alternatives were not discussed or analyzed.

The HCFA staff also indicated that, in their opinion, if the exception had not been granted, physicians practicing in group settings would probably not have assigned their Medicare patients to new physicians in groups. As a result, they thought that much of the intended savings would not have been realized.

To support their position, HCFA staff disclosed conversations they had in November 1990 with a representative from a physicians' trade association who pointed out that physicians could avoid the limits by steering Medicare patients to established physicians in the groups.

Although a representative from the trade association may have claimed that groups would circumvent the intent of the Congress by steering Medicare patients to established physicians, there is no hard evidence that this would have indeed occurred. We believe that any such statement by a representative of a trade association should be viewed as conjecture and should not be sufficient justification for granting an exception to a congressional mandate.

Other Alternatives

We identified three alternatives that might have achieved compliance with legislation limiting new physician payments. One would have been to require medical groups to limit their actual charges to 80 percent of prevailing charges when services were provided by new physicians. Prevailing charges for each type of service could have been easily obtained from carriers. Instructions could have been issued to all medical groups, thus placing the burden on medical groups to comply with the legislation.

A second alternative would have been to require that groups bill Medicare by including on their claim forms a numeric code, called a modifier, indicating that the services were performed by new physicians. Modifiers are frequently used in the claims payment process to provide additional detail about a given service. With claims properly coded, the carriers could automatically compute proper payment amounts.

As a third alternative, HCFA could have used performing physicians' names and carrier-assigned identification numbers to identify new physicians in each group. The HCFA required the inclusion of this data on each claim beginning in April 1989. These numbers are unique for each physician within a carrier and are required separately from groups' billing numbers. As with the second option, carriers could have used these numbers to limit payments for new physicians.

Impact on Proposed Physician Fee Schedule

After we finished our audit field work in June 1991, corrective action was taken to reduce the conversion factor (used to transform relative values to dollar amounts) to account for the new physician limits in group settings, according to HCFA. It estimated that the reduction equated to $50 million annually in future payments. We asked for documentation to support the adjustment, but it was never provided.

Although the Congress provided exceptions to the laws, it did not provide an exception for new physicians who joined medical groups. In our opinion, the HCFA exception policy was not warranted.

By excluding many new physicians, HCFA may have prevented the complete realization of the savings intended by the Congress. **Our review has shown that there were other alternatives that HCFA should have considered in order to comply with the legislation.**

The HCFA removed the exception policy when the physician fee schedule was implemented on January 1, 1992. In addition, it reduced the fee schedule payment amounts to reflect the effect of the exception policy. As a result, we consider that appropriate action has now been taken and that no further recommendations are necessary.

HCFA's Comments

In a response to our draft report (See Appendix), HCFA agreed that the payment limits had not been applied as required but noted that the three alternatives we cited all had implementation problems. It concluded that the first two alternatives (requiring groups to limit their actual charges and requiring groups to code claims with modifiers) would have been impractical and difficult to enforce. It also questioned whether it actually had the authority to mandate actual charges of physicians. The third alternative (use of carrier-assigned identification

numbers) would have required even more resources and a longer lead time than the first two alternatives, in HCFA's opinion.

The HCFA also commented that its exception policy applied only to new physicians in "uniform charge structure groups." It wondered if the AMA's study we cited on page 7 used the same general definition for physicians in "medical groups." It also questioned the significance of the percentages cited in the AMA study, since the study did not indicate the total number of new physicians in medical groups.

And lastly, HCFA stated that medical groups could have avoided the intent of the congressional limits by steering Medicare patients to established physicians and having new physicians provide only primary care services. The HCFA believes that such actions would have been significant impediments to achieving savings.

OIG's Comments

During the course of our audit field work, HCFA representatives indicated to us that they had not discussed or analyzed any possible alternatives for limiting payments to new physicians in groups. We cited three possible alternatives that might have been used by HCFA to implement such limits. There may well have been other alternatives. The HCFA stated that our alternatives would have been too difficult to enforce, but it offered no evidence that this would have been the case. It also indicated that it may not have had the legal authority to tell new physicians what they could charge. Given the congressional mandate that payments to new physicians be limited, it would have been unfortunate if HCFA could not have, in fact, told new physicians in groups that they could not bill and be paid more than what the Congress allowed.

With regard to HCFA's comments that its policy applied only to new physicians in "uniform charge structure groups" and whether the AMA study used the same definition of a group, HCFA was unable to estimate the number of physicians in such "uniform charge structure groups," nor did it have data on how many medical groups were "uniform charge structure groups." However, representatives from the carrier we spoke with advised us that all physicians billing the carrier under medical group numbers were treated as "uniform charge structure groups."

We cited the data from the AMA study as an indication of the potential percentage of new physicians who were in medical groups and who may not have been subject to the congressional limits. The AMA study results are

medical groups and who may not have been subject to the congressional limits. The AMA study results are significant because they tell us that a sizeable percentage of new physicians may be in medical groups and group-like settings, such as HMOs. Although the AMA study did not identify the total universe of new physicians, it would appear that the number may have been large since the AMA sample was 11,081 in itself.

With regard to HCFA's belief that medical groups may well have had new physicians not treat Medicare patients or only provide primary care services in order to avoid the payment limits, there was no evidence that these actions would have, in fact, occurred. A physician trade association representative reportedly made such a claim about new physicians in groups: that is, the physicians would not treat Medicare patients. However, there was no documentary support for this claim. We also question how much credence can be placed on an unsupported claim by a physician trade association representative when the claim may have influenced decisions to cut payments for new physicians.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

Date APR 1 1992

From J. Michael Hudson
Acting Administrator

Subject OIG Draft Report: "Exception Policy for Reimbursement of New Physicians in Medical Groups" (A-09-91-00097)

To Inspector General
Office of the Secretary

We have reviewed the subject draft report which summarizes exceptions in Medicare reimbursement policy that were allowed by the Health Care Financing Administration (HCFA) for new physicians who joined established medical groups. The report highlights the possible effects these exceptions have had on budget neutral implementation of the Medicare physician fee schedule as set forth in Omnibus Budget Reconciliation Act of 1989 (OBRA 89).

OIG concludes that the exceptions for new physicians were not authorized by Congress and, consequently, savings intended by Congress may not have been realized.

* * *

While it is true new physician and practitioner limits were not previously applied in group settings, we did reduce the original baseline conversion factor in order to account for the intended effects of these limits. This reduction was mandated by section 4106(c) of Omnibus Budget Reconciliation Act of 1990 (OBRA 90) as part of the requirements for budget neutral implementation of the fee schedule.

* * *

Thank you for the opportunity to review and comment on this draft report. * * *

Attachment

* * * Office of Audit Services note--Comments have been deleted at this point because they pertain to material not included in this report

Comments of the Health Care Financing Administration (HCFA) on the OIG Draft Report: "Exception Policy for Reimbursement of New Physicians in Medical Groups" (A-09-91-00097)

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HCFA Response

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There is no debate that new physician and practitioner limits were not applied to all group practices in 1991. Since the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) called for the baseline conversion factor for the Medicare physician fee schedule to be set budget neutral relative to 1991 payments, and section 4106(c) of Omnibus Budget Reconciliation Act of 1990 (OBRA 90) further required that new physician and practitioner limits be taken into account in determining 1991 aggregate physician payments, OIG consequently contends that savings were lost.

HCFA has been aware of this problem. In order to be consistent with the wording of the statute, we calculated the conversion factor as if the new physician provisions were applied to all appropriate services, even though we knew customary charges were not actually being reduced for new physicians in uniform charge structure group practices. This meant that we reduced the baseline for 1991 aggregate physician payments by .4 percentage points when we determined the initial conversion factor for the fee schedule. This equates to a reduction of over $100 million* made annually to account for the fact that we did not implement the new physician limits in some group settings prior to 1992, and to account for limits applied to new physicians in their third and fourth year of practice. Therefore, we believe we properly handled the new physician limits when establishing the conversion factor, and that we have reflected the effects of these provisions fully. * * *

* Office of Audit Services note--Of the $100 million, according to HCFA, $50 million applied to the new physician limits in groups and $50 million applied to new physicians in their third and fourth year of practice.

HCFA also disputes OIG's claims concerning alternative actions that may have been open to HCFA in the past. It remains unclear if, prior to completion of both implementation of the Medicare physician fee schedule and the Unique Physician Identifier Numbers (UPIN) system in 1992, HCFA could have determined which individual physicians delivered particular medical services under group provider numbers. However, OIG lists the three following alternatives which they believe HCFA could have used to achieve more complete compliance with the law:

- Require medical groups to limit their actual charges to 80 percent of prevailing charges when services were provided by new physicians;

- Require groups to bill Medicare by including on their claim form a numeric code, called a modifier, indicating that services were provided by new physicians;

- Have HCFA use performing physicians' names and carrier-assigned identification numbers to identify services provided by new physicians in groups.

HCFA finds all three of these alternatives to be problematic at best. We conclude that the first two alternatives would have been impractical and difficult to enforce since they would have relied on accurate self-reporting by physician groups. It is doubtful that the savings envisioned by OIG would have materialized in the absence of extensive and costly post-payment monitoring to verify and ensure compliance. With respect to the first alternative, we also question whether the language of the law implementing the new physician limits (section 1842(b)(4)(F)(i) of the Social Security Act) gives HCFA the authority to mandate actual charges for medical groups containing new physicians. The third alternative would have required even more resources and a longer lead time than the first two options OIG suggested.

* * *

General and Technical Comments

- The term "medical group" is generally used very loosely. It is important to note that HCFA's payment exception policy applied only to new physician members of uniform charge structure groups. These groups shared a uniform customary charge profile under a group provider number.

- On page 7 of this report, OIG references an American Medical Association (AMA) report which found that 37 percent of new physicians practiced in medical groups. HCFA has several concerns about the use of these data, including:

  -- Does the AMA's definition of group match that of uniform charge structure group? Previous exceptions made by HCFA applied only to uniform charge structure groups.

  -- Since the AMA fails to give the number, in addition to the percentage, of new physicians in groups, what is the actual significance of the 37 percent finding? For example, if only 100 new physicians were found in the original sample of 5,865 physicians, then the number of new physicians in groups would be only 37 out of the total sample of 5,865.

- OIG also seems to dismiss the comments of a "representative of a trade association claiming that groups would circumvent the intent of Congress by steering Medicare patients to established physicians" (page 9). Group practices could also avoid the intent of the new physician limits by having these doctors provide only primary care services, which are exempt from the limits under the law. Contrary to OIG, HCFA believes such problems are significant impediments to realizing savings through these provisions.