The OEI Impact Report

Significant Achievements of the Office of Evaluation and Inspections 1985 - 1998

Office of Inspector General
Office of Evaluation and Inspections

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Studies marked with an (*) are the most recent additions to the report.

Introduction

Impact and OEI

The Office of Evaluation and Inspections (OEI) is that part of the Office of Inspector General (OIG) that conducts national short-term management and program evaluations. These evaluations—called inspections—study topics of importance to decision makers at the Department of Health and Human Services (HHS), the Congress, and the public. Although all of our studies are originated by OEI staff, most are developed in close consultation with decision makers. Inspections offer top policy makers a fast, unbiased, and highly reliable way of gathering information and providing advice to improve program performance.

We define impact as real, positive change in HHS programs and policies that we have influenced through our inspection work, briefings, and congressional testimony. Since we were formed as an organization more than 12 years ago, OEI has positively impacted the programs of the Department in two significant ways:

- Helped save the U.S. taxpayer more than $15 billion so far, with additional savings of $45 billion that will accrue over the next five years.

- Helped improve how programs operate, achieve their goals, protect themselves from fraud and abuse, and deliver quality services to the public.

Because inspections are tailored to the needs of policy makers, the issues being evaluated, and the data available, we collect the necessary data in whatever ways make the most sense for each inspection. We insure reliable findings by using a rigorous quality assurance process and conducting all reviews according to inspection standards endorsed by the President's Council on Integrity and Efficiency. And since our "bottom line" is results, we place a premium on feasible recommendations.

OEI's Impact in 1997

1997 proved to be a watershed year for OEI. Many of report findings made national news; we testified before Congress numerous times on issues related to our work; and the President himself took action when one of our studies showed significant defects in the area of home health agencies.

However, the real impact of our work could be seen with the passage of the 1997 Balanced Budget Act. In August, Congress passed and the President signed legislation that implemented a significant number of recommendations OEI has made in our reports over the last several years. These recommendations, now implemented, should save the American taxpayer about $45 billion over the next several years. The issues addressed by the recommendations range from Medicare oxygen services and rural health clinics to child custody reporting and hospital sales.

This Report

The issues mentioned above are discussed briefly in the following pages. This report describes the results of OEI inspections and the contributions they have made to the efficiency and effectiveness of HHS programs. While inspections are an important catalyst for change, we recognize they are not the sole influence in the policy development process. Many employees and managers within the Department of Health and Human Services, as well as others in State and local governments, private sector organizations, trade associations, and non-profit groups, have been instrumental in crafting positive change for these programs. We all recognize that an effective and efficient Department is the ultimate goal we are seeking.

This impact report presents the results of our inspection work since 1985. It is organized to reflect the two major types of results we achieve from inspections—cost savings and program improvements. Both sections are organized according to HHS operating divisions: the Health Care Financing Administration (HCFA), various public health service agencies such as the National Institutes for Health and the Food and Drug Administration, the Administration for Children and Families (ACF), and the Administration on Aging (AoA). In some instances, a report has resulted in both cost savings and program improvements. Those issues most recently resulting in significant impact have been marked by an "*".

Work Yet to Do

Despite the numerous accomplishments listed in the following pages, much work remains to be done. Additional recommendations for cost savings and program improvements, not yet accepted by the Department, are included in the Office of Inspector General (OIG) Red and Orange books.

The on-going work of OEI can be followed by reading other documents, such as the OIG's Semiannual Report and OEI's annual compendium, "OEI Inspection Reports: Fiscal Year 1997." All of the above listed reports can be found on-line through the OEI web site (http://www.os.dhhs.gov/progorg/oei) or the OIG site (http://www.os.dhhs.gov/progorg/oig).

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Part I: Cost Savings

OEI reports have helped HHS policy makers reduce unnecessary spending, resulting in a more effective use of scarce public funds. We believe that HHS programs must always act as prudent purchasers and suppliers of goods and services. From Fiscal Year 1985 through 1997, OEI has saved or recovered more than $15 billion for taxpayers. In a typical year, for every dollar invested in our organization, we save more than $150. These savings came from actions taken by the Administration or the Congress in response to our recommendations to change legislation, regulations, or policy. Listed in the table below are many of the specific savings achieved in descending order of amount. They are followed by write-ups of the items, grouped into subject categories.

Significant OEI Savings Since 1985 (in millions)	
Health Care Financing Administration	
Nursing Facilities	$9,500.00
Overpriced Surgical Procedures	$2,400.00
Oxygen Therapy Reimbursement	$2,100.00
Working Spouses	$2,100.00
Hospital Facility Fees	$960.00
Enteral Nutrition Therapy	$800.00
Medicare Secondary Payer	$685.00
Extent of Unrecovered MSP Funds	$653.00
Laboratory Fees	$595.00
Incontinence Supplies	$500.00
Laboratory Reimbursement	$460.00
Intraocular Lenses	$434.00
Standby Anesthesia	$405.00
IRS/SSA Data Match	$370.00
Prescription Drug Payments	$370.00
Medicaid Estate Recoveries	$310.00

Durable Medical Equipment	$265.00
Hospital Sales	$240.00
Physical Therapy in Physicians' Offices	$235.00
Hospice	$210.00
Hospital Credit Balances	$165.50
Angioplasty	$107.90
Anesthesia Services	$84.00
Prescription Drugs	$75.00
Total Parenteral Nutrition	$54.00
Medical Necessity of ESRD Ambulance	$44.00
Enteral Nutrition	$41.00
Reimbursement for Foreign Graduates	$41.00
Ambulance Payments	$40.00
DRG Focused Reviews	$39.60
Miscoding Patient Transfers	$34.70
Colonoscopy Coding Change	$20.00
Satisfaction with Medicare Handbook	$16.00
CABG Demonstration Project	$14.00
Tests of Lower Extremity Arteries	$14.00
Automobile Insurance	$12.30
Fragmented Physician Claims	$12.00
Payment Practices of ESRD Ambulance	$11.40
Orthotic Body Jackets	$10.40
Low-Cost Ultrasound	$5.70
Employer Group Health Plans	$5.30
Psychiatric Services	$3.40
Inappropriate Hospital Transfers	$3.20
Renal Disease Payments	$2.50

Nail Removals	$2.40
Outmoded Procedures	$1.30
Kidney Transplants	$1.00
Physical Therapy Services	$0.20
Administration for Children and Families	
SLIAG	$1,100.00
Revised Child Support Orders	$570.00
Unpaid Child Support and Tax	$350.00
Non-AFDC child Support Payments	$293.00
Child Support Enforcement Financing	$265.00
AFDC Fraud Detection	$230.00
Enforce Medical Liability	$96.00
Wage Data	$77.00
Interest Bearing Accounts	$14.00
Secondary Name Verification	$4.10
Adoption Assistance	$1.70
Computer Matching Formats	$1.10

Items that have been added to this issue of the OEI Impact Report since the last issue have been marked with an "".*

Health Care Financing Administration

Medical Procedures

Overpriced Surgical Procedures: Medicare saved taxpayers $2.4 billion through legislation which enacted our recommendations to reduce unnecessarily high Medicare surgeon and other fees for cataract and coronary artery bypass graft (CABG) surgeries.

Standby Anesthesia: Through legislation, Congress enacted our recommendation to reimburse standby anesthesia during cataract surgery at a lower rate than general anesthesia, saving Medicare $405 million.

Intraocular Lenses: The Medicare program saved $350 million by adopting an inspection recommendation to reduce payment for the synthetic (intraocular) lens implanted during cataract surgery in an ambulatory surgical center from an average of $350 to a maximum of $200. Subsequent work allowed Congress in the Omnibus Budget Reconciliation Act (OBRA) of 1993 to reduce payments further to a maximum of $150, saving an additional $84 million over 5 years.

Angioplasty: The Medicare program saved taxpayers $107.9 million by reducing the hospital payment for Percutaneous Translumial Coronary Angioplasty, as we suggested.

Anesthesia Services: The HCFA issued regulations we recommended that saved $84 million by establishing separate reimbursement policies for general anesthesia and local standby anesthesia services.

Colonoscopy Coding Change: Based on our recommendation, the Medicare program changed its procedure codes for colonoscopies to prevent payment at this level for lesser procedures, resulting in cost avoidances of $20 million.

CABG Demonstration Project: Our inspection, demonstrating that costs could be reduced for CABG surgery while maintaining quality, sparked a HCFA demonstration to explore alternatives for providing and paying for this surgery, resulting in savings of nearly $14 million each year from the demonstration alone.

* HCFA is considering extending the pilot heart surgery program nationwide and undertaking similar programs for other procedures. HCFA said Medicare would have saved at least $553 annually if the pilot had been extended universally to all Medicare-reimbursed coronary artery bypass graft surgeries.

Tests of Lower Extremity Arteries: Based upon our recommendations to adopt tighter utilization review policies that some carriers have nationwide, the Medicare program saved over $14 million dollars.

Fragmented Physician Claims: HCFA avoided $12 million in payments as a result of our identification of excessive and fragmented claims for five laparotomy and biopsy codes.

Nail Removals: The Medicare program saved taxpayers $2.4 million by implementing our recommendation to eliminate nail removal as an operating room procedure.

Outmoded Procedures: The Michigan carrier acted on our recommendation to reduce their allowed charges for a phonocardiogram and saved Medicare $1.3 million.

Kidney Transplants: The HCFA saved $1 million by implementing our recommendation to prohibit Medicare payments for kidneys sent to foreign countries or transplanted to non-Medicare recipients.

Hospitals and Nursing Homes

* *Nursing Facilities:* Based on a series of inspections, we recommended legislation to simplify and reform payment methods in nursing homes. In the Balanced Budget Act (BBA) of 1997, Congress enacted a prospective payment system for skilled nursing facility services. In addition, the BBA requires nursing facilities to submit bills for Part B covered services to Medicare for resident who are either Medicaid or private pay, known as consolidated billing. These changes will save an estimated $9.5 billion over 5 years.

Hospital Facility Fees: Medicare saved $960 million when legislation enacted our recommendation to reduce the fees hospitals collect for outpatient surgery by reimbursing these services at the lower rate paid to ambulatory surgical centers.

* *Hospital Sales:* In response to our findings that Medicare lost $223 million and stands to lose another $289 million in depreciation adjustments for hospitals sold between 1990 and 1996, Congress enacted legislation to prevent Medicare depreciation adjustments for hospitals sold at a loss. The Congressional Budget Office estimated that this action will save Medicare $240 million over 5 years.

Hospital Credit Balances: The HCFA recovered the $165.5 million we identified that was owed by hospitals to the Medicare program in credit balances and they developed procedures that assure prompt future refunds estimated at $103.4 million annually.

Diagnostic Related Groups Focused Reviews: The Medicare program prevented $39.6 million in wasteful spending by using our recommendation requiring the Peer Review Organizations to conduct focussed reviews of Diagnosis Related Group assignments by hospitals.

Miscoding Patient Transfers: The HCFA avoided $34.7 million in Medicare payments for the inappropriate transfer or readmission of hospital patients by acting on our recommendations to clarify their instructions to hospitals and have the Peer Review Organizations review a sample of all readmissions.

Inappropriate Hospital Transfers: The HCFA eliminated $3.2 million in inappropriate payments by using our recommendation to instruct the Peer Review Organizations to deny payments to hospitals for improperly transferring and readmitting patients.

Medicare Secondary Payer and Employer Group Health Plans

Working Spouses: Medicare saved $2.1 billion when Congress enacted our recommendation to make Medicare the secondary payer for beneficiaries with working spouses under age 65.

Medicare Secondary Payer: The HCFA recovered $685 million for Medicare as a result of our recommendations to improve the identification of other insurers who should have been the primary payers.

Extent of Unrecovered MSP Funds: Legislation created a new health insurance reporting system for all employers who are required to file a Form W-2. The information filed through this reporting process will be used by the Medicare and Medicaid programs, in part to determine primary insurance coverage as we have recommended, and is estimated to save Medicare, alone, $653 million over five years.

Extension of IRS/SSA Data Match for Medicare Secondary Payer: The OBRA 1993 adopted our recommendation to extend an IRS/SSA data match through 1998, providing Medicare with information on other health care coverages and resulting in savings of $370 million over 5 years.

Automobile Insurance: The HCFA acted on our recommendations to improve intermediary procedures in identifying Medicare hospital claims in which automobile insurance should pay as the primary insurer, saving $12.3 million.

Renal Disease Payments: The HCFA avoided $2.5 million in payments by using our recommendation to implement tighter controls in two States, ensuring that Medicare is secondary payer for end stage renal disease benefits.

Employer Group Health Plans: The HCFA prevented unnecessary expenditures of $5.3 million by taking steps we suggested to assure that health providers bill third-party payers when Medicare beneficiaries aged 65 through 69 are working and covered by an employer group health plan.

Medical Equipment and Supplies

* ***Oxygen Therapy Reimbursement:*** In response to our findings that Medicare allowed an average of 174 percent more than the Veterans Administration reimbursement for oxygen concentrators, Congress reduced Medicare reimbursement for oxygen by 25 percent until 1999 and by 30 percent for subsequent years. The Congressional Budget Office estimated this will save $2.1 billion over a 5-year period.

* ***Incontinence Supplies:*** Our report found that concerted efforts by HCFA, OIG, and other law enforcement agencies helped significantly reduce questionable billings in 1995. Questionable billings accounted for almost half ($107 million) of incontinence allowances in 1993. The reduction of questionable billings will save an additional $500 million over 5 years.

Durable Medical Equipment: The Omnibus Budget Reconciliation Acts of 1989 and 1990 enacted our recommendations to reduce Medicare payments for durable medical equipment by $265 million.

Orthotic Body Jackets: Based on our recommendation, the Medicare program saved $10.4 million by instituting methods to detect payment trends, identifying suppliers who have exhibited abusive practices, and, detecting increased use of these products.

Low Cost Ultrasound: Based upon our recommendation, the Medicare program saved $5.7 million by issuing an instruction prohibiting separate payment for tests conducted with pocket dopplers, and revised the Physician Procedural Coding handbook to revise imaging codes for hand-held ultrasound devices.

Ambulance Issues

Medical Necessity of ESRD Ambulance Services: The HCFA is taking steps to develop new regulations that will change the coverage criteria for ambulance services, and ensure that medical necessity is appropriate, an estimated savings of $44 million.

ESRD Ambulance Services: Payment Practices: The HCFA acted on our recommendations to establish a code for scheduled transports, and require uniform use of national ambulance codes, saving between $11.4-$34.1 million.

* ***Ambulance Payments:*** The body of work conducted in the ambulance area was instrumental in persuading Congress to require a fee schedule for ambulance services. After the Balanced Budget Act of 1997 requiring such a fee schedule was passed, which will save $40 million over 5 years, we were again contacted by the Hill regarding further price reductions totaling $242 million that were documented in our most recent report on ambulance payments.

Laboratories

Laboratory Fees: Through congressional action on our recommendations, the Medicare program saved $595 million by first limiting laboratory payments made on a fee schedule to 93 percent, then reducing the median price to 88 percent for the test and reducing future increases.

Laboratory Reimbursement: Legislation, prompted by our recommendation, repealed a requirement to base laboratory reimbursement on a national fee schedule, reducing Medicare expenditures by $460 million.

Physical Therapy

* *Physical Therapy in Physicians' Offices:* Based on our inspection, the Balanced Budget Act of 1997 requires HCFA to apply physical therapy coverage guidelines for other settings to physicians' offices. This will save $235 million over five years.

Physical Therapy Services: A Medicare carrier used our recommendation to prevent over-utilization of physical therapy services by podiatrists and avoided unnecessary costs of $200,000.

Enteral and Parenteral Nutrition

Total Parenteral Nutrition: The HCFA clarified its policies to avoid at least $54 million in claims for patients who didn't meet the coverage guidelines for this invasive therapy.

* *Enteral Nutrition Therapy:* Following a series of reports on the use of enteral nutrition formula and supplies for beneficiaries in nursing homes, Congress amended Medicare payment methods along the lines of our recommendations. The amendments phase in a prospective payment system for skilled nursing facility care. In addressing our recommendations in the Balanced Budget Act of 1997, Congress froze Medicare payments for enteral nutrition, equipment, and supplies from 1998 through 2002 and simplified the process used to reduce inherently unreasonable prices by 15 percent. The savings are estimated at $800 million over 5 years.

* *Parenteral Nutrition:* In response to our findings that Medicare reimburses more for parental nutrition than many State Medicaid programs and Medicare Risk-Contract Health Maintenance Organizations, Congress froze Medicare payments for parenteral nutrition and supplies from 1998 through 2002 and authorized up to 5 competitive bidding demonstrations.

* *Enteral Nutrition:* Medicare pays considerably more for enteral nutrition than nursing homes' costs. Simply paying for these supplies at rates reflective of a nursing home's buying power results in annual savings of $41 million. This inspection helped support HCFA's move to consolidated billing for certain Part B services, developing a

prospective payment system for skilled nursing facilities, and competitive bidding strategies.

Drugs

* ***Prescription Drug Payments:*** In response to our findings that Medicare paid more for prescription drugs than the Medicaid program, and that Medicare payments greatly exceeded suppliers' acquisition costs, Congress reduced Medicare payment rates for drugs (currently based on average wholesale prices) by 5 percent. This change in pricing methodology will save the Medicare program $370 million over a 5-year period. Also, in addressing our recommendations, Congress authorized HCFA to make inherent reasonableness adjustments of up to 15 percent to all Part B services except physician services.

  Prescription Drugs: Legislation that enacted our recommendation to require that drug manufacturers offer rebates to States helped Medicaid obtain savings of $75 million.

Other Health Care Related Issues

* ***Hospice Reports:*** Our reports were the subject of numerous congressional hearings and media coverage that resulted in heighten awareness of problems with hospice care provided in nursing homes. The Balanced Budget Act of 1997 provided more frequent certification of eligibility for the hospice benefit, which will save an estimated $210 million over 5 years. In addition, the Office of Inspector General issued a Fraud Alert to the public regarding these problems.

  Medicaid Estate Recoveries: Our report, which identified millions in lost dollars to Medicaid as a result of inadequate efforts to recover assets from Medicaid beneficiaries, led to new requirements on States to initiate recoveries, saving $310 million over 5 years.

  Medicare Reimbursement for Foreign Graduates: Legislation was passed that enacted our recommendation limiting Medicare funding for direct medical education to residents who have passed the Foreign Medical Graduate Examination, saving $41 million.

* ***Beneficiary Satisfaction with the 1996 Medicare Handbook:*** Based on our report that showed only about half of beneficiaries want the Medicare Handbook annually, HCFA decided not to issue the handbook annually after the 1996 trial. This decision will save Medicare about $16 million annually.

  Psychiatric Services: The HCFA revised regulations and carrier instructions, as we recommended, to strengthen the statutory limitation on psychiatric services which capped physician and non-physician services, avoiding $3.4 million in inappropriate spending.

Administration for Children and Families

Child Support Enforcement

Revised Child Support Orders: Based on our recommendations, the Child Support Enforcement program periodically reviews cases with no or low support orders against IRS income records to establish new or modified court orders on the basis of the absent parents ability to pay, resulting in $570 million in savings.

* ***Unpaid Child Support and Income Tax Deductions:*** As a result of a joint OIG evaluation and audit, the Taxpayer Relief Act of 1997 authorized the sharing of children's social security numbers with IRS for matching purposes, allowing better enforcement of the tax code where child custody and dependancy have been alleged. This change will result in $350 million savings over the next ten years.

Non-AFDC Child Support Payments: The AFDC program avoided expenditures of $293 million by acting on our recommendation to have States periodically review and revise child support orders for absent parents of non-AFDC children.

Child Support Enforcement Financing: The Office of Child Support Enforcement saved taxpayers $265 million by adopting our recommendation to reduce the Federal matching rate for the Child Support Enforcement program administrative costs from 75 percent to 70 percent, and the incentive payment from 15 percent to 12 percent.

Enforce Medical Liability: Based on our recommendations, the Office of Child Support Enforcement saved $96 million in Federal Medicaid expenditures by enforcing provisions which require absent parents to cover their children with medical insurance when it is available and reasonable.

Wage Data for Child Support: The Office of Child Support Enforcement saved $77 million by adopting our recommendation to require that States annually obtain wage information for all absent parents making no or very low payments for children receiving Aid to Families with Dependent Children benefits.

Welfare, Adoption, and Other Issues

State Legalization Impact Assistance Grants: Congress reduced the appropriation for State Legalization Impact Assistance Grants by $1.1 billion over two years on the basis of our projections of State needs for this period.

AFDC Fraud Detection: Based on our recommendation, legislation required States to implement a pre-eligibility fraud detection and prevention program for the AFDC program, avoiding approximately $230 million in fraudulent payments.

Computer Matching Formats: Our recommendation to implement national standard computer matching formats for State-administered benefit programs to use for income and eligibility verification saved $1.1 million.

Secondary Name Verification: Based on our recommendation, the AFDC program avoided $4.1 million in inappropriate benefit payments by adopting our recommendation to check the maiden, other, and primary name of applicants when verifying their Social Security number to identify additional earnings.

Interest Bearing Accounts: Using our recommendation, the Office of Management and Budget saved $14 million by revising Circular A-110 to require all Federal agency grantees to keep Federal funds in bank accounts that pay interest.

Adoption Assistance: The Department saved $1.7 million with legislation that implemented our recommendation to amend Title IV-E of the Adoption Assistance Law creating a "medical assistance only" category to avoid unnecessary income maintenance payments.

Part II: Program Improvements

This section of the impact report describes the actions taken by policy makers to improve programs as a result of recommendations or inspection findings made by OEI. These actions include improvements in program efficiency and effectiveness (how well they operate and achieve their objectives). They also include actions to protect programs against fraud or abuse, track their performance, and educate the public on issues important to their health or social welfare.

Health Care Financing Administration

Home Health

* ***General Reform of Home Health Services:*** Our inspection recommendations led to immediate changes through the Balanced Budget Act of 1997. Designed to strengthen and protect the Medicare home health benefit, the Act incorporated our recommendations by (1) requiring agencies to purchase surety bonds , (2) eliminating periodic interim payments, (3) requiring that home health agency owners submit their Social Security numbers and detailed information about related businesses, (4) authorizing HCFA to re-enroll agencies every three years, and (5) authorizing HCFA to refuse to enter in to agreements with individuals who have been convicted of a felony or who are related to individuals who have been sanctioned by Medicare. In September 1997, President Clinton announced an unprecedented 6-month moratorium on allowing new providers to enter the program until the BBA provisions and other safeguards are implemented. HCFA recently released the surety bond regulations and is now working on the other issues to strengthen the certification process.

  Home Health Aides: The HCFA issued, as a result of our recommendations, guidelines for minimum training requirements for home health aides caring for Medicare patients.

* ***Variations Among Home Health Agencies (HHAs) in Medicare Payments for Home Health Services:*** The Balanced Budget Act of 1997 modified the method used by Medicare to pay home health agencies for home health services. The new method will incorporate prospective payment principles rather than cost per visit payments previously authorized. Until the prospective payment system goes into effect, new payment and visit number limits will prevent unwarranted growth.

* ***Geographical Variations in the Number of Visits Provided by HHAs:*** Based partly on this report, HCFA and the OIG were able to identify high-use providers for detailed audits and investigations, preventing excessive utilization of the benefit in the future.

Nursing Homes and Nursing Facilities

Restraints in Nursing Homes: Our report presenting practical lessons for complying with new Federal rules restricting the use of chemical and physical restraints in nursing homes is being used by States, localities, and nursing homes to formulate plans and identify discrete activities that will reduce the use of restraints.

Resident Abuse in Nursing Homes: Consistent with our report on the extent and reasons for abuse of elderly nursing home patients, HCFA drafted regulations establishing training requirements for nursing home aides and requiring nursing homes to establish processes for handling abuse complaints.

Hospitals and Physicians

Hospital Closures: Our findings that hospital closures were not widespread and Medicare reimbursement levels were not the primary factor in those closures obviated the need for legislative action to address a problem that did not exist.

Coding of Physician Services: Based on our recommendations, HCFA has developed new criteria for Medicare's resource-based payment system.

Hospital-Based Physicians: The HCFA issued, as a result of our recommendation, new instructions to its fiscal intermediaries to refer suspect cases to the OIG where hospitals require hospital-based physicians to pay more than fair market value for goods and services provided by the hospital, potentially violating the anti-kickback statute.

Medical Equipment and Supplies

Medicare Provider Numbers: As a result of our recommendations to institute better controls in issuing and maintaining the provider numbers which allow individuals and businesses to bill Medicare, HCFA developed a comprehensive action plan to ensure that Medicare providers billing the program are licensed, meet standards, and report accurate information on their businesses.

* ***Durable Medical Equipment (DME) Supplier Numbers:*** In response to our inspection, HCFA took early action to improve its program for assuring ethical suppliers of DME to Medicare beneficiaries; first, by instituting a policy to obtain a surety bond for each supplier; second, by visiting new suppliers in certain areas to assure legitimacy; third, by revising its application form to improve its ability to judge whether or not applicants for DME supplier numbers are legitimate; finally, by requesting legislative authority to charge an application fee for supplier numbers.

Durable Medical Equipment: Based on our recommendations, HCFA moved to require physicians to certify the need for durable medical equipment before paying for it under Medicare.

Carrier Shopping: Our findings, along with HCFA's own analysis of billing patterns, resulted in plans to require durable medical equipment suppliers to bill Medicare carriers on the basis of the beneficiary's place of residence, which prevents suppliers from "shopping" their claims to carriers with the most liberal payment policies.

* ***Nebulizer Drug Therapy:*** The HCFA responded to our recommendations to curtail questionable supplier practices by implementing stringent coverage and utilization policies.

* ***Oxygen Therapy Services:*** In response to our findings that oxygen suppliers' equipment and patient monitoring services varied greatly, Congress mandated that the Secretary develop service standards for home oxygen suppliers.

Oxygen Concentrator Reimbursement: As a result of our findings that the Veterans Administration paid far less for oxygen concentrators than the Medicare program, HFCA has drafted a legislative proposal to implement competitive bidding to procure oxygen for Medicare beneficiaries.

Medicare Home Infusion: Based on our recommendations, the DME regional carriers are tracking spending and HCFA revised the coverage issues to provide more specific instructions of implanted infusion pumps.

Medicare Beneficiary Issues

* ***Medicare Beneficiary Complaints:*** In accord with our recommendations, HCFA is modifying the Medicare Peer Review Organization (PRO) regulations to make it easier for beneficiaries to report quality-of-care concerns and for the PROs to respond substantively to them.

* ***Medicare Beneficiary Satisfaction Surveys:*** The HCFA concurred with our recommendation that it develop a plan for better educating beneficiaries on various program areas. The areas included telephone service, second surgical opinions, physician fees, appeal rights, flu immunization, and mammograms. Based partly on our report, HCFA focused its new contractor performance evaluations on these and other program areas.

* ***Beneficiary Awareness of HCFA Publications:*** After an OEI report, HCFA initiated more aggressive efforts to assure that beneficiaries are aware of its publications, posting its publications on the Internet, and initiating an educational campaign for senior citizens and other advocacy groups on its Medicare publications.

* ***Medicare Beneficiary Interest in Health Maintenance Organizations (HMOs):*** Based partly on our report, HCFA expanded service options to allow HMOs to provide point-of-service care, allowing beneficiaries to obtain health care outside of HMO networks.

* *HMO Customer Satisfaction Surveys:* The HCFA's decision to conduct its own Medicare HMO beneficiary satisfaction surveys was largely influenced by our findings that industry satisfaction surveys did not target Medicare enrollees, and that these surveys lacked uniformity and had several technical weaknesses. OEI's reports enforced the idea that HCFA should be performing their own beneficiary surveys and provided the tool to do so. This work opened the area for additional OEI involvement in related policy issues, including appeals and grievances and using disenrollee information to gauge performance.

  Medicare Risk HMOs: Based on our recommendations, HCFA has formed an Outreach Steering Committee to improve effectiveness of beneficiary communication, and has taken steps to collect data to assess beneficiary access to managed care services.

Financial Arrangements

Financial Arrangements between Physicians and Health Care Businesses: As enacted by Congress, Medicare will not pay for services provided by laboratories who have financial relationships with the physicians ordering the tests, based on our finding that Medicare patients of physicians with such relationships used 45 percent more services than Medicare patients in general.

Tracking of Physician Referrals: Based on our recommendations, HCFA now requires that businesses billing Medicare provide information on their physician owners and investors, and that claims forms submitted by those businesses contain the name and identifying number of the referring physician so that HCFA can easily identify inappropriate physician referrals.

Laboratories

* *CLIA's Impact on the Availability of Laboratory Services:* The HCFA used the information in our report to argue against repealing sections of the Clinical Laboratory Improvement Amendments (CLIA) that imposed regulations on physician office laboratories based on the complexity of testing, after we found that CLIA has had little effect on a patient's ability to obtain laboratory services, even in rural areas.

  Clinical Laboratory Improvement Amendments: Following a series of congressional hearings and the release of our report, a new law regulating laboratory testing was enacted which requires laboratories and laboratory personnel to meet requirements based on the kinds and complexity of tests they perform, not where they are located.

Patient Dumping and Transfers

* *Medicare Hospital Discharge Planning:* The 1997 Balanced Budget Act addressed our concern that hospitals are shifting costs from a prospective payment system to a cost-based system, thus maximizing Medicare reimbursement. The new law requires that

Medicare beneficiaries with certain diagnoses who are discharged to post-hospital services be considered "transfers" which limits payments to hospitals for these cases.

* The Balanced Budget Act also addressed our concern that hospitals disclose ownership information and that Medicare beneficiaries are informed of their freedom to choose the home health agency or nursing home to which they will be referred, as we recommended.

Reporting Patient Dumping: As a result of our recommendations, new requirements were placed on hospitals to report suspected cases of patient dumping (i.e., hospitals refusing to treat indigent patients) to appropriate officials.

Patient Dumping: As a result of our work, new procedures for coordinating investigations of patient dumping among HCFA, the Office for Civil Rights, and the OIG were implemented.

Medical Procedures and Patient Services

* ***Patient Self Determination:*** Based on our recommendations, HCFA issued a program guidance memorandum to assist States with implementation of this important new law. Recently, Congress mandated our recommendation that each patient's advance directive be placed accessibly in his medical record to assure that treatment provided conforms to patient wishes.

Cataract Surgery: As a result of a series of studies showing that Medicare paid too much for cataract surgery, HCFA initiated a demonstration project to identify more cost effective ways of paying for and providing this important service.

Coronary Artery Bypass Graft Surgery (CABG): Our inspection, demonstrating that costs could be reduced for CABG surgery while maintaining quality, sparked a HCFA demonstration to explore alternatives for providing and paying for this surgery.

Equity in Organ Transplantation: After our findings demonstrating inequity in the allocation of organs for transplantation, PHS and HCFA changed their rules regarding access to organs by foreign nationals and created a national waiting list to ensure that everyone waiting for a kidney transplant would have access to all kidneys for which they are compatible.

Ultrasound Payments: As a result of our recommendations, changes were made to revise the codes for ultrasound procedures to preclude high payments for inexpensive or non-reimbursable procedures.

* ***Drug Utilization Review:*** In response to our recommendation, HCFA is amending the Drug Utilization Review (DUR) Annual Report instructions to collect more specific information regarding the State efforts to monitor the implementation of the Federal DUR patient counseling requirement.

Outpatient Services: Based on our findings that surgery was being performed in outpatient facilities not subject to any kind of licensure, certification, or accreditation, many States are now actively reconsidering their approaches to regulation of these facilities.

Mammography Facility Inspections: Based on our recommendations, HCFA issued regulations to conform conditions for coverage to the applicable FDA certification requirements that must be met by all Medicare suppliers of services.

Prenatal Care for Low Income Women: The HCFA is increasing the access of low income women to Medicaid prenatal care, as we suggested, by simplifying and streamlining the application process and developing incentives increasing the participation of health providers.

Medicaid Issues

* ***Controlling Medicaid Non-Emergency Transportation Costs:*** Our report highlighted effective practices used by selected States to control fraud and abuse of Medicaid reimbursements for non-emergency transportation cost. HCFA now routinely uses our report to illustrate to States how non-emergency transportation can be controlled.

Controlling Emergency Room Use: Based on our recommendations, HCFA is encouraging States to develop comprehensive initiatives to reduce expensive non-urgent use of emergency rooms by Medicaid recipients.

* ***Children's Dental Services Under Medicaid:*** This inspection is a seminal work in describing the problems poor children have in receiving adequate dental care. Its popularity as a resource is widespread among such groups as the American Academy of Pediatric Dentistry, and the Association of State and Territorial Dental Directors. Our inspection has sparked considerable discussion and action at state and local levels and has been highlighted at national meetings of health practitioners (such as dentists, State Medicaid staff, dental public health officials) at local, state and national meetings such as the American Dental Public Health Association national meeting.

Within HHS, PHS sponsored a national Oral Health Meeting that brought together private and public researchers to discuss the issues in our inspection. Furthermore, HCFA has pursued several initiatives as a result of our study, including (1) the Medicaid Bureau has joined the Department's Oral Health Coordinating Committee to seel solutions to the problems associated with oral health for vulnerable populations and (1) HCFA will co-sponsor (along with HRSA) a national conference on access to dental services for children to seek solutions to the obstacles that prevent children from receiving proper dental care.

Early Periodic Screening, Diagnostic, and Treatment Services: Based on our recommendations, HCFA is modifying the methods it uses to measure whether States are providing these important services to eligible children as required by law.

Medicaid Estate Recoveries: Our report, which identified millions in lost dollars to Medicaid as a result of inadequate efforts to recover assets from Medicaid beneficiaries, caused HCFA to cite estate recoveries in national and regional meetings and in their 1990 best practices guide as an important avenue for recovering additional Medicaid dollars.

* ***Retooling of State Medicaid Agencies:*** The HCFA is using our review of the organizational challenges associated with expanded managed care to help State agencies prepare for these challenges and to review and revise its own monitoring protocols.

Medicaid and Homeless Individuals: As a result of our report, HCFA and SSA are working together to develop a joint strategy to increase Medicaid availability for homeless individuals.

Medicaid Credit Balances: As a result of our findings that significant credit balances in hospitals were not being recovered by the Medicaid program, HCFA developed a guide to assist regional offices in recovering credit balances and clarified policy and procedures to focus on recovery of credit balances.

Pharmacy Closures: Our findings that Medicaid drug reimbursement policies were not putting providers out of business in Georgia, as alleged, precluded unneeded Federal action.

Medicaid Claims Systems

Point of Service Claims Management: As a result of our recommendations, HCFA has agreed to assist State Medicaid agencies that are considering implementation of cost-saving point of service technology to electronically transmit eligibility verification, claims submission, claims adjudication, and utilization review by collecting and distributing to States systems information.

Computerized Submission of Claims: Our work on point of service claims management also encouraged HCFA to promote the development of standard electronic claims formats and their use by State Medicaid agencies.

Electronic Funds Transfer: As a result of our recommendations, HCFA will monitor the implementation of EFT systems to electronically pay State Medicaid claims and distribute information on these efforts to each Medicaid agency.

Health Care Fraud Prevention

* ***Carrier Fraud Units:*** Nearly all of the carriers requested a copy of our report and nearly all of the carriers have re-evaluated the way they handle fraud allegations. As a result, the OIG Office of Investigations is being contacted earlier in the carrier process and decisions on how cases will be pursued (criminal, civil, or administratively) are being made early, resulting in better cases being referred to law enforcement.

* ***Monitoring of Corporate Integrity Plans:*** An in-depth evaluation on corporate integrity plans (CIPs) provided timely data on content provisions of CIPs, important factors for compliance, and aspects of oversight. The information was important for OIG application and for reference as self compliance plans may be instituted by program providers.

Hotline Referral Follow Up: As a result of our inspection work, HCFA developed uniform guidelines for regional office handling of hotline cases and required regional offices to provide status reports for hotline cases within 45 days of receipt.

Medicaid Fraud Referrals: As a result of our work pointing to inadequate fraud referrals from Medicaid agencies to Medicaid Fraud Control Units, HCFA developed comprehensive chapters in a Medicaid Best Practices guide detailing the types of working relationships and case referrals Medicaid agencies should be making, and sent letters to the State Medicaid directors emphasizing the need for case development.

Public Health Service

Public Health Care

* ***National Marrow Donor Registry:*** Based in significant part on our recommendations, HRSA's new contract to operate the registry requires that donor centers and recruitment groups meet performance indicators in recruiting and retaining donors from racial and ethnic minority groups. It is also phasing out inefficient cost reimbursement contracts and tying payment to donor center performance.

* ***Physician Participation in the Vaccine for Children Program:*** Based partly on our report, the Centers for Disease Control (CDC) revised physician reporting requirements and eliminated burdensome paperwork. CDC initiated these program changes to improve physician participation in making public vaccines available to people in outlying, rural areas.

Immunizations: Based on our recommendations, PHS is improving how National Vaccine Injury Compensation Program cases are processed by improving their contact with petitioners and their attorneys and making procedural changes to reflect current scientific knowledge.

Infant Mortality: The PHS targeted funds to geographic areas with the highest infant mortality rates in response to our recommendation that PHS allocate funds so that areas with the greatest need receive adequate funding.

Public Cholesterol Screening: Based on our congressionally requested report showing that cholesterol screening in shopping malls and other public places are compromised by poor quality assurance, inadequate on-site counseling, and the lack of appropriate physician referral, HCFA regulated the conduct of these screenings under the Clinical Laboratories Improvement Act.

* ***Rural Health Clinics:*** Our study in conjunction with one conducted by GAO and numerous congressional hearings resulted in significant changes to the rural health clinic program regarding the method of reimbursement and the frequency of recertification. The HCFA and HRSA have tightened the certification requirements for both Federally designated and Governor-designated rural areas.

Free Health Care Obligations: Based on our findings, PHS is improving hospitals' and other health care facilities' compliance with their free health care obligations for indigent patients under the Hill-Burton program.

School-Based Health Centers: Based on coordination problems profiled in our report, the HHS/Department of Education Interagency Committee on School Health developed a subcommittee to address issues and encourage coordination between school-based health centers and managed care organizations.

* ***IHS Section 638 Contracting***: Based on our recommendation to increase tribal awareness and foster self-determination by improving communication to tribes and increasing contracting opportunities, the Indian Health Service (IHS) began using the Internet. The IHS developed a home page to share information concerning health care in general, legislative activities, agency operations, and contracting requirements and processes. This new medium has proven to be useful and effective in disseminating information to tribes.

Community Health Representatives: Our study of this program prompted IHS to initiate, in cooperation with the Tribes, a complete re-examination of the program's direction.

The Ryan White CARE Act: Congressional staff used our reports and briefings (covering such topics as funding formulas, implementation issues, and case studies) in their activities relating to the Ryan White Comprehensive AIDS Resources Emergency Act.

National Practitioner Data Bank

- ***Hospital Reporting to the National Practitioner Data Bank:*** Our finding that 75 percent of hospitals never reported an adverse action to the Data Bank in the first 3 and

1/3 years of its operation led HRSA to convene a national symposium to determine how to improve reporting and to support further inquiry in the factors influencing hospital reporting to the Data Bank.

National Practitioner Data Bank: The PHS implemented our recommendation to report their turn-around time in responding to Data Bank inquiries in order to improve service in responding to queries. The PHS also used the reports in long-term planning for the Data Bank and for their report to Congress asking for changes in the Data Bank statute.

National Practitioner Data Bank Access: We helped PHS ensure, through revised procedures, that only entities authorized by law can obtain information from the national practitioner data bank, thus guarding the data bank from unauthorized access to its data.

Drugs and Medical Devices

* *Postmarketing Drug Studies:* Based on our recommendations, the Food and Drug Administration (FDA) now has procedures for tracking and reviewing drug studies promised by drug companies and conducted after receiving FDA marketing approval. Postmarketing studies provide important information on new uses and dosing for special populations, including the elderly.

Drug Promotion: The FDA used our findings on inappropriate prescription drug promotional activities to clarify appropriate interactions between pharmaceutical companies and physicians.

* *FDA Urgent Notice:* In response to our report, which they requested, the FDA agreed to conduct a prompt review of their postmarket safety notification program, including an in-depth look at a reformatting of existing alerts and notices, and new technology such as electronic communications.

Reducing Mismedication Among the Elderly: As a result of our reports highlighting the problems of mismedication among the elderly, PHS is conducting a feasibility study to quantify adverse drug related events associated with hospital admissions and is sponsoring a study on patient compliance with their drug regimens.

Listing of Prescription Drugs: The FDA used our review to improve the accuracy of its computerized inventory of all prescription drug products and manufacturers, known as the Drug Listing System, by clarifying the information the industry reports to the system and by improving internal control procedures.

Drug Approval Process: Our analysis of applying user fees in the FDA helped the Congress and the Administration enact user fees to pay for a faster new drug approval process.

Medical Devices: Congress acted on our recommendations in passing the Safe Medical Devices Act of 1990, providing the FDA the authority to initiate recalls, impose civil monetary penalties, and require manufacturers to report product recalls of ineffective or harmful devices.

Substance Abuse and Tobacco

Youth and Alcohol: The Surgeon General used our reports on the problem of youth access to alcohol to mount a nationwide information campaign to alert the public and gain support for stronger enforcement of State laws prohibiting minors from obtaining alcohol.

To help educate youth about the problems associated with alcohol use, the Department of Education distributed 50,000 copies of our reports to School District Superintendents, Regional Centers for Drug Free Schools, and State Education Coordinators.

* Our seminal work on the issues of youth and alcohol was still being cited as the baseline data in 1996 in such publications as *Join Together: A National Resource for Communities Fighting Substance Abuse.*

Youth Access to Tobacco: The Secretary used our reports showing how minors easily buy tobacco products, to develop a model State law preventing their purchase and launch his public information campaign against the problem.

Adolescent Steroid Use: Our report was instrumental in developing the Department's comprehensive research and educational strategy to combat steroid abuse by youth.

Alcohol, Drug Abuse, and Mental Health Services for Homeless Individuals: The PHS is providing a wide variety of technical assistance to State and other grantees serving homeless individuals, based on our reports identifying the special needs of this population.

Drug Abuse Waiting List: As a result of our review of the effectiveness of the drug treatment waiting list reduction program in eliminating long waits for drug treatment services, PHS has agreed to develop a uniform waiting list definition and a systematic way for States to maintain this list.

Indian Alcohol and Substance Abuse Programs: The Indian Health Service (IHS) used our reports as documentation to justify declaring the administration of the Indian alcoholism program a "material weakness," so that problems with the program could receive special attention within IHS.

Crack Babies: The HHS used our study on crack babies to develop departmental demonstration projects for mothers and infants affected by prenatal substance exposure.

Medical Licensure and Discipline

Medical Licensure and Discipline: The Congress used our reports on licensure and discipline of physicians in developing the Health Care Quality Improvement Act which established a national practitioner data bank comprised of all disciplinary actions taken against physicians and made this information available to hospitals and State medical boards to use in credentialing or taking adverse actions against a physician.

Medical Licensure and Discipline Self-Assessment: One of our reports led to PHS funding the Federation of State Medical Boards to develop a self-assessment instrument, an instrument now being used by more than half of the state medical boards.

Other PHS Issues

* *Clinical Practice Guidelines:* Our finding that only 20 percent of survey respondents in small, nonteaching hospitals, nursing homes, and health maintenance organizations had used AHCPR guidelines contributed to a refocusing of AHCPR efforts and a discontinuance of its own guideline development program.

Technology Transfer: In response to our review of its Technology Transfer program, the NIH developed new procedures to streamline the review and approval of Cooperative Research and Development Agreements, revised guidelines addressing fair access for industry partners, and resolved the controversy over the reasonable pricing clause which threatened to undermine support for the program.

NIH Consensus Statements: Based on our survey of continuing medical education directors, NIH expanded their dissemination of consensus statements to all continuing medical education directors, and it continues to explore new media formats to make the materials more useable for medical education.

Scientific Misconduct: In response to our recommendation that PHS develop a more formalized and centralized process to deal with cases of scientific misconduct, PHS changed the way it investigates and deals with these cases.

Health Education Assistance Loan Defaulters: The PHS referred physicians who defaulted on their medical school student loans to the Office of the Inspector General for exclusion from the Medicare and Medicaid programs, in response to our recommendation that they should refer loan defaulters when a settlement (including a settlement to offset the physician's Medicare payment) for repaying a loan cannot be reached with a physician.

Administration for Children and Families

Welfare Issues

Welfare Administrative Costs: Our report raised congressional and departmental awareness of different options for funding welfare administrative costs which would simplify and increase the predictability of Federal expenditures under the existing cost reimbursement system. Our work contributed to the final revision of OMB Circular A-87, "Cost Principles for State, Local and Indian Tribal Governments," which authorized experimentation with alternative reimbursement approaches for administrative costs along the lines of our report.

Oversight of State Child Welfare Programs: Our report provided ACF with a broad range of detailed recommendations for improving Federal monitoring and technical assistance efforts. The report gave ACF practical implementation options in their efforts to "re-invent" their relationship with State child welfare agencies.

Child Welfare and Native American Children: Our report provided the first comprehensive perspective on the extent to which tribes receive Federal child welfare funding and Social Services monies that "pass-through" State agencies, and it gave the Senate Committee on Indian Affairs with a focal point for a hearing on tribal access to Federal funding.

Functional Impairments of AFDC Clients: The ACF has incorporated case studies from our work on functional impairments of AFDC clients into its pilot project providing on-line computer access to its regional staff on national best practices in the JOBS program.

AFDC Fraud: Our report on fraud in the AFDC program resulted in legislation requiring additional front-end verification efforts of welfare applicants preventing fraudulent applicants from receiving benefits.

State Income and Eligibility Verification Systems: Our report has been used by an HHS interagency work group to help strengthen State and Federal computer matching activities.

Head Start

Head Start Expansion: The Secretary's Advisory Committee on Head Start Quality and Expansion used our timely reports on expansion in their deliberations on how to improve the quality of Head Start services.

* *Head Start Expansion: Grantee Experiences*: Partially as a result of our work, ACF revised the Head Start program standards and developed better ways to monitor and evaluate grantee work. ACF also modified the Migrant Head Start program to take into account the special needs of migrant families. The Educational Resources

Information Center (ERIC) included our inspections in their national database and their national publication entitled *Resources in Education*.

Dysfunctional Families in Head Start: Our report on Head Start's capacity to provide assistance to dysfunctional families helped ACF place these multiple problem families into social service centers specifically created to deal with their needs.

Enrollment of Children from Dysfunctional Families: Based on our recommendations, ACF revised its regulations providing greater flexibility for Head Start enrollment of dysfunctional families.

Child Support and Foster Care

* ***Implementation of State Child Support Certified Data Systems:*** OEI's work raised awareness of Congress and the Department about the problems of, and opportunities for, States in developing and implementing child support certified data systems, as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. The ACF has used our report to educate States on successful techniques in implementing data systems, and made it available on their web site for further dissemination.

* ***Grantees & Providers Delinquent in Child Support:*** As a result of our report that identified HHS grantees and providers who owed some $21.5 million in back child support, the Department has established action plans for each agency to ensure that no individual receiving HHS funds is in arrears in their child support, pursuant to recent Executive Orders and the Debt Collection Act.

Child Support Arrearages: Legislation incorporated our recommendation for immediate wage withholding for child support orders into the Family Support Act.

Paternity Establishment: We helped improve paternity establishment practices for absent parents through extensive dissemination of our reports on effective paternity establishment practices to national, State, and local officials and associations.

* ***In-Hospital Voluntary Paternity Acknowledgment Programs:*** As a result of our study that found that child support agencies, hospitals, and vital records agencies are more effectively implementing legislation to improve paternity establishment, the Office of Child Support Enforcement is using our work to design technical assistance documents.

Absent Parent Medical Liability: As a result of our recommendation that absent parents with health insurance provide coverage for their children, the Office of Child Support Enforcement issued regulations allowing States to modify court orders to obtain this medical support instead of relying on publicly financed Medicaid.

Child Support and Foster Care: Based on our findings, ACF is working with States to increase referrals of foster care children to child support agencies to get financial support from their natural parents.

Foster Care: Based on our findings, we presented strategies to assist ACF in restructuring their application and reporting procedures, with special attention on information sharing for the Independent Living program for foster care youths.

Using Relatives for Foster Care: As a result of our study, ACF is examining in detail the issues involved in "kinship care" and bringing together national experts for developing policy on licensing standards and financial reimbursements in this area.

Administration on Aging

Implementation of the Older Americans Act: Our joint effort with AoA helped strengthen that organization's stewardship of the Older Americans Act by providing training, technical assistance, and helping AoA develop an action plan to address weaknesses in the system.

Dissemination of Project Results: In response to our finding that the Administration on Aging failed to disseminate the results of their demonstration projects, AoA established a new division to disseminate these results to field staff.

State Ombudsman Reporting System: Based on our recommendation that State ombudsman programs need to improve their reporting, AoA revised its State ombudsman reporting system to gather important management information.

Other

National Archives Inspection: Our inspection, conducted at the request of the President's Council on Integrity and Efficiency, identified serious problems at the National Archives Inspector General's Office, and resulted in major changes in that office's policies and practices.